# VAN NATTA'S
# WORKERS' COMPENSATION REPORTER

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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.

APRIL-JUNE 1997

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## CITE AS

49 Van Natta ____ (1997)

In the Matter of the Compensation of
**DAVID D. BRADSHAW, Claimant**
WCB Case No. 96-07058
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order which: (1) upheld the insurer's denial of his injury claim for a cervical condition; and (2) upheld the insurer's denial of his occupational disease/injury claim for left carpal tunnel syndrome and left cubital tunnel syndrome. On review, the issues are compensability of the cervical condition, the left carpal tunnel syndrome, and the left cubital tunnel syndrome.

We adopt and affirm the ALJ's order with the following supplementation regarding the compensability of claimant's cubital tunnel syndrome.

The ALJ found that claimant had failed to sustain his burden of proving that his left carpal tunnel and left cubital tunnel conditions are compensable. In reaching this conclusion, the ALJ determined that the medical opinion of the only physician to address causation, Dr. Bert, was unpersuasive because he was unaware of claimant's preexisting carpal tunnel symptoms and, thus, lacked a complete and accurate history.

On review, claimant contends that, even if we discount Dr. Bert's opinion with respect to the carpal tunnel condition, we should not do so with respect to the cubital tunnel condition because there were no preexisting cubital tunnel symptoms. Claimant asserts that Dr. Bert's opinion that his repetitive work was the major cause of the cubital tunnel condition should satisfy his burden of proof. We disagree.

While the record does not establish the presence of prior cubital tunnel symptoms, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In this case, Dr. Bert provided no explanation of his opinion that claimant's employment was the major cause of his cubital tunnel condition. (Ex. 33). Because Dr. Bert's opinion is conclusory and unexplained, we do not find it persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). It, therefore, follows that the ALJ properly upheld the insurer's denial of the cubital tunnel condition.

ORDER

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

In the Matter of the Compensation of
**DION T. BROWN, Claimant**
WCB Case No. 96-03255
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the insurer's denial of claimant's injury claim for a headache condition. In his appellant's brief, claimant argues that the ALJ erred in admitting evidence not previously provided to claimant. On review, the issues are evidence (discovery) and compensability.

We adopt and affirm the ALJ's order, with the following supplementation. We need not address the evidence issue because, even without considering the disputed evidence (an investigator's interview with claimant), we would continue to find Dr. Ellison's opinion insufficient to carry claimant's burden.

ORDER

The ALJ's order dated October 10, 1996 is affirmed.

**Board Chair Hall specially concurring.**

I write separately to explain why Exhibit 9A, a January 19, 1996 transcribed statement by claimant to the insurer's investigator, should have been disclosed to claimant before hearing.

ORS 656.283(7) provides that "impeachment" evidence may be withheld from pre-hearing discovery. It must be understood, however, that only impeachment evidence may be withheld; all other evidence is discoverable. Thus, here, assuming a portion of the statement qualified as impeachment evidence, the statute would permit the carrier to exclude that portion from "pre-hearing" discovery. However, the carrier would still have a duty to timely disclose all other ("non-impeachment") portions of the statement. In other words, the carrier could redact the impeachment portion of the evidence, but must disclose the rest. Such a process is in keeping with both the statute and the rule since, again, it is only impeachment evidence that may be withheld.

Moreover, in this case, I would find that nothing in Exhibit 9A constitutes impeachment evidence. The disputed portion of the statement, which appears after claimant's discussion of his July 1995 motor vehicle accident, is as follows:

> "Q. Okay. Have you contacted the insurer to find, to let them know that you've -- have you had continued headaches since the auto accident?
>
> "A. Yeah, I have. Every -- it seems like every week out of -- I'd say three times out of a day. Either it's me just sitting around watching TV --
>
> "Q. Uh-huh.
>
> "A. You know, in a certain type of lighting and it's hurting or, you know, just doing natural, you know, everyday things.
>
> "Q. Okay.
>
> "A. It hasn't been severe, severe lately, but after the accident, yes, it did." (Ex. 9A18-19).

One cannot tell, from this interchange (or its context), whether claimant responded "Yeah" to indicate that he had contacted the carrier or to indicate that he had continuous headaches since the MVA. In fact, considering the present tense used in subsequent responses, it is most likely that claimant was comparing and describing the severe headaches he had after the MVA and his recent headaches, without ever stating that he had ongoing headaches ever since the MVA. Under these circumstances, I would conclude that this portion of the interview is too confusing to be useful for any purpose. It certainly does not rise to the level of impeachment evidence in any event.

Finally, contrary to the carrier's assertion, claimant did tell Dr. Ellison about his 1995 motor vehicle accident and subsequent period of headaches, followed by a period without headaches (before the January 1996 work injury), and the onset of headaches again thereafter. (Ex. 13A). Thus, claimant's history to Dr. Ellison is consistent with his statement to the investigator.[1] On this basis as well, the statement does not serve as impeachment evidence.

The lack of any impeachment value in claimant's statement to the investigator was ascertainable by the carrier at (and during) the time it had a duty to provide claimant's counsel with discoverable material. Considering the ambiguity of the disputed evidence and the fact that it is most reasonably read as consistent (rather than inconsistent) with claimant's history to his doctor, I would find that the insurer had no reason to treat any part of the interview as impeachment evidence. At a minimum, if there was an "impeachment" portion, the carrier should have redacted that portion and released the balance of claimant's statement. Under these circumstances, I would hold that the carrier's failure to timely disclose Exhibit 9A was unreasonable and contrary to law.

However, because I agree that the claim is not compensable, I submit this special concurrence.

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[1] The ambiguity in this statement undermines the contention or finding that Dr. Ellison's opinion was based on an "inaccurate" history.

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In the Matter of the Compensation of
**DAVID L. GRENBEMER, Claimant**
Own Motion No. 94-0544M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Saif Legal Department, Defense Attorney

By letter dated February 27, 1996, claimant, pro se, requested reconsideration of our January 31, 1996 Own Motion Order Reviewing Carrier Closure, in which we affirmed the SAIF Corporation's October 18, 1995 Notice of Closure. The October 18, 1995 Notice of Closure awarded claimant temporary disability compensation from August 18, 1994 through November 10, 1994, and declared claimant medically stationary as of August 22, 1995. In addition, our January 31, 1996 order held that: (1) claimant's request for lifetime membership in an exercise/physical therapy facility was a medical services issue that was not within the Board's own motion jurisdiction; (2) the Board was without authority to grant claimant's request for an additional permanent disability award; and (3) the $934.80[1] offset claimed by SAIF remained. In his initial request for reconsideration, claimant contested only our decisions regarding the offset issue and the temporary disability award.[2] Specifically, claimant contended that: (1) he is entitled to temporary disability compensation from October 24, 1994 through April 30, 1995;[3] and (2) because he is entitled to the $1,308.72 payment for temporary disability from October 24, 1994 through November 10, 1994, that payment did not represent an overpayment for which SAIF is entitled to an offset.

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[1] Subsequently, during the time this matter was abated awaiting the parties' positions, SAIF conducted an audit of claimant's claim. Based on that audit, SAIF alleges an overpayment of $1,308.72. (SAIF letters dated October 17, 1996, and November 18, 1996). To avoid confusion, we will hereafter refer to $1,308.72 as the amount of SAIF's requested offset.

[2] At times, claimant's ensuing correspondence while the matter remained abated appeared to agree that his claim was medically stationary at claim closure and, at other times, the correspondence appeared to disagree with his medically stationary status at claim closure. Under these circumstances, we find that claimant has raised the issue of premature closure on reconsideration in addition to the issues of temporary disability and offset.

[3] Although not entirely consistent, in some of claimant's subsequent correspondence he argued that he is entitled to temporary disability from October 24, 1994 through August 22, 1995, the date he became medically stationary. Pursuant to this subsequent correspondence, we find that claimant contends on reconsideration that he is entitled to temporary disability from October 24, 1994 through August 22, 1995.

On February 29, 1996, we abated our order to allow time for SAIF to respond to claimant's contentions. Over the following year, a great deal of correspondence has been generated in an attempt to develop a record sufficient for review. Unfortunately, much of this correspondence was duplicative and nonresponsive. Following is a summary of the most relevant correspondence.

SAIF's initial response was received March 6, 1996, wherein SAIF stated that it had no medical documentation in its file to indicate claimant's medically stationary date was different from August 22, 1995, the date claimant was found medically stationary. By letter to SAIF's claims examiner dated March 12, 1996, claimant repeated his request for time loss benefits through April 30, 1995, arguing that his time loss should not have ended as of October 28, 1994, when he was not medically stationary until August 22, 1995.

By letter dated May 6, 1996, the Board's Own Motion Coordinator requested the parties' positions regarding the following issues: (1) whether the parties agreed that claimant is entitled to temporary total disability from August 18, 1994, the date claimant underwent compensable knee surgery, to October 24, 1994, the date claimant apparently returned to part-time light duty work with the employer; (2) whether claimant is entitled to temporary partial disability from October 24, 1994, the date claimant apparently returned to part-time light duty work with the employer, through April 30, 1995, the date claimant apparently returned to regular work; and (3) in light of the temporary partial disability issue, the parties' positions regarding the overpayment claimed by SAIF.

As a result of this request, SAIF notified claimant and the Board that it would be conducting an audit regarding potential additional temporary disability. (SAIF's letter dated May 16, 1996). In response, claimant requested additional time within which to respond to the Board's request for information, suggesting that SAIF's pending audit might resolve the conflict to his satisfaction. Considering the pending audit and claimant's request, we allowed an extension of time for the parties to submit their positions.

By letter dated October 17, 1996, SAIF notified claimant of the results of its audit and enclosed a copy of the audit. SAIF noted that "[f]or the period 10-24-94 through 11-10-94, time-loss was paid after [claimant] returned to part time work and [claimant's] earnings were not pro-rated." According to SAIF, this resulted in an overpayment of $1,308.72.

By letter dated October 21, 1996, claimant responded to SAIF's October 17, 1996 audit report, stating that he was on light duty after October 28, 1994, and did not become medically stationary until August 22, 1995. Claimant repeated his request for time loss through April 30, 1995.

By letter dated November 15, 1996, the Board's Own Motion Coordinator reminded the parties that they had not responded to the specific requests for information made in its May 6, 1996 letter.

By letter dated November 18, 1996, SAIF responded to the Board's request for information. SAIF responded, in part, that: (1) it agreed that claimant was "entitled to temporary total disability from August 18, 1994 to October 24, 1994 in the amount of $4,393.56;" (2) claimant's "earnings during the period of October 24, 1994 to May 1, 1995 preclude TPD [temporary partial disability];" and (3) "SAIF Corporation actually paid [claimant] $5,702.28[,] leaving an overpayment of $1,308.72." Due to claimant's health problems unrelated to the compensable left knee condition, we allowed him additional time within which to state his position. By letter dated March 4, 1997, we received claimant's response to SAIF's contentions, including his assertion that he is entitled to temporary disability from October 24, 1994 through August 22, 1995. Having received the parties' positions, we proceed with our reconsideration.

Premature Closure

For the reasons explained in our January 31, 1996 order, we continue to find that claimant's compensable left knee condition was medically stationary when his claim was closed on October 18, 1995. As noted in our prior order, we make this finding based on the unrebutted opinion of Dr. Chamberlain, claimant's attending physician. Therefore, claimant has failed to prove his condition was not medically stationary at claim closure.

Temporary Disability

The parties do not dispute that claimant is entitled to temporary total disability from August 18, 1994, the date claimant underwent his compensable knee surgery, to October 24, 1994, the date claimant

returned to modified work. (SAIF's November 18, 1996 letter to the Board). SAIF paid claimant $4,393.56 in temporary total disability compensation for this period. Id. Claimant does not contend that this payment was incorrectly calculated. Instead, the dispute centers on whether claimant has established entitlement to temporary disability benefits after October 24, 1994. Claimant contends that he is entitled to temporary total disability compensation from October 24, 1994 through August 22, 1995, the date he became medically stationary. Based on the following, we find that claimant has established entitlement to temporary partial disability from October 24, 1994 to April 13, 1995.

Claimant has the burden of proving by a preponderance of the evidence that he was entitled to temporary disability for the period in question. See ORS 656.266. A claimant's substantive entitlement to temporary disability benefits 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. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Although medical verification of an inability to work is not necessary to be entitled to substantive temporary disability, such evidence may provide proof of disability. SAIF v. Taylor, 126 Or App 658 (1994).

Furthermore, the temporary disability need not be total. Claimant may be entitled to temporary partial disability benefits when the disability becomes only partial. ORS 656.212. Thus, where the disability is partial, claimant is entitled, at least theoretically, to temporary partial disability benefits during the period he is partially disabled. ORS 656.212; David L. Gooding, 47 Van Natta 1468 (1995); Ricardo Morales, 47 Van Natta 1394 (1995). However, ORS 656.212(2) provides that temporary partial disability is calculated based on a comparison of claimant's wages at modified employment and his at-injury wages. Lonnie L. Dysinger, 47 Van Natta 2282 (1995). Therefore, if claimant's wages at modified work were the same as, or greater than, his wages at the time of injury, the calculation of claimant's temporary partial disability would equal zero.

Claimant's regular job is as a field investigator for the Department of Human Resources. Dr. Chamberlain released claimant to part-time, light duty ("desk") work on October 18, 1994. (October 18, 1994 release to work; claimant's February 27, 1996 letter to the Board). Pursuant to this release, claimant returned to part-time "desk" work on October 24, 1994. On January 13, 1995, Dr. Chamberlain released claimant to modified work for three months, or until April 13, 1995. (January 13, 1995 release to work; claimant's February 27, 1996 letter to the Board). In this modified work release, Dr. Chamberlain indicated that claimant could work eight hours per day, with breaks every two hours, and with limitations on lifting/carrying over 25 pounds, bending, twisting, climbing stairs, standing, walking, squatting, and kneeling. (January 13, 1995 release to work).

Both the release to part-time work and the release to working eight hours per day with restrictions constitute releases to modified work. See Gary D. Smith, 45 Van Natta 298 (1993) (a restriction on a worker's ability to perform his regular work is not a release to return to regular work). Thus, based on the medical evidence, we find that claimant was partially disabled from October 24, 1994[4] to April 13, 1995, before being declared medically stationary August 22, 1995 for his left knee condition. Therefore, claimant is entitled to temporary partial disability from October 24, 1994 to April 13, 1995. ORS 656.212; David L. Gooding, 47 Van Natta at 1469; Ricardo Morales, 47 Van Natta at 1394; Alejandro R. Trevino, 48 Van Natta 399 (1996).

However, we note that claimant's temporary partial disability rate may be zero once his temporary partial disability is calculated under ORS 656.212(2).[5] Lonnie L. Dysinger, 47 Van Natta at

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[4] Although claimant was released to part-time, light duty work on October 18, 1994, SAIF concedes that claimant is entitled to temporary total disability from August 18, 1994 to October 24, 1994. (SAIF's November 18, 1996 letter to the Board). Therefore, we find that claimant's entitlement to temporary partial disability begins on October 24, 1994.

[5] Claimant was injured on July 24, 1979, at which time his wages were $1,506.00 per month. In 1994, claimant's wages were $3,008.00 per month. Since temporary partial disability is based on claimant's at-injury wage as compared to his current wage at modified work, once claimant returned to eight hours per day of modified work at his current wage, the rate of temporary disability compensation would be zero. ORS 656.212(2); Lonnie L. Dysinger, 47 Van Natta at 2283. However, that is not necessarily the case during the time claimant was released to and performing only part-time, modified work. Furthermore, for the

2283. We further note that the record before us is not adequate for us to determine the dollar amount of the temporary partial compensation due claimant. In this regard, there is no evidence in the record indicating the number of hours claimant worked on a daily basis during the period in question. This information is necessary because claimant was released to part-time work only to January 13, 1995; thereafter, he was released to full-time, modified work. Since the "Attendance Reporting System" reports in the record only indicate a monthly total number of hours worked, there is no way to determine when during the month of January 1995 claimant worked the hours reported for that month. Thus, we are currently unable to determine the temporary partial disability due during claimant's part-time work in January 1995.

In addition, as provided in the "Attendance Reporting System" reports, the monthly total hours worked, when added to the vacation, sick, and holiday hours taken, total more than the total number of hours available in each month. No explanation is provided for this discrepancy. Finally, we note that SAIF performed an audit of claimant's temporary disability benefits. This audit included a "Pro-rates" section which apparently attempts to calculate on a monthly basis claimant's wages for the hours he worked from October 24, 1994 to May 1, 1995. However, few of the monthly hours worked used in this section match the hours worked reported on the "Attendance Reporting System" reports. There is no explanation for this discrepancy and no way to determine which reported set of hours worked is correct.[6]

Thus, on the present record, although we find claimant entitled to temporary partial disability from October 24, 1994 to April 13, 1995, we are unable to calculate the dollar amount, if any, of the temporary partial compensation due.

Offset

SAIF contends that it is entitled to an offset of $1,308.72 for an alleged overpayment of temporary disability for the period from October 24, 1994 through November 10, 1994. (October 17, 1996 letter from SAIF to claimant). It is the carrier's burden to prove its entitlement to an offset. Eldon E. Hunt, 42 Van Natta 2751, 2753, (1990); Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988).

By letter dated November 18, 1996, SAIF contends that claimant's "[e]arnings during the period of October 24, 1994 to May 1, 1995 preclude TPD [temporary partial disability]." However, as addressed above, the record is currently inadequate for us to determine the dollar amount, if any, of the temporary partial disability due claimant for the period from October 24, 1994 to April 13, 1995. It follows that, because we cannot determine the amount due, if any, we cannot determine whether SAIF has made an overpayment and carried its burden of proving entitlement to an offset.

Thus, on the current record, we are unable to determine the dollar amount, if any, due for the period of temporary partial disability to which claimant is entitled and the dollar amount, if any, of the offset which might be due SAIF. Furthermore, this impasse remains after more than a year of unsuccessful attempts at developing a record sufficient for review regarding these matters. Under these circumstances, we conclude that the most expedient manner in which to resolve these matters is to refer them to the Hearings Division for an evidentiary hearing. OAR 438-012-0040; 438-012-0060.

At the hearing, the assigned Administrative Law Judge (ALJ) shall take evidence regarding the dollar amount due, if any, for the temporary partial disability for the period from October 24, 1994 to April 13, 1995, and the dollar amount of any offset due SAIF. This hearing may be conducted in any manner that the ALJ determines will achieve substantial justice. Following the hearing, the ALJ shall issue a recommendation to the Board within 30 days. In that recommendation, the ALJ shall make findings of fact on the questions of the dollar amount due for the above period of temporary partial

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[6] We note that SAIF sent a letter dated May 16, 1996 to claimant's employer requesting claimant's time sheets and rates of pay for the period from October 24, 1994 to April 30, 1995. However, if SAIF received the necessary information to properly calculate claimant's temporary partial disability, it did not provide copies of this information to the Board. In this regard, SAIF's October 17, 1996 audit of claimant's claim does not include copies of claimant's time sheets. In addition, as noted above, the

disability and SAIF's entitlement to an offset for any overpaid temporary disability. Based on those findings of fact, the ALJ shall recommend to the Board whether it should modify SAIF's October 18, 1995 Notice of Closure. Following the hearing and our receipt of the ALJ's recommendation, we shall implement a briefing schedule, and, upon its completion, proceed with our review and, eventually, issue a final, appealable order.

Finally, since further Board action will be required before resolution of this case, we emphasize that our action today constitutes an interim order. Portions of today's findings and conclusions will be incorporated into our eventual final, appealable order.

IT IS SO ORDERED.

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April 1, 1997 Cite as 49 Van Natta 453 (1997)

In the Matter of the Compensation of
**KENNETH P. SKEEN, Claimant**
Own Motion No. 97-0073M
OWN MOTION ORDER DENYING RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On March 24, 1997, the Board received claimant's attorney's March 19, 1997 letter in which he requested that we amend our February 12, 1997 Own Motion Order.[1] Specifically, claimant's attorney requests that we award him an attorney fee. In support of this request, he submits a copy of a retainer agreement signed by claimant and dated June 4, 1987. We treat these documents as a request for reconsideration and deny the request as untimely.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. OAR 438-012-0065(3) provides that, notwithstanding OAR 438-012-0065(2), in extraordinary circumstances, the Board may, on its own motion, reconsider any prior Board order.

Here, claimant's attorney's request for reconsideration was received on March 24, 1997, more than 30 days, but within 60 days, after the February 12, 1997 mailing date of the order. Thus, if claimant's attorney establishes good cause for his failure to file the request within 30 days after the mailing date of the order, we may consider the request for reconsideration. However, claimant's attorney presents no explanation for his failure to file the request for reconsideration within 30 days after the mailing date of the order. Therefore, we find no good cause or extraordinary circumstances that would justify claimant's attorney's failure to timely request reconsideration.

Accordingly, claimant's attorney's request for reconsideration is denied. The issuance of this order neither stays our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986): Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

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[1] Our February 12, 1997 order authorized the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for proposed surgery relating to his L4-5 condition. We made no award of attorney fees in our order. We note that we may award out-of-compensation attorney fees for an attorney representing a claimant if the attorney is instrumental in obtaining increased disability compensation and an executed attorney retainer agreement has been filed with the Board. See OAR 438-015-0010(4); 438-015-0080. At the time we issued our order, the record contained no executed attorney retainer agreement and no evidence of any work done by claimant's attorney regarding this claim.

In the Matter of the Compensation of
**DAVID F. STEVENSON, Claimant**
WCB Case Nos. 96-03179, 95-12094 & 96-00689
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Lundeen, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of claimant's aggravation claim for a bilateral carpal tunnel syndrome (CTS) condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition. In addition, SAIF contends that the ALJ erred in refusing to order claimant's attorney to testify at hearing. On review, the issues are propriety of the ALJ's evidentiary ruling, compensability, and responsibility.

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

On review, SAIF "assigns as error the ALJ's refusal to order [claimant's attorney's] testimony and the ALJ's refusal to allow SAIF to make an offer of proof of what that testimony would have been." Appellant's Brief, page 4 n.1. We review the ALJ's evidentiary ruling for abuse of discretion. James D. Brusseau II, 43 Van Natta 541 (1991).

Considering the following factors, we do not find that the ALJ abused his discretion in refusing to require claimant's attorney to testify or refusing to permit a further offer of proof: (1) the late notice that SAIF's attorney gave claimant's attorney about the possibility of being called as a witness on SAIF's behalf; (2) the threat to claimant's attorney-client privilege; (3) the prejudice to claimant if his attorney had to withdraw as his legal counsel on the day of hearing; (4) the fact that the documentary evidence purportedly regarding the parties' intent was already admitted in evidence; and (5) the fact that the ALJ permitted SAIF to make an offer of proof short of requiring claimant's attorney to be sworn in and examined.

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

## ORDER

The ALJ's order dated June 17, 1996 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
**STEVE CARLSON, Claimant**
WCB Case No. C700470
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lawrence Baron, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Member Biehl and Moller.

On February 27, 1997, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed agreement provides:

> "The worker has not been able to return to the work force, following the industrial injury, on a regular and ongoing basis. The worker is not employable in his occupation as a carpenter and intends to utilize the funds from this settlement toward retraining. By stipulation of the parties, the Director's Proposed and Final order of October 24, 1996 in WCD File No B78-7254 is vacated." (Emphasis added).

We take official notice that the October 24, 1996 Director's order referred to by the CDA has been affirmed in a December 2, 1996 final order which has apparently not been appealed. The October 24, 1996 order found claimant ineligible for vocational assistance. We lack authority to "vacate" a Director's order. See ORS 656.283(2)(b), (c), (d) (Director's administrative review order is subject to review only by the Director, who conducts a contested case hearing which is subject to judicial review). However, because the CDA fully releases claimant's rights to vocational benefits, we interpret the language quoted above as merely confirming that claimant is not entitled to any past, present or future vocational assistance benefits.

As interpreted by this order, we find that the CDA 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.

In the Matter of the Compensation of
**RICHARD M. FRANKLIN, Claimant**
WCB Case Nos. 95-06472, 95-04840, 95-04388 & 95-00143
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney
Ronald Atwood & Associates, Defense Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order which: (1) upheld the compensability and responsibility denial of claimant's occupational disease claim for hearing loss issued by CNA insurance on behalf of its insured (Teledyne Wah Chang); (2) upheld the compensability and responsibility denial of the same condition issued by the self-insured employer (Willamette Industries); and (3) upheld the compensability and responsibility denial of the same condition issued by the SAIF Corporation on behalf of its insured (Springfield Forest Products). On review, the issues are compensability and, potentially, responsibility.

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

The ALJ determined that claimant had failed to sustain his burden of proving a compensable occupational disease claim for hearing loss because the claim had not resulted in disability or a need for medical treatment. See ORS 656.802(1)(a). Alternatively, the ALJ found that, even if the claim had resulted in disability or a need for treatment, claimant did not prove that his overall employment exposure was the major contributing cause of his alleged hearing loss.

On review, claimant contests the ALJ's finding that his claim did not result in disability or a need for medical treatment. In addition, claimant contends that the medical evidence from two examining physicians, Drs. Benton and Ediger, satisfies his burden of proving medical causation.

We need not address claimant's first contention because, even if we accepted his assertion that his claim resulted in disability or a need for medical treatment, the claim would fail for lack of medical causation. We reach this conclusion for the following reasons

In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of his hearing loss. ORS 656.802(2)(a). Because presbycusis (age-related hearing loss) is a factor in this claim, we find 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, 109 (1985). It is claimant's burden to prove that his alleged occupational disease is compensable. ORS 656.266.

First, we agree with the ALJ's reasons for finding Dr. Benton's medical opinion unpersuasive. With respect to Dr. Ediger, he initially concluded that claimant's work exposure caused "mild" noise-induced hearing loss. (Ex. 16-6). However, Dr. Ediger testified in his deposition that presbycusis was the major contributing cause of claimant's hearing loss. (Ex. 32A-64). Dr. Ediger also testified that, if another audiometric test confirmed the results of his January 1995 audiogram, he would opine that work was the major contributing cause of claimant's hearing loss. (Ex. 32A-68, 74). Citing Dr. Benton's November 30, 1995 audiogram, the results of which Dr. Benton stated "do compare quite closely with that performed in Dr. Ediger's office in January," claimant alleges that Dr. Ediger's testimony satisfies his burden of proof. (Ex. 35). We disagree.

While Dr. Benton stated that the November 1995 audiogram "compare[d] quite closely" with that performed by Dr. Ediger in January 1995, Dr. Benton also stated that the "major difference" was a 10-15 dB discrepancy at the 6000 Hz level. Id. Dr. Benton stated that this was "too much of a discrepancy to be explained by test/retest variability." Id.

Based on Dr. Benton's comments regarding the November 1995 audiogram, we find that there was a significant discrepancy in the Benton/Ediger audiograms. Moreover, the record does not indicate that Dr. Ediger ever evaluated Dr. Benton's audiogram or commented on the significance of the 10-15 Db discrepancy. Under these circumstances, we are unable to conclude that Dr. Benton's November 1995 audiogram provides sufficient confirmation of Dr. Ediger's earlier audiogram. Thus, we are not persuaded that Dr. Ediger's medical opinion satisfies claimant's burden of proof. Accordingly, we affirm the ALJ's determination that claimant's hearing loss condition was not compensable.

ORDER

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

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April 3, 1997 Cite as 49 Van Natta 457 (1997)

In the Matter of the Compensation of
**JAMES S. JONES, Claimant**
WCB Case No. 96-04608
ORDER DENYING RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On February 28, 1997, we affirmed an Administrative Law Judge's (ALJ's) order which set aside the self-insured employer's denial of claimant's current L3-4 and L4-5 facet inflammation condition. On April 2, 1997, we received the employer's March 31, 1997 motion for reconsideration. Contending that claimant's "tenderness" in his midline does not constitute "objective findings" of a facet inflammation condition, the employer seeks abatement and reconsideration of our February 28, 1997 order. Inasmuch as our order has become final, we are without authority to alter our prior decision.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, the 30th day following our February 28, 1997 order was March 30, 1997, a Sunday. Therefore, the final day that we retained authority to modify our February 28, 1997 order was Monday, March 31, 1997. See Anita L. Clifton, 43 Van Natta 1921 (1991). The employer's motion for reconsideration was mailed on March 31, 1997, within the 30-day appeal period. Nevertheless, by the time the request was received by the Board (on April 2, 1997), the 30-day period of ORS 656.295(8) had expired.

Inasmuch as our February 28, 1997 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision.[1] See ORS 656.295(8); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra; Donald J. Bidney, 47 Van Natta 1097 (1995). Consequently, we lack authority to reconsider our final order. See Steve H. Salazar, 49 Van Natta 5 (1997).

Accordingly, the employer's request for reconsideration of our February 28, 1997 order is denied.

IT IS SO ORDERED.

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[1] As we have noted on prior occasions, we attempt to respond to motions for reconsideration as expeditiously as possible. Darlene E. Parks, 48 Van Natta 190 (1996); Connie A. Martin, 42 Van Natta 495, recon den 42 Van Natta 853 (1990) Notwithstanding these stated intentions, the ultimate responsibility for preserving a party's rights of appeal must rest with the party. Id.

In the Matter of the Compensation of
**RICHARD D. NELSON, Claimant**
WCB Case No. 96-05309
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) declined to grant claimant's request to testify, submit an affidavit and to cross-examine the medical arbiter concerning the extent of claimant's scheduled permanent disability; (2) upheld the constitutionality of ORS 656.283(7); and (3) affirmed an Order on Reconsideration awarding 6 percent (11.52 degrees) scheduled permanent disability for loss of use or function of the left arm (elbow). On review, the issues are evidence and extent of scheduled disability.

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

Citing Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), the ALJ rejected claimant's constitutional challenge to the evidentiary prohibition of ORS 656.283(7).[1] Specifically, the ALJ found that the federal law cases cited by claimant did not contravene the Board's determination that due process does not require that the state afford claimant the opportunity to present oral testimony or to cross-examine witnesses in a hearing concerning the extent of permanent partial disability.

On review, claimant renews his due process challenge to ORS 656.283(7). In addition, claimant asserts that he has a statutory right to cross-examine the medical arbiter under ORS 656.327(4).[2] We reject both arguments.

First, as we explained in Joe R. Ray, the procedures afforded during the reconsideration process, including the opportunity to present claimant's position fully in writing,[3] are sufficient to protect against the risk of erroneous deprivation of claimant's interest in permanent disability benefits. Therefore, the evidentiary limitation of ORS 656.283(7) does not violate claimant's due process rights under the Fourteenth Amendment to the United States Constitution. See also Jason R. Williams, 48 Van Natta 1827 (1996); Arlie B. Tompkins, 48 Van Natta 1664 (1996); Duane B. Onstott, 48 Van Natta 753 (1996) (rejecting due process challenge to ORS 656.283(7) where claimant had the opportunity to correct any alleged error in the Order on Reconsideration itself by seeking to abate, withdraw and/or amend the order prior to requesting a hearing).

Claimant's attempt to distinguish Joe R. Ray on its facts is unpersuasive.[4] As we explained in that case, in evaluating the constitutionality of ORS 656.283(7), we focused on the risk of error in extent

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[1] This section limits the evidence admissible in an "extent" hearing to that which was "submitted at the reconsideration required by ORS 656.268." In Plummer v. Precision Castparts Corp., 140 Or App 227, 231 (1996), 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 the reconsideration and not made a part of the reconsideration record." (Emphasis in original).

[2] The employer asserts that, because claimant did not rely on ORS 656.327(4) at hearing, we should not consider this theory 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). We consider claimant's ORS 656.327(4) argument as merely an alternate legal theory in support of his position (raised at hearing) that he has a right to cross-examine the medical arbiter, rather than a new, separate issue. Further, we find no prejudice to the employer in considering this late-raised theory on review, particularly because we are persuaded that claimant's argument must fail. See Michelle C. Mendoza, 37 Van Natta 641 (1985); Anita A. Bade, 36 Van Natta 1093 (1984), aff mem 73 Or App 344 (1985) (distinguishing between a "new issue" and alternative legal theory advanced for the first time on review, and considering the new theory where there was no prejudice to the adverse party).

[3] For example, in this case, had claimant submitted an affidavit to the Department challenging the medical arbiter's methodology and/or findings during the reconsideration process, this evidence would have been part of the record on reconsideration and admissible under ORS 656.283(7).

of permanent partial disability cases generally, rather than the risk of error under the facts of that particular case. We did so expressly because "procedural due process rules are shaped by the risk of error inhered in the truth-finding process as applied to the generality of cases, not the rare exceptions." See Joe R. Ray, 48 Van Natta at 332, n. 14 (citing Matthews v. Eldridge, 424 US 319 (1976)).

Second, contrary to claimant's contention, ORS 656.327(4) does not confer upon him any right to cross-examine the medical arbiter in this case. This provision, part of the statute addressing Director review of medical treatment, sets forth the protections and immunities afforded physicians or medical arbiters who conduct examinations or make findings on behalf of the Department. It provides, in pertinent part, as follows:

> "No member of a panel or a medical arbiter shall be examined or subject to administrative or civil liability regarding participation in or the findings of the panel or medical arbiter or any matter before the panel or medical arbiter other than proceedings under this chapter."

While this section does not prohibit the examination of a Department-appointed physician in a proceeding under ORS Chapter 656, it also does not *authorize* the cross-examination of a medical arbiter by a party in an "extent" hearing nor does it create a specific exception to the evidentiary prohibition set forth in ORS 656.283(7).[5]

Moreover, even prior to the 1995 amendments to ORS 656.283(7), we recognized that a medical arbiter should not be compelled to submit to cross-examination in an extent hearing because the arbiter is appointed by the Director to prepare a report on behalf of the Department on reconsideration and is not intended to be a witness for the claimant or the carrier. See Daniel L. Bourgo, 46 Van Natta 2505, n.1 (1994), aff'd Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73 (1996). More recently, in Constance I. Gassner, 48 Van Natta 2596 (1996), we explained that "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 these findings to the Department." We specifically held that a party may not solicit supplemental opinions from a medical arbiter in a proceeding to evaluate extent of permanent disability and refused to consider such a report even though the report was otherwise admissible under ORS 656.283(7). Id.

Consistent with our analysis in Daniel L. Bourgo and Constance I. Gassner, we find in this case that claimant has no statutory right to cross-examine the medical arbiter about his impairment findings. Moreover, to the extent claimant had questions concerning the medical arbiter's report, those questions should have been directed to the Department during the reconsideration proceeding.[6] See Daniel L. Bourgo, 46 Van Natta at 2509, n.2.

## ORDER

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

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[4] Claimant asserts that the analysis in Joe R. Ray is inapplicable because there, the worker sought additional permanent disability benefits beyond that which he was awarded by the Order on Reconsideration, whereas here, claimant seeks to reverse the Order on Reconsideration's grant of 6 percent scheduled permanent disability and reinstate the 12 percent scheduled permanent disability award set forth in the Notice of Closure.

[5] Because ORS 656.327(4) does not address the admissibility of evidence at a hearing, it is not inconsistent with, or contrary to, the provisions of ORS 656.283(7). Compare Larry A. Thorpe, 48 Van Natta 2608 (1996), where we found that ORS 656.268(6)(e), which specifically authorizes the admission at hearing of a medical arbiter report that was not prepared in time for use in the reconsideration proceeding, constituted an exception to the general limitation on "post-reconsideration" evidence in ORS 656.283(7).

[6] The Department may, in its discretion, request a supplemental or clarifying report from the arbiter. See OAR 436-030-0165(3)(b).

In the Matter of the Compensation of
**ANTHONY G. ALLEN, Claimant**
WCB Case No. C700684
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
W. Todd Westmoreland, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On March 21, 1997, we received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The CDA indicates that claimant has settled his third party law suit. Although the specific amount of the settlement is not provided, the parties represent that the insurer's statutory share would be approximately $250,000. The sole consideration for the CDA is the carrier's waiver of $80,000 of its $250,000 statutorily recoverable third party lien.

Generally, we disapprove CDAs in which the consideration consists of a carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and/or the amount of the carrier's lien. E.g., Michael Salber, 48 Van Natta 757 (1996). We reach this conclusion because we are unable to ascertain the "value" of any consideration flowing to the claimant as a result of the third party settlement and the carrier's waiver of its lien. Id.

In the present case, the parties have expressly stipulated that the insurer's statutory share of the settlement is approximately $250,000 and the insurer has agreed to reduce its lien by $80,000 (an ascertainable amount). Thus, although the exact amount of the third party settlement is unknown, the amount of the insurer's otherwise recoverable lien and the amount of its waiver are known. Under such circumstances, we find that the "value" of the consideration flowing to claimant under the CDA ($80,000) is sufficiently ascertainable to gain Board approval.[1]

We find that the CDA 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] We find this case distinguishable from Salber. In Salber, in contrast to the case at hand, the amount of the otherwise statutorily recoverable lien being waived was not provided in the CDA.

In the Matter of the Compensation of
**VANCE T. FERGUSON, Claimant**
Own Motion No. 97-0100M
INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Donald Beer, Claimant Attorney
American National Fire Ins. Co., 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 1990 injury claim with the American National Fire Insurance Co. expired on December 30, 1995. 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.

The record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1990 own motion claim, beginning September 9, 1996, the date claimant was hospitalized for surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier is found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if the own motion carrier is not found responsible, or if a non-own motion carrier is found to be the responsible carrier. Furthermore, if the own motion carrier is determined to be responsible for claimant's current condition, the parties are requested to submit their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
**STEPHANIE WHITE, Claimant**
WCB Case No. 96-05735
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's low back 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 work at the employer filling orders. On May 14, 1996, claimant was transferred to the shipping department. On May 15, 1996, claimant sought treatment for low back pain. Claimant was treated for low back pain before working for the employer.

The ALJ concluded that claimant failed to prove compensability of her low back condition. Claimant challenges this conclusion, asserting that the medical evidence carries her burden of proof.

Claimant first saw Dr. Mayock, who diagnosed chronic low back pain "exacerbated by recent lifting" and restricted claimant from lifting more than 5 pounds. (Exs. 8, 9-2). On May 23, 1996, claimant was treated by Dr. Winans, D.O., who diagnosed a lumbar strain. (Ex. 10A).

On May 22, 1996, claimant saw Dr. Greaves, who initially diagnosed lumbar strain. (Ex. 12-3). After seeing claimant again on July 16, 1996, Dr. Greaves informed the insurer that claimant "may indeed have a condition of her back which is in need of medical attention and which may restrict her ability to work, however, given her inconsistent follow up, her inconsistent history and the concern for embellishment and her fixation on receiving compensation for what has happened and other issues make it difficult for me to tease out any real medication [sic] issue." (Ex. 15B-2). Dr. Greaves subsequently reiterated to the insurer's attorney that "without a doubt [claimant's] subjective complaints far outweigh any objective findings" and the "functional overlay is of such a nature that I am unable to tease out any consistent objective findings relating to a back injury." (Ex. 19-1).

On August 19, 1996, claimant saw Dr. Reichle, who found "exaggerated pain response in all aspects of the exam", "no reproducible specific tenderness", "full range of motion of the low back", "normal deep tendon reflexes", "normal sensory exam", and "fairly fluid and comfortable movements on casual observance." (Ex. 18).

Finally, Dr. Drummond provided a "check-the-box" opinion stating that she had examined claimant on July 22, 1996 and reviewed Dr. Mayock's May 15, 1996 chartnotes. (Ex. 21). The letter also provided Dr. Drummond's opinion that claimant "suffered an acute lumbar strain on May 14, 1996, and that this strain was caused in major part by the work activities which [claimant] was performing at that time." (Id.)

In evaluating medical evidence, we rely on those opinions that are well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, Dr. Drummond provides the only opinion directly relating claimant's low back condition to her May 14 work activities. Dr. Drummond, however, examined claimant only one time. Furthermore, Dr. Drummond does not address the effect of claimant's preexisting low back condition, which Dr. Mayock found was "exacerbated" by work, or the presence of any functional overlay, which Dr. Greaves found prevented him from determining whether claimant had a medical condition. For these reasons, we are unable to conclude that Dr. Drummond based her opinion on an accurate and complete understanding of claimant's condition. At best, the opinions are in equipoise. Consequently, claimant did not carry her burden of proving compensability. ORS 656.005(7)(a), 656.005(7)(a)(B).

ORDER

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

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In the Matter of the Compensation of
**BOBBI J. BLAKELY, Claimant**
Own Motion No. 96-0530M
OWN MOTION ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 13, 1997 Own Motion Order in which we declined to reopen her 1977 claim for the payment of temporary disability compensation because she failed to establish she was in the work force at the time of her current disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue. On reconsideration, we withdraw our prior order and issue the following order in place of our prior 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 November 19, 1996, Dr. Mohler, claimant's treating physician, performed claimant's bilateral knee arthroscopy. By letters dated November 8, 1996 and March 19, 1997, SAIF advised that it has accepted only claimant's right knee condition as compensable to her 1977 injury claim, and that surgery costs for the right knee portion of claimant's bilateral arthroscopic surgery have been paid. Thus, we conclude that claimant's compensable right knee 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 she qualifies for temporary disability compensation, having been disqualified for social security benefits because she was "gainfully employed" at the time of disability. Claimant has the burden of proof on this issue and must provide persuasive evidence that she remained in the work force at the time of disability.

Claimant submitted a March 5, 1997 letter from the Social Security Administration (SSA), which notified her that she was no longer qualified for social security benefits. In that letter, claimant's SSA claim administrator advised her that "because [claimant has] once again performed substantial gainful work, we have decided that [claimant is] not entitled to payments beginning August 1994."

The receipt of social security benefits does not necessarily establish that a claimant was in the work force, unless it is established that those benefits compensate the claimant for an inability to work because of a compensable industrial injury. See Lowell D. Armon, 48 Van Natta 2416 (1996) (because the claimant established that he was working at the time of disability, we did not find the receipt of social security benefits necessarily determinative); Kenneth C. Felton, 48 Van Natta 725 (1996) (although not working, but receiving social security benefits, the claimant did not establish that he was unable to seek work at the time of disability because of a compensable injury). However, contrary to the particular circumstances in Armon claimant has established that she has been in the work force since August 1994, and has been disqualified for social security benefits because she was performing

"substantial gainful employment."[1] Furthermore, the claim administrator's March 5, 1997 letter indicates that claimant was not entitled to benefits from August 1994 to the present time. Because claimant's surgery took place in November 1996, we conclude that claimant was engaged in gainful employment at the time of disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning November 19, 1996, the date she was hospitalized for surgery.[2] 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.

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[1] In Armon, the claimant established eligibility for social security benefits, but also established that he performed "intermittent work" (although he did not work enough to place his wages at the "substantial gainful work" level). Therefore, we concluded that the claimant was entitled to temporary disability compensation to replace any lost wages, even though those wages might be sporadic or part-time. Lowell D. Armon, 48 Van Natta at 2416. See also Robert D. Hyatt, 48 Van Natta 2202 (1996).

[2] On November 19, 1996, claimant underwent bilateral knee surgery. SAIF contends that claimant's left knee condition is not an accepted portion of her 1977 claim with SAIF, but that its records indicate that claimant has filed a claim for left knee injury with another insurer. An injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if any concurrent temporary disability compensation is due claimant as a result of this order, SAIF may petition the Benefits Section of the Workers' Compensation Division for a *pro rata* distribution of payments. See OAR 436-060-0020(8) and (9).

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April 8, 1997 Cite as 49 Van Natta 464 (1997)

In the Matter of the Compensation of
**KAREN L. BEGEAL, Claimant**
WCB Case No. C700190
ORDER DENYING RECONSIDERATION
Emmons, et al, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

On March 4, 1997, the Board issued an order disapproving the parties' claim disposition agreement (CDA). In our order we adhered to our prior case law which held that a carrier's waiver of an overpayment could not constitute consideration for a CDA and, as such, was unreasonable as a matter of law under ORS 656.236(1)(a)(A). See Timothy W. Moore, 44 Van Natta 2060 (1992). On April 2, 1997, we received SAIF's motion for reconsideration of our order.

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, a final order disapproving the CDA was issued and mailed on March 4, 1997. We received SAIF's letter requesting reconsideration of the CDA on April 2, 1997, 29 days after our order disapproving the CDA. 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).

Accordingly, the motion to reconsider is denied.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**NEAL FALLS, Claimant**
WCB Case No. 96-04726
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se,[1] requests review of Administrative Law Judge (ALJ) Nichols' Order on Stipulated Facts that: (1) awarded claimant's counsel an attorney fee, to be paid by the self-insured employer, for his counsel's services in securing the employer's acceptance of claimant's right wrist sprain injury claim without hearing; and (2) dismissed claimant's hearing request without prejudice as to all other issues that could have been raised at that time. In its brief on review, the employer seeks sanctions under ORS 656.390 for claimant's allegedly frivolous appeal. On review, the issues are attorney fees, the propriety of the ALJ's dismissal and sanctions. We deny the motion for sanctions and affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact and statement of stipulated facts with the following supplementation.

On May 13, 1996, claimant signed a retainer agreement employing his then-attorney of record to represent him in connection with his workers' compensation claim. On May 14, 1996, claimant, through his then-attorney of record, requested a hearing raising the issues of: (1) compensability, referencing the employer's May 10, 1996 denial; and (2) attorney fees. The matter was set for hearing on August 13, 1996.

On December 3, 1996, based on the stipulations of the parties, the ALJ issued an order finding that: (1) the employer accepted the previously denied claim for a right wrist strain on October 31, 1996; (2) claimant's attorney was entitled to an assessed fee of $800 for his services in securing the employer's pre-hearing rescission of that denial; and (3) claimant's request for hearing was dismissed without prejudice as to all other issues that could have been raised at that time.

By letter received by the Board on December 30, 1996, claimant, then pro se, requested review of the ALJ's December 3, 1996 order, stating that he was "dissatisfied with the order."

## CONCLUSIONS OF LAW AND OPINION

### Attorney fees and propriety of Dismissal of Hearing Request

We find no basis to alter the employer-paid attorney fee assessed by the ALJ and adopt the ALJ's reasoning and conclusions regarding the attorney fee issue. The parties stipulated that claimant's then-attorney was entitled to a reasonable fee of $800 pursuant to ORS 656.386(1) for his efforts in obtaining the rescission of the employer's denial. In addition, we note that, pursuant to the retainer agreement, claimant's then-attorney was authorized to act on claimant's behalf and it was as a result of these actions, as enumerated by the ALJ, that the employer rescinded its denial prior to the scheduled hearing.

Regarding the ALJ's dismissal of claimant's hearing request without prejudice, we also agree that that action was appropriate. Again, claimant, through the retainer agreement, authorized his then-attorney to act on his behalf. Furthermore, the parties stipulated to such action. Thus, the record establishes that claimant, through his then-attorney, withdrew his request for hearing. Claimant does not dispute his then-attorney's authority to act on his behalf, nor does he dispute the fact that the ALJ dismissed his request for hearing without prejudice in response to his then-attorney's stipulated agreement to withdraw the hearing request. William A. Martin, 46 Van Natta 1704 (1994); Verita A. Ware, 44 Van Natta 464 (1992). Under these circumstances, the ALJ properly dismissed the remainder of claimant's hearing request without prejudice.

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[1] Claimant is pro se on review; however, he was represented throughout the hearing process.

We further note that the remaining portions of claimant's hearing request were dismissed "without prejudice as to all other issues that could have been raised at this time." Order on Stipulated Facts, page 1. Under such circumstances, the dismissal of the remaining portions of claimant's hearing request will have no preclusive effect on subsequent litigation should claimant wish to raise new issues in a future hearing request. See Claudia I. Hamilton, 42 Van Natta 600 (1990); Glenn L. Woodraska, 41 Van Natta 1472, 1476 (1989).

Sanctions

In its brief, the employer requests that we impose sanctions pursuant to ORS 656.390 against claimant for his allegedly frivolous request for review. In this regard, the employer alleges that claimant's request for review in this matter is "completely without merit." Employer Brief, page 2. We need not determine whether claimant's request for review is frivolous because, for the following reasons, we find that ORS 656.390 does not apply to the facts of this case.

ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harrassment, the Board "may impose an appropriate sanction upon the attorney who filed the request for review." Thus, by its terms, ORS 656.390(1) only provides for sanctions against an attorney who files a frivolous request for review. Here, claimant is not represented on review and filed the request for review on his own. Furthermore, there is no evidence that claimant is an attorney. Therefore, ORS 656.390(1) does not apply.

ORDER

The ALJ's order dated December 3, 1996 is affirmed.

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April 8, 1997 Cite as 49 Van Natta 466 (1997)

In the Matter of the Compensation of
**SHIRLEY WILSON, Claimant**
WCB Case No. 96-07575
ORDER DENYING RECONSIDERATION
Heiling, Dodge & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our March 21, 1997 Order that affirmed the Administrative Law Judge's order that set aside its denial of claimant's right hand and wrist condition. Contending that Dr. Fisher's chart notes do not contain a medical opinion, the employer continues to assert that there is insufficient evidence to find claimant's claim compensable.

After considering the employer's motion, we have nothing further to add to our previous order. Accordingly, the employer's motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our March 21, 1997 order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DELIA M. MINER, Claimant**
WCB Case Nos. 96-05231 & 96-05230
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the insurer's denial of claimant's occupational disease claim for a left carpal tunnel syndrome (CTS) condition; and (2) upheld the insurer's denial of claimant's aggravation claim for a right CTS condition. On review, the issues are compensability and aggravation.

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

The ALJ found that claimant failed to prove that her compensable right CTS condition actually worsened since the last arrangement of compensation, a July 26, 1995 Notice of Closure. In evaluating the worsening issue, the ALJ applied then current law which provided that an actual worsening under ORS 656.273(1) may be established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening greater than that anticipated by the prior award of permanent disability. See Carmen C. Neill, 47 Van Natta 2371 (1995).

Subsequent to the ALJ's order, the court has determined that the term "actual worsening" in ORS 656.273(1) was not intended to include a symptomatic worsening. SAIF v. Walker, 145 Or App 294 (December 24, 1996). Rather, the court has concluded that there must be medical evidence that the symptoms have increased to the point that it can be said that the compensable condition has worsened.

Based on the evidence relied upon by the ALJ, we conclude that claimant has not established that her right wrist condition actually worsened. Consequently, we agree with the ALJ that claimant has not proven her aggravation claim. Walker, 145 Or App 294.

ORDER

The ALJ's order dated October 25, 1996 is affirmed.

In the Matter of the Compensation of
**RICHARD B. MORSE, Claimant**
WCB Case No. 96-02820
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order 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

We adopt and affirm the ALJ's "Opinion" through page ten, with the following supplementation.

The ALJ found that, to the extent that claimant experienced real stress related to his employment (including stress reportedly associated with interactions with a supervisor who was "an impossible person with which to deal"), such stress was "only that type of stress that is ordinary and inherent as contemplated by ORS 656.803(3)(b)[sic]."[1] (Opinion and Order p. 11). We do not adopt this conclusion.

However, we agree with the ALJ that the claim is not compensable, based on the medical evidence, which is provided by Drs. Cox and Thompson.

Claimant sought treatment from Dr. Cox, family physician, on numerous occasions. We cannot say that Dr. Cox' chart notes do more than restate claimant's opinion that his depression was work-related, because the notes offer no reasoning or explanation for associating claimant's psychological problems with his work. (See Exs. 11, 15, 17, 18, 20, 22). We give little if any weight to an unexplained "opinion" such as this. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Beverly M. Brown, 46 Van Natta 2455 (1994). The only other evidence from Dr. Cox is a letter drafted by claimant's attorney and signed by the doctor. (Ex. 26). To the extent that Dr. Cox thereby merely "assumed" that the primary stressor in claimant's life was his tense work environment, we cannot say that Dr. Cox' opinion is based on an accurate and complete history. (See id.). Under these circumstances, we do not find Dr. Cox' opinion particularly persuasive.

Dr. Thompson, psychiatrist, examined claimant and diagnosed a preexisting personality disorder as well as an adjustment disorder. It was Dr. Thompson's opinion that claimant misperceived that he was harassed at work and that his misperception in this regard arose out of a preexisting personality disorder (which was not aggravated by his work exposure). (Exs. 19, 27). Dr. Thompson explained that claimant's history, psychological test results, and the employer's investigative reports support a conclusion that claimant had a preexisting personality disorder which contributes significantly to his current psychological problems. (Exs. 27-8, -11, 27-16-17). Dr. Thompson's opinion in this regard is uncontroverted.

In our view, Dr. Thompson's opinion is well-reasoned and based on an accurate history. Consequently, we rely on it. See Somers v. SAIF, 77 Or App 259 (1986). Under these circumstances, we conclude that claimant has not established that legally cognizable stressors are the major contributing cause of his current psychological condition.

## ORDER

The ALJ's order dated September 18, 1996 is affirmed.

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[1] ORS 656.802(3)(b) provides, in relevant part, that a mental disorder is not compensable unless "[t]he employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation. . . ."

In the Matter of the Compensation of
**LONNIE F. PICKERELL, Claimant**
WCB Case Nos. 96-07370 & 96-05797
ORDER ON REVIEW
Welch, Bruun, 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) Herman's order that upheld the SAIF Corporation's *de facto* denial of his L4-5 and L5-S1 degenerative condition. In its respondent's brief, SAIF asserts that claimant's request for hearing was premature and therefore, the ALJ lacked jurisdiction over this matter. On review, the issues are jurisdiction and compensability.

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

Although Dr. Fuller's September 6, 1996 report indicates that it is "likely" that there was combination between the work incident and the preexisting degenerative condition which caused claimant's need for treatment, Dr. Fuller goes on to state that the only result from the work incident was a "straight forward muscle strain." (Ex. 60). Consequently, we do not find that Dr. Fuller's opinion supports claimant's contention that the compensable injury was the major contributing cause of a combined condition.

ORDER

The ALJ's order dated October 24, 1996 is affirmed.

In the Matter of the Compensation of
**BONNIE L. TURNBULL, Claimant**
Own Motion No. 96-0148M
OWN MOTION ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 10, 1997 Own Motion Order in which we declined to reopen her 1976 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she remained in the work force when her compensable condition worsened requiring surgery or hospitalization. Claimant further requests that the Board either: (1) consider claimant's arguments regarding the compensability of her low back condition; or (2) remand this matter to Administrative Law Judge (ALJ) Spangler for issuance of an order regarding the compensability of her low back condition.

On March 10, 1997, we abated our order, and allowed SAIF 14 days in which to file a response to the motion. No further responses have been received. Therefore, we will proceed with our reconsideration.

Entitlement to Temporary Disability Compensation

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

It is undisputed that claimant's compensable right medial meniscus tear condition has worsened requiring surgery.[1]

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 the current disability. Claimant submits no further evidence regarding the work force issue. In her March 4, 1997 letter to the Board, claimant noted that the Board's prior order found "that claimant was not in the work force at the time of worsening, something claimant did not dispute before the Board." Therefore, because claimant apparently no longer disputes the work force issue nor does she submit evidence to establish that she was in the work force when her right knee condition worsened, we continue to be persuaded that claimant was not in the work force at the time of disability.

Compensability of Claimant's Low Back Condition

In our prior order, we concluded that the Board, in its Own Motion authority, does not have jurisdiction to determine compensability in any workers' compensation claims, save for those claims in which the injury occurred prior to 1966 (except those which resulted in permanent total disability and

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[1] In a December 10, 1996 Opinion and Order, ALJ Spangler set aside SAIF's March 15, 1996 denial of claimant's current right knee medial meniscus tear. That order was not appealed, and has become final by operation of law. See ORS 656.289(3). In our prior order, we noted that, although the ALJ made a recommendation to the Board regarding claimant's low back condition (in addition to his order regarding her right knee condition), the Board, in its Own Motion authority, has no jurisdiction to consider the parties' arguments regarding the compensability of claimant's low back condition. ORS 656.278(1); Bonnie L. Turnbull, 49 Van Natta 139 (1997). Therefore, we offered no opinion regarding the compensability of claimant's current degenerative disc disease, nor regarding claimant's entitlement to temporary disability compensation for a low back fusion. We continue to find that we have no jurisdiction regarding this causation issue.

which occurred within the period from August 5, 1959 and December 31, 1965). See Bonnie L. Turnbull, 49 Van Natta at 139; Gary L. Martin, 48 Van Natta 1802 (1996). Furthermore, we concluded that the ALJ offered only a recommendation to the Board that claimant's current degenerative disc disease was due to a preexisting condition rather than attributable to her 1976 industrial injury.[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 the claimant has available administrative remedies under the provisions of ORS 656.273, the claimant's condition is the subject of a contested case under ORS 656.283 to 656.295, ORS 656.307 or ORS 656.308, or an arbitration or mediation proceeding under ORS 656.307, or a disputed medical services issue is subject to Director review under ORS 656.245(6), 656.260, 656.327 or 656.704(3). In other words, jurisdiction over these disputes rests either with the Hearings Division or with the Director. Gary L. Martin, 48 Van Natta at 1802; Judith R. King, 48 Van Natta 2403 (1996).

Our April 8, 1996 consolidation order requested only that, if the ALJ found that the current requests for treatment were causally related to the compensable injury, the 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 claimant's condition worsened. Our order designated that SAIF had only issued a denial of the compensability of claimant's current right knee medial meniscus tear condition, but that SAIF also "opposes reopening of the claim for a back fusion," because SAIF contended that it had denied claimant's degenerative disc disease on May 16, 1980. Because SAIF issued no formal current condition denial of claimant's current low back condition, it would appear that the issue of the compensability of claimant's degenerative disc disease was not before the ALJ at hearing. Furthermore, the ALJ did not issue a final order or decision with respect to claimant's current low back condition.[3]

Inasmuch as the compensability of claimant's current right knee condition has been determined, we are authorized under ORS 656.278 to consider her eligibility for temporary disability benefits, beginning the date of her knee surgery. However, because claimant's low back condition is apparently still in dispute and / or has not been determined compensable, we may not authorize temporary disability compensation for that condition under ORS 656.278. Furthermore, under the law, the Board, in its Own Motion authority, has sole jurisdiction to authorize only the payment of temporary disability compensation, unless the claimant was injured prior to January 1, 1966 (with exceptions noted above). Gary L. Martin, 48 Van Natta at 1802. Therefore, until a determination regarding the compensability of claimant's low back condition issues, the question of whether claimant is entitled to temporary disability compensation for her low back condition is premature

Finally, claimant requests that we remand the matter of the compensability of her degenerative disc disease condition to the ALJ for issuance of an order. ALJ Spangler's December 10, 1996 order has finally determined that claimant's right knee condition is a compensable component of her 1976 injury claim with SAIF. Because no party appealed the order within the 30-day appeal period, the ALJ's order has become final by operation of law. See ORS 656.289(3). Furthermore, because we lack original jurisdiction to consider a compensability matter under ORS 656.278, we lack the authority to remand the matter of the compensability of claimant's current degenerative disc disease to the ALJ.[4]

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[2] On July 2, 1996, the ALJ issued an Order of Continuance, noting that the Board's Own Motion Order appeared to require fact-finding on the issue of the causal relationship between claimant's current low back condition and her 1976 injury. Therefore, the ALJ continued the case in order to take evidence regarding claimant's low back condition. In his December 10, 1996 order, the ALJ made only a recommendation to the Board regarding whether claimant's current low back condition and need for surgery are compensably related to the 1976 injury.

[3] The ALJ made a recommendation to the Board regarding the compensability of claimant's degenerative disc disease condition. However, as we have explained, the Board, in its Own Motion authority, cannot determine this compensability issue. Therefore, as no final opinion and order has issued regarding claimant's low back, the issue is not properly before the Board under ORS 656.278.

[4] Our reasoning should not be interpreted as a conclusion that the parties are precluded from litigating the compensability of claimant's low back condition. Resolution of that issue will be achieved if and when the question is presented to the appropriate forum.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 10, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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April 9, 1997 Cite as 49 Van Natta 472 (1997)

In the Matter of the Compensation of
**CHARLES L. WALLACE, Claimant**
WCB Case No. 95-12610
ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

On February 14, 1997, we abated our January 21, 1997 order that affirmed the Administrative Law Judge's (ALJ's) order which upheld the insurer's denial of claimant's current low back condition. We took this action to consider claimant 's motion for reconsideration. Having received the insurer's response, we now proceed with our reconsideration.

We begin by briefly recapping the procedural background of the claim. The insurer denied the compensability of claimant's low back claim on August 18, 1995. On October 12, 1995, the insurer issued another denial, which stated that the insurer stood by its position that the original denial should be upheld, but that, as an "alternative" position, if claimant did suffer a low back injury on July 3, 1995, the condition "fully resolved" by August 21, 1995. (Ex. 33). The insurer then wrote that it denied the compensability of "any and all current conditions, physical or psychological, effective August 21, 1995, even if it is established that [claimant] had an actual injury incident on July 3, 1995." Id.

By an October 26, 1995 Notice of Acceptance, the insurer subsequently accepted a "low back strain." (Ex. 34). Claimant and the insurer then executed a settlement stipulation (appoved by an ALJ on November 9, 1995), in which the insurer acknowledged the withdrawal of the August 18, 1995 denial. The parties agreed that the withdrawal of the initial denial would not "prevent the employer from issuing any current conditions denial for any date subsequent to July 3, 1995...." (Ex. 35-2). The agreement further reiterated that the acceptance of the low back strain would not in "any fashion prejudice the employer from issuing a current conditions denial." Id. In the order portion of the stipulation, the parties then recited that all hearing requests were dismissed with prejudice as to all issues raised or raisable, with the exception of the insurer's "continuing right to issue a current condition denial for a date subsequent to July 3, 1995, and subject to the claimant's right to challenge any such current conditions denial in a separate proceeding." (Ex. 35-3).

Claimant requested a hearing, appealing the October 12, 1995 denial of his current condition as of August 21, 1995. On December 4, 1995, the insurer closed the accepted portion of the claim by Notice of Closure, which terminated claimant's award of temporary disability on August 21, 1995 and did not award any permanent disability. (Ex. 39).

The ALJ upheld the insurer's denial of claimant's current low back condition. In doing so, the ALJ determined that the insurer's "pre-closure" current condition denial was procedurally valid and that, on the merits, claimant's current low back condition was not compensable.

On review, we held that the insurer's "pre-closure" denial of claimant's current condition was permissible because the denied condition was not the same as the previously accepted condition. Citing Elizabeth B. Berntsen, 48 Van Natta 1219 (1996), we reiterated that a "pre-closure" denial of a current condition was procedurally invalid in the absence of a "combined" or "consequential" condition, if the denial was for the same condition as that which had been previously accepted. Finding that there was no "combined condition" consisting of the accepted low back strain and a psychological condition, we reasoned that ORS 656.262(7)(b) was not applicable. Persuaded that claimant's current condition was psychologically based, we determined that the condition was not related to the previously accepted low back strain. Relying on Zora A. Ransom, 46 Van Natta 1287 (1994), we concluded that the carrier's denial was valid.

Citing Linda J. Miossec, 46 Van Natta 1730 (1994), and Gary L. Best, 46 Van Natta 1694 (1994), claimant now contends that the insurer's denial should be set aside as an invalid prospective denial because the insurer denied "any and all current conditions, physical or psychological," prior to claim closure on the ground that the accepted condition had "resolved." For the following reasons, we find that the insurer's denial is partially invalid.[1]

In Gary L. Best, 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, that the carrier's notice constituted an improper denial of future responsibility relating to an accepted claim. In Miossec, the carrier accepted a claim as disabling, but also described the accepted condition as "resolved." In accordance with the Best rationale, regardless of whether all present compensation for the claim had been provided, we held that such an acceptance constituted a prohibited prospective denial of future benefits for the compensable condition.

Unlike the acceptances in Best and Miossec, the insurer's acceptance in this case was unequivocal. The insurer accepted a "low back strain." (Ex. 34). However, prior to its official acceptance, the insurer denied "any and all current conditions, physical or psychological," on the ground that claimant's low back strain had "fully resolved." Under these circumstances, we conclude that the effect of both the insurer's denial and its subsequent Notice of Acceptance was to limit its acceptance to a "resolved" low back strain. In accordance with the Best and Miossec rationale, we conclude that the insurer's claim processing in this case constituted an impermissible denial of future responsibility with respect to the compensable low back strain. We, therefore, set aside that portion of the insurer's denial which limited its responsibility to a "resolved" low back strain.[2] Gary L. Best.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review (including reconsideration) with respect to the procedural propriety of the insurer's denial of his low back strain. 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 (including reconsideration) is $2,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs, and argument on reconsideration), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Accordingly, on reconsideration, the ALJ's order dated June 18, 1996 is affirmed in part and reversed in part. The insurer's denial is set aside to the extent that it denies claimant's current symptoms insofar as they pertain to his compensable low back strain. That portion of the claim is

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[1] The insurer argues that we should not consider claimant's argument based on Best and Miossec because he did not cite these cases during briefing before the Board. It is true that claimant's prospective denial theory or argument did not expressly surface until reconsideration of our order was requested. Throughout these proceedings, however, claimant's essential argument has remained constant; i.e., that the insurer's denial was procedurally invalid. Compare Kenneth L. Devi, 48 Van Natta 2557 (1996), on recon 49 Van Natta 108 (1997) (declining to address preclusion issue on reconsideration when issue was not raised on the record before ALJ). Under such circumstances, we do not consider claimant's motion for reconsideration to have raised a "new" issue. Accordingly, we do not consider claimant's arguments on reconsideration to be inappropriate.

[2] The insurer attempts to distinguish Best and Miossec by noting that, unlike those cases, the parties had entered into a stipulation that specifically allowed it to deny any current conditions after July 3, 1995. The insurer neglects to mention, however, that the stipulation also allowed claimant to challenge any current condition denial that the insurer issued. (Ex. 35-3). Moreover, we interpret the language of the stipulation as allowing issuance of a current condition denial after execution of the stipulation. The stipulation contains no language that retroactively upholds the prior October 12, 1995 denial. Under these circumstances, we are persuaded that the November 9, 1995 stipulation does not prevent claimant from challenging the procedural propriety of the October 12, 1995 denial.

remanded to the insurer for further processing according to law. The remainder of the insurer's denial is upheld.[3] For services at hearing and on review regarding the low back strain issue, claimant's attorney is awarded $2,500, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

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[3] Although claimant contends that the insurer's denial of his "current" low back condition should be set aside, after further consideration of his contentions, we continue to conclude that claimant's "current" low back condition is not compensable. Therefore, we adhere to and republish that portion of our prior order which upheld the portion of the insurer's "pre-closure" denial pertaining to claimant's "current" low back condition.

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April 9, 1997 Cite as 49 Van Natta 474 (1997)

In the Matter of the Compensation of
**JUDITH K. NIX, Claimant**
WCB Case No. 93-02704
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Nix v. Freightliner Corporation, 145 Or App 560 (1997). The court has reversed our prior order, Judith Nix, 46 Van Natta 2292 (1994), on recon 47 Van Natta 22 (1995), which held that a portion of an "out-of-compensation" attorney fee created by our increased unscheduled permanent disability award was subject to offset against the self-insured employer's prior overpayment of permanent disability. Relying on OAR 438-015-0085(2), the court has concluded that claimant's "out-of-compensation" attorney fee is not subject to such an offset. Consequently, the court has remanded for reconsideration.

Consistent with the court's rationale, we find that claimant's attorney is entitled to 25 percent of the 12 percent increased unscheduled permanent disability award granted by our prior orders (i.e., $960), payable directly by the employer to claimant's counsel. Thereafter, the employer is authorized to offset its $3,200 overpayment against the remaining portion of claimant's increased award.

Accordingly, as supplemented and modified, we republish our prior orders.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**RANDY R. KACALEK, Claimant**
WCB Case No. 95-13897
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its partial denial of claimant's medical services claim for his L4-5 discectomy, interbody fusion and internal fixation at L4-5 and L5-S1. On review, the issues are jurisdiction and medical services. We vacate.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 1, we change the third sentence of the first paragraph to read: "In January 1989, claimant underwent a Gill procedure at L5 with an L4-5 discectomy." We change the date in the sixth sentence of the first paragraph to "June 1989."

## CONCLUSIONS OF LAW AND OPINION

On December 20, 1991, claimant injured his low back at work. SAIF accepted a claim for L4-5 lumbar disc herniation to the right. (Ex. 33). In February 1996, claimant underwent surgery for L4-5 discectomy, interbody fusion and internal fixation at L4-5 and L5-S1.

On December 22, 1995, SAIF issued a partial denial of claimant's request for medical treatment. (Ex. 70). In the denial, SAIF acknowledged that it had accepted a claim for L4-5 lumbar disc related to an injury on December 20, 1991. SAIF stated:

> "We have recently received information that you are seeking treatment for discogenic and mechanical low back pain that requires an anterior retroperitoneal approach discectomy with vertebral body distraction using interbody cage internal fixation and fusion at L4-S1 which you feel is related to your December 20, 1991 injury. After reviewing the information in your file, we have determined that we are unable to pay for treatment or disability related to the above stated problem. It is our position that the December 20, 1991 injury is not the major contributing cause of your discogenic and mechanical low back pain that requires an anterior retroperitoneal approach discectomy with vertebral body distraction using interbody cage internal fixation and fusion at L4-S1." (Id.)

Claimant requested a hearing on SAIF's partial denial. At hearing, the parties agreed that the issue was "the compensability of medical services performed on February 13, 1996, and more specifically, whether the medical services performed on February 13, 1996 are causally related to claimant's accepted injury of December 20, 1991." (Tr. 2). The ALJ concluded that claimant's February 1996 surgery was causally related, in major part, to the compensable 1991 injury.

After the ALJ issued the order in this case, the court decided SAIF v. Shipley, 147 Or App 26 (1997). The court reversed the Board's order in Dale R. Shipley, 48 Van Natta 397 (1996), which had held that the Hearings Division had jurisdiction to resolve a medical services dispute. In Shipley, the claimant received medical treatment for an off-the-job injury to his knee after closure of his compensable knee injury claim. Although the carrier denied that the claimant's compensable condition had worsened and denied a request to reopen the claim, it did not deny compensability of the original injury.

On appeal, the carrier argued that the Board erred in assuming jurisdiction over the matter, since it involved only a claim for medical benefits on a previously accepted claim. The claimant contended that, because the carrier denied compensability of his current condition and need for

treatment, it denied compensability of the "underlying claim" as described in ORS 656.245(6).[1] The court rejected the claimant's contention. Relying on ORS 656.245(6) and Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995), the court concluded that since the dispute concerned only the compensability of medical services (and not the "underlying claim"), exclusive jurisdiction to review the dispute rested with the Director.

Here, as in Shipley, claimant seeks medical treatment of his current condition. SAIF did not deny compensability of claimant's original 1991 injury. Rather, SAIF denied medical treatment for the low back pain, which claimant felt was related to the 1991 injury. This case involves a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6). Since neither the Hearings Division nor the Board has jurisdiction over this matter, claimant's request for hearing must be dismissed.

ORDER

The ALJ's order dated October 11, 1996 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

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[1] ORS 656.245(6) provides:

"If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550."

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In the Matter of the Compensation of
**DELFINO N. HERRERA, Claimant**
WCB Case No. 96-03887
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; and (2) declined to assess penalties or attorney fees for an allegedly unreasonable denial. On review, the issues are aggravation and penalties and attorney fees.

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

In SAIF v. Walker, 145 Or App 294 (1996), the court held that the "actual worsening" standard of ORS 656.273(1) requires direct medical evidence that the condition has worsened. Here, although claimant experienced a flare-up of symptoms, the medical evidence does not establish any pathological worsening of claimant's low back condition. See Randy S. Moser, 49 Van Natta 78 (1997). Accordingly, we affirm the ALJ's decision that a compensable aggravation claim has not been established under ORS 656.273(1).

ORDER

The ALJ's order dated August 8, 1996, as reconsidered on October 2, 1996, is affirmed.

**Board Member Biehl specially concurring.**

Claimant might have prevailed under our decision in Jason S. Palmer, 48 Van Natta 2394 (1996), which held that, in the absence of a prior permanent disability award, a symptomatic worsening of the

compensable condition could constitute an "actual worsening." However, subsequent to our decision in Palmer, the court issued its opinion in SAIF v. Walker, 145 Or App 294 (1996) (evidence of a symptomatic worsening is insufficient to establish an "actual worsening"). Although I disagree with the Walker rationale, I am constrained by the doctrine of stare decisis to follow the court's holding. Consequently, I reluctantly concur with the ALJ's decision to uphold the aggravation denial.

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April 11, 1997 Cite as 49 Van Natta 477 (1997)

In the Matter of the Compensation of
**LEONA M. PRICE, Claimant**
WCB Case Nos. 96-09629 & 95-10229
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's claim for a consequential upper extremity fibromyalgia condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Findings of Ultimate Fact."

## CONCLUSIONS OF LAW AND OPINION

Since 1991, claimant performed repetitive work activities for the employer which involved her upper extremities. By mid-1992, she experienced a gradual onset of right shoulder pain. The employer initially accepted claimant's claim for a right shoulder strain and later accepted calcific tendinitis of the right shoulder.

In early 1993, claimant developed pain in her left shoulder. In 1994, she developed elbow discomfort. By late 1994, she had diffuse pain in her upper and lower extremities, sleep disturbance, fatigue, mood swings, and occipital headaches. Treatment has been conservative.

On January 9, 1996, the employer issued a partial denial of claimant's claims for left shoulder calcific tendinitis, bilateral epicondylitis, and fibromyalgia. (Ex. 55). Claimant requested a hearing regarding the denied claims. On October 17, 1996, prior to the scheduled hearing, the employer accepted claimant's claim for left shoulder calcific tendinitis. At hearing, claimant argued that her upper extremity fibromyalgia was a compensable consequence of the accepted shoulder tendinitis condition.

The ALJ set aside the employer's denial of the claim for bilateral upper extremity fibromyalgia condition,[1] based on the opinion of Dr. Keller, treating neurologist. We disagree.

Considering the passage of time since the onset of claimant's initial symptoms and the disagreement among the medical experts regarding the diagnosis and etiology of claimant's problems, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. See Barnett v. SAIF, 122 Or App 279 (1993). We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find such reasons.

On March 8, 1995, Dr. Keller stated: "Certainly fibromyalgia syndrome occurs spontaneously without evidence of any kind of work injury. It is difficult for me to say if this arose out of [claimant's] work." (Ex. 43-2). A month later, Dr. Keller noted that claimant was under a lot of stress, which worsened her symptoms. (Ex. 44).

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[1] The ALJ upheld the employer's denial of claimant's claim for bilateral epicondylitis.

In a letter to claimant's attorney, dated August 30, 1995, Dr. Keller opined:

"[T]he fibromyalgia is a secondary process as a result of [claimant's] chronic process as a result of her chronic orthopedic process of rotator cuff tendinitis with secondary calcification. Her symptoms in her right and left shoulder never significantly improved with treatment, therefore, leading to the development of that chronic pain syndrome which I addresses [sic] as fibromyalgia.

"I do not feel that her symptoms in her legs is [sic] related to the work accident issues of her shoulders.

"Therefore, after reviewing my chart, it is my opinion that the fibromyalgia condition that she has at present is a result of her work activities that led to the initial diagnosis of rotator cuff tendinitis with secondary calcification.

"It is also my opinion that her leg problems is [sic] not related to her work activities." (Ex. 49A).

In a letter to the employer, dated October 15, 1995, Dr. Keller reported:

"[Claimant's] symptoms involve her arms, shoulder and legs. [Claimant] is quite stressed, in fear of losing her job, because of her symptoms. I did indicate to her that fibromyalgia can occur spontaneously, without any kind of work injury. However, in this case, since I am asked to specifically address it, it is my medical opinion that her fibromyalgia symptoms involving her neck and right shoulder are temporary and related to her work activities. However, the symptoms involving her legs seems [sic] unrelated to her work activities." (Ex. 52).

Noting that claimant was under a lot of stress in early 1996, Dr. Keller characterized claimant's condition as "post-traumatic fibromyalgia from her work injury of her upper extremities." (Ex. 44A-2). A month later, Dr. Keller stated, "I feel that the patient does meet the criteria for fibromyalgia, and her classification of fibromyalgia is that of secondary [], which is known to be caused by trauma and other factors." (Ex. 44A-3). In May 1996, Dr. Keller explained her opinion that claimant "started out with some bursitis-type symptoms involving her shoulder that chronically became a problems and worked into a secondary fibromyalgia picture." (Ex. 44A-4). Finally, on June 5, 1996, Dr. Keller reported that claimant's fibromyalgia symptoms had worsened due to a fall in Las Vegas. (Ex. 46).

We find Dr. Keller's opinion unpersuasive for several reasons. First, although she initially acknowledged that fibromyalgia occurs "spontaneously," without evidence of work injury and stated that it would be difficult to relate claimant's condition to her work, Dr. Keller then stated that ("secondary") fibromyalgia was caused by trauma and other factors. She eventually concluded that claimant's condition was caused by "work activities" and/or the work "injury." In our view, Dr. Keller has thus changed her opinion significantly over time, without adequate explanation. See Moe v. Ceiling Systems,44 Or App 429 (1980).

Second, to the extent that Dr. Keller explained why she believes claimant's fibromyalgia is related to her work or to the work-related shoulder condition, we find her opinion conclusory. See Somers v. SAIF, 77 Or App 259 (1986).

Third, although Dr. Keller acknowledged causes other than trauma, there is no indication that she weighed the relative contributions of such causes in reaching her conclusion. See Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). Under these circumstances, we decline to rely on Dr. Keller's opinion. See Somers, 77 Or App 259. Because there is no other medical evidence relating claimant's fibromyalgia condition to her work or her compensable condition, we conclude that the claim must fail. See ORS 656.005(7)(a)(A); see also ORS 656.802(2)(a).

The ALJ awarded a $4,000 attorney fee under ORS 656.386(1) for claimant's counsel's services with regard to the fibromyalgia and tendinitis conditions. Because we hereby reinstate the employer's denial of the fibromyalgia condition, claimant is not entitled an attorney fee for services related to that condition. See ORS 656.386(1). Accordingly, 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 left shoulder tendinitis condition is $2,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. The ALJ's attorney fee assessment is modified accordingly.

ORDER

The ALJ's order dated October 31, 1996 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's bilateral upper extremity fibromyalgia condition is reversed. The denial is reinstated and upheld. In lieu of the ALJ's $4,000 assessed attorney fee, claimant is awarded a $2,000 attorney fee (for services related to obtaining a pre-hearing acceptance of claimant's left shoulder calcific tendinitis condition), payable by the employer. The remainder of the order is affirmed.

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April 11, 1997 Cite as 49 Van Natta 479 (1997)

In the Matter of the Compensation of
**VIRGIE WEBB, Claimant**
WCB Case Nos. 96-03688 & 95-09567
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denials of claimant's aggravation claim for her current low back condition; and (2) awarded a penalty for an allegedly unreasonable denial. On review, the issues are jurisdiction, compensability, aggravation and penalties. We vacate in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of "May 20, 1989" in finding of fact no. 8.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. On May 3, 1988, claimant experienced a low back injury, which the insurer accepted as a nondisabling lumbosacral strain. On February 8, 1990, the insurer reclassified the claim as disabling. On August 24, 1990, the insurer issued a Notice of Closure that awarded no permanent disability.

In October 1990, Dr. Bert diagnosed claimant with "disc syndrome." An MRI revealed degenerative disc disease (DDD) at L4-5 and L5-S1, which was the cause of claimant's symptoms. On November 13, 1990, the insurer accepted an aggravation claim for "disc syndrome as per Dr. Bert." (Ex. 20). On November 29, 1990, Dr. Bert performed laminectomies, diskectomies, and posterior fusion surgery for claimant's DDD at L4-5 and L5-S1. An October 15, 1992 Determination Order awarded claimant 30 percent unscheduled permanent disability, which included values for impairment resulting from her November 29, 1990 surgery. The Determination Order stated that claimant's aggravation rights began to run as of August 24, 1990. Neither party requested reconsideration.

In June 1993, claimant injured her low back in a noncompensable motor vehicle accident. She subsequently experienced persistent, increasing low back symptoms. In June 1994, diagnostic tests showed that her symptoms were due to her L4-5 and L5-S1 discs. On July 7, 1995, the insurer denied claimant's "aggravation" claim on the grounds that: (1) her current symptoms were unrelated to her 1988 injury; and (2) the major contributing cause of claimant's current condition was not work-related. On January 3, 1996, Dr. Kitchel performed surgery at L4-5 and L5-S1, which included excision of the remaining disc material and an anterior (as opposed to the prior posterior) fusion.

On April 8, 1996, the insurer received a report from Dr. Woolpert, who had performed a medical records review. On April 10, 1996, the insurer issued an "expanded" aggravation denial on the grounds that claimant's 1988 injury had probably resolved within 30 days, and did not materially change the course of her preexisting DDD, which was the major contributing cause of her low back treatment after the 1988 injury resolved, including the surgical procedures performed by Drs. Bert and Kitchel, and any current disability.

Aggravation

After finding claimant's current low back condition compensable, the ALJ set aside the insurer's aggravation denial. However, based on the record before us, claimant's aggravation rights stemming from the May 3, 1988 injury have expired.

ORS 656.273(4)(b) provides that a claim for aggravation of a nondisabling injury must be made within five years after the date of injury.[1] The record establishes that claimant's May 3, 1988 low back injury claim was initially accepted as nondisabling. (Ex. 4). The insurer reclassified the claim as disabling on February 8, 1990, more than a year after the injury. (Ex. 9). Thus, claimant's aggravation rights expired five years after the date of injury, on May 3, 1993. ORS 656.273(4)(b).

According to the insurer's July 7, 1995 "aggravation" denial, claimant's "aggravation" claim resulted from medical reports indicating that her condition had worsened subsequent to a June 25, 1993 motor vehicle accident, in particular reports from Dr. Kitchel, who recommended going forward with anterior fusion surgery on February 3, 1995. We agree. (See Exs. 60-3, 64). Therefore, claimant's "aggravation" claim was made after the expiration of her aggravation rights.[2] Because claimant's aggravation rights expired before she filed her claim for a worsening, the Board, in its "own motion" capacity, has exclusive jurisdiction over claimant's "aggravation" claim. ORS 656.278(1)(a); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Carl C. Clayton, 47 Van Natta 1069 (1995). By the same token, because the filing requirements of ORS 656.273 are jurisdictional, the Hearings Division did not have jurisdiction over the "aggravation" claim.[3] See 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). We accordingly vacate those portions of the ALJ's order that purported to set aside the "aggravation" denial. Claimant's request for hearing related to the July 7, 1995 aggravation denial is dismissed.

April 10, 1996 Denial

On April 10, 1996, the insurer issued a denial, stating that it was "expanding" on its July 7, 1995 aggravation denial. The denial did not acknowledge that it had accepted any claim. The insurer stated:

> "Please take note that we deny the compensability of your current condition because recently obtained medical evidence indicates:
>
> "1. That prior to your injury of 5-3-88 you had a preexisting, degenerative lumbosacral disc disease condition.

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[1] Aggravation rights are governed by ORS 656.273(4), which 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] In reaching this decision, we note that the August 24, 1990 date given by the Determination Order is not controlling, if in fact claimant's aggravation rights have expired. Timothy D. Beard, 43 Van Natta at 433. Moreover, there is no evidence that claimant's cervical condition was misclassified from the outset. See Smith v. Ridgepine, Inc., 88 Or App 147 (1987).

[3] Although no party raised the issue of the ALJ's jurisdiction to address the employer's March 24, 1995 "aggravation" denial, jurisdictional issues such as this are not dependent on whether a party has raised the issue. See Southwest Forest Industries v. Anders, 299 Or 205 (1985); Jody Crompton, 48 Van Natta 1181 (1996).

"2. That the injury of 5-3-88, at most produced a transient exacerbation of symptoms, which in all probability resolved within 30 days of the event or less.

"3. That the injury of 5-3-88 did not materially change the course of your pre-existing degenerative disc disease.

"4. That the pre-existing condition was the major cause of your subsequent treatment, including the surgical procedures performed by Drs. Bert and Kitchel, and the major contributing cause of any disability you may currently have."

As noted above, because claimant's aggravation rights have expired, the Board has exclusive jurisdiction over reopening this claim for the benefits allowed pursuant to ORS 656.278, which include temporary disability compensation. However, because the Board's own motion jurisdiction does not extend to issues of compensability, we address the compensability of claimant's current low back condition.

Relying on Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996), the ALJ concluded that the insurer was barred from contending that claimant's degenerative disc disease (DDD) is not compensable, because the insurer failed to appeal the Determination Order awarding permanent partial disability for that condition. In addition, the ALJ found that the preponderance of the medical evidence established that the major contributing cause of claimant's current low back condition and need for treatment is her compensable conditions, rather than her intervening MVA. We adopt and affirm that portion of the ALJ's opinion appearing on page 4, including footnote 2.[4]

On review, the insurer appears to contend that ORS 656.262(6)(c) applies in this case to permit its denial. We disagree. As we explained in Patricia A. Landers, 48 Van Natta 1720 (1996), ORS 656.262(6)(c) permits a carrier 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, but only if the carrier has accepted the combined or consequential condition under ORS 656.005(7), whether voluntarily or as a result of a judgment or order. Here, the employer does not contend that it voluntarily accepted claimant's underlying degenerative condition as either a combined or consequential condition, nor was it directed to do so by litigation order. Therefore, ORS 656.262(6)(c) is not applicable.

Moreover, even if the insurer had voluntarily accepted claimant's low back condition as either a combined or consequential condition, for ORS 656.262(6)(c) to apply, the compensable injury must "cease" to be the major contributing cause of claimant's condition. As we explained in Anthony J. McGee, 48 Van Natta 1695 (1996), the word "cease" in ORS 656.262(6)(c) presumes a change in circumstances or a change in causation so that the compensable condition is no longer 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).

Here, the insurer does not argue that there has been a change in claimant's condition or circumstances. To the contrary, the insurer asserts that claimant's degenerative condition has never been a compensable component of claimant's claim and that the degenerative condition is the major contributing cause of claimant's current condition. Inasmuch as that is a basis for a "back-up" denial under ORS 656.262(6)(a), rather than a partial denial under ORS 656.262(6)(c), we do not find the latter statutory provision to be applicable.

Finally, because we have concluded that claimant's compensable conditions are the major contributing cause of claimant's current condition, ORS 656.225[5] does not apply here.

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[4] We do not adopt page 5 of the ALJ's opinion, as it is inapplicable here, where the issue is whether the compensable conditions or an intervening MVA is the major contributing cause of claimant's current condition and need for treatment.

[5] ORS 656.225(1) provides in pertinent part that, 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 work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

Unreasonable April 10, 1996 Denial

We adopt and affirm the ALJ's opinion on this issue.

Attorney Fees

The ALJ awarded claimant's counsel assessed attorney fees of $1,950 for services concerning the aggravation issue and $3,000 for services concerning the compensability issue. Inasmuch as we have vacated the ALJ's order with regard to the aggravation issue, no attorney fee is allowed for services devoted to that 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 in regard to the compensability issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 6, 1996 is affirmed in part, modified in part, and vacated in part. That portion of the ALJ's order which set aside the insurer's aggravation denial and awarded a $1,950 assessed attorney fee is vacated. Claimant's hearing request on the aggravation denial is dismissed. The remainder of the ALJ's order is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded $1,000, payable by the insurer.

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In the Matter of the Compensation of
**CLYDE E. WILLCUTT, Claimant**
WCB Case No. 96-05370
ORDER ON REVIEW
Richard C. Pearce, Claimant Attorney
James Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its partial denial of claimant's consequential cervical condition. Enclosing a copy of a recently discovered "missing" page from an admitted physician's report, claimant moves to supplement the record. Since our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand to the Hearings Division for the taking of additional evidence. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability.

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

Compensability

In setting aside SAIF's partial denial, the ALJ reasoned that claimant had sustained her burden of proving under ORS 656.005(7)(a)(A) that the cervical condition is a direct consequence of treatment claimant received for a compensable 1974 low back injury. On review, SAIF argues that the medical evidence from claimant's treating surgeon, Dr. Grewe, does not expressly support a conclusion that the compensable low back injury caused the left leg numbness/weakness that caused a fall that caused claimant's cervical injury. Therefore, SAIF contends the medical evidence fails to satisfy claimant's burden of proving major causation. We disagree with SAIF's contention.

In Freightliner Corporation v. Arnold, 142 Or App 98 (1996), 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 so concluding, the court reiterated that "[a]n expert's opinion need not be ignored merely because it fails to include 'magic words' such as 'major contributing cause.'" Arnold, 142 Or App at 105 (citing McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986)).

Despite the absence of "magic words," as did the expert opinion in Arnold, Dr. Grewe's opinion satisfies claimant's burden of proof in this case. Prior to and during surgery, Dr. Grewe noted the presence of preexisting degenerative changes at C4-5 and 5-6. Nevertheless, Dr. Grewe attributed claimant's condition to "acute" herniations at C4-5 and 5-6. Viewing Dr. Grewe's opinion as a whole, we conclude that the October 1994 treatment for the compensable low back condition (that injured claimant's sciatic nerve causing left leg numbnerss/weakness) was the major contributing cause of claimant's cervical condition. Moreover, for the reasons expressed by the ALJ, we too find the contrary opinion of Dr. Rosenbaum, who examined claimant one time at SAIF's request, not persuasive.

Accordingly, under either a material or the major contributing cause standard, claimant has established compensability. Therefore, we conclude that the ALJ properly set aside SAIF's partial denial. We, therefore, affirm.

Remand

We may remand a case to the ALJ, if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, we need not resolve this issue. Because claimant prevails without considering this omitted page, the proffered evidence will not likely affect the outcome of the case. Thus, there is no compelling reason to remand. In any event, claimant has offered no reason why the missing page was unobtainable with due diligence prior to the close of the record. Therefore, we deny claimant's request for remand.

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 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), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 15, 1996 is affirmed. For services on review, claimant's attorney's is awarded $1,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
**DEL R. SPUNAUGLE, Claimant**
WCB Case No. 96-04551
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that awarded 14 percent (21 degrees) scheduled permanent disability for loss of use or function of the right leg (knee), whereas an Order on Reconsideration awarded no permanent disability. In its respondent's brief, the self-insured employer asserts that the ALJ erred in declining to admit Exhibits 40A, 41A and 46A. On review, the issues are evidence and extent of scheduled permanent disability.

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

After closing argument, the employer submitted Exhibits 40A, 41A and 46A, documents that were included as part of the reconsideration record, but were not previously offered as evidence at the hearing. Claimant objected to these exhibits as untimely offered. The ALJ found no reason why the exhibits could not have been submitted at the time of hearing and declined to continue the proceeding to admit the evidence. The ALJ further found that the admission of these documents would not have affected the outcome of the case in any event.

On review, the employer asserts that ORS 656.283(7) requires and contemplates that *all* documents submitted at reconsideration be admitted and considered by the ALJ in evaluating the extent of a worker's disability, and argues that the ALJ erred in declining to admit Exhibits 40A, 41A and 46A into the record at hearing. We disagree.

Although ORS 656.283(7) limits the evidence admissible in an "extent" hearing to that which was submitted at the reconsideration process required by ORS 656.268, there is no requirement that the ALJ admit and consider every document that was part of the Director's reconsideration record. See Juan C. Rogriguez, 48 Van Natta 762 (1996) (ALJ did not abuse discretion in denying the claimant's request to continue the hearing for admission of the Director's reconsideration record because it is a party's responsibility to present the relevant evidence for admission into the record at hearing.) Indeed, the applicable rules contemplate that the parties present at hearing only those portions of the Director's reconsideration record that are relevant and material to the issues in dispute. See OAR 438-007-0018(3), (5) and (7).

Moreover, even if the employer's evidentiary argument was well-taken, we conclude that the proffered evidence would not affect the outcome of this case. Therefore, it is not necessary to determine whether the ALJ erred by excluding Exhibits 40A, 41A and 46A. See Jose L. Duran, 47 Van Natta 449 (1995); Larry D. Poor, 46 Van Natta 2451 (1994).

ORDER

The ALJ's order dated September 30, 1996 is affirmed.

In the Matter of the Compensation of
**HOWARD L. BROWNE, Claimant**
Own Motion No. 96-0211M
OWN MOTION ORDER ON RECONSIDERATION
Michael M. Bruce, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 14, 1997 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability benefits because he failed to establish that the current condition for which he requested Own Motion relief was a compensable component of his L4-5 injury claim with the SAIF Corporation.[1] With his request for reconsideration, claimant submits information regarding his May 28, 1996 multi-level surgery, which included surgery to his compensable L4-5 level disc injury.

On March 18, 1997, we abated our prior order to allow the SAIF Corporation an opportunity to respond to claimant's motion. SAIF has not responded. Therefore, on reconsideration, we withdraw our prior order and issue the following order in place of our February 14, 1997 order.

We recite a brief history of this claim. On August 10, 1982, claimant sustained a compensable L4-5 injury to his back. On January 24, 1996, Dr. Bert, claimant's treating physician, requested authorization for decompression surgery at the L3-4 level.

On April 25, 1996, SAIF denied the compensability of claimant's lateral recess stenosis at L3-4. Claimant requested a hearing. (WCB Case No. 96-05769). On May 28, 1996, claimant underwent multilevel back surgery.

On June 27, 1996, the Board postponed action on the Own Motion request pending resolution of the pending litigation. On January 28, 1997, Administrative Law Judge (ALJ) T. Lavere Johnson approved the parties' "Stipulation and Disputed Claim Settlement." Pursuant to that settlement, claimant agreed that SAIF's April 25, 1996 denial of claimant's L3-4 lateral recess stenosis would remain in full force and effect. In addition, claimant stipulated that his request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues raised or raisable."[2]

On February 14, 1997, the Board issued an Own Motion Order, in which we declined to authorize the reopening of claimant's 1982 injury claim for the payment of temporary disability compensation because claimant had not established that his current L3-4 disc condition (for which SAIF notified the Board that claimant requested Own Motion relief), was a compensable portion of his accepted L4-5 injury claim.

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

On March 14, 1997, claimant submitted a May 28, 1996 operative report from Dr. Grewe, in which Dr. Grewe noted that claimant's operation included: (1) bilateral, four level, L2 through S1 decompression laminotomies and foraminotomies; and (2) bilateral L1-2 partial laminectomy with removal on interspinous process of bursa. In addition, claimant submitted a May 13, 1996 letter from SAIF, in which it acknowledges that surgery had been requested for multilevel disc decompression, and in which it advised that it was responsible for the L4-5 level only. SAIF further advised that "Dr. Grewe[']s office has called [SAIF] and informed me they will be sep[a]rating the charges for [claimant's] surgery and recuperation based on our companies[']' respective responsibility."

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[1] In its April 25, 1996 Carrier's Own Motion Recommendation, SAIF lists claimant's current condition (the condition for which claimant requested Own Motion relief, and the condition which was the subject of SAIF's April 25, 1996 denial) as "lateral recess stenosis at L3-4."

[2] The January 28, 1997 Stipulation and Disputed Claim Settlement pertains only to claimant's L3-4 condition as denied by SAIF on April 25, 1996. Therefore, pursuant to the January 28, 1997 DCS, SAIF's denial of claimant's current L3-4 condition remains in full force and effect.

Claimant contends that SAIF denied only his lateral recess stenosis at the L3-4 level condition. Claimant's surgery was for multilevel decompression laminotomies and foraminotomies, as well as bilateral L1-2 partial laminectomy. However, SAIF has provided that it is responsible for "surgery and recuperation" at claimant's L4-5 level. We conclude that claimant's L4-5 level surgery was provided as part of his May 28, 1996 multilevel surgical procedure. On this record, we find that claimant's compensable L4-5 injury worsened requiring surgery.

Accordingly, we conclude that it is appropriate to authorize the reopening of claimant's 1982 injury claim for the payment of temporary disability compensation, commencing May 28, 1996, the date he was hospitalized for multilevel back surgery.[3] When claimant is medically stationary with respect to his compensable condition(s), 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.

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[3] SAIF is not precluded from voluntarily paying for surgical costs and / or temporary disability compensation (TTD) for treatment to conditions other than the compensable injury. However, regarding claimant's multilevel surgical procedure, SAIF stated in its May 13, 1996 letter to Blue Cross / Blue Shield that it "is responsible for the L4-5 level only." Because claimant's L3-4 condition remains in denied status, we do not have jurisdiction to authorize the reopening of claimant's 1982 claim for payment of TTD for his L3-4 condition. Finally, we note that claimant's multilevel surgery may have included other noncompensable areas of claimant's back, including L2 through S1 decompression laminotomies and foraminotomies, as well as L1-2 partial laminectomy. We do not have the authority to authorize TTD for any surgical procedure save for that performed on claimant's compensable condition(s). See ORS 656.278(1); Morris B. Grover, 48 Van Natta 2325 (1996).

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April 15, 1997 Cite as 49 Van Natta 486 (1997)

In the Matter of the Compensation of
**VIRGINIA M. LEWIS, Claimant**
WCB Case No. 93-03617
ORDER ON REMAND
Max Rae, Claimant Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to its March 5, 1997 order, the court has reversed our prior order, Virginia M. Lewis, 46 Van Natta 1215 (1994), that affirmed an Administrative Law Judge's (ALJ's) order which had affirmed a Director's determination finding that claimant was not a subject worker. Noting the Department's acknowledgement that the ALJ's order contained incorrect appeal rights, the court has remanded to the Board with instructions to dismiss claimant's request for review and "grant leave to the Director to issue a corrected order stating the correct appeal rights."

In accordance with the court's instructions, claimant's request for Board review is dismissed. In addition, the Director is granted leave to issue a corrected order stating the correct appeal rights.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CECIL A. MAGDEN, Claimant**
Own Motion No. 97-0066M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our February 20, 1997 Own Motion Order in which we declined to reopen claimant's 1987 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability. With its request for reconsideration, SAIF submitted additional information regarding the work force issue.

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. 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).

SAIF's request for reconsideration of our February 20, 1997 order was received by the Board on March 28, 1997, more than 30 days after the mailing date of our order. However, in its March 27, 1997 letter, SAIF advised that claimant's check stubs (evidence claimant submitted to SAIF to prove he was in the work force at the time of disability) were "received at SAIF Corporation on March 3, 1997." In addition, SAIF notes that "the check stubs were misrouted, thus accounting for the timelag in submission" to the Board.

Although we find that SAIF did not timely request reconsideration of our prior order, we further conclude that claimant submitted the information to SAIF timely. Furthermore, claimant's "proof of work" evidence was misrouted at SAIF. Finally, the SAIF claims examiner submitted claimant's work force evidence to the Board expeditiously after she received it, and requested, on claimant's behalf, that the Board consider the information.

We are persuaded that claimant's diligence in submitting the work force evidence timely to SAIF, as well as SAIF's explanation that claimant's submission was misrouted by SAIF (which accounts for its untimely submission to the Board), constitute "good cause" for SAIF's untimely reconsideration request. See OAR 438-012-0065(2). Therefore, on reconsideration, we withdraw our prior order and issue the following order in place of our February 20, 1997 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.

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

Claimant contends that he qualifies for temporary disability compensation because he continued working until his compensable condition worsened requiring surgery. Claimant submitted two check stubs from his place of employment, Les Schwab Tire Centers, for payroll periods ending January 31, 1997 and February 15, 1997. These payroll stubs reflect claimant's cumulative pay amounts for 1997. We are persuaded that the payroll stubs establish that he was working at the time of disability.[1] On this record, we conclude that claimant has established that he was in the work force at the time of disability.

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[1] Furthermore, SAIF agrees that claimant's check stubs "substantiate [claimant's] participation in the workforce." Therefore, it appears that SAIF no longer contests that claimant was not 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.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**TERRY E. STRAIN, Claimant**
WCB Case No. 96-04561
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

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

On page 2, we change the third full paragraph to read:

> "An x-ray report dated May 11, 1994 indicated that claimant had atypical L4-5 facet joints that were probably a developmental variation and she also had changes in the sacroiliac joints that were likely an inflammatory arthritis. (Ex. 6). The x-ray report indicated that all of the changes likely preexisted the December 1993 injury."

We change the third sentence in the fourth full paragraph on page 2 to read: "Dr. Hall noted that claimant had gained 36 pounds over the past two years."

The ALJ found that claimant's current low back condition was not the same as the accepted low back strain. The ALJ concluded that claimant failed to establish compensability of her current condition by failing to prove that her compensable 1993 injury was the major contributing cause of her current condition pursuant to ORS 656.005(7)(a)(B).

On review, claimant argues that her condition is the same condition accepted by the employer in February 1994. Claimant also contends that ORS 656.005(7)(a)(B) does not apply because there is no medical evidence that she has a "combined condition." Finally, claimant argues that Dr. Hall's opinion establishes an "actual worsening" under ORS 656.273.

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." Subsequent to the ALJ's order, the court determined that the term "actual worsening" was not intended to include a symptomatic worsening. SAIF v. Walker, 145 Or App 294, 305 (1996). Rather, the court concluded that the statute "requires that there be direct medical evidence that a condition has worsened" and that, absent such evidence, it is no longer permissible for the Board "to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim." Id. Proof of a pathological worsening is required. Id.

Claimant's accepted condition from her 1993 injury is a low back strain. (Ex. 4). Even if we assume, without deciding, that claimant's condition is the same condition accepted by the employer in February 1994, we conclude that she has not established an actual worsening of her condition.

Claimant argues that, although Dr. Hall did not use the words "pathological worsening," his opinion supports that conclusion. We disagree.

Claimant sought treatment from Dr. Hall on January 15, 1996. Although Dr. Hall reported that claimant had increased low back pain, he did not provide a specific diagnosis. (Ex. 5). He reported that claimant had some loss of lateral and rotatory motion. (Id.) On January 22, 1996, Dr. Hall reported that claimant's examination showed no changes except for decreased motion. (Ex. 7A).

Claimant's January 22, 1996 lumbar spine x-rays were compared with the 1994 x-rays. (Ex. 8). The radiologist noted a minor scoliotic curve concave along the left, but commented that it "may be chance positioning today." (Id.) The radiologist reported that the "study is otherwise not changed since the workup of May 11, 1994[.]" (Id.)

In a concurrence report from claimant's attorney, Dr. Hall agreed with the following statement:

> "On January 15, 1996, you examined [claimant] and took a history which included problems again with her low back. She reported problems getting out of bed occasionally and having to be careful in her job activities. She also reported that she had helped to scoot her mother up in her bed and had felt some back pain. You indicated that she had a loss of range of motion, which loss was objectively greater than in your previous examination. Based on these findings and [claimant's] history, you signed and filed an aggravation form." (Ex. 10a-2).

Drs. Wilson and Arbeene examined claimant on behalf of the employer. Although they reported that the ranges of motion of the lumbar spine were restricted, they concluded that the ranges of motion were invalid and did not fit the validity criteria. (Ex. 14). They concluded that claimant had not suffered a pathological worsening of her accepted lower back strain, which they felt had long since resolved. (Ex. 9-6). They noted that claimant had preexisting degenerative disc disease at multiple levels that was unrelated to the strain. (Ex. 9-5).

When the medical evidence is divided, we give the most weight to opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Conversely, we give the least weight to conclusory, poorly analyzed opinions, such as unexplained, conclusory "check-the-box" reports. Marta I. Gomez, 46 Van Natta 1654 (1994).

We are not persuaded by Dr. Hall's conclusory opinion. Although Dr. Hall reported that claimant had decreased range of motion, he did not explain whether claimant's underlying compensable condition had worsened or whether she merely had a symptomatic worsening. Even if we assume that claimant's range of motion findings were valid, Dr. Hall's reports are not sufficient to establish a pathological worsening of her 1993 low back strain. The remaining medical reports do not provide "direct medical evidence that a condition has worsened." Walker, 145 Or App at 306. Accordingly, we conclude that claimant has failed to prove an aggravation of her compensable condition. Consequently, the ALJ's order is affirmed.

ORDER

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

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April 15, 1997 Cite as 49 Van Natta 489 (1997)

In the Matter of the Compensation of
**JOHN M. WILSON, Claimant**
WCB Case No. C700569
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Jeff Gerner (Saif), Defense Attorney

On March 10, 1997 the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition for approval, the worker, the insurer or self-insured employer requests the Board to disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on March 10, 1997. The statutory 30th day following the submission is April 9, 1997. Claimant filed his request for disapproval of the disposition on April 8, 1997. Accordingly, we disapprove the disposition. Id.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

IT IS SO ORDERED.

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April 16, 1997 Cite as 49 Van Natta 490 (1997)

In the Matter of the Compensation of
**HARRY R. BOSTWICK, Claimant**
Own Motion No. 97-0149M
OWN MOTION ORDER
Myrick, Seagraves, et al, Claimant Attorneys
Travelers Insurance Company, Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable 1968 left knee (and left knee total replacement) injury. Claimant's aggravation rights expired on August 11, 1974. The insurer recommends against reopening the claim on the ground 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 January 24, 1997, Dr. Galt, claimant's treating orthopedic surgeon, recommended that claimant undergo arthrotomy and exploration of his left knee, anticipating the removal of the polyethylene of the tibial component and replacement in claimant's left knee. 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).

The insurer contends that claimant was not in the work force at the time of disability because he "had removed [himself] from the workforce from 1990 through 1996 due to an unrelated workers[']compensation injury to [his] right knee." Furthermore, the insurer contends that claimant did not provide any evidence that he was looking for work just prior to his left knee surgery.

Contrary to the insurer's contention, claimant contends that he qualifies for temporary disability compensation in his 1968 claim because he was receiving time loss in another workers' compensation claim until January 9, 1997 (that claim was closed on February 28, 1997). 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.

Claimant does not dispute that he was not working or seeking work at the time of current disability. However, by definition, while claimant is receiving time loss due to a compensable injury, he remains in the work force because he was unable to work due to a compensable injury. See Michael C. Johnstone, 48 Van Natta 761 (1996); William L. Halbrook, 46 Van Natta 79 (1994); Dawkins v. Pacific Motor Trucking, 308 Or at 258. Furthermore, the insurer agrees that claimant was unable to work due to an "unrelated" (unrelated to his 1968 injury claim) workers' compensation injury.

Here, we conclude that claimant had not voluntarily removed himself from the work force at the time of disability. Claimant sustained another compensable injury which prevented him from working at the time of his current disability. Claimant submitted a copy of a February 28, 1997 Notice of Closure which closed his 1971 injury claim with another insurer with an award of temporary disability compensation from August 15, 1990 through January 9, 1997. Thus, claimant's inability to work from 1990 through 1996 was because of a compensable injury, and is supported by his receipt of temporary disability compensation.[1]

Furthermore, in his March 13, 1997 signed statement, claimant contended that he was "not able to work from 1990 to early 1997 because I had 9 surgeries on my right knee area." Medical documentation in the record supports claimant's contention. Finally, in a February 3, 1997 chart note, Dr. Clark, claimant's treating physician, noted that claimant had been involved in shoe repair businesses his entire life, and continued to try to perform that type of work "to some degree."[2] Therefore, we reject the insurer's argument that claimant had withdrawn from the work force at the time of disability because he was receiving temporary disability compensation for another workers' compensation injury claim.

On this record, we conclude that claimant has established that he was willing to work, but unable to work because of a compensable injury at the time of his January 1997 disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning February 17, 1997, the date he was hospitalized for left knee surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] Temporary disability compensation is provided in workers' compensation claims to compensate injured workers for interrupted income due to "temporary disability" caused by a compensable injury. A worker's inability to work due to any compensable injury is sufficient to satisfy the "futility" component of the Dawkins criteria listed herein. See Michael C. Johnstone, 48 Van Natta at 761.

[2] Claimant's signed statement in addition to medical reports in the record documenting his multiple surgeries and attempts to try to work are sufficient to satisfy the "willingness" portion of the "futility" criterion in Dawkins, 308 Or at 258. See William Halbrook, 46 Van Natta at 79.

In the Matter of the Compensation of
**JOHN T. HAMMERSLEY, Claimant**
WCB Case No. 96-07835
ORDER ON REVIEW
John M. Pitcher, Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant, pro se,[1] requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration that awarded 4.06 percent (7.8 degrees) scheduled permanent disability for loss of binaural hearing and awarded no unscheduled permanent disability for a tinnitus condition. On review, the issue is extent of unscheduled permanent disability.

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

Based on the March 12, 1996 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 96-051, as amended by WCD Admin. Orders 96-068 and 96-072. See OAR 436-035-0003(2), (3). Former OAR 436-035-0390(7)(b) provides a value of 5 percent impairment for "[t]innitus which by a preponderance of medical opinion requires job modification." Claimant has the burden of proving the extent of any disability related to his compensable hearing loss condition. ORS 656.266.

Here, we agree with the ALJ that the preponderance of medical opinion fails to establish that the tinnitus condition requires job modification. In this regard, only the opinion of Dr. Reynolds, the medical arbiter, might support claimant's position. (Ex. 6). However, for the following reasons, in addition to those addressed by the ALJ, we find that Dr. Reynolds' opinion does not meet claimant's burden of proof.

In the "Impression" section of Dr. Reynolds' opinion, he discusses only claimant's hearing loss, and does not mention the tinnitus condition. Immediately following this section, Dr. Reynolds states that "[g]iven [claimant's] history, [he] should be placed in areas of work in which he will not be exposed to loud noise. If he finds the tinnitus to be debilitating it may be reasonable to provide him with a tinnitus masker, as well." (Ex. 6-2, -3). Dr. Reynolds does not relate the job modification to the tinnitus condition.

In addition, given the juxtaposition of Dr. Reynolds' exclusive discussion of claimant's hearing loss, without mention of tinnitus, with the job modification, we find it more probable that the job modification relates to the hearing loss. Finally, even if the use of a "tinnitus masker" can be considered a job modification, Dr. Reynolds expresses this only in terms of possibility, not as a requirement, as the applicable rule requires. Former OAR 436-035-0390(7)(b).

ORDER

The ALJ's order dated December 30, 1996 is affirmed.

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[1] Although represented at hearing, claimant is pro se on review. The Board sent claimant and the insurer a briefing schedule. As the appealing party, claimant's appellant's brief was due 21 days from the date of notice of the briefing schedule. No brief has been received from claimant. Nonetheless, since he has not requested that his appeal be dismissed, we have proceeded with our review. In reaching this decision, we note that, if either party is dissatisfied with the result of our review, that party may request reconsideration of our order and submit their written positions at that time. However, since our authority to further consider this case expires within 30 days from the date of this order, we must receive any reconsideration request as soon as possible.

In the Matter of the Compensation of
**BRAD D. LINNELL, Claimant**
Own Motion No. 95-0448M
OWN MOTION ORDER ON RECONSIDERATION
Black, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On November 3, 1995, we declined to reopen claimant's claim for the payment of temporary disability compensation because he failed to establish that his current L4-5 condition was a compensable component of his 1982 industrial injury claim with the SAIF Corporation.

In a February 27, 1997 letter, claimant requests that the Board authorize the reopening of his claim for the payment of temporary disability benefits. With his letter, claimant enclosed a copy of a May 24, 1996 Opinion and Order, which set aside the SAIF Corporation's August 31, 1995 denial of his current condition in this claim. We treat claimant's letter as a request for reconsideration of our November 3, 1995 Own Motion Order.

Pursuant to OAR 438-012-0065(2), claimant had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if he could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding these filing deadlines. Id.

In his May 24, 1996 order, the ALJ found that claimant had established "good cause" for his late appeal of SAIF's August 31, 1995 denial of his L4-5 condition.[1] Addressing the merits of claimant's denied claim, the ALJ further determined that the issue to be determined at hearing was the compensability of claimant's L5-S1 disc condition. Finally, the ALJ concluded that SAIF's August 31, 1995 denial was amended at hearing to include its denial of claimant's L5-S1 disc condition.[2]

Although claimant did not timely request reconsideration of our November 3, 1995 Own Motion Order, we conclude that a pivotal issue on which our order was premised (i. e., the appeal of SAIF's August 31, 1995 denial of claimant's L4-5 condition) was subsequently and finally litigated and resolved.[3] Under the particular circumstances of this case, we conclude that good cause has been established to warrant our further consideration of this matter. See OAR 438-012-0065(2). Consequently, we withdraw our prior order for the purposes of reconsideration and proceed with our review of the record.

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

Claimant underwent L4-5 disc excision surgery on March 27, 1995. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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[1] In his order, the ALJ noted that the test for determining whether "good cause" exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by (former) ORCP 18.160. Relative to that test, the ALJ found that the copy of the denial mailed by SAIF to claimant apparently did not reach him. Further, the ALJ found that, although claimant's attorney had also received a copy of the denial, it was buried in the middle of a packet of Own Motion documents. Finally, the ALJ concluded that it was not until the attorney received a copy of the Board's November 3, 1995 Own Motion Order that he realized that a denial existed. The record indicates that on that same date, the attorney requested a hearing to appeal the previously "undetected" denial.

[2] In his May 24, 1996 order, the ALJ set aside SAIF's denial of claimant's L5-S1 disc herniation. Because SAIF's August 31, 1995 denial of claimant's L4-5 condition was amended at hearing to include the L5-S1 condition, we conclude that the ALJ set aside SAIF's August 31, 1995 denial, which included claimant's L4-5 condition as well as his L5-S1 disc herniation.

[3] The record establishes that SAIF requested Board review of the ALJ's May 24, 1996 order, but subsequently withdrew its request. The Board issued a final Order of Dismissal in that case on August 14, 1996.

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 his current disability.[4] In a March 5, 1997 letter, we requested the parties' positions regarding claimant's request to reopen his 1982 claim, and allowed the parties 21 days to submit those respective positions. Claimant has not responded to our request or to SAIF's contention that he was not in the work force at the time of disability. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was in the work force during the period in question. On this record, we find that claimant has not carried his burden of proving that he was in the work force at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 3, 1995 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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[4] We note that, in SAIF's August 31, 1995 recommendation, it indicated (in the check-the-box portion of the questionnaire) that it agreed that claimant was in the work force at the time of disability. However, in its August 31, 1995 cover letter attached to the recommendation, the SAIF claims examiner noted that "[t]he worker indicates that he has his own shop but we have no proof of earnings." In its March 5, 1997 letter to the Board, SAIF noted that it had again reviewed claimant's claim file, and still had no documentation to support claimant's contention that he was in the work force at the time of his surgery. Further, in its March 21, 1997 letter, SAIF reiterated that its "position remains that with the lack of proof of earnings, [claimant] was not in the work force." In that letter, SAIF contended that the agreement indicated by its checking "yes" in the work force box in the 1995 recommendation was a "typing error."

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In the Matter of the Compensation of
**PHYLLIS G. NEASE, Claimant**
WCB Case No. 96-03809
CORRECTED ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Reinisch, et al, Defense Attorneys

It has come to our attention that our Second Order on Reconsideration, which republished our February 26, 1997 Order on Review and March 21, 1997 Order on Reconsideration, contained a clerical error. Specifically, our order neglected to include a date indicating when the order was mailed. To correct this oversight, we withdraw our prior order and replace it with the following order.

Claimant requests reconsideration of our February 26, 1997 Order on Review and March 21, 1997 Order on Reconsideration. For the second time, claimant requests reconsideration, again asserting that we erred in relying on the impairment findings of claimant's treating doctor, Dr. Kho, over the findings of the medical arbiter, Dr. Gritzka.

Claimant asks whether the Board found as a matter of fact that claimant was not medically stationary at the time of reconsideration. This question misses the mark. For purposes of closing the claim and rating impairment, the pertinent issue is whether claimant was medically stationary *at the time of claim closure.* Here, the record contains no persuasive evidence that claimant was not medically stationary as to her accepted lumbar strain at the time of claim closure.[1] Dr. Kho declared her

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[1] Indeed, claimant did not raise "premature closure" as an issue in her request for hearing.

stationary in October 1995, and reported again in response to Dr. Gritzka's findings that claimant had been medically stationary with regard to her injury in October 1995 but had worsened. Although Dr. Gritzka believed that claimant was not stationary when he examined her in March 1996, he did not discuss whether her condition related to her accepted injury or her preexisting, underlying (noncompensable) degenerative facet arthropathy. Therefore, we adhere to our reliance on Dr. Kho's findings of impairment in rating the permanent impairment related to claimant's accepted injury.

Although we cited evidence in our prior orders indicating that claimant did not remain medically stationary throughout the reconsideration process, we never specifically found that claimant was not medically stationary at the time of reconsideration, because that fact was not essential to our determination of claimant's permanent impairment. If claimant contends that her "post-closure" condition became non-medically stationary and that such a condition constitutes an "actual worsening" due to her original injury, she may wish to consider pursuing an aggravation claim. In any event, because that issue was not before us in this proceeding, we decline to make any further comments on that subject.

Finally, we note that claimant has the burden of proving the extent of her permanent disability. ORS 656.266. We have found the findings of the medical arbiter are unpersuasive for the reasons set forth in our prior orders. The only other evidence we may look to in evaluating claimant's permanent impairment are the findings of Dr. Kho. See ORS 656.245(3)(b)(3); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). Even if we were to find Dr. Kho's findings unpersuasive (for the reasons asserted by claimant), that would not alter our assessment of the medical arbiter's opinion or make the arbiter's findings any more reliable. On the contrary, under those circumstances, we would find that claimant has failed to prove she is entitled to any permanent disability beyond the award granted by the Order on Reconsideration.[2]

Accordingly, our February 26, 1997 and March 21, 1997 orders are withdrawn. On reconsideration, as supplemented herein, we republish our February 26 and March 21, 1997 orders. 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 Order on Reconsideration awarded claimant 17 percent unscheduled permanent disability for her low back injury. However, because the employer did not dispute our prior orders increasing claimant's award to 22 percent unscheduled permanent disability, we would not reduce that award.

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In the Matter of the Compensation of
**MIKA T. POE, Claimant**
WCB Case Nos. 96-07222 & 96-05805
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Liberty Northwest Insurance Corporation requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of responsibility for claimant's "new injury" claim for a cervical condition; and (2) upheld the SAIF Corporation's partial denial of responsibility for the same condition. In addition, Liberty challenges the ALJ's ruling to exclude Proposed Exhibit 24. On review, the issues are responsibility and evidence.

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

On review, Liberty challenges the ALJ's ruling to freeze the evidentiary record as of September 10, 1996, the originally scheduled date of hearing, and to exclude Proposed Exhibit 24. We uphold the ALJ's ruling.

ORS 656.283(7) provides that an ALJ is not bound by common law or statutory rules of evidence and may conduct the hearing in any manner that will achieve substantial justice. The statute grants the ALJ broad discretion in the admission of evidence. See Brown v. SAIF, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. See Sandra L. Dehart, 46 Van Natta 244 (1994); Evan I. Lyman, II, 45 Van Natta 2301 (1993).

Here, the hearing was originally scheduled for September 10, 1996. Due to the unavailability of an employer representative, however, the ALJ postponed the hearing and reset it for October 22, 1996. Meanwhile, Liberty's attorney requested leave to obtain a report from Dr. Teal. In response, claimant moved that the record be frozen as of September 10, 1996. The ALJ "tentatively" denied the motion, but allowed for further argument on the motion at the October 22 rescheduled hearing. Liberty obtained Dr. Teal's report dated October 7, 1996 and offered it at hearing.

The ALJ refused to admit the report and, instead, granted claimant's motion to freeze the evidentiary record as of September 10, 1996, explaining that the parties should not be in any better position than they would have been had the originally scheduled hearing been convened on September 10. The ALJ noted that the hearing had been postponed due to the unavailability of an employer representative, not due to a substantive matter. Based on our review of the record, we are persuaded that the ALJ's rationale for freezing the record was reasonable under the circumstances of this case. Accordingly, we do not conclude that the ALJ abused his discretion in refusing to admit Proposed Exhibit 24.

Furthermore, we note that, even if we had considered Proposed Exhibit 24, it would not have altered our conclusion that the greater weight of the evidence establishes claimant's "new injury" claim with Liberty's insured. Claimant treated with Dr. Teal on only one occasion after the July 1995 accepted injury with SAIF's insured. (Tr. 17). There is no indication that Dr. Teal examined claimant at any time after the May 2, 1996 incident with Liberty's insured, though he reviewed the medical records following that incident. We conclude, therefore, that Dr. Teal's opportunity to evaluate the contribution of the 1996 incident to claimant's subsequent need for treatment was very limited. For that reason, if we had considered Dr. Teal's opinion, we would have discounted its probative value relative to the more persuasive opinions rendered by Drs. James, Weller and Tearse, all of whom had an opportunity to examine claimant after the 1996 incident.

ORDER

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

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April 16, 1997 Cite as 49 Van Natta 496 (1997)

In the Matter of the Compensation of
**WILLIAM J. SLAYTON, Claimant**
WCB Case No. 96-05444
ORDER ON REVIEW
Estell & Smith, Claimant Attorneys
Scheminske, Lyons, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that affirmed an Order on Reconsideration that awarded no scheduled permanent disability for loss of use or function of the right arm. On review, claimant requests that his claim be "remanded" to the Department for a medical arbiter exam. In its respondent's brief, the self-insured employer seeks sanctions under ORS 656.390 for claimant's allegedly frivolous request for Board review. On review, the issues are compensability, claims processing, and sanctions.

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

Claims Processing

On review, claimant requests that his claim be "remanded" to the Department for a medical arbiter exam. In support of this request, claimant notes the following. On May 13, 1996, claimant

timely filed a request for reconsideration of the March 25, 1996 Notice of Closure. (Exs. 21, 21B). At that time, he did not disagree with the medical impairment findings used to rate his disability and, therefore, did not request a medical arbiter exam. (Ex. 21B-1). Also on May 13, 1996, claimant requested a copy of the complete record provided to the Department for purposes of the reconsideration. (Ex. 21B-3). Claimant alleges that the employer did not mail claimant's copy of the record until May 30, 1996.

Claimant further alleges that, after reviewing the records provided by the employer, he determined that there were two medical reports that the employer failed to provide to the Department. On June 4, 1996, claimant filed a supplemental request for reconsideration, which, in addition to the issues raised by the initial request, included a request for a medical arbiter exam and copies of the two above-mentioned medical reports. (Ex. 21C). The supplemental request for reconsideration was received by the Department on June 5, 1996, the same date the Order on Reconsideration was issued. (Exs. 21C-4, 22). No medical arbiter was appointed. Claimant requested a hearing regarding the Order on Reconsideration on June 7, 1996.

On review, claimant argues that the employer untimely provided him with copies of all documents pertaining to the claim. OAR 436-030-0135(4)(a) requires the carrier to provide copies of all documents pertaining to the claim to the Department and the worker or the worker's representative within ten working days of the mailing date of the reconsideration request. Claimant alleges that the employer did not meet this ten-day deadline, which resulted in claimant's supplemental Reconsideration request being received by the Department on the same day the Order on Reconsideration was issued. Under these circumstances, claimant argues, the Department should have withdrawn the Order on Reconsideration, admitted the additional medical reports, and granted claimant's request for a medical arbiter's exam. In support of this argument, claimant cites OAR 436-030-0115(5).[1] Because this situation was not corrected during the reconsideration process or at hearing, claimant requests that we "remand" his claim to the Department for a medical arbiter exam[2] and "reconsideration based upon all the evidence." (Claimant's Opening Brief, page 3-4).

The employer counters that claimant did not raise any issue at hearing regarding his supplemental reconsideration request and the Department's alleged failure to appoint a medical arbiter, nor did he request that the case be remanded to the Department, as he does on review. The employer notes that, at claimant's request, the case was litigated at hearing on the record, without convening a hearing. Furthermore, the employer argues, claimant's sole argument in his written argument to the ALJ was that, under a physical capacity evaluation with which his attending physician concurred, his scheduled permanent disability award should be calculated at 21 percent. Therefore, the employer contends, the Board should not consider this new issue on review. We agree.

Claimant's position could be characterized as merely a different theory regarding his appeal of the Order on Reconsideration, rather than a separate and new defense. However, we conclude that the employer would be prejudiced if we resolved this case on the basis of claimant's arguments regarding the supplemental reconsideration request. Claimant's evidentiary showing and written argument at the hearing addressed the extent of disability on the record presented at hearing. To now decide this case on a completely different basis would be fundamentally unfair, and we decline to do so. See Mavis v. SAIF, 45 Or App 1059 (1980); Gunther H. Jacobi, 41 Van Natta 1031 (1989).

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[1] OAR 436-030-0115(5) provides that "[p]ursuant to OAR 436-030-0008(1), at the director's discretion, an Order on Reconsideration can be abated, withdrawn and/or amended." OAR 436-030-0008(1) provides for dispute resolution before the Director as follows:

> "(a) Determination Orders issued by the department and Notices of Closure issued by insurers are appealed to the director in accordance with the reconsideration procedures described in 436-030-0115 through 436-030-0185.
>
> "(b) Abating, withdrawing or amending an Order on Reconsideration: If a hearing has not been requested, at the director's discretion, the department may abate, withdraw and/or amend an Order on Reconsideration within the time limit permitted to appeal a Notice of Closure or Determination Order."

[2] We note that we are not authorized to remand to the Department for appointment of a medical arbiter. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). However, we may remand to the ALJ to await the parties' pursuit of appointment of a medical arbiter by the Department, with any post-reconsideration medical arbiter report admissible at hearing pursuant to ORS 656.268(6)(e). Patricia A. Brown, 48 Van Natta 1164 (1996); Linda M. Cross, 45 Van Natta 2130 (1993).

Sanctions

The employer seeks sanctions under ORS 656.390, based on claimant's allegedly frivolous request for review regarding the extent issue and the supplemental reconsideration request issue. Specifically, the employer asks that the Board assess a sanction against claimant's attorney in the amount of a reasonable attorney fee for the employer's counsel's services on review.

ORS 656.390(1) allows the Board to impose an appropriate sanction against an attorney who files a frivolous request for review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see also Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996).

The employer contends that claimant had no colorable argument regarding the extent of his permanent disability. In this regard, the employer argues that the physical capacity evaluation, with which claimant's attending physician concurred, found that the measurements of claimant's ranges of motion were invalid. Therefore, the employer argues, claimant failed to meet his burden of proving extent of disability and initiated this appeal without reasonable prospect of prevailing. We disagree.

Although we agree with the ALJ's assessment of the evidence and find that claimant failed to prove any permanent disability, we do not find that the appeal of the extent issue was initiated without reasonable prospect of prevailing. At hearing, claimant argued that the physical capacity evaluation, while finding the overall evaluation regarding claimant's work endurance was invalid, did not find the ranges of motion invalid. Therefore, claimant argued, the range of motion measurements should be relied on. Even though we disagree with this analysis of the physical capacity evaluation, we find that claimant presented a colorable argument regarding the extent issue.[3]

The employer also argues that it is well established that the Board will not address issues not raised at hearing. The employer asserts that claimant's arguments regarding the supplemental reconsideration request represent a new argument which requests different relief on review than was requested at hearing. As noted above, while we ultimately concluded that it would be fundamentally unfair to decide the case on a basis not presented at hearing, we noted that claimant's position could be characterized as merely a different theory regarding his appeal of the Order on Reconsideration, rather than a separate and new defense. Given these circumstances, we do not find claimant's request for review frivolous.

Thus, we find that claimant raised colorable arguments regarding the extent issue and the supplemental reconsideration request that were sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Rhonda L. Hittle, 47 Van Natta 2124 (1995). Under these circumstances, we cannot say that claimant's request for review was "frivolous." Accordingly, the employer's request for a sanction is denied.

ORDER

The ALJ's order dated October 31, 1996 is affirmed.

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[3] In addition, although claimant makes no explicit argument on review regarding the extent issue, 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, there is no dispute that the extent issue was before the ALJ.

In the Matter of the Compensation of
**MIR ILIAIFAR, Claimant**
WCB Case No. 96-05052
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's low back injury claim. On review, the issue is whether claimant's injury arose out of and in the course of his employment. We reverse.

## FINDINGS OF FACT

Claimant, age 35 at the time of hearing, works as a car salesman for the employer. In connection with his employment, the employer furnished claimant with a "demonstrator" vehicle, which he was to use primarily for transport to and from work.

Claimant compensably injured his back at work on December 12, 1995. On Friday, December 22, 1995, claimant's treating doctor released him from work for the following week. The next day, claimant telephoned his supervisor and reported that he was released from work. The supervisor requested a copy of the off-work authorization, which claimant understood he was to personally deliver to the employer. Claimant advised his supervisor that he would deliver the off-work slip as soon as he could.

On December 28, 1995, claimant again spoke with his supervisor by telephone. The supervisor again requested the off-work slip and claimant advised he would deliver it the next day. On the afternoon of December 29, 1995, claimant left his home in Beaverton in his demonstrator car to deliver the off-work slip to his place of employment on Martin Luther King, Jr. Blvd. in Portland. On his way to the employer's premises, claimant stopped to do some banking at a downtown bank. After leaving the bank and while on his way to the employer's premises, claimant's vehicle was rear-ended. The rear-end collision resulted in claimant's herniated disc at L4-5.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was within the course and scope of his employment when he was injured on December 29, 1995 because claimant was acting in furtherance of the employer's business at the time. Specifically, the ALJ determined that claimant was required to personally deliver his off-work slip to the employer, that this condition of employment put claimant in a position to be injured, and that an injury while transporting the off-work slip was an anticipated risk of claimant's employment.

On review, SAIF asserts that claimant was outside the course and scope of his employment because he was not required to personally deliver the off-work slip to his employer. Alternatively, SAIF argues that even if claimant was required to make the delivery personally, he was not "in the course of" his employment at the time of his injury.

For the reasons set forth below, we agree with SAIF that claimant's injury did not occur within the course and scope of his employment.

An injury is compensable if it "aris[es] out of and in the course of employment." ORS 656.005(7)(a). The "arising out of" employment prong concerns the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). The "in the course of" employment prong concerns the time, place and circumstances of the injury. Id. The two prongs constitute a unitary work-connection test, i.e., whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Id. Both the "arising out of" and "in the course of" prongs must be satisfied to some degree. Krushwitz v. McDonald's Restaurants, 323 Or 520, 531 (1996).

Under the "going and coming" rule, injuries sustained while an employee is traveling to and from work do not occur in the course of employment and are not compensable. Krushwitz, 323 Or at 526; Cope v. West American Ins. Co., 309 Or 232, 237 (1990). There are exceptions to this general rule, however, which justify treating the employee as if he or she were in the course of employment. One such exception is the "special errand" exception, which applies when an employee sustains an injury while off the employer's premises, but while that employee was proceeding to perform, or while proceeding to the performance of, a special task or mission.[1] See Philpott v. State Ind. Acc. Comm., 237 Or 37, 41 (1963). In Krushwitz, the Court held that the "special errand" exception applies "only when *either* the employee was acting in 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." (Emphasis in original).

Here, we find it significant that claimant was not actually traveling to perform any "work" on the day of his injury. Although he was going to the employer's premises at the time of his injury, he had been released from work because of his prior back injury. Therefore, neither the "going and coming" rule nor the "special errand" exception are directly applicable.[2] Further, even assuming the "special errand" analysis could be applied by analogy where the employee travels to the employer's premises for an employment-related purpose but not to perform work, we do not consider claimant's personal delivery of an off-work authorization in this case to be an act within the course of his employment.

Although the employer directed claimant to drop off a copy of his off-work slip,[3] claimant's actions were not in furtherance of the employer's business (the sale of automobiles), nor was claimant acting on the employer's behalf at the time of his injury. Claimant made the trip primarily for his own benefit, to secure his entitlement to continued temporary disability benefits in connection with his prior injury claim. In addition, although claimant used his demonstrator vehicle to make the delivery, the employer did not have any right to control the time, manner of travel, or route to be taken on claimant's trip. Indeed, the record establishes that, regardless of whether or not claimant was actually required to personally deliver the off-work slip, he made the delivery when it was convenient for him to do so. (Ex. 8-14, 8-15; Tr. 16-18) Finally, we find nothing about claimant's mid-afternoon trip to the employer's premises on December 29, 1995 which resulted in a substantially increased risk over his usual trips to and from work.[4] Under these circumstances, we conclude the "special errand" exception does not apply, even by analogy.

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[1] Larson states the "special errand" exception as follows:

> "When an employee, having identifiable time and space limits on his employment, makes an off-premises journey which would normally not be covered under the usual going and coming rule, the journey may be brought within the course of employment by the fact that the trouble and time of making the journey, or the special inconvenience, hazard, or urgency of making it in the particular circumstances, is itself sufficiently substantial to be viewed as an integral part of the service itself." 1 Larson, Workmen's Compensation Law 4-204, Sec. 16.11 (1995).

[2] We have found no Oregon cases in which the "special errand" exception was applied where the worker was injured while traveling to the employer's premises for purposes other than to perform work. Compare Mathew S. Wilkinson, 49 Van Natta 45 (1997) (the claimant's injury, which occurred on his day off while walking to his employer's house to receive a draw from his paycheck, did not arise out of, or in the course of, his employment). Indeed, in Krushwitz, Court specifically recognized its "traditionally narrow approach to applying exceptions to the going and coming rule," and declined to expand the definition of the "special errand" rule to fit the circumstances of that case. 323 Or at 529.

[3] Simply because an injury results from fulfilling a condition of employment does not render the injury compensable. For example, in Haugen v. SAIF, 37 Or App 601 (1978), the claimant, a police officer, was injured while he was performing weight lifting exercises at home, in furtherance of his employment contract requirement that he maintain himself in good physical condition. In finding that his injury did not arise out of or in the course of his employment, the court noted that the employer did not prescribe what the claimant was to do to stay in good condition, and that the claimant assumed the attendant risk of meeting his job qualifications. See also James H. Henthorne, 35 Van Natta 1311 (1983) (a trip to the barber shop or other grooming activity is not within the course of employment even if the claimant were expected to have good grooming as a condition of employment).

[4] Compare Hickey v. Union Pacific R. Co., 104 Or App 724 (1990) ("special errand" exception applicable where the claimant was fatally injured on his way home after returning to work in the late evening to complete task that the employer needed done by early the next morning; the court found that the late night trip substantially increased and created a risk of injury over and above that which the decedent normally bore going to and from work during his regular work hours.").

Claimant alternatively argues that his injury is compensable under the "employer's conveyance" exception to the coming and going rule, which applies when a worker is injured while being transported to work in a vehicle under the employer's control. See Giltner v. Commodore Con. Carriers, 14 Or App 340 (1972); Jenkins v. Tandy Corp., 86 Or App 133, 137, rev den 304 Or 279 (1987). We disagree.

As discussed above, claimant was not traveling to his place of employment to perform work on the day of his injury. Therefore, neither the going and coming rule nor this second exception are directly applicable. Second, even if the exception could be applied by analogy, it does not fit the circumstances in this case. The "employer's conveyance" exception applies when travel is a part of the employee's service, or when the employer assumes control over the employee's transportation to and from the work site. See generally 1 Larson, Workmen's Compensation Law, 4-215, § 17-11 (1994); Chris L. Sargent, 47 Van Natta 959 (1995) (the claimant, who was injured while a passenger in a truck owned and operated by the employer traveling to a job site destination known only by the employer, was injured in the course of employment). Here, although the employer furnished claimant with a demonstrator vehicle, travel was not part of claimant's job duties nor did the employer control the conditions of claimant's transportation to the place of employment, especially on the day of his injury.

Accordingly, we conclude claimant's December 29, 1995 injury did not occur in the course of his employment and is therefore not compensable.

ORDER

The ALJ's order dated October 16, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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April 16, 1997 Cite as 49 Van Natta 501 (1997)

In the Matter of the Compensation of
**MARCIA G. WILLIAMS, Claimant**
WCB Case No. 96-06746
ORDER OF ABATEMENT
Cole, Cary & Wing, Claimant Attorneys
John M. Pitcher, Defense Attorney

Claimant requests reconsideration of our March 25, 1997 order that reversed the Administrative Law Judge's (ALJ's) order that affirmed the Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability for claimant's mental condition. Claimant contends that, since the accepted psychological condition is a consequential condition, the holdings in Boyd K. Belden, 49 Van Natta 59 (1997), and Robin W. Spivey, 48 Van Natta 2363 (1996), apply to this case. Citing ORS 656.268(16), she argues that she is entitled to a permanent disability award for her Class II, minimal range impairment since this impairment is due to her depression, which is a direct medical sequelae of the original accepted condition that has never been denied.

In order to consider this matter, we withdraw our March 25, 1997 order. The self-insured 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.

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In the Matter of the Compensation of
**HAROLD G. JACKSON, Claimant**
WCB Case No. 96-07267
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded 7 percent (22.4 degrees) unscheduled permanent disability for claimant's low back condition, whereas an Order on Reconsideration had awarded none. On review, the issue is the extent of unscheduled permanent disability.

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

Claimant's lumbar flexion measurement is 50 degrees, rather than 15 degrees (see Ex. 45-3). (Opinion and Order p.1).

We accord little weight to Dr. Ward's concurrence with First Northwest Health's examination report regarding claimant's impairment, because we find the examiners' report unpersuasive due to its lack of clarity. (See Exs. 34, 36).

The examiners measured claimant's low back range of motion, noted no functional interference, and opined that the range of motion findings were invalid (based on the difference between claimant's supine and standing straight leg raising). (Ex. 34-3-5). The examiners "anticipated" no permanent impairment as a result of the compensable injury and stated that none was presently measurable. However, they also observed that claimant's examination was "essentially normal, despite a mild reduction in lateral lumbar bending and extension." (Ex. 34-5, emphasis added). From this report, we cannot tell whether the examiners believed some or all of claimant's findings were invalid or even whether they believed that claimant had injury-related permanent impairment at the time of their examination.[1] Under these circumstances, we conclude, as did the ALJ, that the medical arbiter's impairment findings are the most persuasive evidence concerning claimant's injury-related permanent impairment.

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

ORDER

The ALJ's order dated December 6, 1996 is affirmed. For services on review, claimant is awarded a $500 attorney fee, payable by the self-insured employer.

[1] Even assuming that the First Northwest Health examiners and Dr. Ward, treating physician, intended to state that claimant did not have measurable impairment "at that time," we would not find those opinions inconsistent with the medical arbiter's later valid findings.

In the Matter of the Compensation of
**JEFFREY L. SCOTT, Claimant**
WCB Case No. 95-11252
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) found that claimant's neck and back injury claim was not prematurely closed; (2) declined to remand the claim to the Appellate Review Unit to consider evidence not submitted at the time of reconsideration; (3) upheld the insurer's denial of claimant's aggravation claim; and (4) declined to award a penalty for allegedly unreasonable claims processing. On review, the issues are premature closure, remand to the Appellate Unit, aggravation, and penalties.

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

On review, although acknowledging our decision in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), claimant argues that the ALJ should have considered evidence not submitted at the time of reconsideration, which pertained to the issue of premature closure. Claimant argues that if all of the evidence is considered, he has met his burden of proof and has shown that his claim was prematurely closed.

We agree with the ALJ's decision to decline to consider evidence not previously submitted at the time of reconsideration. In Arlie B. Tompkins, 48 Van Natta 1664 (1996), we extended our holding in the Ray case to include cases involving the issue of premature closure. In other words, we concluded that, under amended ORS 656.283(7), evidence not submitted at reconsideration concerning the claimant's medically stationary status at the time of claim closure, was statutorily inadmissible at a subsequent hearing. Tomkins, 48 Van Natta at 1664. Additionally, in Tomkins, we found that the amended statute did not violate the claimant's due process rights. Accordingly, we affirm the ALJ's decision on the issue of premature closure.

Claimant also disagrees with the ALJ's conclusion that he had no authority to remand the claim to the Department's Appellate Review Unit, even though the ALJ found that the insurer did not submit all necessary documents at the time of reconsideration. However, in Juan C. Rodriguez, 48 Van Natta 762 (1996), we noted that the worker cited no authority to remand the claim to obtain copies of the evidence in the reconsideration record. Furthermore, we concluded that, to the extent that the claimant sought remand, he had not shown due diligence in attempting to obtain the reconsideration record, nor had he shown specific evidence that might change the result if remand was found to be appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Similarly, in the present case, claimant contends that it was the insurer's duty to submit all evidence to the Appellate Review Unit. Nevertheless, as noted by the ALJ, claimant was not precluded from submitting any relevant evidence. Furthermore, we agree with the ALJ that any oversight could have been brought to the Director's attention, and the Order on Reconsideration could have been abated and withdrawn. Former OAR 436-30-135(1)(e). Finally, we conclude that claimant has failed to establish that inclusion of the omitted evidence in the reconsideration record might change the result. Accordingly, we do not find remand appropriate (assuming without deciding that we have the authority to remand this claim to the ALJ for further remand to the Appellate Review Unit). Therefore, we deny claimant's motion for remand.

Claimant also disagrees with the ALJ's conclusion that he failed to establish a compensable aggravation. In reaching his conclusion, the ALJ applied Carmen C. Neill, 47 Van Natta 2371 (1995), and found that claimant had not established either a pathological or a symptomatic worsening of the compensable condition.

Subsequent to the ALJ's order, the court issued its decision in SAIF v. Walker, 145 Or App 294 (1996). In Walker, the court held that an "actual worsening" of a compensable condition pursuant to ORS 656.273(1) did not include a symptomatic worsening. Rather, the court concluded that the statute

requires that there be direct medical evidence that a condition has worsened, and absent such evidence, the Board cannot infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim. Id.

Here, we agree with the ALJ's conclusion that claimant has not proven an actual worsening of his condition. Accordingly, based on the rationale expressed in Walker, we need not address claimant's arguments on review concerning a symptomatic worsening.

ORDER

The ALJ's order dated November 4, 1996 is affirmed.

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In the Matter of the Compensation of
**JAMES A. CURTS, Claimant**
WCB Case No. 95-11306
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's current low back condition. Claimant moves to dismiss SAIF's request for review. On review, the issues are claimant's motion to dismiss and compensability. We deny claimant's motion and affirm.

FINDINGS OF FACT

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

Claimant first sought treatment for his March 15, 1994 work injury on March 18, 1994, rather than March 16, 1994. (See O&O p.2; Exs. 1,2,4,5).

On December 13, 1996, SAIF filed a "Withdrawal" of its December 5, 1996 request for review. Later on the same day, December 13, 1996, SAIF filed a motion to reinstate its request for review. Claimant objected to SAIF's motion for reinstatement.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we consider claimant's motion to dismiss.

Claimant objects to SAIF's motion to reinstate the request for review (which it had withdrawn the same day), contending that we should dismiss the request pursuant to SAIF's withdrawal. We disagree.

We have previously held that we retain jurisdiction to consider requests for review until those requests have be dismissed via Board order. Mary J. McFadden, 44 Van Natta 2414 (1992). Although a withdrawal of a request for review may initiate the dismissal process, it is the dismissal order which terminates our appellate review authority. Id.

Here, prior to our taking any action on SAIF's withdrawal, SAIF explained that the withdrawal had been requested by mistake and requested reinstatement. SAIF's request for review and its request for reinstatement were both timely filed. Under such circumstances, we retain jurisdiction to proceed with our review. See id.; Sharon E. Kelly (Van Gorder), 39 Van Natta 467 (1987). Accordingly, claimant's motion to dismiss is denied.

We adopt the ALJ's "Conclusions and Opinion" on the merits.

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 $1,200 payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated November 21, 1996 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**MODESTO MONTANO-GARCIA, Claimant**
WCB Case No. 96-03971
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that increased claimant's unscheduled permanent disability award for a low back injury from 35 percent (112 degrees), as awarded by an Order on Reconsideration, to 44 degrees (140.8 degrees). SAIF also contends that claimant was precluded from raising the issue of increased unscheduled permanent disability at hearing. On review, the issue is extent of unscheduled permanent disability. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following supplementation. Claimant's at-injury job description, as agreed to by claimant, included, inter alia, lifting of up to 100 pounds, moving and setting up irrigation pipes, operating tractors and farm implements, performing mechanical work, painting, and performing farm maintenance. (Exs. 22A, 22C).

## CONCLUSIONS OF LAW AND OPINION

At hearing and on review, SAIF argues that claimant is precluded from raising the issue of increased unscheduled permanent disability in his "closing arguments" at hearing, since his hearing request only raised the issue of scheduled permanent disability. Because we ultimately conclude that claimant is entitled to a lesser award of unscheduled permanent disability than that awarded by the Order on Reconsideration, we need not address SAIF's argument.

We adopt the ALJ's reasoning and conclusions regarding the following values: impairment (14 percent); age (0); formal education (1); and adaptability (6), with the following supplementation regarding the adaptability factor. We also write to address the value to be assigned to the Specific Vocational Preparation (SVP) factor.[1]

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[1] Claimant became medically stationary on October 4, 1995, and his claim was closed by Notice of Closure on January 8, 1996. Accordingly, the applicable standards are set forth in WCD Admin. Order 6-1992 (effective March 13, 1992), as amended by WCD Admin. Orders 93-056 (effective December 14, 1993), 95-060 (effective August 23, 1995 (Temp.)), 95-063 (effective September 21, 1995 (Temp.)), 96-068 (effective August 19, 1996 (Temp.)), and 96-072 (effective February 15, 1997). OAR 436-035-0003(1), (2), and (3).

Adaptability is measured by comparing 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(1). We agree with the ALJ that claimant has a BFC of heavy and a RFC of sedentary/light, which translates to an adaptability factor of 6. OAR 436-035-0310(6). However, we base our determination of the BFC factor on the following reasoning.

Under the facts of this case, claimant's BFC is determined by the highest strength category assigned in the Dictionary of Occupational Titles (DOT) for the most physically demanding job that the worker has 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 shall apply. Id.

Claimant has performed his at-injury type of work for more than five years. Therefore, claimant's at-injury job is the most physically demanding job performed in the five years prior to determination. Claimant's at-injury job description, as agreed to by claimant, included, inter alia, lifting of up to 100 pounds, moving and setting up irrigation pipes, operating tractors and farm implements, performing mechanical work, painting, and performing farm maintenance. (Exs. 22A, 22C). We find that claimant's duties are most accurately described by a combination of the following DOT codes: (1) DOT 404.663-010 (Farmworker, field crop I (agriculture)), hereinafter Farmworker I, which has a strength code of medium and a SVP code of 5; (2) DOT 409.685-014 (Irrigator, sprinkling system (agriculture)), which has a strength code of medium and a SVP code of 2; and (3) DOT 409.683-010 (Farm-machine operator (agriculture)), which has a strength code of heavy and a SVP code of 3. Thus, the highest strength requirement among these DOT codes is the "heavy" strength required by the farm-machine operator job.

On review, claimant argues that the ALJ correctly determined that, as between Farmworker I and DOT 404.687-010 (Farmworker, field crop II (agriculture)), hereinafter Farmworker II,[2] the latter code best described claimant's at-injury job. We disagree.

The Farmworker II job description includes little, if any, use of machinery, which is a large part of claimant's at-injury job description. (Exs. 22A, 22C). In addition, little, if any, of the work described in the Farmworker II job description is included in claimant's at-injury job description. Finally, claimant argues that the Farmworker I job description includes supervisory duties, which his at-injury job did not include. Therefore, claimant argues, the Farmworker I job description does not apply. We disagree. The Farmworker I job description states the worker "[m]ay oversee work crew engaged in planting, weeding, or harvesting activities." We do not find that this statement means that the Farmworker I job requires supervisory duties, only that the job could include such duties. Given the remainder of the Farmworker I job description, and the problems with the Farmworker II job description, as addressed above, we find that the Farmworker I job description, in conjunction with the descriptions for Irrigator and Farm-machine operator, most accurately describe claimant's work duties.

This determination also applies in determining the SVP. In this regard, the SVP value is the highest SVP, as determined by the DOT code, of any job that the worker has met in the five years prior to determination. Former OAR 436-35-300(3). Furthermore, when a combination of DOT codes most accurately describes a worker's duties, the highest SVP shall apply. Former OAR 436-35-300(3)(a).

Here, as discussed above, a combination of DOT codes most accurately describes claimant's job duties in the five years prior to determination, specifically, DOT 404.663-010, DOT 409.685-014, and DOT 409.683-010. Of these, DOT 404.663-010, Farmworker I, has the highest SVP, with a SVP of 5. Former OAR 436-35-300(3)(a). A SVP of 5 is rated as a SVP value of 2. Former OAR 436-35-300(4). This SVP value (2) is added to claimant's formal education factor (1) for a total education factor of 3. Former OAR 436-35-300(6).

Having determined the values of all the factors, we proceed to determine claimant's unscheduled permanent disability award. Former OAR 436-35-280. Claimant's age (0) and education (3) factors are added for a sum of (3), which is multiplied by the adaptability factor (6), for a product of 18. That value is added to the impairment factor (14), for a total award of 32 percent unscheduled permanent disability. We reduce the ALJ's award accordingly.

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[2] The Farmworker II job has a strength code of heavy and a SVP code of 2.

Finally, we note that the ALJ awarded claimant's attorney a fee of $1,500 pursuant to ORS 656.382(2) for successfully defending SAIF's challenge to the unscheduled permanent disability award. However, we have determined that claimant is entitled to 32 percent unscheduled permanent disability, which is less than the 35 percent unscheduled permanent disability awarded by the Order on Reconsideration and challenged by SAIF. Therefore, claimant's attorney is not entitled to an assessed fee pursuant to ORS 656.382(2). Accordingly, we reverse the ALJ's $1,500 assessed fee.

ORDER

The ALJ's order dated November 22, 1996 is modified in part, reversed in part, and affirmed in part. In lieu of the ALJ's award, the Order on Reconsideration's award of 44 percent (140.8 degrees) unscheduled permanent disability is reduced to 32 percent (102.4 degrees) unscheduled permanent disability for a low back injury. Claimant's counsel's out-of-compensation attorney fee from this award shall be adjusted accordingly. The ALJ's "out-of-compensation" attorney award and $1,500 assessed attorney fee award pursuant to ORS 656.382(2) are reversed. The remainder of the ALJ's order is affirmed.

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In the Matter of the Compensation of
**DONALD STARBUCK, Claimant**
WCB Case No. 96-04800
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's back injury claim; and (2) awarded an attorney fee of $3,500. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

Compensability

We adopt and affirm the portion of the ALJ's order regarding compensability. See Tony D. Houck, 48 Van Natta 2443 (1996).

Attorney Fees

The ALJ awarded an attorney fee of $3,500 for claimant's counsel's services at hearing. The employer contends that the fee is excessive, asserting that a fee of $2,000 would be more appropriate. Claimant responds that the attorney fee is "perfectly in line" with fees awarded in similar cases.

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 back injury. Eight exhibits were received into evidence, none of which was generated or submitted by claimant's counsel. There were no depositions taken. The hearing lasted one and one-half hours and the transcript consists of 46 pages. Claimant testified on his own behalf and one witness testified for the employer. Claimant's counsel did not submit a statement of services or an affidavit describing counsel's time expenditures.

The ALJ noted that claimant's injury "is not overwhelming nor life threatening." (O & O at 4). As compared to typical compensability cases, the issue here was of below average complexity. The only issue was whether there were sufficient objective findings in the medical reports to support a claim. We conclude that the claim's value and the benefits secured are of average proportions. The hearing was not lengthy, lasting only one and one-half hours. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering these factors, we consider the ALJ's $3,500 award to be excessive. Specifically, after consideration of the aforementioned factors, we conclude that $2,500 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 and the risk that claimant's counsel might go uncompensated. Since claimant's counsel did not submit an affidavit of time or statement of services indicating how much time was expended in advocating claimant's claim, we have based our determination on the record as developed at hearing. Compare Schoch v. Leupold & Stevens, 325 Or 112 (1997) (the claimant submitted an affidavit and summary of services rendered by counsel).

Furthermore, 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 $750, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review concerning the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated October 24, 1996 is affirmed in part and modified in part. In lieu of the ALJ's $3,500 attorney fee award, claimant's counsel is awarded a $2,500 attorney fee, payable by the self-insured employer. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $750, payable by the self-insured employer.

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In the Matter of the Compensation of
**MICHAEL L. STROUP, Claimant**
WCB Case Nos. 96-05528 & 96-03311
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's claim for a torn right medial meniscus. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had established a compensable claim for his torn right medial meniscus. We agree, however, we base our conclusion on the following reasoning.

The ALJ concluded, and the parties apparently agree, that the claim is correctly analyzed as an occupational disease as claimant did not experience a discrete event or trauma which caused the torn

meniscus. On review, the insurer concedes that the tear is conclusive evidence of a pathological worsening. Appellant's brief, pg. 2. However, the insurer argues that, pursuant to ORS 656.802(2)(b), claimant is required to prove that work is the major contributing cause of the torn meniscus. Moreover, the insurer contends that claimant has a preexisting degenerative condition as defined by ORS 656.005(24) which must be weighed in determining whether claimant has met the "major contributing cause" standard. Dietz v. Ramuda, 130 Or App 397 (1994).

Here, two physicians, Dr. Stanford, who examined claimant on behalf of the insurer, and claimant's treating doctor, Dr. Mandiberg, have offered opinions regarding the issue of causation. Dr. Stanford opined that claimant's degenerative condition was the major contributing cause of the current torn meniscus. Dr. Stanford concluded that claimant's particular problem was a condition that many men his age had and the particular problem resulted more naturally than from any particular work activity.

Dr. Mandiberg, however, disagreed with Dr. Stanford's opinion. Dr. Mandiberg took a detailed history of claimant's 30-year work activities and knee problems. Dr. Mandiberg noted that, for a long period of time, claimant's work involved the use of jacks which had to be manually maneuvered. More recently, claimant used electrical jacks, but he told Dr. Mandiberg that when there was 2,000 pounds on the jack, it still had to be maneuvered, and the twisting and turning required caused claimant the most (knee) pain. (Ex. 1-1).

Dr. Mandiberg also described claimant's history of discomfort in both knees over the past ten years, with a more recent history of right knee pain over the past two years. Based on the type of work claimant performed, and the fact that claimant worked eleven hours per day, Dr. Mandiberg found that work activities, rather than home activities, were the major cause of claimant's tear. (Ex. 1-1). Following his review of Dr. Stanford's opinion and after performing claimant's right knee surgery, Dr. Mandiberg adhered to his opinion regarding causation. (Ex. 9).

After reviewing both expert medical opinions, we conclude that Dr. Mandiberg has offered the most persuasive opinion. First, we note that Dr. Stanford found claimant to be a "vague historian." (Ex. 4-2). However, as noted above, Dr. Mandiberg obtained a complete and detailed description of claimant's work activities and history of knee complaints. (Ex. 1). Therefore, because we find that Dr. Stanford had a less complete history of the extent of claimant's work activities and problems, we find his opinion less persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Additionally, Dr. Stanford acknowledged that a "weightbearing twisting injury" is the type of injury which would have caused a meniscus tear, yet he concluded that claimant's work did not cause such a condition. (Ex. 15-2). However, both weightbearing and twisting were activities performed by claimant at work that Dr. Mandiberg found to be responsible for causing claimant's condition. (Exs. 1-1; 16). Therefore, without further explanation or elaboration by Dr. Stanford, we find his reasoning to be unpersuasive.

On review, the insurer argues that Dr. Mandiberg's opinion should be rejected. The insurer contends that Dr. Mandiberg acknowledges that claimant has a degenerative condition. Nevertheless, the insurer argues that in determining the major contributing cause of claimant's current condition, Dr. Mandiberg has not considered or weighed the contribution of the degenerative condition.

We disagree with the insurer's assessment of Dr. Mandiberg's opinion. Dr. Mandiberg, claimant's treating physician and the surgeon who performed his knee surgery, understood the details of claimant's work activity. (Ex. 7-1) Furthermore, Mandiberg specifically addressed the degenerative process and its contribution. For example, Dr. Mandiberg explained that, "...as you get older your menisci degenerate, but it does not mean they actually tear. This gentleman's major physical activity in his life is his activity delivering foods, as I have previously delineated." (Ex. 9). Dr. Mandiberg later acknowledged that, "[a]ll of our body tissues degenerate over time, including menisci." However, Dr. Mandiberg reiterated that "(claimant's) dominant activity in his life is his work activity which involves a lot of twisting and turning and, therefore, the major contributing factor towards the meniscal tear is his work activities." (Ex. 16).

Under the circumstances, we conclude that Dr. Mandiberg properly considered both the degenerative process and the work activity, and ultimately concluded that claimant's work was the major contributing cause of his meniscal tear. See Dietz, 130 Or App at 397. Furthermore, based on his

accurate and complete history, we find that Dr. Mandiberg has offered the most persuasive medical opinion in the record regarding causation. Accordingly, we affirm the ALJ's order.

Claimant's attorney is entitled to an assessed attorney fee for defending against the insurer's 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 assessed attorney fee for claimant's counsel's services on review is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's uncontested statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The ALJ's order dated October 31, 1996, as corrected November 1, 1996, is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,500, to be paid by the insurer.

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April 18, 1997 Cite as 49 Van Natta 510 (1997)

In the Matter of the Compensation of
**MICHAEL J. WAGAMAN, Claimant**
WCB Case No. C700727
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Scott M. McNutt, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On March 25, 1997, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The summary page of the proposed disposition agreement provides that the total due claimant under the CDA is **$5,625** and the total due claimant's attorney is **$1,875**. However, on page 3, the CDA provides for a consideration of "five thousand six hundred twenty-five dollars (2,500) to claimant and the sum of one thousand eight hundred seventy-five dollars (1,875) to claimant's attorney."

The summary page and the written amount given on page 3 are consistent and provide that the consideration to be paid claimant is $5,625 and that the attorney fee is $1,875. However, the numerical amount given in parentheses on page 3, ($2,500) is inconsistent with the written amount preceding it and with the remainder of the CDA. Thus, we conclude that the amount given in parentheses on page 3 ($2,500) is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration to be paid to claimant of $5,625 with a $1,875 attorney fee payable to claimant's attorney.

As interpreted by this order, the CDA is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $1,875, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CHARLES C. DAY, Claimant**
Own Motion No. 96-0575M
INTERIM OWN MOTION ORDER
Cole, et al, Claimant Attorneys
Cowling, et al, Defense Attorneys

Claimant requests that the Board authorize the payment of temporary disability compensation for his current right long, ring and little trigger finger condition. Claimant further requests that, if the employer denies that his current condition is compensably related to his 1988 industrial injury, the Board reinstate his request for hearing with the Hearings Division. Finally, claimant requests that the Board "order [claimant's] claim processed under the own motion authority of the Board, and additionally penalize the employer for unreasonable delay and refusal to provide compensation, as well as respond appropriately to the processing of this claim for benefits including medical care."

FINDINGS OF FACT

Claimant has an accepted 1988 bilateral carpal tunnel injury claim with the employer. Claimant's aggravation rights on that claim expired on September 28, 1995.

On May 28, 1996, claimant underwent release surgery on his right long, ring and little trigger fingers.

In June 1996, claimant requested a hearing with the Hearings Division, raising "denial, penalty, and attorney fees" as issues. (WCB Case No. 96-05302).

In an August 19, 1996 Order of Dismissal, Administrative Law Judge (ALJ) Brazeau dismissed (without prejudice) claimant's request for hearing. The ALJ's order recited that dismissal of the hearing request was appropriate because "a new claim has arisen, requiring the employer to begin processing." Furthermore, the ALJ's order noted that "claimant's request for hearing is within the Board's Own Motion jurisdiction." That order was not appealed.

In a December 11, 1996 letter, claimant notified the Board that more than 90 days had passed since the ALJ had issued his August 19, 1996 order and that Dr. Bitter's office had verified nonpayment of medical services for claimant's May 1996 surgery. Claimant requested that "the Board contact [the employer] directly and ascertain their position with regard to this matter." In his letter, claimant further noted that "[b]y copy of this letter to [the employer], we are informing them that we intend to proceed to request sanctions for failure to process this claim and such penalties as may be appropriate for their denial of compensable services."

On December 16, 1996, we acknowledged receipt of claimant's December 11, 1996 letter, and advised the parties that, under OAR 438-012-0030(1), the employer was required to submit a written recommendation to the Board within 90 days of receiving an own motion claim. We also notified the parties that, until disputes are resolved regarding compensability, responsibility or the reasonableness and necessity of medical services, the Board, under ORS 656.278, did not have jurisdiction to authorize temporary disability compensation to otherwise qualified claimants. See OAR 438-012-0050. Finally, we advised the employer that, notwithstanding a declaration of a written or *de facto* denial of compensability, responsibility or reasonableness and necessity of medical treatment, a carrier was obligated to submit an Own Motion recommendation to the Board regarding claimant's request to reopen his 1988 injury claim for the payment of temporary disability compensation within the prescribed timeframe.

On December 20, 1996, the employer submitted its position (but did not submit a Carrier's Own Motion Recommendation form) to the Board regarding claimant's request for own motion relief and other issues. The employer contended that claimant had not filed any request that it expand its acceptance on claimant's 1988 injury claim to include claimant's current trigger finger condition. Furthermore, it was the employer's position that claimant had not perfected a new occupational disease claim for his current trigger finger condition. Finally, the employer asserted that claimant had not made a request for Own Motion relief.

On January 17, 1997, we again notified the employer that, in order to activate a request for Own Motion relief, OAR 438-012-0020(3)(b) required only that the carrier receive any document that reasonably notified it that a claimant's compensable injury required surgery or hospitalization. In our letter, we advised the employer that the 90 days within which to submit such a recommendation to the Board had passed, and that, under the Board's administrative rules, the employer was required to submit a recommendation for Own Motion relief.

In a January 22, 1997 letter, claimant requested relief in the form of payment of all medical costs related to his May 28, 1996 trigger finger surgery, including such disability compensation "as [claimant] may be entitled under law." Claimant further requested that "[i]f the employer takes the position the medical treatment was not for a condition compensably related to the injury of November 8, 1988, then claimant requests the Board refer the carrier's position to the hearings division for reinstatement of our request for hearing."

In a January 29, 1997 letter, the employer contended that it must receive a "clear, formal and written demand that the trigger finger condition be accepted as part of the carpal tunnel syndrome claim before [it] must accept, deny or process the condition under that claim."

On February 13, 1997, we again wrote the parties. We noted that, if there was a dispute between the parties concerning whether claimant's condition was causally related to the compensable injury or whether it represented a new occupational disease, the dispute must be brought before the Hearings Division. The parties were further advised that, if claimant asserted that his prior request for hearing should be "reinstated," the request should be made to the Hearings Division under ORS 656.283, rather than to the Board under ORS 656.278. Finally, the employer was reminded to forward to the Board an Own Motion recommendation which addressed the criteria set forth in OAR 438-012-0030, and that the parties advise the Board of the status of any dispute concerning the causal relationship between claimant's compensable injury and his request for own motion relief.

In a February 27, 1997 letter, claimant responded that it was apparent that a dispute existed "concerning the processing of a claim, and indeed, whether a claim was ever presented." In that letter, claimant further noted that "we hereby make this written request for compensation on claimant's behalf." In addition, claimant stated that he "desires his employer to accept [the May 28, 1996] surgery as a compensable consequence of his 1988 hand injuries and provide him with disability compensation as an own motion matter." Moreover, claimant's letter indicated that "[a]s for any unrelated condition, claimant demands the employer compensate him for Dr. Bitter's medical treatment and related disabilities as a new injury unrelated to his 1988 compensable claim." Finally, claimant requested that the Board determine whether the employer's conduct "constitute[s] unreasonable delay or unreasonable refusal to pay compensation or delay the acceptance or denial of any claim for own motion ruling."

On April 3, 1997, claimant requested that the Board order his claim processed under the Board's Own Motion authority, and that the Board penalize the employer for its allegedly unreasonable delay and refusal to provide compensation and "respond appropriately to the processing of this claim for benefits including medical care."

On April 9, 1997, the employer submitted an Own Motion recommendation, in which it neither recommended reopening or denying claimant's request, but, rather it indicated: "cannot respond; no claim." On page two of the recommendation form, the employer indicated that it opposed authorization of temporary disability compensation, contending that no claim for own motion relief has been presented. The employer did not indicate that it disagreed (or that it agreed) that claimant's current condition was causally related to his compensable injury, or that it was responsible for claimant's current condition.

## CONCLUSIONS OF LAW AND OPINION

### Entitlement to Temporary Disability Compensation

Under ORS 656.278, the Board has jurisdiction only over matters pertaining to requests for "Own Motion relief." The benefits, or relief, over which the Board has jurisdiction under ORS 656.278, translate to requests for temporary disability compensation for compensable injuries which require surgery or hospitalization. ORS 656.278(1). Because we do not have jurisdiction over claimant's request

for medical benefits or over the issue of whether he perfected a claim for those benefits (either new or expanded), we limit our discussion to claimant's request for the Board's Own Motion relief.[1]

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

In a May 28, 1996 operative report, Dr. Bitter indicated that claimant underwent a surgical release of his right long, ring and little trigger fingers. As noted previously, the employer does not challenge the propriety of the performed surgery. The employer agreed that it spoke with Dr. Bitter in August 1996 regarding the "etiology" of claimant's trigger finger condition.[2] Therefore, we conclude that claimant did request Own Motion relief (time loss associated with the May 1996 surgery). However, because we have no jurisdiction to consider or decide the compensability of claimant's current condition (his right trigger finger condition which has neither been accepted or denied), we are without authority to award temporary disability compensation to claimant for "the worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization." ORS 656.278(1)(a). See Gary L. Martin, 48 Van Natta 1802 (1996); Bonnie L. Turnbull, 49 Van Natta 139 (1997).

Inasmuch as the "compensability question" between the parties remains unresolved, we are not authorized to reopen claimant's 1988 injury claim for the payment of temporary disability benefits. ORS 656.278(1)(a); Gary L. Martin, 48 Van Natta at 1802; Bonnie L. Turnbull, 49 Van Natta at 139. Once resolution of that question is achieved, we would be able to address the remaining portion of the statutory predicate to determine claimant's entitlement to temporary disability compensation under ORS 656.278(1).

Reinstatement of Hearing Request

Claimant requests that the Board "refer the carrier's position to the hearings division for reinstatement of our request for hearing." Yet, we do not have jurisdiction over the issue which needs to be resolved prior to our consideration of claimant's entitlement to a TTD award, i. e., compensability of claimant's current condition under his 1988 claim or a new injury / occupational disease claim.[3] Moreover, at the present time, no "non-dismissed" hearing request is currently pending before the Hearings Division.

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[1] We note here the distinction between filing an "injury / occupational disease claim" and filing a "claim for Own Motion relief." The employer contends that claimant has neither filed a new injury / occupational disease claim, nor a claim for medical benefits under his 1988 industrial injury claim. The employer further contends that claimant has not filed an Own Motion claim.

We have stated, under ORS 656.278, we do not have jurisdiction to consider the matter of whether claimant filed a new injury or occupational disease claim, nor do we have jurisdiction over a claim for medical benefits. However, claimant's request for "Own Motion relief" must be processed within the requirements of OAR 438-012-0030. The Board's rules provide that a recommendation must be submitted by the carrier within 90 days of notification of a request for Own Motion relief, regardless of whether the carrier has resolved any compensability or responsibility issues associated with the claim, unless the carrier specifically requests an extension for submission of the recommendation. Therefore, if the carrier was notified of a request for surgery or hospitalization for a claimant whose claim is currently in Own Motion status, we consider that notification to be sufficient as a claim for Own Motion relief.

[2] Dr. Bitter forwarded to the employer a written Health Insurance Claim Form on May 31, 1996, which indicated that claimant had undergone a "hand - trigger finger release" on 5-28-96. Because this document (a claim form notifying the employer of surgery) was directed to the employer, we conclude that it was sufficient to establish an "Own Motion Claim." See OAR 438-012-0020(3)(b); OAR 438-012-0001(1).

[3] If a claimant contends that the carrier did not respond to a claim for a new injury or occupational disease, the parties must litigate that matter at the Hearings Division. If the carrier did not respond to a request for payment of medical benefits under an injury claim or under a new injury or occupational disease claim, that is still a matter to be litigated at hearing. However, in order to generate a request for Own Motion relief, a claimant must only establish that he would be entitled to such benefits (by virtue of undergoing surgery or being hospitalized) if his current condition were found to be compensably related to his accepted injury. Notwithstanding this procedural requirement, until the condition for which a claimant requests own motion relief is determined compensable, the Board is without authority to grant "Own Motion relief."

Although we may refer matters concerning authorization of temporary disability compensation or enforcement of our orders to the Hearings Division for evidentiary hearing, after the hearing, the ALJ is only authorized to make a recommendation (rather than issuing a final order) regarding those benefits to the Board. See OAR 438-012-0040; 438-012-0050; Bonnie L. Turnbull, 49 Van Natta at 139. However, in matters of compensability, responsibility and reasonableness and necessity of medical services, we are unable to act on a request for Own Motion relief until claimant has exhausted his available administrative remedies pursuant to our rules. See OAR 438-012-0031; Gary L. Martin, 48 Van Natta at 1802. Thus, unless and until a hearing request is pending before the Hearings Division that pertains to the compensability of claimant's right trigger finger condition, any request for referral of this matter to an ALJ for consolidation with claimant's Own Motion request would be premature.

Penalties / Sanctions

According to OAR 438-012-0001(1), an "Own Motion Claim" means a written request by or on behalf of a claimant for temporary disability compensation, where claimant's aggravation rights have expired. OAR 438-012-0020(1) also requires that the Own Motion claim be first directed to and processed by the Own Motion carrier. Furthermore, OAR 438-012-0020(3) states that:

> "An insurer is deemed to have notice of an own motion claim for temporary disability compensation when one of the following documents is submitted to the insurer by or on behalf of the claimant after the expiration of aggravation rights:
>
> "(a) A written request for temporary disability compensation or a claim reopening; or
>
> "(b) Any document that reasonably notifies the insurer that the claimant's compensable injury requires surgery or hospitalization."

We have determined that Dr. Bitter made a written "claim" or request for payment for claimant's May 1996 surgery. We have further determined that this request, as clarified in August 1996, was sufficient to put the employer on notice that an own motion claimant required surgery. Nevertheless, since we have found it premature to resolve claimant's entitlement to temporary disability benefits, it is likewise premature to determine whether the employer's conduct warrants a penalty for unreasonable claims processing.

Accordingly, because the compensability dispute between the parties remains unresolved, claimant's requests for Own Motion relief are denied as premature. Since this decision does not finally resolve the issue of claimant's entitlement to temporary disability (or his other requests), this order is *interim* in nature. If and when the necessary prerequisites for final resolution of these matters are satisfied, the parties may again present their respective positions for our review and determination.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**BRAD D. LINNELL, Claimant**
Own Motion No. 95-0448M
OWN MOTION ORDER OF ABATEMENT
Black, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 16, 1997 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 SAIF Corporation is requested to file a response to the motion within 14 days of the date of this order. Because it is unclear whether SAIF was copied with claimant's request, a copy of claimant's April 18, 1997 letter as well as an attached letter dated March 14, 1997 has been enclosed to SAIF. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MARY S. ORDAZ, Claimant**
WCB Case No. 96-06031
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that affirmed the Order on Reconsideration award of 22 percent (70.4 degrees) unscheduled permanent disability for her cervical condition. On review, the issue is extent of unscheduled permanent disability. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. On page 2, we change the third sentence to read: "Following the July 22, 1993 injury, claimant first treated with Dr. Cummings, her family physician."

## CONCLUSIONS OF LAW AND OPINION

### SVP Rating

The parties dispute the value of claimant's Specific Vocational Preparation (SVP). Claimant's SVP is based on the jobs she has performed during the five years preceding the time of determination. Former OAR 436-35-300(3) (WCD Admin. Order No. 93-056). SVP is the amount of "lapsed time required by a typical worker to learn the techniques, acquire the information and develop the facility needed for average performance in a specific job-worker situation." Former OAR 436-35-300(3)(a). The SVP range is from one to nine, and is associated with each Dictionary of Occupational Titles (DOT) code. Id.

Although claimant worked as a nurse's aide when she was injured, she lacked the necessary training time for "Nurse Assistant," DOT #355.674-014. In the five years before the time of determination, claimant worked 6.5 months as a cook at a school district kitchen. Claimant's job involved cooking and serving hot food and dishwashing. (Ex. 3-1). In addition, claimant worked in a grocery store delicatessen, using a food slicer, making sandwiches, using a deep fryer and acting as a cashier. (Exs. 3-2; 14-1). She also worked as a cook and cashier in a hospital from August 1994 through March 1995. (Exs. 14-2, 28-2). Her job involved preparing and serving food, chopping vegetables, dishing out food and putting trays on carts. (Ex. 18B-3). Claimant used a slicer and a cash register. (Ex. 14-2).

The ALJ found that the most appropriate DOT classification was "School Cafeteria Cook," DOT # 313.381-030, which has an SVP of 6. Claimant contends that the "School Cafeteria Cook," DOT # 313.381-030 classification was not appropriate because she did not meet the minimum training time necessary for that position.

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 was unable to perform the work of a finish carpenter. Consequently, we determined that the claimant's experience as a finish carpenter was sufficient to satisfy the requirements for the SVP value.

Here, the DOT for "School Cafeteria Cook," DOT # 313.381-030, has an SVP of 6. For an SVP of 6, the length of time to proficiency is "[o]ver 1 year up to and including 2 years." Dictionary of Occupational Titles, Vol. II, at 1009 (4th ed. 1991). The insurer acknowledges that claimant's 6.5 months as a cook for a school district does not, by itself, meet the minimum training time period of "[o]ver 1

year." Therefore, unlike Edward F. Ebert, there is no rebuttable presumption of proficiency since claimant did not work more than the minimum time period prescribed for proficiency. Nevertheless, the insurer contends that the SVP training time may be drawn from one or more employers. The insurer refers to claimant's experience working for a grocery store delicatessen and a hospital kitchen.

Former OAR 436-35-300(3)(b)(A) provides that "[a] worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the maximum period specified in the table in section 4 of this rule." (Emphasis added). The DOT for "School Cafeteria Cook," DOT # 313.381-030, has an SVP of 6. Although the insurer relies on claimant's work in a hospital kitchen, the SVP for "Food-Service Worker, Hospital," DOT # 319.677-014, is rated as a "2." Therefore, the training time for that job is not in the same job classification and cannot be used to meet claimant's SVP training time.

Furthermore, although the insurer relies on claimant's work in a grocery store delicatessen, her job duties in that position would fit under "Sandwich Maker," DOT # 317.664-010, and "Kitchen Helper," DOT # 318.687-010, both of which have an SVP rating of "2." We agree with the ALJ that claimant's job duties do not match the description for "Cook (hotel & rest.)," DOT # 313.361-014, which has an SVP of "7." Therefore, since claimant had no other work experience in the same job classification of SVP 6, we conclude that she did not satisfy the SVP training time for the DOT for "School Cafeteria Cook," DOT # 313.381-030.[1]

After reviewing the record, we agree with claimant that the most appropriate DOT classification is "Food-Service Worker, Hospital," DOT # 319.677-014. In a "Work/Educational History" form, claimant described her work at the hospital kitchen as a cook and cashier. (Ex. 14-2). The December 2, 1994 report from Dr. Reimer stated that claimant's job as a cook's assistant at a hospital kitchen involved "performing all of the duties of a cook's assistant, including the lifting and carrying of pots, pans, and kettles; stirring, opening, pouring, dishing and cleaning." (Ex. 14B-6). The July 5, 1995 report from Dr. Gardner described claimant's job as a food service worker at a hospital as follows:

> "Her job involves preparation and serving of food. She states that the heaviest aspect of her job would be lifting big tubs of mayonnaise, big coffee pots or cases of fruit. Perhaps some of these weigh as much as 50 lb. The most repetitive aspect of her work, she says, would be chopping vegetables in order to prepare salads. She may spend as much as 20 percent of her time doing this. Another repetitive activity is the actual dishing out of the food. In addition, she puts trays on carts, between 25 and 130 a day, another repetitive activity." (Ex. 18B-3).

In summary, we conclude that the most appropriate DOT classification is "Food-Service Worker, Hospital," DOT # 319.677-014, which has an SVP rating of "2."

Residual Functional Capacity

Adaptability is measured by comparing 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). RFC refers to "an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition." Former OAR 436-35-310(3)(b).

The ALJ concluded that claimant's RFC was "light." Claimant contends that her RFC should be rated as "sedentary/light" with restrictions, which places her in the "sedentary" category, based on the September 27, 1995 physical capacity evaluation. (Ex. 21).

Citing ORS 656.245(3)(b)(B) and Koitzsch v. Liberty Northwest, 125 Or App 666 (1994), the insurer argues that the Board may not consider the physical capacities evaluation because it was not ratified by the treating doctor. We disagree.

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[1] Former OAR 436-35-300(3)(a) provides, in part: "When a combination of DOT codes most accurately describes a worker's duties, the highest SVP shall apply if the worker has met the specific vocational preparation training time for that specific code." Here, since claimant has not satisfied the SVP training time for the DOT for "School Cafeteria Cook," DOT # 313.381-030, we do not consider that DOT code for purposes of "combining" the DOT codes.

In Koitzsch, the court held that ORS 656.245(3)(b)(B) prohibits the use of carrier-requested medical examinations to impeach an attending physician's impairment findings. Here, however, the issue is adaptability and the parties do not dispute claimant's impairment. The calculation of adaptability is a process separate from determining permanent impairment. Darlene E. Parks, 47 Van Natta 2404 n.3 (1995), Deborah A. Johnston, 47 Van Natta 1949 (1995).

Former OAR 436-35-310(5) provides that RFC is the greatest capacity evidenced by the attending physician's release or "[a] preponderance of medical opinion which includes but is not limited to a second-level PCE or WCE as defined in OAR 436-10-040 or any other medical evaluation * * *." Thus, former OAR 436-35-310(5)(b) expressly includes medical opinions from a "second-level PCE or WCE." Since the insurer does not dispute that claimant's September 27, 1995 physical capacity evaluation constitutes a "second-level PCE" pursuant to former OAR 436-35-310(5)(b), we may consider that report for purposes of determining claimant's RFC.

On July 19, 1995, Dr. Miller, claimant's attending physician, reported that claimant should not do work that required lifting anything repetitively over 35 pounds. (Ex. 19). On June 4, 1996, Dr. Scheinberg, the medical arbiter, concluded that claimant could occasionally lift 25 pounds. (Ex. 28-5). He found that claimant could not climb or safely descend ladders and would be "unable to perform any work requiring placing the neck in acute flexion or extension for any period of time, or acute right or left rotation." (Ex. 28-6).

On September 27, 1995, the physical capacity evaluator concluded that claimant "demonstrated residual functional capacities that corresponded to the light physical demand level." (Ex. 21-7). The evaluator determined that claimant had a "[g]ood demonstrated tolerance for handling materials up to 20 pounds maximum." (Id.) The evaluator administered a self-evaluation test to claimant, which indicated that claimant perceived herself as being limited to the sedentary physical demand level. (Ex. 21-5). The evaluator commented:

> "Her perception was not validated by her actual performance which more closely corresponded to the light physical demand level. The internal validity check for this test suggested that the RPC [rating of perceived capacity] is of questionable validity." (Id.)

Although the evaluator found that claimant demonstrated limited tolerance for forward reaching, he noted pain behavior with her forward reaching activities. (Ex. 21-5, -6). The evaluator found that, depending on the ergonomics of the work area, claimant's operation of hand controls would be limited to occasional to frequent. (Ex. 21-5).

Claimant contends that the September 27, 1995 physical capacity evaluation establishes that she has "restrictions" of frequent reaching and pushing/pulling. We disagree.

A worker has "restrictions" if the preponderance of medical opinion shows that the worker is permanently limited "[f]rom frequently performing at least two of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling." Former OAR 436-35-310(3)(l)(C). We do not agree with claimant that she is restricted from frequent "pushing/pulling." The evaluator indicated that claimant's ability to operate hand controls was occasional to frequent, depending on the ergonomics of the work area. The evaluator concluded that claimant had limited tolerance for unsupported forward reaching and poor tolerance for handling materials greater than 20 pounds. On the other hand, he concluded that claimant demonstrated good upper extremity function and good tolerance for handling materials up to 20 pounds. Under these circumstances, we are not persuaded that claimant's pushing/pulling activities were permanently restricted. Since claimant has not established that she is permanently precluded from "at least two" of the aforementioned activities, she does not have "restrictions" pursuant to former OAR 436-35-310(3)(l)(C).

We conclude that the preponderance of medical opinion estabishes that claimant's RFC is "light." We are most persuaded by Dr. Scheinberg's evaluation, which was closer in time to the June 24, 1996 Order on Reconsideration than Dr. Miller's report. Dr. Scheinberg's opinion is supported by the physical capacity evaluator's conclusion that claimant "demonstrated residual functional capacities that corresponded to the light physical demand level." (Ex. 21-7).

In sum, claimant's BFC was medium and her RFC was "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

As discussed earlier, claimant's SVP rating is "2." Therefore, claimant is entitled to a skills value of 4. Former OAR 436-35-300(4).

The total value of claimant's age (0), education (1) and skills (4) is (5). That value is multiplied by the adaptability value of (3) for a total of 15. Former OAR 436-35-280(6). When this value is added to the value for impairment (16), the result is 31. Former OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 31 percent (99.2 degrees). Consequently, we modify the ALJ's order to increase claimant's unscheduled disability award from 22 percent to 31 percent.

Because our order also results in increased unscheduled permanent disability, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. ORS 656.386(2).

ORDER

The ALJ's order dated October 22, 1996 is modified. In addition to the Order on Reconsideration award of 22 percent (70.4 degrees) unscheduled permanent disability, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total award of 31 percent (99.2 degrees) for her cervical condition. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the insurer directly to claimant's attorney.

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April 21, 1997 Cite as 49 Van Natta 518 (1997)

In the Matter of the Compensation of
**ALAN E. NIX, Claimant**
WCB Case No. 94-00546
ORDER ON REMAND
Bennett, Hartman, et al, Claimant Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to its January 16, 1997 order, the court has reversed our prior order, Alan E. Nix, 47 Van Natta 2082 (1995), that affirmed an Administrative Law Judge's (ALJ's) order which had affirmed a Director's determination finding that claimant was not a subject worker. Noting the Department's acknowledgment that the ALJ's order contained incorrect appeal rights, the court has remanded to the Board with instructions to dismiss claimant's request for review and "grant leave to the Director to issue a corrected order stating the correct appeal rights."

In accordance with the court's instructions, claimant's request for Board review is dismissed. Likewise, consistent with the court's directive, the Director is granted leave to issue a corrected order stating the correct appeal rights.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DANIEL J. BERGMANN, Claimant**
Own Motion No. 94-0203M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's February 18, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from January 12, 1995 through December 8, 1996. SAIF declared claimant medically stationary as of February 5, 1997. Claimant does not contend that he was not medically stationary when his claim was closed. Rather, claimant contends "that he is entitled to temporary partial disability benefits from December 8, 1996 through February 7, 1997." Claimant further requests a penalty for SAIF's allegedly unreasonable termination of benefits "prior to issuance of the claim closure."

Entitlement to Temporary Disability Benefits

Claimant contends that he is entitled to additional temporary partial disability (TPD) benefits beyond December 8, 1996, when SAIF terminated temporary total disability benefits (TTD). Claimant does not contend that his medically stationary date is incorrect or that he was not medically stationary at claim closure. In any event, the record would not support such a contention.[1] However, claimant further asserts that his job at injury was "chipper operator," but that, currently, because he is unable to do his job-at-injury, he owns and manages a pizza parlor. We treat claimant's assertion that his current work is "significantly different" from his job-at-injury, as his contention that he returned only to modified work, and, therefore, was entitled to temporary partial disability compensation during the period from December 8, 1996 through claim closure.[2]

A claimant's entitlement to substantive temporary disability benefits 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. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992); Donna Anderson, 46 Van Natta 1160 (1994).[3] Therefore, claimant's substantive entitlement to temporary disability benefits ended on his medically stationary date. SAIF paid claimant time loss benefits through December 8, 1996. To be entitled to further substantive benefits, claimant must establish that he was disabled due to the compensable injury from December 9, 1996 through February 5, 1997, the date he became medically stationary.

In his November 21, 1996 chart note, Dr. Jones stated that he released claimant "to return to full time work in two weeks." Dr. Jones anticipated that claimant would return to work on December 9, 1996. The physician noted that claimant should wear his orthotics at that time, and that claimant should return "in three months to close his case." In his February 5, 1997 report, Dr. Jones does not indicate that claimant did not return to work on December 9, 1996. Finally, claimant does not provide evidence that he did not return to work at that time or that, although he returned to work on December 9, 1996,

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[1] In a February 5, 1997 Physical Examination and Report, Dr. Jones, claimant's treating physician, opined that claimant "is now medically stationary." Dr. Jones' opinion is unrebutted. Furthermore, there is no evidence that claimant was not medically stationary at the time his claim was closed on February 18, 1997.

[2] If claimant is contending that SAIF has paid inappropriately calculated time loss, he must specifically indicate that assertion. See Lonnie L. Dysinger, 47 Van Natta 2282 (1995). However, the record before us does not indicate that this is the case.

[3] The Court of Appeals has held that we may not impose a "procedural" overpayment by ordering a carrier to pay temporary disability benefits beyond a claimant's substantive entitlement to those benefits. See Lebanon Plywood v. Seiber, 113 Or App at 654; Donna Anderson, 46 Van Natta 1160 (1994).

he did not return to work on a full-time basis. See amended ORS 656.212; Debra Dale, 47 Van Natta 2344 (1995) (the claimant did not establish "lost wages" after she returned to work, and, therefore, was not entitled to TPD).[4]

Here, claimant's 1983 injury claim was closed on February 18, 1997. Claimant requests temporary partial disability benefits "from December 8, 1996 through February 7, 1997."[5] The record does not establish that claimant was disabled, totally or partially, between December 9, 1996 and February 5, 1997. Therefore, we conclude that claimant has not established entitlement to TTD or TPD after December 8, 1996, the date SAIF terminated those benefits.

Penalty

Because we have concluded that claimant is not entitled to further temporary disability compensation in this claim, we do not find that SAIF unreasonably terminated his benefits. Therefore, we decline to penalize SAIF for allegedly unreasonable termination of temporary disability compensation prior to claim closure.

Accordingly, we affirm SAIF's February 18, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[4] To the extent that claimant may contend that his return to work as owner / operator of a pizza parlor qualifies as "modified" work (because he is no longer able to work in the same capacity as he did when he incurred his compensable injury), we would disagree with such a contention. It appears that claimant has returned to the same job he was doing prior to his current disability; therefore, his current job has not been "modified." Furthermore, although Dr. Jones instructed claimant to wear his "orthotics," he did not indicate that any modifications in claimant's prior work were necessary to accommodate the orthotics. If this were the case, claimant must establish wages lost because of the modification or that he returned to work at less than full time. See Debra Dale, 47 Van Natta at 2344.

[5] The request for TPD through February 7, 1997 may be a typographical error, since claimant does not appear to contest the February 5, 1997 medically stationary date. Therefore, we assume that claimant requests TPD through February 5, 1997, his medically stationary date.

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In the Matter of the Compensation of
**VANCE T. FERGUSON, Claimant**
Own Motion No. 97-0100M
AMENDED INTERIM OWN MOTION ORDER
CONSENTING TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Popick & Merkel, Claimant Attorneys
Stoel Rives, Defense Attorneys

On April 8, 1997, the Board issued an Interim Own Motion Order Consenting to Designation of Paying Agent under ORS 656.307, in which it authorized the payment of interim temporary disability compensation beginning September 9, 1996, the date claimant underwent right lateral epicondylar and carpal tunnel release surgery. However, on April 17, 1997, the Department notified the Board that it requests the Board's approval for an order designating a paying agent for claimant's left lateral epicondylitis condition. Therefore, to correct this error, the Board's April 8, 1997 order is withdrawn and replaced by the following order.

Under OAR 438-012-0032, the Board shall notify 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 the payment of compensation. 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 1990 injury claim with the American National Fire Insurance Company expired on December 30, 1995. Thus, the claim is subject to ORS 656.278.

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). 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.

With its request for reconsideration of our order, the Benefits Section submitted a March 10, 1997 Independent Medical Evaluation report, in which Dr. Kaesche, examining physician, opined that "[t]he proposed surgery for the [claimant's] carpal tunnel release and lateral release of the left elbow are reasonable and necessary."

Here, the record establishes that there has been a worsening of claimant's compensable left lateral epicondylitis condition requiring surgery. Inasmuch as claimant would be entitled to Own Motion relief if the Own Motion insurer is found responsible for claimant's current left lateral epicondylitis condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1990 Own Motion claim, beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307. On February 28, 1997, the Board postponed action on claimant's request for temporary disability compensation in his 1990 claim pending the outcome of litigation at the Hearings Division. (WCB Case No. 96-09497). That hearing is currently scheduled before Administrative Law Judge (ALJ) Lipton on May 16, 1997. In our order, we requested that, after the ALJ issues his order or if the matter is resolved by settlement agreement, the parties should advise the Board of their respective positions regarding Own Motion relief.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 8, 1997 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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April 22, 1997 Cite as 49 Van Natta 521 (1997)

In the Matter of the Compensation of
**DENNIS E. FLANARY, Claimant**
WCB Case No. 96-08136
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's low back condition. 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 he is entitled to an award of permanent disability for a chronic condition which limits his ability to repetitively use his low back. OAR 436-035-0320(5). Claimant contends that a report from Dr. Gambee, his treating physician, establishes that he has a chronic condition. (Ex. 17).

As noted by the ALJ, Dr. Gambee imposed a permanent 30 pound lifting restriction on claimant. (Ex. 12). Dr. Gambee later reported that claimant's permanent restrictions related directly to the work injury. (Ex. 17). Despite Dr. Gambee's report, however, we are not persuaded that claimant has established entitlement to a chronic condition award. We have previously held that work limitations imposed to avoid the likelihood of reinjury do not establish an inability (or partial inability) to

repetitively use a body area due to the compensable injury. Harriet Olson, 47 Van Natta 1917 (1995); David A. Kamp, 46 Van Natta 389, 390 (1994). Accordingly, without any further support in the medical record, we find that Dr. Gambee's lifting restriction is inadequate for purposes of establishing that claimant has a chronic condition.

Accordingly, for this additional reason, we agree with the ALJ that claimant is not entitled to an award of permanent disability.

ORDER

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

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April 22, 1997 Cite as 49 Van Natta 522 (1997)

In the Matter of the Compensation of
**LARRY E. MERRYMAN, Claimant**
Own Motion No. 97-0010M
OWN MOTION ORDER OF DISMISSAL
Estell & Smith, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable contusion of upper left thigh and contusion of right arm and hand injury. Claimant's aggravation rights in this claim expired on September 4, 1996. Claimant requested temporary disability compensation for his current right carpal tunnel syndrome condition. On March 11, 1997, the Board consolidated the own motion request with a hearing as litigation on related issues was pending before the Hearings Division. (WCB Case No. 97-01131).

On April 21, 1997, Administrative Law Judge (ALJ) T. Lavere Johnson approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division. The parties agreed that SAIF would withdraw its February 18, 1997 denial, and that its January 7, 1997 denial "shall stand." In addition, claimant's hearing request was dismissed with prejudice.

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).

Here, SAIF's January 7, 1997 denial of claimant's current right carpal tunnel syndrome condition, remains in full force and effect. In light of such a stipulation, we are without authority to authorize temporary disability compensation for claimant's current right carpal tunnel syndrome condition, as SAIF has not accepted responsibility for that condition under his 1990 injury claim. Should claimant's circumstances change, and SAIF accept responsibility for his current condition under his 1990 claim, claimant may again request own motion relief.

Accordingly, the request for own motion relief is dismissed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JAVITA RIVERS, Claimant**
WCB Case No. 95-01083
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's aggravation claim. 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."

## CONCLUSIONS OF LAW AND OPINION

The employer argues that res judicata precludes claimant's current claim for an October 1994 worsening of her neck and left shoulder condition. We need not address this argument, because we find that the aggravation claim fails even if it is not precluded.

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." Subsequent to the ALJ's order, the court has determined that the term "actual worsening" was not intended to include a symptomatic worsening. SAIF v. Walker, 145 Or App 294 (1996). Rather, the court has concluded that there must be medical evidence that the symptoms have increased to the point that it can be said that the compensable condition has worsened.

The medical evidence evaluating claimant's condition since the July 7, 1994 Determination Order (the last arrangement of compensation) is provided by Drs. Farris and Lazar. Dr. Farris examined claimant on December 29, 1994 and noted that claimant's subjective complaints outweighed her objective findings. (Ex. 68-6). Dr. Farris opined that, although claimant "appeared to experience a symptomatic worsening of her neck and left shoulder condition in October 1994, [] there is no evidence to suggest that a material worsening of her condition occurred at that time." (Ex. 68-7).

Dr. Lazar, attending physician, concurred with Dr. Farris' report. (Ex. 69; see Ex. 71). Dr. Lazar also concurred with statements indicating that claimant's October 1994 condition did not represent a worsening of her compensable condition. (Ex. 72).

Under these circumstances, we find no evidence of anything more than a symptomatic worsening of claimant's condition. Accordingly, on this record, we are unable to conclude that claimant's condition actually worsened since the last arrangement of compensation and the aggravation claim must fail. See Walker, 145 Or App 294.

## ORDER

The ALJ's order dated October 24, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee is reversed.

In the Matter of the Compensation of
**KRYZSZTOF ZIELINSKI, Claimant**
WCB Case No. C700845
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Richard F. McGinty, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On April 7, 1997 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 his rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The cover page of the CDA provides that claimant's counsel will receive an attorney fee of $4,875 and that the total due claimant under the CDA is $25,125. The cover page provides that the total compensation is $30,000. Below these amounts, there is an explanation which provides:

> "Total compensation value in consideration of [the insurer's] waiver of its third party statutory lien in the amount of $24,200.00 is $54,200.00. In addition to the $24,000.00 of which [the insurer] is waiving its lien, [third party insurer] will pay [the insurer] $10,000.00. Claimant and claimant's attorney agree that [the insurer] will receive this entire amount and they waive any percentage that would normally be apportioned."

On page 2, paragraph 12, the CDA provides: "Claimant has settled his third party law suit against [the third party insurer] for an amount of $55,000.00. Pursuant to ORS 656.593, [the insurer's] statutory share would be approximately $24,200.00. In a separate agreement, [the third party insurer] has agreed to pay [the insurer] an additional $10,000.00 of [sic] which claimant agrees will go entirely [the insurer]." The CDA further provides that consideration for the CDA is a partial release by [the insurer] of its statutory share in the amount of $24,000.00. The CDA also provides that claimant's attorney shall receive his attorney fee from the third party settlement.

We interpret the parties' CDA as follows. The third party settlement is $65,000 ($55,000 plus the $10,000 that [the insurer] will receive directly from the third party carrier). Claimant's attorney will receive an attorney fee from the third party settlement in the amount of $4,875.[1] There is no attorney fee payable from the CDA. The insurer's otherwise reasonable statutory third party lien is $24,200. Of that amount, the insurer agrees to waive $14,200. (In other words, the consideration for the CDA is the insurer's agreement to reduce its otherwise reasonable third party lien from $24,200 to $10,000).

Based on the above interpretation, the agreement is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

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[1] We note that the summary page is inconsistent with the body of the CDA to the extent that it appears to provide for an attorney fee payable out of the CDA proceeds. Based on the body of the CDA, however, we interpret the agreement as providing that the attorney fee will be paid out of the third party settlement; no attorney fee is payable from the CDA "consideration."

In the Matter of the Compensation of
**WILLIAM C. BLACK, Claimant**
Own Motion No. 95-0543M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Insurance Corporation, Insurance Carrier

Claimant, pro se, requests review of the insurer's January 20, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from January 8, 1996 through January 5, 1997. The insurer declared claimant medically stationary as of December 27, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Claimant further indicates that "I believe that the pain I have to live with the rest of my life is worth some compensation." We treat claimant's statement as a request for further permanent disability benefits in his 1989 injury claim.

Entitlement to Temporary Disability Benefits

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 January 20, 1997 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 a March 18, 1997 letter, we requested the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on March 26, 1997, however, no further response has been received from claimant.[1] Therefore, we will proceed with our review.

In a December 27, 1996 chart note, Dr. Irvine, claimant's treating physician, reported that claimant's left rotator cuff sprain condition "[s]hows 140 degrees of flexion, 140 degrees of abduction, 35 degrees of external rotation, full internal rotation and full extension." Dr. Irvine further opined that:

> "I now consider [claimant] medically stationary with a permanent partial disability due to the aforementioned loss of motion as well as Grade I crepitus about the shoulder. He is capable of normal duty work, effective 1/6/97. He is medically stationary, effective 1/6/97 and will return prn with any difficulties."

In a December 27, 1996 Physical Status Update, Dr. Irvine released claimant to return to light duty work from December 27, 1996 until January 6, 1997, and released claimant to return to regular duty on January 6, 1997. Dr. Irvine reiterated that claimant was medically stationary as of January 6, 1997. Dr. Irvine's opinion is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. However, we modify the insurer's closure to indicate that claimant was medically stationary on January 6, 1997.[2] We conclude that the remainder of the insurer's closure was proper.

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[1] Because it was unclear whether the insurer had copied claimant with the documents it submitted to the Board, on March 28, 1997, we forwarded copies of those documents to claimant, and allowed claimant further time to respond to the insurer's submissions. Despite that action, we have received nothing further from claimant.

[2] There is no evidence in the record to establish that claimant was medically stationary on December 27, 1996. Claimant was released to light duty work on that date, however, Dr. Irvine twice opined that claimant would be considered medically stationary on January 6, 1997. (See Dr. Irvine's December 27, 1997 chart note and Physical Status Update report). Because the record establishes that claimant was medically stationary on January 6, 1997 and that he returned to regular, full-time work on that date, we modify the insurer's Notice of Closure to reflect that claimant was medically stationary on January 6, 1997. This modification does not affect claimant's entitlement to temporary disability compensation, as the insurer paid temporary disability through January 5, 1997. See ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

Permanent Disability Benefits

Claimant contends that he is entitled to additional compensation for "the pain I have to live with the rest of my life." Requesting clarification of the law with respect to permanent disability in Own Motion claims, claimant petitioned the Board for review of his claim for an award of additional permanent disability.

The Board's Own Motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b). 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).

Here, claimant's aggravation rights expired on December 26, 1994. Because we have established that claimant's aggravation rights have expired and, thus, that his claim is in Own Motion status, we are without authority to award any further permanent disability benefits. See Miltenberger v. Howard's Plumbing, 93 Or App at 475; Independent Paper Stock v. Wincer, 100 Or App at 625. Therefore, we are unable to grant claimant's request for an award of permanent disability. See Charles H. Jones, 47 Van Natta 1546 (1995); David L. Grenbemer, 48 Van Natta 195 (1996).

Accordingly, we affirm the insurer's January 20, 1997 Notice of Closure, as modified to reflect that claimant was medically stationary on January 6, 1997.

IT IS SO ORDERED.

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April 23, 1997 Cite as 49 Van Natta 526 (1997)

In the Matter of the Compensation of
**JANET K. CLARK, Claimant**
WCB Case No. 96-05120
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the insurer's denial of her injury claim for a left shoulder condition. On review, the issue is compensability.

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

In lieu of the finding that claimant experienced soreness in both shoulders on January 17, 1996, we find that claimant experienced soreness in only the left shoulder on that date. We do not find that claimant had right shoulder problems prior to the January 21, 1996 incident at work.

Despite our modification of the ALJ's findings, we agree with the ALJ's ultimate conclusion that claimant has not carried her burden of proof by a preponderance of the evidence. Dr. Wuest, the only physician to opine that the work incident was the major contributing cause of the subsequent need for treatment, could not say whether the incident was the major contributing cause of the left shoulder condition diagnosed as left calcific rotator cuff tendinitis. (Ex. 12-15). Inasmuch as the calcific rotator cuff tendinitis has been the condition requiring treatment since the work incident, we read Dr. Wuest's opinion as supporting no more than a "precipitating" causal relationship between the work incident and the subsequent need for treatment. (Ex. 12, pp. 14-15). Therefore, we conclude that his opinion is not sufficient to carry claimant's burden of proof under the "major contributing cause" standard. See Dietz v. Ramuda, 130 Or App 397 (1994); Alec E. Snyder, 47 Van Natta 838 (1995).

ORDER

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

In the Matter of the Compensation of
**DANIEL J. HIDY, Claimant**
WCB Case No. 96-05678
ORDER ON REVIEW
Furniss, Shearer, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that awarded 18 percent (57.6 degrees) unscheduled permanent disability for a back condition, whereas an Order on Reconsideration had awarded 15 percent (48 degrees). The insurer moves to strike portions of claimant's brief which refer to evidence not in the record. On review, the issues are motion to strike and extent of unscheduled permanent disability. We deny the insurer's motion and modify.

## FINDINGS OF FACT

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

We find that the medical arbiter put claimant in the "heavy/medium" (rather than "heavy") category of residual functional capacity, indicating that he could lift 70 pounds occasionally, 50 frequently and 30 constantly. See O&O p. 2.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Strike

The insurer moves to strike portions of claimant's brief which refer to claimant's offer of proof regarding what he would have said if the ALJ had allowed testimony regarding claimant's residual functional capacity upon returning to work.

We consider the parties' arguments only insofar as they are supported by the record. See Gilbert T. Hale, 43 Van Natta 2329, 2330 (1991) (Board is capable of ignoring unsupported assertions of fact).

In this case, the ALJ explained that he could not consider claimant's testimony regarding his return to work, because such evidence was not part of the reconsideration record. We agree with the ALJ that "post-reconsideration" evidence may not be considered for the purpose of rating claimant's permanent disability. See ORS 656.283(7); John C. Katona, 48 Van Natta 1574 (1996); Dean J. Evans, 48 Van Natta 1092 (1996). Accordingly (because no "post-reconsideration" evidence has been considered), there is no need to strike the above-described portions of claimant's brief, and the motion is denied.

### Extent of Unscheduled Permanent Disability

We adopt the first five paragraphs of the section of the ALJ's "Conclusions and Opinion" entitled "Rating of Disability," which describe the applicable standards and find that claimant is not entitled to an impairment rating for lost lumbar flexion, based on the arbiter's application of the SLR validity test. See Benjamin G. Santos, 46 Van Natta 1912 (1994).

Claimant argues that he is entitled to an adaptability value greater than one, because his residual functional capacity is less than his base functional capacity. In this regard, claimant also contends that the evidence is insufficient to establish that he actually returned fully to his regular heavy work as a tire mechanic.

The most persuasive evidence regarding claimant's residual functional capacity is the April 26, 1996 report of Drs. Thomas, Masters, and Adams-Bell, medical arbiters.[1] (Ex. 33). Based on that report, we find that claimant's adaptability value should be 2, rather than one.

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[1] In reaching this conclusion, we note that the treating physician's concurrence with a "pre-closure" PCE report is not helpful in determining claimant's residual functional capacity, because the evaluators were unable to project claimant's lifting ability. (See Exs. 30, 31).

The arbiters reported claimant's history indicating that he had returned to modified work as a tire mechanic three months after his back surgery "and then gradually returned to full duty." (Ex. 33-1). Claimant also told the arbiters that he tried to get help if the tires were heavy "but otherwise he does the work." (Id.) Although the arbiters reported that claimant lifts over 70 pounds frequently (Ex. 33-2), with specific regard to claimant's "residual functional capacity," the arbiters concluded that claimant can lift 70 pounds occasionally, 50 pounds frequently, and 30 pounds constantly, without restrictions. (Ex. 33-3).[2]

The applicable standards provide, in relevant part, at OAR 436-35-310(3):

"* * *

"(h) 'Medium (M)' means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently.

"(i) 'Medium/Heavy (M/H)' means the worker has the ability to do more than medium activities, but less than the full range of heavy activities. . . .

"(j) 'Heavy (H)' means the worker has the ability to occasionally lift 100 pounds and the ability to frequently lift or carry objects weighing 50 pounds."

We are persuaded that claimant has not fully returned to "heavy" work.[3] Further considering claimant's base functional capacity, "H,"[4] the above-quoted rule, and the arbiters' findings, we conclude that claimant in fact has the ability to perform less than the full range of heavy activities. Accordingly, on this record, we find that claimant's residual functional capacity is "M/H," for an adaptability value of "2." See OAR 436-35-310(6).

When the adaptability value, 2, is multiplied by age/education factor, 3, the product is 6. When that value is added to claimant's 15 percent impairment value, the result is 21 percent unscheduled permanent disability.

## ORDER

The ALJ's order dated September 24, 1996 is modified. In lieu of the Order on Reconsideration's unscheduled permanent disability award, and in addition to the ALJ's 18 percent (57.6 degrees) unscheduled permanent disability award, claimant is awarded 3 percent (9.6 degrees), for a total award to date of 21 percent (67.2 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to the attorney. However, the total "out-of-compensation attorney fee award granted by this order and the ALJ's order shall not exceed $3,800.

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[2] The arbiters' recitation of claimant's history might be interpreted as indicating that claimant successfully returned to his regular work by the time of the arbiters' examination. However, based on the arbiters' express opinion regarding claimant's residual functional capacity, we find it to be less than heavy and therefore less than required for claimant to have returned fully to his regular heavy work as a tire mechanic work.

[3] See n.2, supra.

[4] See Ex. 32A-3; see also DOT 915 684-010.

In the Matter of the Compensation of
**GEORGE D. KOSKELA, Claimant**
WCB Case No. 95-08576
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that: (1) declined to admit into evidence the testimony of claimant, his physician or his vocational counselor at a hearing regarding his appeal of an Order on Reconsideration; and (2) declined to grant him permanent total disability. On review, the issues are constitutionality, evidence and permanent total disability.

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

The ALJ declined, pursuant to amended ORS 656.283(7), to consider any evidence that was not previously submitted at the Department's reconsideration proceeding. On review, claimant contends that the ALJ's ruling violated his right to due process under the Fourteenth Amendment to the United States Constitution, and denied him any substantial remedy in violation of Article 1, section 10 of the Oregon Constitution.

Amended ORS 656.283(7) provides, in relevant part: "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing...." In Joe R. Ray, 48 Van Natta 325 (1996), we interpreted that provision to prohibit the admission at hearing of evidence concerning the extent of a claimant's permanent partial disability (PPD), which was not previously submitted at reconsideration. In addition, we rejected the claimant's argument that the prohibition of "post-reconsideration" evidence under amended ORS 656.283(7) violated his procedural due process rights under the Fourteenth Amendment to the United States Constitution. We reasoned that, although the claimant's entitlement to PPD is a constitutionally significant (i.e., "property") interest, the procedures afforded during the reconsideration process were sufficient to guard against an erroneous deprivation of his interest in PPD.

Our decision in Ray was partially overruled by the Court of Appeals, to the extent that Ray barred the admission of "post-reconsideration" evidence at hearings that were held prior to the June 7, 1995 effective date of the 1995 amendments to ORS 656.283(7). See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996). However, where a hearing concerning PPD was held after June 7, 1995, we have held that the evidentiary limitation in amended ORS 656.283(7), as interpreted in Ray, is applicable. Dean J. Evans, 48 Van Natta 1092, 1093, recon 48 Van Natta 1196 (1996).

Here, claimant argues that, because he is seeking entitlement to permanent total disability (PTD) and there are significant differences between a proceeding to determine PPD and one to determine PTD, "due process" requires an evidentiary hearing and the right to confront and cross-examine witnesses. We disagree and conclude that the reconsideration procedures afforded claimant due process.

Claimant correctly points out that the criteria for determining PTD are different from the criteria for determining the extent of PPD. Whereas PPD is awarded for permanent loss of earning capacity (unscheduled PPD) or permanent loss of use or function of a body part (scheduled PPD), see ORS 656.214(2) & (5), PTD is awarded for permanent incapacity to regularly perform work at a gainful and suitable occupation, see ORS 656.206(1)(a). As the ALJ noted, PTD benefits are calculated on the basis of wage replacement. ORS 656.206(2); SAIF v. Stephen, 308 Or 41, 46 (1989). Therefore, claimant's interest in PTD benefits is more significant than the claimant's interest in PPD benefits in Ray. In addition, a claimant seeking PTD has the burden to prove he is willing to seek regular gainful employment and has made reasonable efforts to obtain such employment. See ORS 656.206(3).

Notwithstanding the differences between PTD and PPD, we are persuaded that the procedures afforded during the reconsideration process were sufficient to guard against an erroneous deprivation of claimant's interest in PTD benefits. A written Determination Order was mailed to claimant on October 5, 1994; it explained his disability award and advised him of his right to seek reconsideration of that

award before the Department. (Ex. 115-1). Claimant had 180 days from the October 5, 1994 mailing date of the Determination Order in which to request reconsideration. See former OAR 436-30-115(1).[1] Claimant availed himself of that opportunity and filed his request for reconsideration on February 27, 1995. The parties then had six working days to submit information into the reconsideration record, with copies to the opposing party. Former OAR 436-30-145(2). The Department had the discretion to extend the six day deadline if additional information was needed for reconsideration. ORS 656.268(6)(b); former OAR 436-30-145(2). The reconsideration process afforded claimant the right to correct or clarify information in the record that was erroneous and submit any medical evidence that should have been but was not submitted by the attending physician at the time of claim closure. ORS 656.268(6)(a); former OAR 436-30-155(2).

In addition, claimant had the right to an examination by a medical arbiter if he was dissatisfied with his attending physician's impairment findings. ORS 656.268(7)(a). Finally, even after issuance of the Order on Reconsideration, the Director had the discretion to abate, withdraw and/or amend the reconsideration order within the time limit permitted to appeal the Determination Order, until a hearing was requested. Former OAR 436-30-008(1), 436-30-115(3).

Taken together, the reconsideration procedures enabled claimant to present in writing the lay, medical and vocational evidence supporting his entitlement to PTD benefits. That is, claimant had the opportunity to present essentially the same evidence on reconsideration which he sought to present at hearing, albeit in somewhat different form.[2] The substance of any lay and/or expert witnesses' testimonies could have been presented by sworn affidavits at the time of reconsideration. In this regard, we reject claimant's argument that oral testimony was necessary for him to establish he was willing to seek employment and made reasonable efforts to obtain such employment; that evidence could have been presented by affidavit at reconsideration. The evidentiary limitation in amended ORS 656.283(7) is on the form and timing, not the substance, of the evidence relevant to the PTD issue.

Claimant argues that his own credibility is critical to determining the reasonableness of his efforts to obtain employment and, therefore, the right to confront and cross-examine witnesses is central to due process. We disagree. As we previously stated, claimant's evidence regarding his work-seeking efforts could have been presented by affidavit during the reconsideration process. Moreover, keeping in mind (as we noted in Ray) that credibility is not usually an issue in permanent (total or partial) disability cases, we are persuaded that the reconsideration process afforded claimant a sufficient opportunity to present evidence to refute the employer's evidence. In short, consistent with our holding in the PPD context in Ray, we conclude there is no right to confront or cross-examine witnesses in hearings concerning PTD.[3]

Because claimant had the opportunity to present his position and evidence fully at the reconsideration proceeding, we find there was a low risk of erroneous deprivation of his interest in PTD benefits. Thus, although there is less process available under amended ORS 656.283(7), we are not

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[1] The administrative rules applicable to the reconsideration process in this claim are set forth in WCD Admin. Order No. 94-059 (eff. 1/1/95).

[2] In fact, claimant presented additional evidence at the reconsideration proceeding to supplement the information developed at the time of claim closure. The Department evaluator's "Explanatory Notes" indicate that claimant and the employer each submitted medical reports to support their respective positions. (Ex. 116-3).

[3] The dissent asserts that the claimant's credibility will always be an issue in a PTD case because of the necessity for him to prove his motivation to work. A demeanor-based assessment of the claimant's credibility may be helpful in determining his motivation. Nevertheless, the claimant's motivation to work can also be determined on the basis of documentary evidence of his past conduct, e.g., a sworn affidavit describing work search activities or vocational reports of the claimant's cooperation with vocational rehabilitation. Such documentary evidence can be submitted at reconsideration, without the need for live testimony.

In any event, there is no statutory bar to the Department considering live testimony and cross-examination of witnesses at the reconsideration proceeding. Although the Department rules generally define "reconsideration proceeding" so as not to include personal appearances by any of the parties, the Department is allowed discretion to request such personal appearances. See former OAR 436-30-115(2). In this particular case, claimant never requested an opportunity to personally appear at the reconsideration proceeding; hence, he cannot belatedly assert that he was precluded from doing so.

persuaded that the statutory limitation violates claimant's right to due process under the Fourteenth Amendment to the United States Constitution.[4]

Based on the same reasoning (i.e., that claimant had an opportunity to present essentially the same evidence on reconsideration that he now seeks to admit), we also conclude that claimant was not deprived of a substantial remedy in violation of Article 1, section 10 of the Oregon Constitution. The court has upheld the legislature's authority to impose limits on the bringing of a workers' compensation claim. See State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603 (1990). In Borisoff, the court rejected the worker's contention that the legislature's elimination of the Board's "own motion" authority to award permanent disability deprived claimant of a remedy by due course of law, in violation of Article 1, section 10 of the Oregon Constitution. The court reasoned that the legislature could legitimately decide that claims for permanent disability should not be subject to adjustment pursuant to the Board's discretionary authority more than five years after the last arrangement of compensation, (i.e., after the five-year aggravation rights for a compensable injury have expired).

Similarly, in this case, we conclude that the legislature could legitimately impose a time limit on the development and presentation of evidence concerning claimant's entitlement to PTD benefits, without violating Article 1, section 10 of the Oregon Constitution. Accordingly, we uphold the ALJ's evidentiary ruling and reject claimant's constitutional challenges to amended ORS 656.283(7).

Finally, we note that claimant offered at hearing the testimony of a vocational consultant, Byron McNaught. In Virginia McClearen, 48 Van Natta 2536 (1996), we considered the effect of ORS 656.287(1) on the admissibility of "post-reconsideration" vocational evidence in PTD hearings. 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."

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[4] The dissent contends that we are retroactively applying amended ORS 656.283(7) to the facts of this case and that the retroactive application of an evidentiary limitation violates claimant's procedural due process rights. We note, first of all, that the dissent's assertions are not raised by claimant on Board review. Claimant's constitutional "due process" challenge is more limited. He argues that the application of amended ORS 656.283(7) to PTD cases violates the right to procedural due process under the Fourteenth Amendment.

Assuming that claimant had raised a constitutional challenge to the retroactive application of amended ORS 656.283(7), we would not agree that its application was unconstitutional, for the following reason. The Order on Reconsideration in this case issued on July 13, 1995, and claimant requested a hearing on the reconsideration order on July 24, 1995. Before filing his hearing request, claimant could have moved the Director for abatement of the reconsideration order to allow him an opportunity to submit additional evidence in the light of amended ORS 656.283(7) and the retroactive limitation on admissible evidence at hearing. Former OAR 436-30-008(1)(b). Although the former rule did not expressly authorize the Director to abate a reconsideration order based on the submission of additional evidence, it did not preclude the Director from exercising his broad discretion to do so. Nevertheless, claimant did not avail himself of the opportunity to request an abatement, nor did he make any attempt to submit additional evidence to the Department after issuance of the reconsideration order. Under the facts of this case, therefore, we are persuaded that claimant had sufficient notice of the amended law and had an opportunity to submit additional information at the reconsideration proceeding, prior to the filing of the hearing request.

Finally, even if we assumed that amended ORS 656.283(7) did not take effect until after the hearing had been requested in this matter, we would still conclude that retroactive application of amended ORS 656.283(7) did not violate claimant's procedural due process rights. Claimant requested reconsideration and knew of his right to submit evidence supporting his PTD claim within six working days. Although he may not have been aware that there would be a subsequent, retroactive limitation on admissible evidence at hearing, he knew that he could submit his evidence at the reconsideration proceeding. He has made no showing that the Department refused to consider any evidence that he submitted at reconsideration. In fact, there is evidence that the Department actually considered additional evidence submitted by claimant. See infra n 2. Because there was sufficient process provided to claimant at the reconsideration proceeding, the application of amended ORS 656.283(7), even if retroactive, did not unconstitutionally deprive claimant of his procedural due process rights.

We noted that the text of ORS 656.287(1) appeared to grant unqualified authority for the admission of expert vocational evidence in PTD hearings. Id. However, when viewing ORS 656.287(1) in its statutory context, which includes ORS 656.283(7)'s limitation on "post-reconsideration" evidence, we interpreted ORS 656.287(1) as a conditional grant of authority for the admission of expert vocational evidence. Id. We concluded that ORS 656.287(1) authorizes the admission of vocational reports at hearing 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. Id. Those 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. Id. We further concluded that if the adverse party elected to cross-examine the vocational consultant at hearing, the consultant's testimony is admissible pursuant to ORS 656.287(1). Id.

To apply the McClearen analysis to the vocational evidence in this case, we must first identify any vocational reports that were submitted at reconsideration before the Department. See Neil A. Laufer, 49 Van Natta 26 (1997). If any such reports are identified, we must then determine if the vocational consultants who authored those reports were made available for testimony and cross-examination at hearing, upon the adverse party's request. Id. If so, the vocational reports are admissible at hearing. Id. In addition, if the adverse party elected to cross-examine the vocational consultants who authored the admissible reports, the testimonies of those consultants are also admissible at hearing. Id.

Here, we find no evidence that Byron McNaught authored any vocational report that was submitted at reconsideration. Therefore, his testimony was properly excluded at hearing, pursuant to amended ORS 656.283(7). See Virginia McClearen, supra.

Accordingly, we agree with the ALJ that claimant has not proven an entitlement to an award of PTD.

## ORDER

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

**Board Chair Hall dissenting.**

The majority applies amended ORS 656.283(7) to bar claimant from presenting at hearing evidence that was not previously submitted at reconsideration. Because the application of amended ORS 656.283(7) to the facts of this case is effectively retroactive, and the Department's reconsideration proceeding is an inadequate process for determining entitlement to permanent total disability (PTD) benefits, I conclude that the majority's decision violates claimant's procedural due process rights and, thus, I respectfully dissent.

As a preliminary matter, I must acknowledge some reluctance to dissent in this particular case because the record does not indicate what, if any, evidence claimant sought to submit at reconsideration but the Department refused to consider. Such a showing would have bolstered claimant's constitutional challenge. Nevertheless, I am persuaded that the reconsideration proceeding is, now in the face of the ban on "post-reconsideration" evidence being admitted at hearing, constitutionally inadequate to protect against the erroneous deprivation of claimant's "property" interest in PTD benefits.

In Joe R. Ray, 48 Van Natta 325, 335-39 (1996), I dissented from the majority's retroactive application of amended ORS 656.283(7) to a case involving a claimant's entitlement to permanent partial disability (PPD) benefits. There, the reconsideration order issued, and the hearing was held, before the June 7, 1995 effective date of Senate Bill 369 (SB 369). The majority retroactively applied amended ORS 656.283(7) to bar consideration of any evidence that was not previously submitted at reconsideration, despite the fact that there was no bar against "post-reconsideration" evidence in effect at the time of the reconsideration proceeding. Reasoning that the claimant in Ray had been effectively deprived of a meaningful opportunity to be heard in proving his entitlement to PPD benefits, I concluded that his procedural due process rights had been violated.

The facts of this case differ from Ray in two important respects: (1) this case does not present a purely retroactive application of SB 369; and (2) this case concerns claimant's entitlement to PTD benefits. Application of SB 369 is not purely retroactive in this case because the new law took effect

while the reconsideration proceeding was still pending, about five weeks before the issuance of the reconsideration order on July 13, 1995. The question remains, however, whether claimant received adequate notice of amended ORS 656.283(7)'s prohibition of "post-reconsideration" evidence and had a sufficient opportunity to submit evidence prior to issuance of the reconsideration order. I conclude he did not.

Prior to issuance of the reconsideration order in this case, there was no case law interpreting amended ORS 656.283(7)'s evidentiary limitation. Without case law to clarify the statute and its retroactive application, claimant had a reasonable degree of uncertainty as to whether the law would be retroactively applied to cases in which the reconsideration proceeding was initiated prior to the effective date of SB 369. Furthermore, the Department's rules required the parties to submit their evidence at reconsideration within six working days after the February 27, 1995 filing of the request for reconsideration. See former OAR 436-30-145(2). The rules further provided that evidence submitted after the sixth working day deadline may not be considered in the reconsideration proceeding. Former OAR 436-30-145(2)(a). Thus, by the time the new law went into effect, the time period allowed for submission of evidence at reconsideration had expired. Given the lack of sufficient notice and opportunity to be heard under the new law, I conclude that the application of amended ORS 656.283(7) to bar the admission of "post-reconsideration" evidence in this case is effectively retroactive.[1]

The majority notes that the retroactivity issue was not raised by claimant on Board review. Nevertheless, when analyzing this case in the context of existing case law and understanding how this case fits into that body of case law, the similarity between this case and Ray requires discussion of the retroactivity issue. For that reason, the issue is effectively before us and must be addressed.

The retroactive application of a new evidentiary law to a pending case, where the evidentiary record has already been developed, does not satisfy the requirements of procedural due process under the Fourteenth Amendment. "The heart of procedural due process is (1) notice of the charge and (2) an opportunity to be heard." OSEA v. Rainier School Dist. No. 13, 311 Or 188, 195 (1991) (citing Tupper v. Fairview Hospital, 276 Or 657, 662 (1976)). Logic dictates that, if one is not apprised in advance of the particulars of the government's actions, the opportunity to be heard regarding those actions will likely be of little value. See Bell v. Burson, 402 US 535, 91 S Ct 1586 (1971) (due process normally requires that, prior to any license suspension, licensee be given notice of intent to suspend and notice of the availability of a hearing). In other words, for due process purposes, the "opportunity to be heard" is, in part, contingent on notice regarding the scope of that opportunity. To pass constitutional muster, then, "due process" notice should include information about the particulars of the opportunity to be heard. Imposing such a requirement serves to warn the affected party of his or her obligation to take certain actions within an established time frame, or to risk the governmental deprivation of a benefit.

Here, the majority maintains that claimant was not prevented from submitting at the reconsideration proceeding the evidence on which he now relies. That may be so, but how can the majority so easily dismiss the fact that, at the time claimant submitted evidence at reconsideration, he was unaware that there would be a subsequent, retroactive limitation on admissible evidence at hearing? What meaningful opportunity did claimant have to submit all of his evidence at reconsideration when the law in effect at that time allowed him to submit additional evidence at hearing? I submit there was none, because the statutory limitation on admissible evidence at hearing did not take effect until after the six day period allowed for submitting his evidence at reconsideration had passed. Like Ray, this is a case where the proverbial goal posts were moved "after the fact." The result is an unconstitutional violation of claimant's procedural due process rights.

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[1] This case is somewhat analogous to Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996), where the court held that evidence which was properly admitted at hearing under the (former) law in effect at that time, could not subsequently be excluded from the record based on the retroactive application of amended ORS 656.283(7). The court reasoned that the admissibility of evidence at hearing should be judged under the law in effect at the time of its admission. Extending the court's rationale to the facts of this case, I conclude that the admissibility of evidence at hearing should be governed by the same (former) law that was in effect when claimant submitted evidence at reconsideration. Because the former law did not bar the admission of "post-reconsideration" evidence at hearing, such evidence should be admissible at hearing.

I take issue with the majority's notion that claimant could have requested an abatement of the reconsideration order for consideration of additional evidence, even after the six-day period allowed for the submission of evidence had expired. That notion is contradicted by the Department rules in effect at the time of the reconsideration proceeding in this case; those rules expressly barred consideration of evidence submitted after the six-day deadline. See former OAR 436-30-145(2)(a). If anything, the rules would have assured claimant that the Department would not have abated or withdrawn its reconsideration order based on the submission of additional evidence. Under those circumstances, claimant could not have been expected to make a futile request for abatement.

In addition to the problems of inadequate notice, my conclusion that the reconsideration process is now constitutionally inadequate comports with the Oregon Supreme Court's reasoning in Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993). There, the Court construed former ORS 656.283(2) to authorize a full evidentiary hearing regarding vocational assistance disputes. There, as here, the issue was the adequacy of process, i.e., what process is "due." Finding no answer in the statutes or legislative history, the Court looked to the "broader administrative law context" for guidance. The Court said that "when a particular action by...government is directed at a relatively small number of identifiable persons, and when that action also involves the application of existing policy to a specific factual setting, the requirement of quasi-judicial procedures has been implied from the governing law." 317 Or at 535-36 (quoting Neuberger v. City of Portland, 288 Or 155, 161 (1980)). Finding that the vocational assistance dispute involved a classic contested case proceeding, the Court construed former ORS 656.283 to contemplate an informal investigation and order by the Director; a hearing at which the parties develop a record and on the basis of which, an ALJ finds facts to determine whether the Director's order survives review; and, finally, further review by the Board. Id. at 537.

The Court adopted such a construction to avoid the constitutional litigation that any other holding would have invited. Id. Because the Director had not developed an evidentiary record or held an evidentiary hearing, the Court concluded that the ALJ was permitted to find facts on a record developed at hearing. Id. at 531, 537. The Court recognized that "[a] different result would have obtained had the director conducted a contested case hearing, made a record, and entered findings of fact thereon." Id. at 535 n 4.

Following the Court's lead in Colclasure, I find that this case is also a classic contested case, because it involves the application of law to a specific factual setting and requires the determination of an individual's legal rights. See id. at 533. Therefore, based on traditional principles of administrative law, and specifically contested case procedures, there is the requirement of quasi-judicial procedures, including an adjudicative hearing at which the parties develop a record, upon which the factfinder relies in making factual findings necessary to the ultimate determination.

The question, therefore, is whether the "reconsideration proceeding" provided the quasi-judicial procedures required for this contested case. The focus must necessarily be on the adequacy of the reconsideration proceeding, because as this case and others illustrate, the subsequent hearing before the ALJ no longer provides an opportunity to be heard or an opportunity to present and rebut evidence. Indeed, the limitations on evidence and issues regarding claim closures and disability determinations, mandated by ORS 656.283(7), have essentially transformed the "hearing" before the ALJ into an appellate review; parties generally are not allowed to raise issues or present evidence at hearing that were not raised or presented at reconsideration. See, e.g., Noel L. Baier, 49 Van Natta 290 (1997) ("post-reconsideration" evidence inadmissible in substantive temporary disability hearing); Virginia McClearen, 48 Van Natta 2536 (1996) (with the exception of testimony by vocational consultant who submitted report at reconsideration, "post-reconsideration" evidence is inadmissible in PTD hearing); Tim L. Besheone, 48 Van Natta 2337 (1996) ("post-reconsideration" impeachment evidence inadmissible in PPD hearing); Arlie B. Tompkins, 48 Van Natta 1664 (1996) ("post-reconsideration" evidence inadmissible in premature closure hearing); Dean J. Evans, 48 Van Natta 1092 (1996) ("post-reconsideration" evidence inadmissible in PPD hearing); Joe R. Ray, 48 Van Natta 325 (1996).

The result of the Board's case law barring admission of evidence at hearing on claim closure and determination issues is that parties have no cure for not submitting evidence at the reconsideration proceeding. Yet, the reconsideration proceeding is not a contested case proceeding; it does not afford the parties a meaningful opportunity to rebut opposing evidence, nor does it allow parties to confront or cross-examine witnesses in an in-person hearing. Even the majority does not suggest that the reconsideration proceeding is a contested case proceeding. In short, there is no longer a contested case proceeding to review claim closures or disability determinations.

The absence of a contested case proceeding substantially elevates the risk of an erroneous deprivation of property interest in workers' compensation benefits. This leads to the second distinction between this case and Ray. Claimant's property interest in PTD benefits is significantly greater than was the claimant's property interest in PPD benefits in Ray. Furthermore, as the majority acknowledges, there are fundamental differences between PPD and PTD. The most significant difference is that, whereas PPD determinations have been effectively reduced to a formula using the Director's "standards" for rating disability, judging PTD is based on an evaluation of medical and/or vocational evidence of the claimant's incapacity to regularly perform work at a gainful and suitable occupation, along with evidence of the claimant's willingness and motivation to obtain work. In the PTD setting, there is a more compelling need for contested case procedures that allow for an in-person hearing, with the opportunity to rebut evidence and to confront and cross-examine witnesses.

I disagree with the majority's conclusion that procedural due process in the PTD setting does not require an opportunity to confront and cross-examine witnesses. My disagreement begins with the majority's basic premise that credibility is not usually an issue in PTD cases. Credibility is always an issue in PTD cases, because a central issue in such cases is whether claimant has made reasonable work search efforts, or if such efforts are futile, whether claimant has demonstrated the requisite willingness to work. ORS 656.206(3). Without proof of work search efforts or willingness to work, PTD may not be awarded. For that reason, claimant's attitude or motivation to return to work is critical in PTD cases. SAIF v. Stephen, 308 Or 41 (1989); Sinclair v. Champion International Corp., 117 Or App 515 (1992). In determining whether the claimant is sufficiently motivated to work, the factfinder must assess claimant's credibility, as well as the credibility of other witnesses testifying to claimant's motivation, or lack thereof.

Documentary evidence, which apparently is all that the Department will admit at reconsideration, is not a sufficient evidentiary basis for assessing credibility. The factfinder must be able to observe a witness' appearance and demeanor under cross-examination. In this context, and contrary to the majority's suggestion, the "form" of the evidence is its "substance." A sworn affidavit is different from live testimony in both form and substance, because an affidavit offers no opportunity to confront or cross-examine evidence. Because the reconsideration proceeding does not offer the contested case procedures necessary to determine entitlement to PTD, there is a high risk of erroneous deprivation of claimant's significant property interest in PTD benefits.

The inadequacy of the reconsideration procedures to guard against the erroneous deprivation of PTD benefits, and the statutory ban on "post-reconsideration" evidence at hearing, combine to violate claimant's procedural due process rights under the Fourteenth Amendment. Therefore, in this and other PTD cases, I conclude that amended ORS 656.283(7) must be struck down as unconstitutional. Consistent with procedural due process, as well as traditional principles of administrative law, I would apply former ORS 656.283(7) and remand this case to the ALJ for a full evidentiary hearing, including testimonies and cross-examinations of witnesses.

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In the Matter of the Compensation of
**MICHAEL C. BATORI, Claimant**
Own Motion No. 97-0151M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On April 11, 1997, we issued our Own Motion Order which declined to reopen claimant's 1979 injury claim with the SAIF Corporation because he had not responded to SAIF's request for evidence that would establish that he was in the work force at the time of his current disability. On April 16, 1997, we received claimant's notarized statement of earnings, as well as a letter in which he stated that he had previously mailed the information to SAIF, but that "it took two weeks to get to [SAIF]." On April 21, 1997, we issued our Own Motion Order in which we authorized the reopening claimant's 1979 injury claim for the payment of temporary disability compensation.

We have received SAIF's April 18, 1997 letter, in which it contends that claimant has not met his burden of proving that he was in the work force at the time of disability. We treat SAIF's submission as a request for reconsideration of our April 21, 1997 order.

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

In our April 21, 1997 order, we reported that, in a January 15, 1997 medical report, Dr. Easley, claimant's treating physician, recommended claimant undergo arthroscopy of his left knee. Thus, we concluded 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 has not proven that he was in the work force at the time of disability. It further contends that "if [claimant] had earnings during [1996 and 1997,] he should produce copies of W2 forms, pay stubs or tax returns for 1996 rather than just a statement." Claimant does have the burden of proof on this issue and must provide persuasive evidence that he remained in the work force at the time of disability.

In our April 21, 1997 reconsideration order, we were persuaded by claimant's notarized statement that he was self-employed and had continued working at the time of disability.[1] We find no new evidence which would persuade us otherwise. Contrary to SAIF's assertions, we have previously found that current W2 forms and / or current tax returns, are not requisite documents of proof of work. See Daniel Martushev, 48 Van Natta 1033 (1996) (the claimant submitted work invoices which established that he was gainfully employed during the relevant time period); Rodney D. Sullivan, 48 Van Natta 1143 (1996), on recon 48 Van Natta 1176 (1996) (although the claimant submitted a tax return to support his contention that he was in the work force at the time of disability, the tax return did not meet the criterion for proof of work during the relevant time period).

Here, claimant submitted a notarized document, on his business letterhead, which states that he had substantial earnings in 1996, as well as earnings through February 26, 1997. The sworn statement contains a notary seal, as well as claimant's signature. Furthermore, in a January 15, 1997 medical report, Dr. Easley, claimant's treating physician, noted (with respect to claimant's "Disability Status/Work Restrictions"), that claimant "is able to continue with his architectural work as long as he does not have to walk on uneven terrain." Dr. Easley's report lists claimant's employer as "BatoriCo, Inc.," the same employer listed on the letterhead of the notarized document claimant submitted.[2]

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[1] In his March 20, 1997 statement, claimant declared that he is president and owner of a business, and that his earnings for 1996 and 1997 were substantial. We do not require that a claimant submit W2 forms, pay stubs or tax returns as proof of work. However, if submitted for the appropriate time frame, those documents are compelling evidence that a claimant was in the work force. Furthermore, attached to the Board's Addendum to Bulletin 2-1994 (effective January 1, 1996), we have provided carriers with a "work force letter," which offers suggestions and alternative documentation which a claimant might submit to establish that he / she was in the work force at the time of disability. We require that the carrier send this letter to a claimant if it recommends that timeloss be denied because the claimant was not in the work force at the time of disability. The record contains a copy of the "work force" letter forwarded to claimant by SAIF. The record also contains a copy of a February 24, 1997 letter from SAIF to claimant which requests "proof of earnings for the past two years," which "may be in the form of pay stubs, copies of W-2 forms or other wage documentation."

As we have noted, although W2 forms, tax returns and pay stubs are compelling forms of documentation, our "work force" letter also provides that claimants may submit "any documents which prove you were working during the relevant time period"; SAIF's letter provided that claimant could submit "other wage information." Although the provision of the recommended documentation is preferable, we will consider any other documentation that a claimant submits, so long as it provides evidence that the claimant was in the work force during the relevant time frame. The "relevant time frame" requirement would not necessarily require a claimant to provide proof of earnings for the past two years, as SAIF's letter requests. Each case must be evaluated on its own particular set of facts, after due consideration of the presented documentation and the contrary evidence or arguments.

[2] Standing alone, Dr. Easley's statement may not be persuasive evidence that claimant was actually working at the time of disability. However, taken in conjunction with claimant's submission, we find that Dr. Easley's notation supports claimant's position that he is self-employed and currently working.

On this record, we continue to conclude that claimant has established that he was working at the time of disability.

Accordingly, we withdraw our April 21, 1997 order. On reconsideration, we adhere to and republish our April 21, 1997 Own Motion Order on Reconsideration 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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April 24, 1997 Cite as 49 Van Natta 537 (1997)

In the Matter of the Compensation of
**CHRIS A. BERNHARDT, Claimant**
Own Motion No. 97-0199M
OWN MOTION ORDER
Jensen, Fadeley, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable right inguinal hernia injury. Claimant's aggravation rights expired on September 26, 1995. SAIF asks the Board to authorize the reopening of claimant's claim.

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

In a March 3, 1997 chart note, Dr. McDuffie, claimant's treating physician, recommended that claimant undergo bilateral hernia repair surgery. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. We therefore have the authority to authorize the reopening of claimant's claim for temporary disability compensation commencing March 21, 1997, the date he was hospitalized for the surgery. Id.[1]

Accordingly, the information submitted to us demonstrates that the reopening of claimant's claim was appropriate. 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] In its April 18, 1997 cover letter, SAIF noted that it paid to claimant concurrent timeloss benefits between claim numbers 7276128F (an accepted left inguinal hernia claim) and 7081957L (this claim for right inguinal hernia injury), based on the highest compensation rate between both claims of $440.86 per week. Based on that compensation rate, SAIF noted that each of those claims paid a total of $661.29 for the time period from March 21, 1997 to April 11, 1997, when claimant returned to work.

In the Matter of the Compensation of
**KELLY R. EISENBERG, Claimant**
WCB Case No. 95-10119
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order which: (1) held that claimant's thoracic strain and left ulnar neuropathy claims were not barred by a prior settlement stipulation agreement; (2) set aside the employer's partial denials of claimant's thoracic strain and left ulnar neuropathy claims; (3) found that claim closure was premature; and (4) awarded an assessed attorney fee of $5,000. On review, the issues are the preclusive effect of a settlement stipulation agreement, compensability, premature closure and attorney fees. We reverse in part, modify in part, and affirm in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Settlement Stipulation Agreement

On review, the employer contends that the parties' settlement stipulation agreement barred claimant's current claims for a thoracic strain and left ulnar neuropathy. Reasoning that the compensability of those conditions could have been raised as an issue prior to approval of the agreement, the employer argues that the terms of the agreement disposed of that issue. We agree and reverse.

A settlement stipulation agreement (SSA) is a negotiated, signed, meeting of minds; upon approval by an ALJ, it has the finality and effect of a judgment. Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993). When an agreement is unambiguous, its interpretation is as a matter of law. Good Samaritan Hospital v. Stoddard, 126 Or App 69, 72 (1994).

The SSA in this case begins with a recitation of claim history leading up to the agreement. It recites that claimant's injury claim was originally accepted for a cervical strain; that the claim was closed with an award of temporary disability benefits only; and that claimant requested that the Workers' Compensation Division assess a penalty and attorney fee against the employer for untimely claim processing. In addition, the SSA states: "Also on March 6, 1995 the claimant and his attorney requested a hearing raising issues of de facto denial and failure to timely accept or deny the claim."

Finally, the SSA states:

> "The parties agree that to resolve all issues including, but not limited to, processing, attorney fees, and penalties, the employer and its claims servicing agent shall pay $250.00.
>
> "* * * * *
>
> "IT IS SO STIPULATED and the parties agree that all issues pending before the Hearings Division of the Workers' Compensation Board or the Workers' Compensation Division which were raised or which could have been raised can be dismissed with prejudice." (Ex. 38A).

The SSA was executed by the parties in early June 1995 and approved by an ALJ on July 25, 1995.

According to its unambiguous terms, the SSA settled all issues which were raised or which could have been raised. The issue, therefore, is whether the compensability of claimant's thoracic strain and left ulnar neuropathy conditions was an issue which could have been raised prior to the SSA.

Based on our review of the record, we find that claimant's thoracic strain had been diagnosed and treated prior to the SSA. In May 1995, about one month before executing the SSA, claimant began treating with Dr. Bennett, D.C., for a diagnosis of "acute aggravation of chronic thoracic joint strain and thoracic/costal dysfunction." (Ex. 34-1). Also in May 1995, Dr. Bennett filed an 827 claim form and wrote a letter to the employer's claims administrator, stating that the thoracic spine condition was the result of the accepted 1994 injury. (Exs. 35, 35AA). Because the thoracic strain was diagnosed, treated, and related to the accepted injury prior to execution of the SSA, we conclude that the compensability of that particular condition could have been raised and negotiated prior to execution of the SSA. Therefore, in accordance with the unambiguous terms of the SSA, the compensability of the thoracic strain was finally settled and may not be raised at this time.

The ALJ concluded that the compensability of the thoracic strain condition could not be "raised" as an issue at hearing because claimant did not satisfy the claim filing requirements of ORS 656.262(6)(d). That provision states:

> "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."

Reasoning that claimant did not first communicate in writing to the employer his objection to the notice of acceptance before asserting a "de facto" denial, the ALJ concluded there was no "claim" for the thoracic strain. Without a "claim," the ALJ held that the issue of compensability as to the condition could not have been raised for purposes of the SSA. We disagree with the ALJ's reasoning and conclusion in this regard.

SSA's may resolve any contested matter. ORS 656.236(1); Trevisan v. SAIF, 146 Or App 358, 362 (1997). Parties are not required to satisfy formal claim filing requirements before negotiating and settling a contested matter by SSA. The "written objection" requirement in ORS 656.262(6)(d) may be a legal predicate before asserting a "de facto" denial at hearing, but it is not required to resolve a contested matter by SSA.[1] See Stoddard, 126 Or App at 72-73 (A denial is not a legal predicate before the claimant could be held to have settled a claim under an SSA). In this case, for example, claimant's thoracic strain had been diagnosed, and there was a medical opinion relating the strain to the compensable injury, prior to execution of the SSA. Thus, the compensability of the strain could have been raised prior to the SSA. Because the SSA expressly resolved all such "raisable" issues, claimant is barred from raising the compensability of the thoracic strain as an issue at this time.

Our conclusion is different with regard to the left ulnar neuropathy condition. The record shows that the ulnar neuropathy condition was not diagnosed until May 1996, when Dr. Saviers performed electrodiagnostic studies on the left arm. (Ex. 52). Prior to those studies, claimant's doctors felt that claimant's left arm symptoms were referred from a spinal condition. Inasmuch as the ulnar neuropathy condition was not diagnosed until long after approval of the SSA, we conclude it was not an issue which could have been raised at that time. Accordingly, the claim for left ulnar neuropathy is not barred by the terms of the SSA, nor is it barred by principles of waiver or claim/issue preclusion.

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[1] Given our conclusion that the "written objection" requirement in ORS 656.262(6)(d) does not apply to the facts of this case, we do not need to address the employer's contention that claimant's March 6, 1995 hearing request satisfied that requirement. We note, however, that our decision in Guillermo Rivera, 47 Van Natta 1723 (1995), which is cited by the employer, was subsequently disavowed in Shannon E. Jenkins, 48 Van Natta 1482 (1996). In Jenkins, we held that the worker's written objection under ORS 656.262(6)(d) must precede the worker's request for hearing. Id. at 1486.

Compensability

Because the compensability of the thoracic strain is barred by the SSA, we uphold the employer's denial of that particular condition. With regard to the employer's denial of the left ulnar neuropathy condition, we adopt the ALJ's conclusion and opinion concerning the compensability of that condition. In particular, we agree with the ALJ's reliance on the well-reasoned opinion of Dr. Purtzer, (Exs. 55, 69), over the conclusory opinions of Drs. Sullivan and Watson, (Exs. 68, 75).

Premature Closure

Generally, a claimant must be medically stationary from all compensable conditions before a claim may properly be closed. Rogers v. Tri-Met, 75 Or App 470 (1985); Deborah A. Rosenbaum, 48 Van Natta 1192 (1996). Under the 1995 legislature amendments (Senate Bill 369), the issue of premature closure (or the claimant's medically stationary status) must first be raised at the Department's reconsideration proceeding before it can be raised at hearing. See ORS 656.268(8), 656.283(7).[2] In addition, only evidence that was submitted at the reconsideration proceeding is admissible at hearing for the purpose of deciding the premature closure issue.[3] See id.; Arlie B. Tompkins, 48 Van Natta 1664 (1996).

Here, claimant raised the premature closure issue at reconsideration and it was considered by the Department, (Ex. 41-3); however, the Department's determination of that issue was limited to the cervical strain condition that was in accepted status at the time of the reconsideration proceeding. (Ex. 41). Thus, although we have determined that claimant's left ulnar neuropathy condition is compensable and should therefore be processed under the claim, it was not among the conditions considered by the Department in its reconsideration of the claim closure, nor was evidence regarding the ulnar neuropathy condition submitted at the reconsideration proceeding.

Given the current statutory scheme, our conclusion that the ulnar neuropathy condition is compensable does not automatically lead to the conclusion that the claim was prematurely closed. Rather, where an additional condition is accepted, either voluntarily or by litigation order, after the reconsideration proceeding, we have held that the condition must be processed by the employer according to law. See Anthony J. Telesmanich, 49 Van Natta 166 (1997) (order on reconsideration); Rodney V. Boqua, 48 Van Natta 357 (1996). We explained that, depending on the circumstances and the medical evidence, the processing of the "post-reconsideration" accepted condition may, or may not, involve the "reopening" of the claim and a determination of extent of permanent disability. See id.

Consistent with our analysis in Telesmanich and Boqua, the employer must process claimant's left ulnar neuropathy condition according to law, including payment of any additional compensation to which claimant may be entitled as a result of the condition. In the event that claimant disagrees with the employer's processing of the claim, he may request another hearing under ORS 656.283(1).

Finally, since the record establishes that claimant's "pre-ALJ order" accepted cervical strain condition was medically stationary at the time of claim closure, (Exs. 27, 28, 29), and claimant does not contend otherwise, we find that the claim was properly closed. Therefore, we reverse the ALJ's premature closure finding and reinstate the Order on Reconsideration.

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee of $5,000 for prevailing against the employer's denials of the thoracic strain and left ulnar neuropathy claims. See ORS 656.386(1). Because we have reinstated and upheld the denial of the thoracic strain, claimant's assessed fee award must be reduced accordingly. After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable attorney fee for claimant's attorney's services at hearing regarding the left ulnar neuropathy claim is $2,300, to be paid by the employer. In reaching this conclusion, we

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[2] Though not applicable here, there is a statutory exception to this rule for issues that arose out of the reconsideration order itself. See ORS 656.268(8), 656.283(7).

[3] Based on our review of the record, it does not appear that the parties presented a stipulation identifying the exhibits in the hearing record which were also included in the reconsideration record, nor did they offer disputed portions of the reconsideration record. See OAR 438-007-0018(7).

have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's services might have gone uncompensated.

Claimant's attorney is also entitled to an assessed attorney fee for services on Board 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 attorney fee for claimant's attorney's services on review regarding the left ulnar neuropathy issue is $700, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated October 17, 1996 is reversed in part, modified in part, and affirmed in part. The portions of the ALJ's order that set aside the self-insured employer's partial denial of the thoracic strain claim and set aside the Notice of Closure as premature are reversed. The employer's partial denial of the thoracic strain claim is reinstated and upheld. The ALJ's $5,000 assessed fee award is reduced to $2,300, to be paid by the employer. The Order on Reconsideration which affirmed the Notice of Closure is affirmed. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $700, to be paid by the employer.

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April 24, 1997 Cite as 49 Van Natta 541 (1997)

In the Matter of the Compensation of
**JASON J. LAFOYA, Claimant**
WCB Case No. 96-07965
ORDER ON REVIEW
Parker, Bush & Lane, 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 that: (1) found that claimant was an Oregon subject worker; (2) set aside its denial of claimant's low back injury claim; and (3) assessed a penalty for an allegedly unreasonable denial. On review, the issues are subjectivity and penalties. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of his finding of "ultimate fact" that claimant was an Oregon subject worker who was temporarily out-of-state at the time of injury.

## CONCLUSIONS OF LAW AND OPINION

The employer began work at a church in Washington in March 1996. It maintained both Oregon and Washington workers' compensation coverage. (Tr. 18, 19). Claimant, a drywall hanger, was hired by the employer in June 1996 and worked both in Oregon and Washington.

On June 14, 1996, claimant injured his back while in the course and scope of his employment at the church work site in Washington. Claimant filed claims in both Oregon and Washington. The insurer denied the Oregon claim on the ground that claimant was not an Oregon subject worker. Claimant requested a hearing.

The ALJ set aside the insurer's denial, reasoning that claimant was an Oregon subject worker temporarily in Washington when injured and, thus, entitled to benefits as though he were injured in

Oregon. See ORS 656.126(1);[1] Kolar v. B&C Contractors, 36 Or App 65 (1978). In reaching this conclusion, the ALJ acknowledged the existence of an interstate reciprocity agreement between Oregon and Washington pertaining to jurisdiction over out-of-state injuries, but determined that it did not apply to this case since the work site where claimant was injured was not a "temporary workplace."[2] The ALJ also found the insurer's denial to have been unreasonably issued, thereby requiring the assessment of a 25 percent penalty pursuant to ORS 656.262(11).

On review, the insurer contends that the ALJ's order should be reversed in light of Rodney W. Carothers, 48 Van Natta 2372 (1996). We agree.

In Carothers, the claimant's Oregon employer assigned him to work at a Washington job site. The employer had obtained Washington coverage for the claimant and his coworkers. Some three months after his assignment, the claimant sustained a work-related injury. His Washington claim was accepted, while his Oregon claim was denied. Contending that he was an Oregon employee temporarily absent from the state when he suffered his injury, the claimant argued that he had established a compensable Oregon claim under the "permanent employment relation" test. See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186 (1992). We agreed that, if the claimant's claim was subject to the "permanent employment relation" test, his Oregon claim was compensable. However, in light of the Washington-Oregon interstate agreement executed under ORS 656.126(5),[3] we concluded that the claimant was not employed at a temporary Washington workplace and, thus, was not entitled to Oregon workers' compensation coverage.

In reaching our conclusion, we emphasized that the "permanent employment relation" test remained applicable to "non-interstate agreement" cases. However, in cases which were subject to an interstate agreement executed in compliance with ORS 656.126(5), we determined that such an agreement "superseded" the "permanent employment relation" test.[4] We reasoned that such an interpretation provided stability and predictability for Oregon employers who performed work in Washington, in that such employers would know with certainty when Washington coverage would be needed; i.e., when performing work in Washington for more than 30 days within a calendar year.

In this case, claimant was injured at a Washington job site where the employer's work was performed for more than 30 days within a calendar year. Thus, like the claimant in Carothers, claimant in this case was also not injured at a "temporary workplace." Therefore, in accordance with our interpretation of the interstate agreement in Carothers, we conclude that claimant is not entitled to

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[1] 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."

[2] 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. In the event of an injury to an Oregon worker at a "temporary workplace," the agreement provides that the exclusive remedy is provided by Oregon workers' compensation law. The interstate 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. (Ex. 1).

[3] 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.

[4] We recognized in Carothers that the Court of Appeals had applied the permanent employment relation test in Power Master, Inc. v. National Council on Comp. Ins., 109 Or App 296 (1991), to an injury occurring in Washington, but we concluded that Power Master was not controlling since it involved a different version of the interstate agreement.

Oregon workers' compensation benefits because he was not an Oregon subject worker at the time of injury. Because the ALJ found otherwise, we reverse.[5]

Finally, the ALJ assessed a 25 percent penalty, finding that the insurer's denial on subjectivity grounds was unreasonable. Since we have concluded that the insurer's denial was proper, it follows that the assessment of a penalty was not warranted. It, too, is reversed.

ORDER

The ALJ's order dated December 5, 1996 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award and penalty assessment are also reversed.

[5] Claimant argues that Carothers should be overruled, contesting our conclusion that Oregon coverage is not required at a job site in Washington other than a "temporary workplace." Specifically, claimant asserts that the interstate agreement is silent about an employers' obligation for continued Oregon coverage for Oregon workers in Washington and that the statutory scheme of ORS 656.126(1), in conjunction with the offset/credit provisions of ORS 656.126(6), invites "dual coverage." After further consideration of the issue, we adhere to our reasoning in Carothers that Oregon coverage for employees working in Washington is only required under the interstate agreement where work is performed for 30 days or less at a specific location. As to claimant's contention that the statutory scheme invites "dual coverage," we find that such a conclusion would essentially render the interstate agreement meaningless, in that there would be Oregon coverage if a claimant was employed at a "temporary workplace" and Oregon coverage if he was not. Finally, we reject claimant's argument that our interpretation of the interstate agreement is inconsistent with ORS 656.126(1). Although ORS 656.126(1) does focus on the activity of the worker, while the interstate agreement emphasizes the duration of the employer's work in Washington, we do not find the provisions to be inconsistent. In other words, we find that the reciprocity agreement could, consistent with ORS 656.126(1), limit Oregon coverage of Oregon workers temporarily out-of-state to those performing work at a "temporary workplace," as defined in the interstate agreement executed pursuant to ORS 656.126(5).



In the Matter of the Compensation of
**RANDAL W. PIPER, Claimant**
WCB Case No. 96-05123
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration which awarded no scheduled permanent disability. In his brief, claimant seeks remand to the Director for issuance of a corrected medical arbiter's report. On review, the issues are the extent of scheduled permanent disability and remand to the Director.

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

At hearing, claimant contended that he suffered from a loss of strength not compensated by the disability rating standards, and sought remand to the Director for adoption of a temporary rule under ORS 656.726(3)(f)(C). The ALJ found that because claimant's disability (loss of grip strength) was addressed by the standards, remand to the Director under ORS 656.726(3)(f)(C) was inappropriate.[1]

On review, claimant requests that the Board remand this matter to the Director with instructions that the medical arbiter be required to address claimant's grip strength deficit in the manner required by the standards. Although we are sympathetic to claimant's situation, we have previously found, in similar circumstances, that we lack authority to remand a claim for a supplemental arbiter's examination.

In Steven K. Rule, 47 Van Natta 83 (1995), the claimant believed that the medical arbiter's examination was inadequate and requested remand to the Director for another arbiter's examination to

[1] The ALJ noted that the medical arbiter had made findings of loss of grip strength, but had not reported these findings in the manner required by the disability rating standards (the standards require that loss of grip strength be reported under the 0 to 5 muscle grading system, whereas the medical arbiter had reported the loss of strength in terms of pounds of strength).

obtain valid impairment measurements. We noted that, although we had the authority to remand to the Director for the adoption of temporary rules to address permanent impairment not covered by the disability standards, see Gallino v. Courtesy-Buick-GMC, 124 Or App 538 (1993), the claimant did not contend that the standards did not adequately address his permanent impairment.[2] In addition, we noted that the Department had accepted and relied on the medical arbiter's report, did not find the report incomplete, and did not direct the arbiter to perform a supplemental examination. Under such circumstances, we found no basis to remand. Steven K. Rule, 47 Van Natta at 84.

Here, as in Rule, claimant does not contend that the standards do not adequately address his permanent impairment. In addition, as in Rule, the Department accepted the medical arbiter's report and relied on it to determine the extent of claimant's permanent disability. The Department did not find the arbiter's report incomplete and did not direct the arbiter to perform a supplemental examination. Given these circumstances, we find no basis for remand. Id at 84; see also Beverly L. Cardin, 46 Van Natta 770 (1994).

ORDER

The ALJ's order dated October 25, 1996 is affirmed.

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[2] We have previously held that we lack authority to remand to the Director pursuant to ORS 656.726(3)(f)(C) where the worker has not established that the standards do not address his disability. Robert W. Wilmot, 48 Van Natta 1525 (1996); Terry J. Hockett, 48 Van Natta 1297 (1996).

**Board Member Biehl specially concurring.**

The quagmire claimant finds himself in compels me to write separately. Although claimant clearly has a ratable disability, the medical arbiter failed to report the disability in a manner that could be rated under the standards. The existing system does not appear to provide for an adequate means of correcting this problem. The Board lacks the statutory authority to require the medical arbiter to issue a corrected report.

There is a problem with a remedial system which does not provide a remedy for a worker, such as this one, who clearly has ratable permanent disability as a result of a compensable injury. This flaw in the system leaves workers such as claimant without a means of obtaining permanent disability benefits to which they are legally entitled.

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April 24, 1997 Cite as 49 Van Natta 544 (1997)

In the Matter of the Compensation of
**BOBBI J. BLAKELY, Claimant**
Own Motion No. 96-0530M
OWN MOTION ORDER OF ABATEMENT
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our April 9, 1997 Own Motion Order on Reconsideration, in which we authorized the reopening of claimant's 1977 injury claim for the payment of temporary disability compensation. SAIF contends that the Board's reliance on a March 5, 1997 letter from the Social Security Administration's Disability Section that claimant no longer qualified for social security benefits because she "once again performed substantial work," was misplaced. Further contending that it has no information that about work claimant performed since August 1994, SAIF requests that the Board require more information from claimant about her work status, "particularly the work she was performing at the time of surgery in November, 1996."

In order to allow sufficient time to consider the motion for reconsideration, we abate our prior orders. 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.

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In the Matter of the Compensation of
**GERALD L. WITHAM, Claimant**
WCB Case No. 96-00488
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's current low back condition. Claimant cross-requests review of that portion of the ALJ's order that declined to award claimant additional temporary partial disability benefits. On review, the issues are compensability and temporary disability. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the findings of ultimate fact. We summarize the pertinent facts as follows:

Claimant, age 32 at the time of hearing, has performed heavy construction work for years. In 1982, he injured his back bending over to pick up a board. In December 1983, Dr. Bergquist performed an L4-5 bilateral hemilaminotomy and discectomy. Claimant then reinjured his back in June 1987 while lifting scaffolding, but he continued to perform heavy work without further surgery. He was found to have multi-level degenerative disc disease and osteoarthritis.

On June 8, 1995, claimant strained his back lifting sheet rock. He sought treatment and was taken off work by Dr. Abbott. Claimant's symptoms continued despite conservative treatment. In August 1995, claimant was examined by Drs. Barth and Bald at the insurer's request.

In September 1995, claimant returned to Dr. Bergquist for treatment. A September 21, 1995 MRI showed disc bulges at L2-3, L3-4 and L4-5 with secondary mild stenosis plus a small soft tissue density in the right lateral recess at L4-5, which was thought to be scar tissue. On September 25, 1995, Dr. Bergquist ruled out the need for further surgery and released claimant to part-time modified work. Dr. Bergquist advised claimant to "work at his own pace" to avoid pain exacerbation.

The employer offered claimant a part-time light to moderate duty position approved by Dr. Bergquist, which claimant accepted. Understanding Dr. Bergquist's proviso to mean that he work only as many hours as he felt capable of working, claimant did not work all of the part-time hours available. During the two week period beginning on October 21, 1995, claimant worked 26.5 of the 40 available hours. During the two week period beginning on November 4, 1995, claimant worked 12 of the 40 available hours, thereby working a total of 38.5 out of the 80 available hours during the four-week pay period. The employer paid claimant temporary disability of 80 hours for this four week period (and his wages for the 38.5 hours worked) but did not pay claimant the 41.5 hours that he did not work during this time period.

During November 1995, claimant came under the care of Dr. Hawkins, a chiropractor. On December 15, 1995, claimant was examined by Drs. Farris and Wilson at the insurer's request. In mid-January 1996, claimant began treating with Dr. Puziss, an orthopedist.

Meanwhile, on January 4, 1996, the insurer issued a partial denial, asserting that claimant's accepted low back injury was no longer the cause of his ongoing disability and need for treatment. Claimant requested a hearing on the denial, as well as the temporary disability issue.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The ALJ found that claimant's compensable injury did not combine with his underlying degenerative disc disease and osteoarthritis to cause or prolong his disability or need for treatment, and concluded that the insurer's denial of the combined condition was improper. Alternatively, the ALJ determined that even if claimant's compensable injury combined with his preexisting condition at some point, the compensable injury remained the major contributing cause of his ongoing symptoms.

On review, the insurer asserts that a preponderance of the evidence establishes that claimant's compensable lumbar strain injury combined with his preexisting, underlying low back condition, and that by December 15, 1995, the compensable strain ceased to be the major contributing cause of his disability and need for treatment.[1] We agree that claimant's current condition is not compensable and uphold the denial.

Under ORS 656.005(7)(a)(B), if an otherwise compensable injury combines *at any time* with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only *so long as* the otherwise compensable injury is the major contributing cause. (Emphasis added). A "preexisting condition" includes any injury or disease that contributes to or predisposes a worker to disability or need for treatment and that precedes the onset of the claim. ORS 656.005(24).

Here, it is undisputed that claimant had a preexisting low back condition, including osteophytes and bulging discs at multiple levels. It is also undisputed that claimant compensably strained his low back on June 8, 1995 while lifting sheet rock. Unlike the ALJ, we are persuaded by the expert medical evidence that, at some point on or after June 8, 1995, claimant's accepted lumbar strain combined with his preexisting degenerative condition to cause or prolong his disability or need for treatment. Indeed, Dr. Puziss specifically opined that claimant's preexisting degenerative disc disease combined with the on-the-job injury. (Ex. 68A). In January 1996, Dr. Puziss diagnosed claimant's condition as chronic low back strain syndrome, a degenerative spine underlying the recent strain. (Ex. 55-3). Dr. Farris also opined that claimant's strain injury combined with his underlying degenerative condition to prolong his symptoms. (See Exs. 68, 72-10).

Because we are persuaded that claimant's current condition constitutes a "combined condition," the condition is compensable only to the extent that claimant's accepted lumbar strain is the major contributing cause of his ongoing disability and need for treatment. ORS 656.005(7)(a)(B). For the reasons that follow, we conclude that claimant's current condition is not compensable.

Since there are various factors contributing to claimant's low back condition, this case presents a complex medical question requiring expert medical opinion for its resolution. Uris v. Workers Compensation Dept., 247 Or (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). Further, because claimant's current condition is subject to the major contributing cause standard, the persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined. Dietz v. Ramuda, 130 Or App 397 (1994), rev den 321 Or 416 (1995). The fact that a work injury caused or precipitated a claimant's condition does not necessarily mean that the injury was the major contributing cause of the condition. Id.; See also Robinson v. SAIF, 147 Or App 157 (1997).

After considering the medical opinions in the record, we are not persuaded that claimant's accepted lumbar strain is the major contributing cause of his current disability or need for treatment of his combined condition. Indeed, Drs. Bald, Farris and Gambee specifically opined that claimant's preexisting degenerative condition was the major contributing cause of his current condition and need for treatment. (See Exs. 67, 65, 70, 72-10). Although Dr. Puziss related claimant's work injury to his current condition, his opinion establishes only that the work injury was the precipitating cause of claimant's current need for treatment.[2] (Exs. 66A, 68A). Dr. Puziss relies on the fact that claimant was

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[1] The insurer also contends that its pre-closure denial of claimant's current condition was appropriate and necessary under ORS 656.262(7)(b). We have held that this section is applicable only when the accepted condition is a combined condition. See Robin W. Spivey, 48 Van Natta 2363 (1996); Fe D. Delariarte, 49 Van Natta 39 (1997). In this case, the accepted condition is a "lumbar strain" without any combined component. Therefore, the insurer was not obligated to issue a pre-closure denial of claimant's current condition for purposes of ORS 656.262(7)(b).

[2] Although Dr. Hawkins also related claimant's current condition to his work injury, we are unpersuaded by this opinion because it is framed in terms of possibility rather than probability. See Gormley v. SAIF, 52 Or App 1055 (1981). Dr. Hawkins challenged the assessment of Drs. Barth and Bald (that the soft tissue density noted on claimant's lumbar MRI was scar tissue related to his prior surgery) by suggesting that "it is just as plausible" that this soft tissue density represents a disc bulge at L4-5 resulting from claimant's June 8, 1995 work injury. (Ex. 61). In addition, Dr. Hawkins' opinion does not address the relative contribution of the different causes of claimant's symptoms, including his underlying degenerative disc disease, and is therefore insufficient under the Dietz v. Ramuda standard.

asymptomatic and not in need of treatment before his injury and in need of treatment afterwards. (Ex. 66A) This is the same type of "but for" analysis that we have rejected as unpersuasive in Alec E. Synder, 47 Van Natta 838 (1995) and Cody L. Lambert, 48 Van Natta 115 (1996). The analysis is equally unpersuasive here. Consequently, Dr. Puziss' opinion is insufficient to sustain claimant's burden of proof under ORS 656.005(7)(a)(B).

Temporary Disability

Claimant asserts that he is entitled to temporary disability for the 41.5 hours he did not work between October 21, 1995 and November 17, 1995. We find to the contrary.

Dr. Bergquist released claimant to return to modified, light duty work for four hours per day with the recommendation that claimant work at his own pace. Contrary to claimant's understanding of Dr. Bergquist's suggestion, claimant was not authorized to work less than four hours per day. Rather, he was simply advised to pace himself during his four-hour shift. Under these circumstances, claimant is not entitled to temporary disability for those part-time hours (under "four-hour shifts") he chose not to work.

ORDER

The ALJ's order dated August 29, 1996 is reversed in part and affirmed in part. That part of the order that set aside a portion of the January 4, 1996 denial is reversed and the entire denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the order is affirmed.

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April 25, 1997 Cite as 49 Van Natta 547 (1997)

In the Matter of the Compensation of
**PHILLIP L. SHORES, Claimant**
WCB Case No. 96-04616
ORDER ON RECONSIDERATION
Coughlin, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant has requested reconsideration of our March 28, 1997 order that reversed an Administrative Law Judge's (ALJ's) order and upheld the SAIF Corporation's denial of claimant's injury claim for his current cervical condition. Specifically, claimant seeks clarification of our comment that he did not object to the ALJ's alternative "noncompensability" finding and reconsideration of our decision which found that his C6-7 herniated disc condition was not compensable.

After further consideration of this matter, we acknowledge that claimant did object to the ALJ's "alternative" conclusion that claimant's cervical condition was not compensable on the merits. However, because we agree with the ALJ that the record does not establish that claimant's 1995 work injury is the major contributing cause of his current cervical condition, we continue to adopt the ALJ's reasoning and conclusions regarding the etiology of claimant's current condition (based on the medical evidence).

Accordingly, our March 28, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 28, 1997 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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In the Matter of the Compensation of
**TERI S. CALLAHAN, Claimant**
WCB Case No. 96-02777
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that increased claimant's unscheduled permanent disability award from 26 percent (83.2 degrees), as awarded by an Order on Reconsideration, to 44 percent (140.8 degrees). The employer argues that claimant is precluded from contesting the November 27, 1995 Corrected Notice of Closure because she did not specifically request reconsideration of that notice. On review, the issues are jurisdiction (preclusion) and extent of unscheduled permanent disability. We reverse with regard to the extent of permanent disability issue.

## FINDINGS OF FACT

We adopt the ALJ's "Findings" except for the last paragraph.

## CONCLUSIONS OF LAW AND OPINION

### Jurisdiction (Preclusion)

The ALJ found that claimant was not precluded from contesting the November 27, 1995 Notice of Closure, which corrected a November 10, 1995 Notice of Closure, because the March 13, 1996 Order on Reconsideration reconsidered both closure notices.[1] We agree.

The parties stipulated that claimant timely requested reconsideration of the November 10, 1995 Notice of Closure and that she did not specifically request reconsideration of the November 27, 1995 Corrected Notice of Closure.[2] In addition, the corrected notice provided: "This correction becomes part of and should be attached to the 11-10-95 notice of closure which remains the same in all other respects." (Ex. 57, emphasis added). The corrected notice also provided 60-day appeal rights regarding changes made by the corrected order.

Given this language, the fact that the reconsideration request raised the issue addressed by both closure notices (extent of disability), and the fact that the request was made within 180 days of the first notice (per its appeal rights) and within 60 days of the corrected notice (per its appeal rights), we conclude that the request for reconsideration was a timely appeal of both closure notices. See Filberto B. Rosas, 48 Van Natta 1511, 1512 (1996). Accordingly, we agree with the ALJ that his jurisdiction to address the extent of claimant's disability was not limited by claimant's failure to expressly appeal the Corrected Notice of Closure.

### Extent of Permanent Disability

We apply the disability standards in effect on the date of the Determination Order and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C). OAR 436-35-003(2). Claimant's claim was closed by Notice of Closure dated November 10, 1995, as corrected November 27, 1995. Accordingly, those standards contained in WCD Admin. Orders 6-1992 and 93-056 apply to claimant's claim.

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[1] Thus, because the Hearings Division has jurisdiction to review only Orders on Reconsideration (not Notices of Closure), the ALJ reasoned that he had jurisdiction to address the extent of claimant's permanent disability.

[2] The corrected notice referred to the initial notice and corrected claimant's adaptability, based on additional medical evidence regarding claimant's residual functional capacity.

The parties dispute whether claimant has greater unscheduled permanent disability than the 26 percent awarded on reconsideration. Specifically, claimant and the employer disagree as to the correct impairment rating and adaptability factor. The parties do not dispute claimant's age and education values, which total 4.

Impairment

The ALJ rated claimant's lumbar flexion and extension (in addition to her right and left lateral flexion) despite Dr. Neumann's questioning the validity of those measurements. In reaching this conclusion, the ALJ reasoned that Dr. Neumann inappropriately concluded that his measurements were invalid based on a misapplication of WCD Bulletin No. 242 (Rev.), effective February 1, 1995. We disagree.

We have previously held that the validity of range of motion testing must be determined by the medical examiner performing the tests. Harvey Clark, 47 Van Natta 136 (1995); Michael D. Walker, 46 Van Natta 1914 (1994). 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 establish permanent disability.[3] See Harvey Clark, 47 Van Natta 136 (1995) (where the medical arbiter found the claimant's range of motion findings invalid, the Board found that the claimant failed to prove impairment); Benjamin G. Santos, 46 Van Natta 1912 (1994) (where the medical arbiter found the claimant's lumbar flexion measurement invalid based on the SLR validity test, the Board found the measurement properly excluded from calculation of the claimant's impairment).

We note that Dr. Peterson, treating physician, measured claimant's lumbar range of motion and commented that he did "not feel that the range of motion data contributes significant information regarding [claimant's] level of disability." (Exs. 47-2, 52-2). Under these circumstances, we do not find that Dr. Peterson's measurements constitute persuasive evidence of injury-related permanent impairment.

Accordingly, based on those impairment findings which Dr. Neumann found valid and claimant's L3-4 microdiskectomy,[4] we conclude that claimant is entitled to a 14 percent impairment rating, as determined on reconsideration. (See Ex. 60-5).

Adaptability

The parties agree that claimant's BFC is "heavy." The ALJ found that claimant's RFC value should be 4, based on Dr. Peterson's opinion that claimant is able to lift up to 50 pounds occasionally, with limited ability to sit for extended periods. We agree that claimant is limited to occasional lifting up to 50 pounds, but we do not find that she has sitting restrictions under the applicable rule.

OAR 436-35-310(3)(l) provides, in relevant part:

"'Restrictions' means that, by a preponderance of medical opinion, the worker is permanently limited by:

"(A) Sitting, standing, or walking less than two hours at a time; or

"* * * * *

"(C) From frequently performing at least two of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling.

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[3] We further note that Dr. Neumann also questioned claimant's effort and the validity of her range of motion measurements based on observing her getting up and down from the examining table. (Ex. 58-4).

[4] 12 degrees right lateral flexion (2.6 %); 10 degrees left lateral flexion (3%); and an L3-4 microdiskectomy (9 %), combined for a total impairment rating of 14% unscheduled impairment.

"* * * * *

"(n) 'Frequently' means the activity or condition exists up to 2/3 of the time." (WCD Admin. Order 93-056) (emphasis added).

Here, after a September 29, 1995 closing examination, Dr. Peterson opined that claimant should avoid heavy lifting, bending, and prolonged sitting or driving. (Ex. 52-2). On October 26, 1995, Dr. Peterson stated that claimant was released to regular work without restrictions. (Ex. 53). On November 3, 1995, Dr. Peterson amended his closing examination and opined that claimant should not "engage in anything more than occasional bending and lifting of objects up to 50 pounds." (Ex. 54).

On this evidence, we find that claimant is permanently restricted (at most) to "occasional" bending and from "prolonged" sitting. However, we cannot say that she is subject to a two-hour sitting limitation or that she is restricted from "frequently" performing at least two activities. Accordingly, we find Dr. Peterson's opinion insufficient to establish restrictions under the rule. See Guadalupe Benetiz, 48 Van Natta 2238, 2239 (1996); Ann K. Bias, 48 Van Natta 1130 (1996). Accordingly, we conclude that claimant's residual functional capacity is classified as medium, for an adaptability factor of 3. See former OAR 436-35-310(3)(h).

Finally, when claimant's impairment value (14 percent) is added to her social and vocational values[5] (4 x 3 = 12), the result is 26 percent unscheduled permanent disability, as awarded on reconsideration.

## ORDER

The ALJ's order dated October 17, 1996 is reversed. The Order on Reconsideration is affirmed. The ALJ's "out-of-compensation" attorney fee award is reversed.

[5] 4 (age and education factors) X 3 (adaptability) = 12.

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In the Matter of the Compensation of
**ALTA M. HESSON, Claimant**
WCB Case No. 96-04243
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that upheld the self-insured employer's denial of her C6-7 disk herniation. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 1, we change the second sentence to read: "On March 29, 1996, claimant filed a claim for a neck injury related to an incident on September 13, 1995, when she reached for a box while operating the "Smith" candy belt." On page 1, we change the date in the third sentence of the first paragraph to "September 14, 1995." We change the date in the fifth sentence to "September 21, 1995." In the last paragraph of the findings of fact, we change the date of claimant's surgery to "April 8, 1996." We do not adopt the ALJ's findings of ultimate fact.

## CONCLUSIONS OF LAW AND OPINION

On September 13, 1995, claimant felt a "pop" in her neck as she reached up for a box stacked above the candy belt at work. (Tr. 5; Ex. 1A). On March 18, 1996, Dr. Kirkpatrick diagnosed a herniated disc at C6-7 with right radiculopathy. (Ex. 4). On April 8,1996, Dr. Kirkpatrick performed an anterior C6-7 diskectomy, foraminotomy and interbody fusion with iliac bone graft. (Ex. 7).

The ALJ concluded that Dr. Kirkpatrick's opinion on causation was not persuasive because it was based on a history that claimant had experienced a continuity of symptoms without any intervening trauma. The ALJ found that claimant had experienced a traumatic intervening event from coughing episodes when she had pneumonia in December 1995.

Claimant argues that Dr. Kirkpatrick's opinion establishes that her September 13, 1995 work incident was the major contributing cause of her C6-7 herniation and need for surgery.[1] Claimant asserts that she was in constant neck and shoulder pain from the date of injury, with intermittent waxing and waning. Claimant contends that there is no medical evidence to support the ALJ's conclusion that her coughing episodes from pneumonia constituted a significant intervening event.

Because of the development of claimant's symptoms over time and the various possible causes of her herniated disk, the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. 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).

Claimant's treating physician was Dr. Kirkpatrick, who first examined her on March 18, 1996. Dr. Kirkpatrick reported that claimant's problem started at work in September 1995, when she was reaching for a box and "as she turned and raised her arms and tilted her head back to look at the top she felt a sudden 'click' sensation in her neck followed by sudden tightness in her shoulder muscles." (Ex. 4-1). Claimant noticed neck stiffness and then severe neck pain. She was sent home by the company nurse and was on light duty for one week. Dr. Kirkpatrick reported that claimant "then returned to normal duty and the symptoms were somewhat better but they never went away." (Id.) Claimant told him she had ongoing neck pain after she was laid off, and in January of 1996 the pain rapidly got worse. The pain began to radiate into the right arm with numbness and weakness. (Id.) Dr. Kirkpatrick diagnosed a C6-7 herniated disk with right C7 radiculopathy, severe. (Ex. 4-3). Dr. Kirkpatrick subsequently concluded that the September 13, 1995 work incident was the major cause of claimant's herniated disk condition. (Exs. 12, 13).

The employer contends that Dr. Kirkpatrick had an inaccurate history of claimant's symptoms. The employer argues that claimant's testimony regarding her continuous symptoms since the September 13, 1995 work incident is not supported by the record. We agree.

On September 13, 1995, claimant felt a "pop" in her neck as she reached up for a box stacked above the belt. (Tr. 5; Ex. 1A). Claimant informed her supervisor of the incident and filled out an accident report. (Ex. 1A-2). On September 14, 1995, claimant visited the company nurse. Nurse Joslin reported that claimant felt a pinching pain near her neck and then a pain across the shoulder. (Ex. 1-1). Nurse Joslin diagnosed a trapezius muscle strain, left, severe. (Id.) The nurse recommended alternating ice and heat and medication. Claimant was taken off work for the rest of the day and was on modified work for a week. (Tr. 62; Ex. 1-1).

On September 21, 1995, Nurse Joslin reported that claimant "states she feels fine and is requesting a release to regular work, which is given." (Ex. 1-2). At hearing, claimant agreed that she told Nurse Joslin she was feeling fine on September 21, 1995 because she did not like being on light duty. (Tr. 8). Claimant said that sitting in one place during light duty seemed to "aggravate everything" and she asked to be on regular duty so she could move. (Id.) However, claimant had not mentioned any physical problems during light duty to her associate supervisor, Ms. White. (Tr. 114). Ms. Perry, one of claimant's "line leaders," testified that claimant told her that light duty was "boring" and she would be glad to get back to regular work. (Tr. 101). After returning to regular work, Ms. White testified that claimant did not appear to have any problems physically performing the work and claimant did not indicate that she was having any problems. (Tr. 114).

On October 3, 1995, claimant filled out another accident report, complaining that the fast movement of the "Smith" belt and the odd body position in working on the belt were causing stress to her neck and shoulder areas. (Ex. 1A-5). On October 5, 1995, claimant visited Nurse Joslin, complaining of trapezius muscle pain after working on the "Smith" belt. (Ex. 1A-9). Claimant was placed on a permanent restriction of no work on the "Smith" belt. (Ex. 1A-8).

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[1] Although claimant asserts that she has met her burden of proving that her compensable injury was the major contributing cause of the herniated disk, we find that claimant has not established the compensability of her condition under either the material or major contributing cause standard.

On November 2, 1995, claimant testified that the candy belt was running too fast for her to pack candy. (Tr. 11). She could not keep up the pace and she got upset and walked off the belt. (Id.) Claimant asked to be sent home. (Tr. 12). Claimant was seen by Nurse Joslin on November 2, 1995, who reported that claimant was having chest pains and was feeling ill. (Ex. 1A-11). The nurse diagnosed anxiety and emotional upset, and possible depression. (Id.) Nurse Joslin testified that claimant did not make any physical complaints other than the palpitations and chest pains. (Tr. 107). Ms. Perry also testified that claimant complained only of chest pains. (Tr. 101). Claimant was laid off on November 3, 1995.

Claimant testified that her shoulder and neck pain got progressively worse and intensified after she was laid off. (Tr. 13). She finally saw a doctor in January 1996, when she could not feel her arm any more. (Id.) Claimant testified that, by December 31, 1995, she was in "extreme pain" because of her neck and shoulder. (Tr. 132). At that time, she was not yet having pain in her arms, but she had numbness in her hands. (Id.)

Claimant was treated for pneumonia on December 31, 1995, January 13, 1996 and January 14, 1996. (Ex. 5B). The December 31, 1995 chart note states that claimant "coughed until vomiting." (Ex. 5B-1). None of those medical reports referred to any shoulder or neck pain.

On January 28, 1996, claimant sought treatment in the Urgent Care Department, complaining of right shoulder and arm pain for two days. (Ex. 5A-1). She was also seen in Urgent Care for the same problem on February 6, 1996, February 18, 1996 and February 28, 1996. (Exs. 5A-2, -5, -6). At hearing, claimant was asked why she did not tell the Urgent Care physicians that her injury was work-related, particularly since there was an issue concerning payment for treatment. (Tr. 22). Claimant replied: "I know I told Dr. Arditti. I might not have told the others. I was just more concerned with trying to get better, trying to find out what was wrong with me." (Id.)

On March 5, 1996, claimant sought treatment from Nurse Practitioner Arditti, who reported that claimant's symptoms first began in September 1995, when she was reaching overhead at work to lift a box. (Ex. 2). When claimant was seen by Dr. Kirkpatrick on March 18, 1996, she also related her symptoms to the September 1995 work incident. (Ex. 4).

Based on this record, we are not persuaded by claimant's assertion that she had constant neck and shoulder pain since September 13, 1995, with intermittent waxing and waning. The testimony of the other witnesses and the medical records are inconsistent with claimant's testimony that her neck and shoulder pain was continuous and got progressively worse. In particular, we note that claimant did not mention any neck or shoulder problems when she sought treatment for pneumonia on December 31, 1995 and January 1996, even though she testified that, by December 31, 1995, she was in "extreme pain" because of her neck and shoulder and she had numbness in her hands. (Tr. 132). Furthermore, claimant's testimony is inconsistent with the January 28, 1996 chart note which indicated that claimant said she had been experiencing right shoulder and arm pain for two days.

In a deposition, Dr. Kirkpatrick explained that a herniated disk could be caused by many things, such as a lifting injury, twisting and tilting, a car accident, a fall, and even a bad sneeze. (Ex. 13-17). Dr. Kirkpatrick testified that he relied on claimant's history that her problem started in September 1995 and got somewhat better, but it never went away. (Ex. 13-14). Dr. Kirkpatrick said that his opinion on causation was based on the continuity of claimant's symptoms, as well as the waxing and waning of those symptoms. (Ex. 13-14, -27). However, due to the inconsistencies in the record regarding claimant's history of her neck and shoulder symptoms, we are not persuaded that Dr. Kirkpatrick had an accurate and complete history of claimant's symptoms. Consequently, we do not find his opinion on causation persuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977). There are no other medical opinions on causation. Under these circumstances, we conclude that claimant has not carried her burden of proving that the C6-7 herniated disk condition is compensable.

## ORDER

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

In the Matter of the Compensation of
**REBECCA L. JONES, Claimant**
WCB Case No. 95-13807
ORDER ON REVIEW
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant, pro se, requests review of that portion of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration's award of 6 percent (11.52 degrees) scheduled permanent disability for loss of use or function of the right arm. In its respondent's brief, the self-insured employer moves to strike claimant's brief, asserting that claimant refers to information that was not part of the record at hearing. On review, the issues are the employer's motion to strike and extent of scheduled permanent disability. We modify.

## FINDINGS OF FACT

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

Claimant has accepted claims for right elbow tendinitis, right lateral epicondylitis and left carpal tunnel syndrome. On January 3, 1996, claimant's treating doctor, Dr. Bowman, declared her condition medically stationary. In testing claimant's right hand, Dr. Bowman found full range of motion with decreased (4/5) grip strength. He also indicated that claimant had permanent restrictions on her ability to repetitively use her right arm. On January 26, 1996, the employer issued a Notice of Closure awarding claimant 15 percent scheduled permanent disability of the right arm.

Claimant requested reconsideration and was evaluated by a medical arbiter panel on April 5, 1996. In evaluating claimant's right arm, the arbiters found minimal loss range of motion as well as a loss of repetitive use. The arbiters also indicated that claimant's muscle strength was 5/5 and there was no atrophy.

An April 19, 1996 Order on Reconsideration awarded claimant a total of 8 percent scheduled permanent disability based on the findings of the medical arbiter panel.[1]

## CONCLUSIONS OF LAW AND OPINION

### Motion to Strike

The employer challenges claimant's brief on the grounds it contains inadmissible evidence. Insofar as claimant's brief contains testimony and information that was not part of the record before the Appellate Unit on Reconsideration, such evidence is inadmissible under ORS 656.283(7) and may not be considered at hearing and on review. Accordingly, in reviewing this case, we consider only those arguments presented by the parties that are based on material that was part of the record on reconsideration and at hearing. See Maria Leyva, 48 Van Natta 288 (1996) (Board will not consider any evidence that was not previously made a part of the record); Haribu R. Steward, 45 Van Natta 2086 (1993).

### Extent of Scheduled Permanent Disability

Based on the findings of the medical arbiter panel, the ALJ found that claimant was not entitled to an impairment value for loss of strength in her right hand.[2] On review, claimant argues that the

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[1] The Order on Reconsideration erroneously awarded claimant 3 percent loss of motion for the right arm which should have been attributed to the left arm. The ALJ's order properly provided for a 3 percent award with respect to claimant's left arm in addition to the award for the right arm.

[2] It is not clear from the record in this case whether the ALJ actually admitted certain exhibits, including Exhibit 56 (the medical arbiters' report) into evidence, as the Opinion and Order only mentions the receipt of Exhibits 1 through 53, 18A, 46A, 50A, 50B and 51A into evidence; in addition, Ex. 56 is not located with these other exhibits in the file. We note, however, that the ALJ's order refers to the medical arbiters' report and the parties cite to this report in their briefs. Furthermore, neither party has raised any objection to the admission of Exhibit 56. Under these circumstances, we conclude that the ALJ intended to admit (and implicitly did admit) the medical arbiters' report (Exhibit 56) into evidence. See, e.g., Nellie M. Ledbetter, 43 Van Natta 570 (1993).

Board should rely on Dr. Bowman's closing report (finding that claimant had 4/5 grip strength in her right hand) over the arbiter's determination that she had full strength. We agree.

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

In this case, we find Dr. Bowman's closing examination to constitute the most thorough and accurate evaluation of claimant's permanent impairment. As indicated in his report, Dr. Bowman measured claimant's strength with a dynamometer, taking three readings for each hand. (Ex. 51a). Based on this testing, Dr. Bowman concluded that claimant would have a permanent loss of grip strength in her right hand, as well as a loss of repetitive use. The medical arbiters, on the other hand, did not identify the method used to test claimant's power. The arbiters simply reported that claimant had 5/5 power throughout, with no atrophy or vesiculation. (Ex. 56-2). Under these circumstances, we find Dr. Bowman's evaluation of claimant's permanent impairment to be more persuasive. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board relied on the grip strength findings of the attending physician, who conducted grip strength tests, rather than the findings of the medical arbiter, who merely conducted a clinical examination); Timothy W. Reintzell, 44 Van Natta 1534, 1535 (1992) (same).

Accordingly, based on Dr. Bowman's closing examination, claimant is entitled to a value of 10 for loss of forearm strength (OAR 436-35-110(8)(a)) which, when converted to an arm value (see OAR 436-35-120(4)), is 8 percent of the arm combined with 5 percent for her chronic condition (OAR 436-35-010(6)) for a total (right arm) award of 13 percent scheduled permanent disability.

ORDER

The ALJ's order dated October 3, 1996 is modified in part and affirmed in part. In addition to the Order and Reconsideration and ALJ's awards of 6 percent (11.52 degrees) scheduled permanent disability for claimant's right arm, claimant is awarded 7 percent (13.44 degrees) scheduled disability for the right arm, for a total award to date of 13 percent (24.96 percent) scheduled disability for the right arm. The remainder of the ALJ's order is affirmed.

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April 28, 1997 Cite as 49 Van Natta 554 (1997)

In the Matter of the Compensation of
**THOMAS J. KOLLEN, Claimant**
WCB Case No. 96-03549
SECOND ORDER ON RECONSIDERATION
Flaxel & Nylander, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 7, 1997 Order on Reconsideration which: (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. SAIF requests that we reconsider and clarify our holding.

In its previous request for reconsideration, SAIF argued that the phrase "actual weeks of employment" in former OAR 436-60-025(5)(a) (WCD Admin. Order 94-055) was ambiguous. According to SAIF, "actual weeks of employment" could include those weeks during which claimant was on the job and actually worked or the phrase could refer to the total period of employment, regardless of whether claimant actually performed any work during a particular week. SAIF asserted that the second interpretation was apparently adopted by the Department, because it upheld SAIF's calculation of claimant's average weekly wage by using the entire 13.4 weeks of employment.

On reconsideration, we concluded that, even if we assumed that SAIF was correct that the phrase "actual weeks of employment" in former OAR 436-60-025(5)(a) could be interpreted to refer to the total period of employment, regardless of whether a worker actually performed any work during a particular week, that interpretation had no application in this case. We disagreed with SAIF's assertion that claimant continued to be "employed" between November 27, 1995 and January 2, 1996.

In our previous Order on Reconsideration, we agreed with the ALJ that claimant was laid off and did not work from November 27, 1995 through December 31, 1995. Claimant testified that he was laid off on November 27, 1995 because the employer did not have any more work for him at that time. (Tr. 3-4, 13). The employer also agreed that claimant was laid off on November 27, 1995 because there was not enough work. (Tr. 25, Ex. 8). Claimant said that the employer told him that if he found another job, he should take it. (Tr. 4, 14). Claimant did not know whether he would be brought back if more work was available, although that was a possibility. (Tr. 13, 14). Although claimant looked for other work, he was unable to find another job. (Tr. 4, 18). He said that he had to look for other work in order to obtain unemployment benefits. (Tr. 4, 14). Claimant checked in with the employer periodically to see if any work was available. (Tr. 14). Claimant was "rehired" on January 2, 1996. (Tr. 4).

Since claimant was not receiving any wages between November 27, 1995 and January 2, 1996 and was told to seek other employment, we concluded that he was not employed by the employer during that period. On reconsideration, we adhered to our conclusion that SAIF had incorrectly recalculated claimant's temporary total disability benefits and we held that the time period between November 27, 1995 and January 2, 1996 should not be included in determining claimant's average weekly wage.

SAIF has filed a second motion for reconsideration, asking for a clarification of our February 7, 1997 Order on Reconsideration. On March 5, 1997 we withdrew our order for further consideration. On reconsideration, we agree that a clarification is appropriate.

In our previous Order on Reconsideration, we concluded that claimant was "rehired" on January 2, 1996.[1] Claimant was injured at work on January 3, 1996. Former OAR 436-60-025(5)(a) (WCD Admin. Order 94-055) provides, in part: "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." Since claimant was employed less than four weeks at the time of his injury, we must determine the parties' intent of the most recent wage earning agreement. We make that determination by reviewing the information provided by the employer on the "801" form and the testimony at hearing. See Qualified Contractors v. Smith, 126 Or App 131 (1994); Ralph L. Keller, 48 Van Natta 146 (1996).

Here, the "801" form completed by the owner of the company stated that claimant worked eight hours per day, five days per week, at $10 per hour. (Ex. 3). Claimant testified that, when he was hired in October 1995, he was to be paid $10 per hour and he was to work a minimum of 40 hours per week with possible overtime. (Tr. 3). Between October 1995 and November 27, 1995, claimant testified that his hours averaged 40 hours per week. (Tr. 11). When he was rehired in January, claimant understood that his pay rate would remain the same and he would again be expected to work a minimum of 40 hours a week. (Tr. 6).

The employer testified that, when claimant came back to work on January 2, 1996, he was paid the same wage. (Tr. 26). The employer did not make any guarantees to claimant other than the representations made when he came to work in October 1995. (Id.) The employer agreed with claimant's expectation that he was to be available to work 40 hours a week. (Tr. 28).

Based on the "801" form filled out by the employer and the testimony at hearing, we conclude that the parties' intent at the time of claimant's rehire on January 2, 1996 was for claimant to work an average of 40 hours per week at the rate of $10 per hour. Although claimant argued to the Director that some overtime was anticipated (Ex. 5), we are not persuaded that the parties intended for claimant to regularly work overtime. Therefore, we conclude that the temporary total disability rate should be calculated based on a 40 hour work week at $10 per hour, or a total of $400 per week.

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[1] In making this determination, we change footnote 3 of the ALJ's findings of fact on page 2 to read: "Claimant did not work from November 27, 1995 through December 31, 1995."

Accordingly, on reconsideration, as supplemented and modified herein, we republish our December 13, 1996 order, as reconsidered on February 7, 1997. The parties' rights of appeal shall begin to run from the date of this order.

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In the Matter of the Compensation of
**STANLEY W. TALLEY, Claimant**
WCB Case No. 93-04190
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that dismissed his hearing request for lack of jurisdiction. On review, the issue is jurisdiction.

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

In 1993, claimant requested a hearing seeking review of a March 19, 1993 Director's order finding that he was no longer eligible for vocational assistance. On June 28, 1994, the ALJ issued an Opinion and Order that set aside the Director's order. Claimant requested abatement and reconsideration of the ALJ's order and, on July 26, 1994, the Opinion and Order was abated.

While the Opinion and Order remained in abated status, the Oregon Legislature made significant changes in the workers' compensation law, including the 1995 enactment of amended ORS 656.283(3)(c), which vests exclusive jurisdiction over review of vocational assistance orders with the Director.[1] In November 1996, the ALJ determined that the Board no longer had jurisdiction to review claimant's 1993 vocational assistance order, and set aside the Order of Abatement, vacated his June 28, 1994 Opinion and Order and dismissed claimant's request for hearing.

On review, claimant asserts that the Board retains jurisdiction to review the vocational assistance order in this case because the provisions of amended ORS 656.283(3)(c) do not apply retroactively to orders issued prior to the statute's enactment. We disagree.

We held in Ross M. Enyart, 47 Van Natta 1540 (1995) that the Legislature expressly intended that amended ORS 656.283(3)(c) apply retroactively and that the Director now has exclusive jurisdiction over all vocational assistance disputes, including those pending before the Board and Hearings Division at the time the law was enacted. See also, Robert B. Enders, 47 Van Natta 1651 (1995).

Moreover, in Danell L. Sweisberger, 48 Van Natta 441 (1996), we expressly rejected the argument that claimant asserts here. We found that the Director's exclusive jurisdiction over vocational assistance matters extended to review of administrative orders issued pursuant to the predecessor statute (former ORS 656.283) as well as orders issued under subparagraph (b) of amended ORS 656.283(2). We construed the amended statute to divest the Board and the Hearings Division of jurisdiction to review vocational assistance administrative orders issued by the Director in all pending and future cases, without exception. Id.; see also Ferral C. Crowder, 48 Van Natta 2322 (1996).

Accordingly, as the ALJ found, the Board's Hearings Division lacks jurisdiction to review the vocational assistance order at issue in this case.

ORDER

The ALJ's order dated November 18, 1996 is affirmed.

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[1] This section provides, in pertinent part, 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."

In the Matter of the Compensation of
**KYLE L. ELLIS, Claimant**
WCB Case No. 96-08108
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order which affirmed an Order on Reconsideration that reduced claimant's award of scheduled permanent partial disability for loss of use or function of his left hand from 17 percent (25.5 degrees), as awarded by a Notice of Closure, to 11 percent (16.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

Claimant sustained a compensable left hand injury on August 21, 1995. A Notice of Closure issued on May 20, 1996, which awarded claimant 17 percent scheduled permanent disability for loss of use or function of the left forearm based on reduced range of motion and loss of strength. (Ex. 18a). Claimant requested reconsideration, which resulted in an August 27, 1996 Order on Reconsideration that reduced claimant's scheduled award to 11 percent. The reconsideration order's award was based on reduced range of motion and the presence of a "chronic" condition. (Ex. 27). Claimant requested a hearing, in which the issues were reduced to whether claimant was entitled to impairment for loss of grip strength.

In affirming the reconsideration order, the ALJ relied on the impairment findings of the medical arbiter panel, whose August 14, 1996 report the ALJ interpreted as not establishing a loss of strength. The ALJ rejected claimant's contention that his impairment should be based on the findings of his attending physician, Dr. Bowman, who reported that claimant had "4/5 strength" in his left forearm/hand. (Ex. 16). The ALJ reasoned that Dr. Bowman's opinion alone did not constitute a preponderance of medical evidence sufficient to establish a level of impairment different from that found by the medical arbiter panel. See OAR 436-035-0007(13).

On review, claimant contends that the ALJ should have relied on the impairment findings of Dr. Bowman because of his greater familiarity with claimant's condition. Claimant asserts that Dr. Bowman's opinion establishes that he has a loss of grip strength, which, when combined with the "chronic" condition and range of motion findings in the reconsideration order, entitle him to a total scheduled award of 27 percent. Alternatively, claimant argues that the medical arbiters found a loss of grip strength that, when combined with the panel's other impairment findings, results in a total scheduled award of 20 percent. For the following reasons, we find that the ALJ properly affirmed the reconsideration order.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Orfan A. Babury, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs.[1] 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 the medical arbiter panel provided the most persuasive medical opinion addressing claimant's permanent impairment. Inasmuch as permanent disability is rated at the time of the August 27, 1996 reconsideration order, their August 14, 1996 evaluation of claimant's

[1] The attending physician's opinion by itself can constitute a "preponderance of evidence." E.g. Debra A. Ashdown, 47 Van Natta 1025 (1995).

permanent impairment is more probative than that of Dr. Bowman, who commented on claimant's grip strength in April 1996 and who adopted the February 15, 1996 impairment findings of a physical therapist. (Ex. 16).[2]

Having determined that the ALJ properly rated claimant's impairment based on the medical arbiters' report, we turn to the issue of whether that report establishes that claimant is entitled to an award of permanent impairment for loss of grip strength. For the reasons cited by the ALJ, we find that it does not. Therefore, we conclude the ALJ properly affirmed the reconsideration order.

ORDER

The ALJ's order dated December 31, 1996 is affirmed.

[2] 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, we are persuaded that the record establishes that claimant's grip strength had improved from the time claimant had been declared medically stationary by Dr. Bowman in February 1996 and the time of the medical arbiter's examination in August 1996. (compare Exs. 12, 13, 14, 15 with Ex. 26-4). Under these circumstances, we conclude that the medical arbiters' report is more probative on the issue of grip strength.

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In the Matter of the Compensation of
**LARRY R. FRAUMENI, Claimant**
WCB Case No. 96-06653
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

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

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

In September 1985, claimant injured his back when he slipped and fell while walking up stairs carrying boxes of laundry detergent. (Ex. 1). Since that time, he has experienced intermittent low back symptoms.

Claimant began working for the employer as a CNA in early 1996. On March 10, 1996, claimant and a co-worker were transferring a patient into bed, when claimant experienced the onset of back pain. (Ex. 17). The next day, claimant was seen by a nurse practitioner, who noted decreased range of motion and palpable tenderness across the bilateral trapezius, rhomboids and in the lumbar area. (Ex. 19). Claimant then sought follow up treatment with Dr. Naugle, who diagnosed a chronic lumbo-dorsal strain.

Claimant was eventually referred to Dr. Henderson, who found "no objective evidence of significant problems" in claimant's neck and back when he examined claimant on April 15, 1996. In mid-May 1996, claimant saw Dr. Webb who found decreased range of motion and diagnosed cervical, thoracic and lumbosacral spine strain.[1] (Ex. 30). Dr. Webb later opined that claimant's decreased range of motion was consistent with, and caused in major part by, the injury claimant sustained on March 10, 1996. (Ex. 33).

[1] All three treating doctors were advised of claimant's prior back injury.

On May 21, 1996, the employer denied claimant's neck and back injury on the grounds there was no objective medical evidence to substantiate that he suffered injuries to his neck, thoracic or lumbar regions. (Ex. 32). At hearing, the employer sought to amend the denial on the grounds that claimant's incident at work on March 10, 1996 was not a material cause of his disability or need for treatment for his neck or back. (Tr. 4). Claimant objected to the amendment.

The ALJ denied the employer's motion to orally amend its denial at hearing.[2] The ALJ further found that, contrary to the employer's written denial, claimant's March 10, 1996 injury was established by medical evidence supported by objective findings. Specifically, the ALJ determined that both Dr. Naugle and Dr. Webb reported decreased range of motion related, at least in part, to the March 10, 1996 incident.

On review, the employer argues that claimant must prove the compensability of his neck and back injury under the major contributing cause standard because of his prior back injury and history of low back pain. The employer further asserts that the incident of March 10, 1996 was not the major contributing cause of claimant's disability and need for treatment after that date, and that Dr. Webb's opinion to the contrary is not persuasive. We reject the employer's arguments.

At hearing, in connection with its motion to amend the denial, the employer's counsel specifically asserted: "I won't be arguing that [claimant] had a preexisting condition and that it's incumbent upon him to establish a major contributing causal relationship . . . ." (Tr. 3, emphasis added). Under the circumstances, we consider the employer's counsel's statement as a concession that claimant's March 10, 1996 injury did not involve a "combined condition" under ORS 656.005(7)(a)(B).

Since the employer conceded at hearing that claimant's injury was not subject to the major contributing cause standard, we decline to consider the employer's contrary position on review. Indeed, to allow the case to be decided on a different standard from what was litigated at hearing would be fundamentally unfair. See Sean W. Miller, 45 Van Natta 2337 (1993) (Board declined to consider the carrier's challenge to the claimant's claim under ORS 656.005(7)(a)(B) where the defense was raised for the first time on review); Greg S. Meier, 45 Van Natta 922 (1993), on recon 45 Van Natta 1015 (1993) (Board declined to consider a carrier's challenge to a claim based on insufficiency of medical evidence when the carrier had only contested the claim on "not arising out of employment" grounds at the hearing); Linda R. Burrow, 44 Van Natta 71 (1992) (Where hearing was based on denial of causal relationship, Board declined to consider a new "course and scope" defense on review).

In this case, claimant has the burden of establishing by medical evidence supported by objective findings that he sustained an accidental injury at work on March 10, 1995. ORS 656.005(7)(a). Objective findings in support of medical evidence are "verifiable indications of injury or disease" that may include range of motion. ORS 656.005(19); see also, Francisco Betonio, 48 Van Natta 976 (1996) (reduced range of motion was "measurable" finding and a verifiable indication of injury); Naomi Whitman, 48 Van Natta 891 (1996) (same).

As the ALJ noted, both Dr. Naugle, who saw claimant within a few days of the incident, and Dr. Webb, who saw claimant two months later, found reduced range of motion and tenderness about the trapezius area bilaterally. We agree with the ALJ that these findings represent "objective findings" of injury under ORS 656.005(19). Further, although Dr. Naugle and Webb disagreed about the extent to which claimant's work injury contributed to his condition,[3] the evidence establishes that this incident was at least a material cause of claimant's disability and need for treatment after March 10, 1996. We therefore find the claim compensable.

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[2] As discussed below, even if the ALJ had permitted the employer to orally amend the denial in this regard, claimant has established that the work incident was at least a material cause of his disability and need for treatment. Thus, we need not resolve the ALJ's procedural ruling.

[3] Dr. Webb opined that claimant's injury of March 10, 1996 was the major contributing cause of his need for treatment for cervical, thoracic and lumbosacral strain (Ex. 33-1), whereas Dr. Naugle opined that the injury may have "contributed to" claimant's low back and myofascial pain syndrome but was not the major cause of his disability and need for treatment. (Ex. 35).

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 November 4, 1996 is affirmed. For services on review, claimant's counsel is awarded $1,500, payable by the employer.

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In the Matter of the Compensation of
**MARY R. CHRISTY, Claimant**
WCB Case No. 96-08203
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

Claimant contends that she proved the compensability of her left shoulder dislocation and subacromial impingement syndrome. In particular, claimant contends that a report from Dr. Manley, claimant's treating orthopedist, satisfied her burden of proof.

Although Dr. Manley indicated in one report that a work event was the major contributing cause of claimant's current left shoulder condition (Ex. 13), he subsequently concurred with a report from Dr. Strukel, who performed a records review at SAIF's request, finding that the major contributing cause was a preexisting condition (Exs. 12-2, 14). We find that Dr. Manley's concurrence reduces the persuasiveness of his opinion since the first report and the concurrence are not consistent. Consequently, because Dr. Manley was the only physician to support causation and his opinion is not persuasive, we agree with the ALJ that compensability was not established. See ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated December 13, 1996 is affirmed.

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In the Matter of the Compensation of
**DAVID E. COLLINS, Claimant**
WCB Case No. 95-10805
ORDER ON REVIEW (REMANDING)
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Menashe's order which upheld the self-insured employer's denial of his occupational disease claim for a nasal-sinus condition. In his "briefs" and correspondence with the Board, claimant refers to his efforts to develop medical evidence to support his claim and to his need to have the case returned to the Hearings Division "to allow [him] further time to locate an attorney." Claimant has also appended medical documentation that he seeks to make part of the record.[1] Since our review is limited to the record developed before the ALJ, we treat claimant's submissions and representations as a motion to remand for further proceedings. On review, the issues are compensability and motion to remand. We vacate and remand.

## FINDINGS OF FACT

Through legal counsel, claimant filed a request for hearing on September 22, 1995, contesting the employer's August 23, 1995 denial of his occupational disease claim for a nasal-sinus condition. The hearing was initially scheduled to convene on December 20, 1995.

One month prior to the scheduled hearing, the employer sent notice to claimant that he had been scheduled for a medical examination on December 7, 1995. Approximately one week following mailing of the notice, claimant's counsel requested that the hearing be postponed because claimant's college final examinations prevented him from attending the employer-scheduled medical evaluation. Counsel for the employer concurred with that request.

The hearing was rescheduled to April 4, 1996. However, the hearing was again postponed when claimant's first attorney withdrew as counsel. This second postponement resulted from a telephone conference call two days prior to the hearing, at which time claimant was apparently represented by new counsel. The hearing was rescheduled, this time for August 27, 1996.

Claimant's second legal counsel appeared along with claimant when the hearing convened as scheduled. However, the attorney explained to the ALJ that he had resigned as claimant's counsel and that he "thought" he had so advised claimant a month previously. (Tr. 1). The attorney further explained that he and claimant had discussed the hearing the day before it convened. At that time, claimant believed he was still represented and was relying on the attorney for representation. Id. After moving for a "continuance," the attorney left the hearing room.

## CONCLUSIONS OF LAW AND OPINION

The ALJ declined the motion for a continuance. The ALJ reasoned that a decision on the merits of the claim was appropriate, given the length of time the case had been pending and the fact that claimant had been given an adequate opportunity to develop medical evidence to support the claim. (Tr. 4). The ALJ then allowed claimant to testify and subsequently issued an order upholding the employer's denial.

We first address the issue of whether claimant's motion for a "continuance" should have been granted. Based on the following reasoning, we conclude that it should have been.

OAR 438-006-0081, the postponement rule, provides that hearings "shall not be postponed except by order of [an ALJ] upon a finding of extraordinary circumstances beyond the control of the party...requesting the postponement." Subsection (4) of the same rule provides that "extraordinary

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[1] It appears that some of the proposed evidence is already in the record and that some was generated after the August 27, 1996 hearing. The employer has objected to claimant's "post-briefing schedule" submissions, contending that they are "laced with factual assertions outside the record and irrelevant information about subsequent events." We treat claimant's submissions as further supplementation regarding the question of whether this matter should be remanded for further development.

circumstances" shall not include "[i]ncomplete case preparation, unless the [ALJ] finds that completion of the record could not be accomplished with due diligence."

The continuance rule, OAR 438-006-0091, provides:

> "The parties shall be prepared to present all of their evidence at the scheduled hearing. Continuances are disfavored. The Administrative Law Judge may continue a hearing for further proceedings. The Administrative Law Judge shall state the specific reason for the continuance:
>
> "(1) If the time allocated for the scheduled hearing is insufficient to allow all parties to present their evidence and argument;
>
> "(2) Upon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence;
>
> "(3) Upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence or for any party to respond to an issue raised for the first time at a hearing; or
>
> "(4) For any reason that would justify postponement of a schedule hearing under OAR 438-006-0081."

Because the language of the continuance rule is permissive (i.e., "may") and delegates to the ALJ a range of discretion in granting a continuance, we review an ALJ's ruling (on a continuance motion) for abuse of discretion. See Georgia-Pacific Corp. v. Kight, 126 Or App 244, 246 (1994). The postponement rule, on the other hand, contains mandatory language ("shall"), and requires that a postponement motion not be granted unless there are "extraordinary circumstances."

Considering that claimant's motion was made prior to the hearing and in the context of claimant's attorney's termination of representation, we find that claimant's motion to "continue" the hearing was in effect a motion to "postpone" the hearing. Having determined the nature of claimant's motion, we now determine whether "extraordinary circumstances" existed to justify a postponement. For the following reasons, we conclude that such circumstances did exist.

In Alan J. Davis, 47 Van Natta 273 (1995), we reversed the order of an ALJ who dismissed the claimant's request for hearing after declining to grant the claimant's seventh request for a postponement, which was in part based on the fact that the claimant retained an attorney whom he subsequently had to fire just prior to hearing. We acknowledged that the claimant did not attempt to retain an attorney until less than a month before the scheduled hearing, when he had four months to retain one. Nevertheless, because the claimant eventually made such an attempt and apparently believed that he had successfully retained legal representation prior to hearing, we concluded that the subsequent termination of that representation prior to the hearing constituted "extraordinary circumstances" beyond the control of the claimant. Although we recognized that the question was a very close one, we noted that claimant's prior postponements were not granted based on a failure to obtain legal representation. In light of such circumstances, we found that the record could not be completed with due diligence.

Like the claimant in Davis, claimant here also apparently believed that he had successfully retained legal representation for the hearing convened to decide the compensability of his occupational disease claim. Moreover, like the claimant in Davis, neither of claimant's prior postponements were granted based on a failure to obtain legal representation. To the contrary, claimant had obtained counsel only to have such counsel withdraw that representation shortly before the scheduled hearing. Claimant's first attorney apparently withdrew shortly before the scheduled April 4, 1996 hearing. Similarly, although the second attorney "thought" he had previously informed claimant that he had resigned a month before the hearing, there is no record of such a withdrawal in the Hearings Division file.

Finding no evidence to contradict claimant's apparent belief and desire that the attorney would represent his interests at the hearing, and considering the abrupt nature of the attorney's departure from the proceedings, we find that "extraordinary circumstances" existed to justify a postponement of the

hearing so that claimant could obtain legal counsel.[2] Accordingly, we conclude that, under the circumstances, the record could not be completed with due diligence. Compare Rebecca Marks, 45 Van Natta 802 (1993) (no postponement warranted where the claimant had six months prior to hearing to secure legal counsel, but had not attempted to do so, when prior postponement had been granted for the same reason).

We may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Under the circumstances, we find that remand is appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Therefore, we remand to the ALJ with instructions to schedule a hearing in the ordinary course of business. At that hearing, the parties shall have the opportunity to once again present evidence regarding the issues raised by claimant's hearing request.

Accordingly, the ALJ's order dated September 11, 1996 is vacated. This matter is remanded to ALJ Menashe for further proceedings consistent with this order.[3] Following these further proceedings, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[2] Claimant's wish to be represented at the hearing by legal counsel is evidenced by his statement prior to testifying that he was "out of [his] league here." (Tr. 5).

[3] Claimant has also submitted an August 1995 letter from an Operations Vice-President for the employer. Noting that the record and briefing schedule have already been closed, the employer objects to this submission. Inasmuch as we have found it appropriate to remand this matter for the rescheduling of the postponed hearing, it is unnecessary for us to consider this report. Rather, the report and its contents can be addressed when the rescheduled hearing is convened.

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In the Matter of the Compensation of
**TERESA KERSEY-SHERBINA, Claimant**
WCB Case No. 96-06593
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order which: (1) determined that the self-insured employer's partial denial issued in response to her objection to the Notice of Acceptance of her low back claim was not premature; and (2) upheld the employer's partial denial of claimant's L5 spondylolysis and L5-S1 disc herniation with left S1 nerve root involvement. On review, the issue is the procedural validity of the employer's denial.

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

Claimant sought treatment in March 1996 for progressive low back pain over the previous six months. On May 30, 1996, the employer issued a Notice of Claim Acceptance for an acute low back strain/sprain.

On June 5, 1996, claimant's counsel advised the employer that "[h]aving reviewed the material submitted in conjunction with [its] Notice of Claims Acceptance, I must take issue with the conditions accepted..." Specifically, claimant's counsel requested that the employer "enlarge" its acceptance notice to include L5 spondylolysis and an L5-S1 disc herniation with elements of left L5 nerve root involvement. (Ex. 26).

In response to claimant's counsel's request, the employer denied those conditions on July 2, 1996 on the ground that they were not related to claimant's employment or to her accepted claim. (Ex. 34). Claimant then requested a hearing, contending that the employer's denial was premature. Subsequently, both claimant and the employer solicited medical reports addressing the causal relationship, if any, between claimant's accepted claim and the additional conditions.

The ALJ upheld the employer's denial, finding that it was not prematurely issued. In reaching this conclusion, the ALJ rejected claimant's argument that her objection to the acceptance notice pursuant to ORS 656.262(6)(d)[1] was not the proper subject of a denial. The ALJ reasoned that, since claimant's request for acceptance of the named conditions necessarily included a claim or contention that they were compensable, the employer's response (a denial) was appropriate under the statutory scheme.

On review, claimant contends that ORS 656.262(6)(d) does not require issuance of a denial of a request to enlarge an acceptance where, as here, all compensation has been paid.[2] Citing Ramona Hamilton, 48 Van Natta 2438 (1996) (denial issued in absence of a "new medical condition" claim under ORS 656.262(7)(a) is a nullity), claimant asserts that the employer's denial was premature. For the following reasons, we agree with the ALJ that the employer's denial in this case was proper.

In Hamilton, we held that, in the absence of a "new medical condition" claim under ORS 656.262(7)(a),[3] a carrier's "precautionary" denial was premature and invalid. Following closure of an accepted low back injury claim in Hamilton, the claimant began receiving treatment for a degenerative arthritis and vascular condition. Thereafter, the carrier denied those conditions, contending that, under Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), it was not required to wait for a new medical condition claim before it could clarify the scope of its acceptance. We disagreed with the carrier's assertion. Reasoning that claimant had not "clear[ly] request[ed] formal written acceptance" of the new medical conditions, we concluded that no claim under ORS 656.262(7)(a) had been filed.

Unlike Hamilton, which concerned the application of ORS 656.262(7)(a), this case concerns a different statute: ORS 656.262(6)(d). In contrast to the former statute, ORS 656.262(6)(d) does not require the presence of a "claim." To the contrary, ORS 656.262(6)(d) merely requires an "objection" to an acceptance notice. We recognize that, unlike ORS 656.262(7)(a) which specifically mentions the carrier's right to issue a "denial," ORS 656.262(6)(d) does not use that term. Instead, the latter statute gives the employer 30 days from receipt of claimant's "objection" to the acceptance notice either to revise the acceptance or to "make other written clarification."

While the statutory language in ORS 656.262(6)(d) appears to allow a carrier to respond to a claimant's objection to an acceptance notice in a manner other than a formal claim denial, it also does not prevent a carrier from issuing a "written clarification" in the form of a denial. Moreover, the statute contemplates a claimant raising the issue of "de facto" denial at a hearing. Accordingly, if a "de facto"

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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."

[2] Claimant concedes that the preponderance of the medical evidence in this case establishes that her spondylolysis is not contributory to her need for treatment or disability, and that an L5-S1 herniation does not exist. (Appellant's Brief p. 2).

[3] 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."

denial can flow from a claimant's objection to a Notice of Acceptance (assuming he or she has complied with the communication requirements of the statute), we are persuaded that a formal denial is a permissible option for a carrier. Therefore, we conclude that the employer's denial in this case was a legally appropriate response under ORS 656.262(6)(d) to claimant's "objection" to the acceptance notice.[4]

ORDER

The ALJ's order dated October 31, 1996 is affirmed.

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[4] Because we are able to discern the legislature's intent when it enacted ORS 656.262(6)(d) 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, 317 Or 606 (1993).

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In the Matter of the Compensation of
**RICHARD A. LONG, JR., Claimant**
WCB Case No. 96-08034
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration which awarded no scheduled permanent disability for claimant's right ear tinnitus and hearing loss conditions. On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as a salesperson in the fertilizer/chemical business. On October 10, 1994, claimant was working in the employer's shop when a large hitch fell to the floor nearby and produced a loud noise. Claimant had an immediate onset of ringing and mild pain in his right ear. Claimant also noticed that his hearing in the right ear seemed diminished.

On October 12, 1994, claimant treated with Dr. Lundquist, an otolaryngologist.

In December 1994, claimant was seen by Dr. S. Hodgson, who evaluated him on behalf of SAIF. Dr. Hodgson reported that claimant had noticed gradual improvement in his right ear hearing following the work incident, although the ringing had persisted. Dr. Hodgson was unable to document any permanent hearing loss or disability due to the injury, but found that claimant might have impairment due to tinnitus if the condition did not resolve.

On December 15, 1994, claimant's claim was accepted as a nondisabling claim for right ear tinnitus.

On April 10, 1995, Dr. Lundquist requested further evaluation of claimant's tinnitus.

On June 13, 1995, claimant was evaluated at the Oregon Hearing Research Center for his tinnitus condition. Dr. Johnson recommended a tinnitus instrument and reported that claimant's condition was probably permanent.

On November 3, 1995, Dr. Lundquist agreed that the right ear tinnitus condition was permanent and resulted from the work incident. However, Dr. Lundquist did not find that work was the major cause of any high frequency hearing loss.

On December 18, 1995, claimant requested that his claim be reclassified from nondisabling to disabling.

A January 18, 1996 Determination Order found that claimant's injury would remain classified as nondisabling. Claimant subsequently requested reconsideration of the Determination Order.

On March 12, 1996, SAIF issued a partial denial of claimant's high frequency hearing loss of the right ear, but stated that it would continue to provide medical benefits related to the accepted tinnitus, right ear, and low frequency hearing loss, right ear.

On April 2, 1996, claimant was evaluated by a panel of medical arbiters. An audiogram was also performed on that date.

An April 23, 1996 Order on Reconsideration ordered claimant's claim to be reclassified as disabling.

A May 20, 1996 Notice of Closure found that claimant was not entitled to temporary disability or permanent disability benefits for the accepted claim. On May 28, 1996, claimant requested reconsideration and a medical arbiter panel examination.

On July 15, 1996, claimant was examined by a panel of medical arbiters and an audiogram was performed. Dr. Mettler reported that claimant had 0% hearing losses in the right ear, the left ear and binaurally. Dr. Mettler also reported that claimant had high-tone hearing loss which was more likely due to hunting rather than the one exposure at work.

On August 12, 1996, claimant was examined by another medical arbiter, Dr. R. Hodgson. Dr. Hodgson recommended that the tinnitus be given a value of 3 percent and he found a 26.75% loss in the right ear, and 3.34% for binaural hearing.

An August 23, 1996 Order on Reconsideration declined to award permanent disability benefits, and the May 20, 1996 Notice of Closure was affirmed.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had no ratable permanent impairment that was due to the work injury. On review, claimant argues that he is entitled to an award of permanent impairment for his tinnitus and right ear hearing loss conditions.

OAR 436-035-0390(7)(b) provides, in part, that tinnitus which by a preponderance of medical opinion requires job modification is valued at 5%. Claimant argues that an offer of proof he has submitted regarding his job shows that his tinnitus has required his job to be modified. Claimant also argues that the first medical arbiters suggested that his job should be modified by having his cab radio volume adjusted to a suitable level. (Ex. 26).

Because claimant's offer of proof was not submitted at the time of reconsideration, we cannot consider it on review. See amended ORS 656.283(7); Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996); Dean I. Evans, 48 Van Natta 1092 (1996). Furthermore, as SAIF argues, the administrative rule requires a preponderance of medical opinion in order to establish entitlement to an award under the rule.

Finally, after reviewing the medical evidence, we are unable to find that a preponderance of medical evidence supports the requirement for job modification. Although the first medical arbiter panel suggested that a radio volume adjustment might be helpful, they also concluded that claimant was capable of performing his customary work. (Ex. 26-4). An arbiter exam performed four months later noted that claimant "continued working and remains at the same job without restrictions." (Ex. 35-1). Under the circumstances, we are unable to find that claimant has proven entitlement to an award for his tinnitus condition. See Gary R. Peyton, 45 Van Natta 2288 (1993)(A recommendation for more effective hearing protection was a safety measure which did not affect the claimant's work duties or the performance of his regular work. Because the medical evidence established that the claimant's tinnitus did not prevent him from performing his regular work, the claimant was not required to modify his job duties and was not entitled to an award of permanent disability for his tinnitus).

Claimant also argues that his audiological exams show that he has a ratable hearing loss in the right ear. Claimant's accepted condition, however, is a low frequency loss condition, whereas the high frequency condition was denied by SAIF. (Exs. 23, 24). Claimant's treating doctor, Dr. Lundquist, was

unable to determine whether claimant's low frequency responses in the right ear were within normal limits. (Ex. 15). Dr. Camp, one of the first medical arbiters that examined claimant, reported that claimant had bilateral nerve deafness due to repetitive trap shooting during his childhood and midteens. (Ex. 27-3). Dr. Holden, who examined claimant in the final arbiter exam, reported that claimant had sensorineural hearing loss from chronic noise exposure in use of firearms and (an) on the job injury. (Ex. 35-1). Dr. Mettler, of the same arbiter panel, reported that claimant had "high-tone hearing loss in both ears." Dr. Mettler found that hunting, rather than the single noise exposure at work, was most likely the cause. (Ex. 36-2). Finally, Dr. R. Hodgson, from the arbiter panel, reported that claimant had a high tone hearing loss in both ears and low tone loss in the right ear. (Ex. 37-2).

After reviewing the medical record, we are unable to find that a preponderance of the evidence shows that claimant has a ratable right ear hearing loss condition that is due to the injury. ORS 656.214(2). The medical opinions which might arguably support claimant's position either fail to distinguish between claimant's accepted condition and the denied high frequency loss condition, or do not explain whether claimant's loss is due to the injury, rather than his exposure to firearms. Accordingly, we agree with the ALJ that claimant has failed to establish an award of permanent disability, under the standards.

The ALJ's order dated December 24, 1996 is affirmed.

IT IS SO ORDERED.

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May 1, 1997 Cite as 49 Van Natta 567 (1997)

In the Matter of the Compensation of

ELVIA H. HILLNER, Claimant

WCB Case No. 96-11311

ORDER DENYING MOTION TO DISMISS

Moscato, Skopil, et al, Defense Attorneys

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Rodnar's April 2, 1997 Order of Dismissal. Asserting that claimant's then-attorney withdrew her hearing request, the self-insured employer seeks dismissal of her appeal. The motion is denied.

## FINDINGS OF FACT

On December 20, 1996, claimant, through her then-attorney, filed a hearing request regarding a December 17, 1996 Order on Reconsideration. On March 28, 1997, prior to the scheduled hearing, claimant's then-attorney withdrew claimant's request for hearing on claimant's behalf. The ALJ's Order of Dismissal issued on April 2, 1997. The ALJ's order contained a notice advising the parties of appeal rights on the order.

On April 10, 1997, the Board received claimant's hand-written April 4, 1997 letter expressing dissatisfaction with the ALJ's Order of Dismissal; claimant requested Board review. The request indicated that a copy of the request had been mailed to her former attorney, the employer, its claims administrators, and its attorneys.

A computer-generated acknowledgment of claimant's request for review was mailed by the Board on April 16, 1997. Copies were mailed to all parties to the proceeding and their representatives.

## CONCLUSIONS OF LAW AND OPINION

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

The employer neither contends that claimant's request for review was untimely filed nor that it received improper notice of the appeal. In any event, the record would not support such contentions, as claimant's letter indicated that a copy of her request for review was sent to the parties to the proceeding, and the Board acknowledged the request for review some 14 days after the ALJ's order, well within the 30-day period. Instead, the employer moves to dismiss claimant's request for review on the basis that, because her hearing request was withdrawn, we have no jurisdiction to review the matter. We disagree.

The ALJ's April 2, 1997 dismissal order properly contained a statement of the parties' rights to appeal, notifying them that the order would become final unless one of them sought Board review within 30 days after the mailing date of the order. Within the aforementioned 30-day period, claimant filed her request for Board review of the ALJ's decision. ORS 656.289(3); ORS 656.295(2). Thus, as a procedural matter, we are authorized to examine the propriety of the ALJ's decision to dismiss claimant's hearing request. See Mike D. Sullivan, 45 Van Natta 990 (1993); Donald L. Lowe, 41 Van Natta 1873 (1989).[1]

Accordingly, the employer's motion to dismiss is denied. In light of these circumstances, the briefing schedule shall be revised as follows. Since claimant has already submitted her appellant's brief (her written argument explaining why she disagrees with the ALJ's decision), the employer's respondent's brief shall be due 21 days after the mailing date of this order. Claimant's reply brief shall be due 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] Citing Karen D. Maloney, 47 Van Natta 436 (1995), the employer asserts that we have no jurisdiction to consider claimant's appeal because her hearing request has been withdrawn. Maloney does not stand for the proposition that the employer presently advances. In Maloney, we affirmed an ALJ's order which had dismissed a carrier's cross-request for hearing of an Order on Reconsideration as untimely. In doing so, we reasoned that, because the claimant had fully withdrawn her timely hearing request, the ALJ lacked jurisdiction to consider the carrier's untimely hearing request regarding the reconsideration order. Maloney does not hold that we are without appellate jurisdiction to review a timely appeal from an ALJ's dismissal order which was based on a withdrawn hearing request. To the contrary, Maloney supports such a conclusion because, rather than dismissing the carrier's appeal in Maloney, we proceeded to review its contention that the ALJ had improperly dismissed a hearing request.

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May 1, 1997 Cite as 49 Van Natta 568 (1997)

In the Matter of the Compensation of
**JUDITH K. NIX, Claimant**
WCB Case No. 93-02704
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

On April 9, 1997, we issued an Order on Remand that directed the self-insured employer to directly pay claimant's counsel 25 percent of the 12 percent increased unscheduled permanent disability award granted by our prior orders. Asserting that the permanent disability award has "long ago been paid" and that we have previously rejected the same request from claimant's counsel in another case (WCB Case No. 95-02805), the employer seeks reconsideration and a decision that it is not required to pay the "out-of-compensation" attorney fee directly to claimant's counsel.

In order to further consider this matter, we withdraw our April 9, 1997 order. Claimant is granted an opportunity to respond. To be considered, that 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.

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In the Matter of the Compensation of
**ALKA THORNSBERRY, JR., Claimant**
Own Motion No. 96-0553M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable 1986 industrial injury. Claimant's aggravation rights on that claim expired on February 3, 1992. SAIF opposes reopening the claim on the ground that claimant was not in the work force at the time of disability.

In reviewing this record, we find that, on March 8, 1994, the Board approved the parties' Claim Disposition Agreement (CDA), whereby claimant released his rights to the following workers' compensation benefits: temporary disability benefits, permanent disability benefits, vocational rehabilitation, own motion benefits under ORS 656.278, aggravation rights per ORS 656.273, survivor's benefits, and all other workers' compensation benefits except compensable medical services under ORS 656.245.[1]

In its March 24, 1997 recommendation, SAIF indicated that claimant underwent "compensable surgery accepted November 21, 1996." Furthermore, SAIF conceded that claimant's current condition is compensable and that it is responsible for claimant's current condition. Therefore, SAIF has accepted claimant's medical services as compensable.

However, claimant has permanently relinquished his rights to all past, present and future temporary disability compensation in this claim pursuant to the March 8, 1994 CDA. Therefore, claimant's request for temporary disability compensation is denied.[2]

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

IT IS SO ORDERED.

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[1] SAIF initially issued a denial of the compensability of claimant's current L4-5 disc extrusion condition However, it rescinded that denial on November 21, 1996 and accepted claimant's L4-5 disc condition as compensably related to his 1986 injury claim. Although a new condition has subsequently been accepted in this claim, that medical condition is treated and processed as a compensable condition in claimant's 1986 injury claim, and has the same aggravation rights. See Mark D. Fuller, 46 Van Natta 63 (1994). Claimant's aggravation rights on his 1986 injury claim have expired, thus placing the claim in Own Motion status. Furthermore, claimant's entitlement to any further temporary disability in his 1986 injury claim (regardless of when the current condition was accepted) was extinguished by the March 8, 1994 CDA. See Trevitts v. Hoffman-Marmolejo, 138 Or App 455 (1996).

[2] We need not consider the merits of SAIF's contention that claimant was not in the work force at the time of his current disability, as the CDA renders this issue moot.

In the Matter of the Compensation of
**ELIZABETH HELLER, Claimant**
WCB Case No. C700985
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On April 22, 1997, 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.

In paragraph 12, page 3, the proposed CDA provides: " * * * the claimant retains those rights which give the Workers' Compensation Board the right to re-open the claim for curative treatment pursuant to ORS 656.278."

Under ORS 656.278(1)(a), the Board may authorize the payment of temporary disability compensation where there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. However, the Board lacks authority to authorize the payment of medical benefits, except where the date of injury is earlier than January 1, 1966. ORS 656.278(1)(b). (Since claimant's injury occurred in 1990, the exception contained in ORS 656.278(1)(b) is inapplicable here). Moreover, a request for temporary disability under ORS 656.278 will be denied where a claimant has released her rights to all past, present and future temporary disability compensation in a CDA. See Alka Thornsberry, 49 Van Natta 569 (1997). Here, because claimant has released her rights to past, present and future temporary disability benefits in the CDA, a request for such benefits under ORS 656.278 will be denied. Id.

Thus, the CDA is inaccurate to the extent that it attempts to retain rights "which give the Workers' Compensation Board the right to re-open the claim for curative treatment pursuant to ORS 656.278." As explained above, the Board has no such authority to reopen a claim for "curative treatment under ORS 656.278."

Alternatively, claimant may have been attempting to retain her rights to curative care under ORS 656.245(1)(c)(L). However, this is unnecessary since a claimant cannot release her rights to those medical services in a CDA. See ORS 656.236(1) (unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services).

As clarified by this order, the agreement 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 payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
**ANTHONY J. McKENNA, Claimant**
WCB Case Nos. 95-07570, 95-02480 & 94-07262
ORDER ON RECONSIDERATION
Jerome P. Larkin (Saif), Defense Attorney
Bottini, et al, Defense Attorneys

On March 3, 1997, we withdrew our January 31, 1997 Order on Review that: (1) directed Safeco to accept claimant's injury claim for an "L4-5 disc derangement/bulge" condition; (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition; (3) upheld Safeco's denials of claimant's aggravation and occupational disease claims for the same condition; (4) denied claimant's motions to remand and strike Safeco's Cross-Reply Brief; and (5) declined to award interim compensation or assess penalties or sanctions. Specifically, claimant challenges our conclusions that: (1) he had not proven an aggravation claim for his compensable L4-5 disc condition; (2) it was unnecessary to determine whether the Administrative Law Judge (ALJ) had improperly excluded a medical report from Dr. Thompson because admission of the report would not have affected the outcome of our "aggravation" decision; (3) sanctions against Safeco Insurance for a frivolous appeal or for purposes of harassment, as well as additional penalties for allegedly unreasonable claim processing, were not warranted; and (4) the opinion from claimant's attending physician, Dr. Carroll, was not persuasive.

On reconsideration, claimant also moves: (1) for admission of documents not previously submitted (Proposed exhibits X and XX, attached to claimant's February 28, 1997 "Motion for Admission of New Discovery []," and numerous documents attached to claimant's Reply Brief); (2) to strike Safeco's allegedly unsigned pleadings regarding briefing extensions and its October 8, 1996 and November 18, 1996 briefs; and (3) to strike Safeco's and SAIF's objections to his motions for admission of documents not previously submitted.

In addition to claimant's motion for abatement and reconsideration, we have received and considered SAIF's response to that motion, claimant's reply to SAIF's response, claimant's "Motion for Admission of New Discovery []" and proposed exhibits "X" and "XX", claimant's objection to SAFECO's motion for a briefing extension and motion to strike SAFECO's unsigned pleadings, the parties' correspondence regarding jurisdiction, claimant's motion for a briefing extension, SAFECO's response to claimant's motion for reconsideration and "Motion for Admission of New Discovery []," and claimant's reply to Safeco's response to claimant's motion for reconsideration and attached documents.[1]

We now proceed with our reconsideration.

Claimant moves to supplement the record with proposed Exhibits "X" and "XX," (Safeco's "Payment History Screen," with cover letter dated February 11, 1997, and Safeco's January 30, 1997 package of documents received since March, 1996, with index, dated January 30, 1997), and numerous documents attached to his April 21, 1997 "Reply to Safeco's March 31, 1997, including claimant's affidavit dated April 21, 1997. Safeco opposes claimant's motion to supplement the record.

We first note that we have no authority to consider any evidence not already included in the record. Consequently, we treat the motion to supplement the record as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985); see ORS 656.295(5). We may remand to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the post-hearing 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 Cain v. Woolley Enterprises, 301 Or 650, 654 (1986) (citing Compton v. Weyerhaeuser Co., 301 Or 641 (1986). We consider the disputed evidence only for the purpose of determining whether remand is appropriate.

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[1] There is no contention that these documents were not provided to all parties or that any party's opportunity to be heard on reconsideration was impaired by the form or timing of any submission. Under these circumstances, we deny claimant's motions to strike pleadings, arguments, and briefs. See Gilbert T. Hale, 43 Van Natta 2329, 2330 (1991) (Board is capable of disregarding unsupported assertions of fact).

The evidence submitted for the first time on reconsideration arises out of claimant's request for Safeco's payment records. Claimant contends that these documents are relevant to his request for penalties for late payment of medical bills allegedly for diagnostic medical services. However, as we explained in our initial order, claimant is not entitled to penalties based on medical services for noncompensable conditions. See Counts v. International Paper Company, 146 Or App 768 (1997). Moreover, after reviewing claimant's submissions, we cannot say that these documents establish Safeco's unreasonable conduct (or untimely payment) of bills related to claimant's compensable back strain and L4-5 condition.[2] Under these circumstances, we find that the post-hearing submissions are not reasonably likely to affect the outcome of the case. Accordingly, claimant's motion to remand for submission of additional evidence is denied.

Our initial order set aside Safeco's partial denial of claimant's injury claim for an L4-5 disc condition,[3] but upheld the remainder of the Safeco denials of claimant's claims for a low back condition (including his aggravation claim), because we found the medical evidence insufficient to establish that the condition is work-related or that the compensable L4-5 condition worsened.[4] Further, finding the evidence insufficient to establish that either Safeco or SAIF received notice of medically authorized time loss due the compensable condition, we concluded that no interim compensation is due under the claims. We also found penalties and sanctions inappropriate (other than the penalty conceded by Safeco), because there are no "amounts due" and Safeco's cross-request for review was neither frivolous nor filed for the purpose of harassment.

After reviewing and considering the parties' additional arguments, we conclude that the questions raised on reconsideration were adequately addressed by our initial order. Accordingly, we republish our January 31, 1997 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] "[I]f diagnostic services are necessary to determine the cause or extent of a compensable injury, the tests are compensable whether or not the condition that is discovered as a result of them is compensable." Counts at 771. In this case, however, there is no showing that the medical services referenced in claimant's submissions on reconsideration were necessary to determine the cause or extent of claimant's compensable injury. Consequently, even if these bills were paid late, they would not support a penalty.

[3] See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).

[4] We found no persuasive evidence that claimant's compensable L4-5 condition worsened pathologically or that any symptomatic worsening was greater than anticipated by the prior permanent disability award. See Order on Review, n. 11. On reconsideration, we continue to find that claimant has proven an aggravation claim, because he has not established that his compensable condition actually worsened. See SAIF v. Walker, 145 Or App 294 (1996).

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In the Matter of the Compensation of
**GEORGE SCHUKOW, Claimant**
Own Motion No. 95-0059M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's November 12, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from February 2, 1995 through November 7, 1996. SAIF declared claimant medically stationary as of November 7, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. In the alternative, claimant requests temporary disability compensation (TTD) through December 15, 1996 "and possibly longer."

Premature Claim Closure

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be

expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 12, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

SAIF closed claimant's claim on November 12, 1996. Claimant contends that, in late October 1996, he "filled out paperwork indicating that his treating physician (psychiatrist) was Dr. Telew." Claimant further contends that, at the time Dr. Fiallos declared him medically stationary, "Dr. Fiallos was not his treating physician and did not have the authority to make such a statement." Finally, contending that he was not copied with Dr. Telew's report, claimant requested that SAIF forward that report as well as "whatever form claimant filled out that indicating [sic] he was naming Dr. Telew as his attending physician, as well as Dr. Telew's chartnotes." We have received both physicians' reports, and are satisfied that SAIF has forwarded the same information to claimant in this matter.[1] Therefore, we will proceed with our review.

In a November 7, 1996 letter, Dr. Fiallos, psychiatrist treating claimant since June 1996, opined that claimant "has now reached a medically stable condition and I do not anticipate any great gains by continuing efforts and engagement in ongoing intensive psychotherapy." In a December 27, 1996 "Record of Telephone Conversation," SAIF's claims examiner noted that she had spoken with Dr. Telew on that date, and that Dr. Telew agreed that claimant was medically stable. In a March 31, 1997 handwritten response to SAIF's January 10, 1997 request for information regarding the status of claimant's psychological condition, Dr. Telew indicated that "I believe [claimant] was medically stationary many years prior to 1996." These opinions are unrebutted.

Claimant contends that, at the end of October 1996, he "filled out paperwork indicating that his treating physician (psychiatrist) was Dr. Telew." In an April 8, 1997 letter, SAIF stated that it had received no "change of attending physician" form since Dr. Fiallos assumed claimant's care on June 17, 1996. No other documentation has been received by the Board which would indicate that claimant applied for a change of attending physicians in October 1996, or that another physician had accepted claimant's care. Furthermore, although claimant contends that he was scheduled for examination by Dr. Telew on November 1, 1996, that appointment was apparently rescheduled to December 15, 1996, after SAIF closed his claim.[2] Therefore, assuming without deciding, that Dr. Telew became claimant's

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[1] In an April 2, 1997 letter, SAIF's claims examiner notified the Board that its closure in this claim was based on Dr. Fiallos' November 7, 1996 report and opinion. SAIF noted that, at the time of closure, Dr. Telew had verbally agreed with Dr. Fiallos' opinion, however, it did not obtain Dr. Telew's written concurrence "until recently." In an April 9, 1997 letter, SAIF's claims examiner responded to our April 4, 1997 and April 7, 1997 letters, in which we requested that SAIF forward a copy of Dr. Fiallos' report to the Board, and that SAIF copy claimant with "all information it considered in closing claimant's claim." In her April 9, 1997 letter, SAIF's claims examiner advised that claimant had been copied with all evidence SAIF considered in closing the claim. With her letter to the Board, the claims examiner enclosed a copy of Dr. Fiallos' report.

[2] There is no objective medical evidence in the record regarding claimant's current psychological condition. Furthermore, there is little medical evidence in the record which existed prior to and at claim closure, with the exception of Dr. Fiallos' opinion. Finally, Dr. Telew does not provide any report or objective test results which might establish that claimant was not medically stationary at claim closure. Therefore, Dr. Fiallos' opinion is persuasive, in that he was the only physician / psychiatrist to examine claimant at claim closure. Compare Richard Uhing, 48 Van Natta 465 (1996) (the claim closure set aside where, although the claimant changed his primary care physician subsequent to claim closure, surgery was recommended and pending prior to closure, and the Board concluded that the claimant's new physician's opinion included objective medical evidence that existed prior to claim closure).

treating physician in October 1996, Dr. Telew's opinion would not be pertinent to claimant's condition at the time of claim closure, because Dr. Telew did not examine claimant until after that time.

In any case, Dr. Fiallos, assumed claimant's care in June 1996, and examined claimant at claim closure. In his November 7, 1996 report, Dr. Fiallos noted that he had assumed claimant's care from Dr. Aflatooni (whose charts and records Dr. Fiallos had reviewed), and that he had "the opportunity to meet with [claimant] on four occasions." Dr. Fiallos opined that claimant should be placed on a regular schedule for "medication maintenance management," but with the provision "that if there is any crisis or acuity that [claimant] can be seen in a shorter period of time but in no way to restart endless ongoing psychotherapy which is not proving fruitful at this point."

In his March 31, 1997 opinion, Dr. Telew indicated that he agreed with Dr. Fiallos' opinion that claimant was medically stationary. In fact, Dr. Telew opined that claimant was medically stationary many years prior to 1996. Thus, regardless of whether Dr. Telew was officially claimant's treating physician on November 12, 1996, he supports Dr. Fiallos' opinion that claimant was medically stationary at claim closure. Thus, we are persuaded by Dr. Fiallos' opinion, as supported by Dr. Telew's opinion, that claimant was medically stationary on the date SAIF closed his claim. Weiland v. SAIF, 64 Or App at 810; Somers v. SAIF, 77 Or App at 259.

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

Entitlement to Temporary Disability Compensation

Claimant contends that he is entitled to further temporary disability compensation in this claim. Claimant's entitlement to substantive temporary disability compensation ended on November 7, 1996, the date SAIF declared him medically stationary. SAIF paid claimant time loss benefits through November 7, 1996. Furthermore, the Board is without authority to create an administrative "overpayment" by awarding temporary disability between the medically stationary date and the date SAIF closed the claim. We have concluded that SAIF's closure was proper. Therefore, we find that no further temporary disability compensation is due. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

Accordingly, we affirm SAIF's November 12, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JOHN K. WILBUR, Claimant**
WCB Case No. C700730
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On March 24, 1995, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

The proposed agreement provides that, "[i]n consideration of a partial release by [the insurer] of its statutory share in the amount of $2,500 claimant releases all rights to all workers' compensation benefits allowed by law . . ." Pg. 2, no. 12. By letter of April 3, 1997, we requested an addendum to provide the amount of the third party settlement. See, Kenneth Hoag, 43 Van Natta 991 (1991) (Board generally disapproves CDAs in which the consideration consists of the carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and/or the amount of the carrier's lien).

The parties have not submitted the requested addendum within the 21-day time period, as required by OAR 438-009-0020(4)(a). Under the circumstances, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-009-0020(4)(b). Accordingly, we disapprove the agreement.[1]

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-150(5)(k) and (7)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

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[1] In light of this decision, we need not address the question of whether claimant's counsel's April 23, 1997 letter withdrawing the CDA was timely submitted to the Board.

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In the Matter of the Compensation of
**KRYZSZTOF ZIELINSKI, Claimant**
WCB Case No. C700845
ORDER OF ABATEMENT
Richard F. McGinty, Claimant Attorney
Lundeen, et al, Defense Attorneys

On April 22, 1997, we issued an order approving the parties' claim disposition agreement (CDA) in the above-captioned matter. On April 28, 1997, we received claimant's timely request for abatement and reconsideration of our order. We withdraw our prior order for further consideration.

In approving the parties' CDA, we noted that claimant settled his third party action for a total of $65,000 ($55,000 plus an additional $10,000 payable directly to the workers' compensation insurer from the third party insurer in satisfaction of the workers' compensation insurer's $24,200 lien). In light of such circumstances, we reasoned that the $14,200 reduction in the workers' compensation insurer's third party lien represented the total consideration for the disposition. Finally, since the body of the CDA provided that claimant's counsel's attorney fee was payable from the third party settlement, we determined that, contrary to the summary page of the CDA, no attorney fee was payable from the CDA; i.e., the $14,200 reduction in the workers' compensation insurer's third party lien.

With his motion for reconsideration, claimant has submitted an addendum to the CDA which has been signed by the parties and provides: "Claimant's attorney shall receive an attorney fee from the third party settlement **and $4875 from the new money ($30,000.00) portion of this Claims Disposition Agreement**. No fee is to be taken from the additional $10,000.00 paid by [the third party insurer] to [the insurer]." (Emphasis in original).

Notwithstanding the addendum's reference to $30,000 in "new money," we do not consider funds flowing from the third party insurer to claimant as "consideration" for the release of his workers' compensation rights. Rather, as previously explained, we continue to construe the total consideration for the CDA to be the workers' compensation insurer's waiver of $14,200 of its $24,200 statutory third party lien.

Based on such an interpretation, in the absence of extraordinary circumstances, the maximum attorney fee allowed by OAR 438-015-0052(1) would be $3,295; i.e., 25 percent of the first $12,500 and 10 percent of the remaining $1,700. Yet, the parties' proposed addendum provides for an attorney fee of $4,875, payable out of the CDA consideration.

Lacking the parties' express representation of the extraordinary circumstances justifying the proposed attorney fee, the CDA as presently amended cannot receive our approval. To assist us in proceeding with our further review, the parties are requested to submit a further revised CDA which details the circumstances surrounding the settlement of claimant's third party claim and his counsel's efforts in negotiating that agreement, as well as the CDA. Such circumstances would necessarily include the amount of claimant's counsel's fee arising from the third party settlement and further clarification of the term "new money."

On our receipt of a supplemented addendum (signed by claimant, his counsel, and the insurer's counsel), we shall proceed with our further consideration of the amended CDA. Pending receipt of that amendment, our prior order shall remain abated.

IT IS SO ORDERED.

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May 5, 1997 Cite as 49 Van Natta 576 (1997)

In the Matter of the Compensation of
**DIANE M. VERGARA, Claimant**
WCB Case No. 96-04051
ORDER ON REVIEW
Gayle A. Shields, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Schultz's order that set aside its denial of claimant's right wrist condition. Claimant cross-requests review of that portion of the ALJ's order that admitted a medical report generated from a "post-denial" insurer-arranged medical examination (IME). On review, the issues are evidence and compensability.

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

In March 1996, the employer denied compensability of right carpal tunnel syndrome (CTS). Claimant requested a hearing. In mid July 1996, claimant was notified of an IME with Dr. Nye, hand surgeon, scheduled for July 23, 1996, two days before the hearing. Claimant filed a motion with the ALJ to "quash" the IME notice, arguing that claimant was not statutorily required to attend the examination. The ALJ denied the motion.

At hearing, claimant objected to the admission of Dr. Nye's report, again arguing that she should not have been compelled to attend the IME. The ALJ also denied this motion and admitted the report into evidence. On review, claimant continues to challenge the admissibility of Dr. Nye's report and the ALJ's ruling that she was required to attend the IME.

We agree with the ALJ that claimant's treating physician, Dr. Puziss, provided the most persuasive opinion concerning the cause of claimant's right wrist condition. We also agree that, based on Dr. Puziss' opinion, claimant carried her burden of proof, whether that standard is material or major contributing cause. ORS 656.005(7)(a), 656.005(7)(a)(B). Consequently, the outcome of the case is the same whether or not the ALJ erred in admitting Dr. Nye's report or denying claimant's motion to "quash" the IME notice. Therefore, we conclude that any error was harmless and we decline to resolve the propriety of the ALJ's rulings.

Claimant's attorney is entitled to an assessed fee for services on review concerning the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding 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.

ORDER

The ALJ's order dated October 30, 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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May 5, 1997 Cite as 49 Van Natta 577 (1997)

In the Matter of the Compensation of
**MICHELLE ZAMARRON, Claimant**
Own Motion No. 97-0133M
OWN MOTION ORDER
Richard F. McGinty, Claimant Attorney
Liberty Northwest, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for her compensable low back strain with disc bulge herniation at L3-4, L4-5 and L5-S1, resulting in L5 laminectomy, L4-5 discectomy and lumbosacral discectomy. Claimant's aggravation rights expired on March 24, 1994. The insurer opposes reopening the claim on the ground 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 August 5, 1996, claimant was admitted to the hospital for placement of an epidural catheter. Claimant was discharged on August 13, 1996. Thus, we conclude that claimant's compensable injury worsened requiring hospitalization.

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

The insurer contends that claimant was not in the work force at the time of disability. Claimant contends that she qualifies for temporary disability compensation because she was participating in a rehabilitation program, and was receiving Aid to Families with Dependent Children (AFDC) assistance at the time of disability. Claimant has the burden of proof on this issue, and must provide persuasive evidence that she was in the work force at the time of disability.

Claimant provided an AFDC Responsibility Agreement dated December 12, 1995. The agreement, between claimant and AFDC, states that "[e]ach adult member of [claimant's] household who gets cash assistance must participate in work search activities as required." The agreement further requires that the Texas Department of Human Services assist claimant in becoming self-sufficient by "[p]roviding help in finding employment and necessary support services within available resources."

In an April 19, 1996 letter, Mr. Isabel, vocational rehabilitation counselor, stated that claimant "is an active client with the Texas Rehabilitation Commission, as a disabled individual." In an Individualized Written Rehabilitation Report dated April 19, 1996, Mr. Isabel approved vocational training services, including job application training, interview training, job seeking skills training, and resume training. Claimant's training was approved from April 1996 through October 1996. Claimant submitted a job application record, in which she asserted that she made applications with various companies in May and June 1996. In that application record, claimant further contended that she

worked with YGS Placement Service, and applied for jobs to which she was referred. Finally, claimant asserts that, in order to receive welfare assistance, she was required to volunteer 20 hours per week with the JOBS program.[1]

We have previously held that a claimant who qualifies for "unemployment" benefits has met the second criterion of the Dawkins standards listed above, in that the receipt of unemployment benefits establishes *prima facie* evidence that the claimant was willing to work and was making reasonable efforts to obtain employment. See Carol L. Conaway, 43 Van Natta 2267 (1991); John T. Seiber, 43 Van Natta 136 (1991). In that respect, an analogous conclusion could be drawn with respect to the "willing and seeking" requirements for receipt of AFDC assistance. Here, in order to qualify for AFDC benefits, claimant was required to establish that she was seeking work. See Carol L Conaway, 43 Van Natta at 2267. Claimant further meets the "willingness" requirement by actively participating in a vocational rehabilitation program, and through her volunteer work with the JOBS program.[2] Because she was willing to receive training in the skill areas of interviewing and resume-writing, we are further persuaded that she was willing to work. Finally, claimant's active participation in the vocational rehabilitation persuades us that she did not voluntarily withdraw from the work force.[3] See Gilbert R. Brown, 43 Van Natta 585 (1991); Dennis G. Hanson, 48 Van Natta 1071 (1996). Rather, we are persuaded that, through her cooperation with her vocational rehabilitation program, and by contacting various employers and meeting the requirements for AFDC assistance, claimant was willing to work and seeking work at the time of disability.

On this record, we conclude that claimant has established that she 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 August 5, 1996, the date she was hospitalized for treatment of her compensable condition. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] Although claimant stated that she was a "volunteer with [the] JOBS program 20 hours per week," we have previously found that "volunteer work" is not gainful employment. See Linda K. Misner-Wertz, 46 Van Natta 124 (1994); Danell L. Sweisberger, 44 Van Natta 913 (1992). However, we have found that other types of "work" which do not qualify as "wage earning," can serve to demonstrate a willingness to work, which, when combined with evidence that a claimant was either seeking work or that a work search was futile because of a compensable injury, may establish that a claimant was in the work force. See e. g., Bonnie Ozment, 46 Van Natta 80 (1994) (the claimant established that foster parenting demonstrated a willingness to work, however she failed to establish that she was employed or seeking employment at the time of disability).

[2] We reiterate that, although "volunteer work" is not considered employment insofar as it pertains to remuneration for services rendered, we do consider volunteer work to be an indicator of a claimant's "willingness" to work. See Stephen v. Oregon Shipyards, 115 Or App 521 (1992); Arthur R. Morris, 42 Van Natta 2820 (1990; Linda K. Misner-Wertz, 46 Van Natta at 124; Bonnie Ozment, 46 Van Natta 80 (1994).

[3] In contrast to the circumstances presented here, we have previously found that a claimant who was provided with vocational rehabilitation services, but who did not cooperate by actively participating or seeking work, did not establish a willingness to seek work. See Marlene J. Andre, 48 Van Natta 404 (1996); Katherine L. Hunt, 45 Van Natta 1166 (1993).

In the Matter of the Compensation of
**ROBERT H. HANNAH, Claimant**
WCB Case No. 96-06195
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members en banc.

EBI Companies requests review of Administrative Law Judge (ALJ) McWilliams' order that awarded claimant's counsel an insurer-paid attorney fee under ORS 656.308(2)(d) when EBI rescinded its responsibility denial prior to hearing and accepted claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is claimant's entitlement to an attorney fee award under ORS 656.308(2)(d).[1] We affirm.

## FINDINGS OF FACT

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

Claimant was simultaneously employed by two employers, one insured by EBI and the other by Lumbermens Mutual Casualty Company (Lumbermens). He was diagnosed with bilateral carpal tunnel syndrome (CTS) in April 1996, and filed claims against EBI and Lumbermens. By letter dated May 20, 1996, Lumbermens denied the claim on grounds that the CTS is not related to employment with its insured and that another employer may be responsible for the condition. The following day, claimant retained counsel to represent him in this matter.

By letter dated June 20, 1996, EBI denied the claim on grounds that the CTS condition was caused by work exposure prior to employment with its insured. EBI subsequently requested designation of a paying agent under ORS 656.307.

On July 3, 1996, claimant's counsel filed a hearing request contesting EBI's June 20 denial, raising issues of compensability and responsibility. (WCB Case No. 96-06195). The same day, claimant's counsel also filed a hearing request contesting Lumbermens' May 20 denial, raising issues of compensability and responsibility.[2] (WCB Case No. 96-06196). The cases were consolidated, and a hearing was scheduled for September 18, 1996.

Claimant's counsel requested medical and claim documents from EBI, corresponded with claimant on numerous occasions, and responded to EBI's attorney's request for a list of claimant's past treating physicians.

Meanwhile, at EBI's request, claimant was examined by hand specialist, Dr. Jewell. Claimant's counsel prepared his client for the examination. Based on the examination, Dr. Jewell issued a report on July 29, 1996 opining that claimant's work exposure with EBI's insured contributed more to the progression of CTS than his exposure with Lumbermens' insured.

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[1] On review, the parties' briefs also address claimant's entitlement to an insurer-paid fee under ORS 656.386(1). In closing arguments before the ALJ, however, claimant narrowly framed the "sole" issue as his "entitlement to an assessed attorney fee pursuant to ORS 656.308(2)(d)." Therefore, we decline to address any other statutory basis for an attorney fee. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

[2] This finding of fact is based on our review of the hearings file in WCB Case No. 96-06196, which was originally consolidated with this case but was dismissed by a separate order. Though we generally lack authority to consider evidence that was not admitted into the record at hearing, see ORS 656.295(5), we may take official notice of any fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2). Here, we find that the hearings file in WCB Case No. 96-06196 is an unquestionably accurate source for determining procedural facts regarding the filing and disposition of claimant's hearing request concerning Lumbermens' denial. See, e.g., Susan K. Teeters, 40 Van Natta 1115 (1988) (Board held it was proper to take official notice of a hearing request where it had only procedural significance).

Claimant's counsel verbally assured Lumbermens' attorney that the hearing request from Lumbermens' denial would be withdrawn upon EBI's acceptance of the claim. On August 19, 1996, EBI accepted the claim for bilateral CTS. Subsequently, by letter dated September 17, 1996, claimant's counsel withdrew the hearing request concerning Lumbermens' denial in WCB Case No. 96-06196, and that case was dismissed by the ALJ on October 8, 1996.[3]

Meanwhile, claimant and EBI proceeded with closing arguments on the issue of claimant's entitlement to an attorney fee under ORS 656.308(2)(d). The attorney fee issue is the subject of this review.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's counsel is entitled to an insurer-paid attorney fee of $1,000 for prevailing against EBI's responsibility denial. On review, EBI contends that claimant did not prove the requisite elements for entitlement to an attorney fee under ORS 656.308(2)(d), which provides:

> "Notwithstanding [statutory provisions not applicable to this case], a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

EBI argues that: (1) claimant's counsel did not make an "appearance" because no hearing was convened in this matter; and (2) counsel did not "actively and meaningfully participate" because he did not advocate that a particular insurer should be responsible for the claim. We disagree and affirm the attorney fee award.

In interpreting a statute, our first task is to discern the legislature's intent. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). In attempting to discern the intent of the legislature, the first level of analysis is to examine the text and context of the statute. Id. at 610-11. The context of the statute includes other provisions of the same statute and other related statutes. Id. at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. Id.

Here, the statutes do not define the term "appearance." However, from our reading of ORS 656.308(2)(d), we find no requirement that the claimant's attorney appear at a "hearing" in order to qualify for an attorney fee. In fact, the statute does not mention a "hearing" as a prerequisite for an attorney fee. In the context of ORS 656.308(2)(d), the term "appearance" is a legal term. "Appearance by attorney" is defined as "[a]n act of an attorney in prosecuting an action on behalf of his client." Black's Law Dictionary 50 (Abr. 5th ed 1983). Here, claimant's attorney's filing of hearing requests concerning the carriers' denials was an act of prosecuting an action on behalf of his client. Accordingly, we agree with the ALJ's finding that claimant's attorney made an "appearance" within the meaning of ORS 656.308(2)(d).

The statutes also do not define the term "meaningful." Therefore, we turn to the statutory context. Another statute, ORS 656.307(5), also uses the term "meaningful participation" as a prerequisite for an insurer-paid attorney fee in the responsibility context. ORS 656.307(5) authorizes an insurer-paid attorney fee if a claimant's counsel "actively and meaningfully participates" in a responsibility proceeding involving multiple insurers or employers, where a paying agent has been designated.[4] In Keenon v. Employers Overload, 114 Or App 344 (1992), the court stated:

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[3] See supra n 2.

[4] ORS 656.307(5) provides, in relevant part:

"If the claimant appears at any such proceeding [concerning responsibility under ORS 656.307] and actively and meaningfully participates through an attorney, the [ALJ] may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the [ALJ] to be the party responsible for paying the claim."

ORS 656.307 does not apply to this claim because a paying agent was not designated.

> "Unless a claimant has a material, substantial interest in deciding who is the responsible party and takes a position advocating that interest, participation by the claimant's attorney, even if helpful to the arbitrator[5], would be meaningless to the claimant. Because claimant did not advocate that a particular employer is the responsible party, his participation was not 'meaningful'...." Id. at 347.

In Darrell W. Vinson, 47 Van Natta 356 (1995), we considered the quoted language from Keenon and further clarified the use of the term "meaningful" in ORS 656.307(5):

> "[I]t is the 'significance' or 'purpose' of counsel's participation that determines its meaningfulness, not the ultimate result of the arbitration proceeding. Given counsel's duty to protect and advance the interests of his client, we believe that the 'significance' or 'purpose' of counsel's participation in the arbitration proceeding must be viewed in the light of his client's best interests. That is, where counsel takes a position that, if adopted, would advance the interests of his client, it can safely be said that counsel's participation has 'significance' and 'purpose' and, therefore, has meaning. The fact that counsel's position does not ultimately prevail does not render his participation meaningless, although that fact may be considered in determining the amount of the fee award." Id. at 359. (Emphases in original.)

Thus, to prove "meaningful" participation under ORS 656.307(5), counsel must take a position, based on a "material, substantial interest" of the claimant, which advocates that a particular insurer or employer is the responsible party. See Shelley C. Nikolaus, 48 Van Natta 750 (1996) (counsel advocating that responsibility should be assigned to claim with longer aggravation rights is meaningful participation); Michael J. Joseph, 47 Van Natta 2043, 2050 (1995) (counsel advocating that responsibility should be assigned to claim with higher temporary total disability rate is meaningful participation). Viewing ORS 656.307(5) as the context for interpretation of the term "meaningful" in ORS 656.308(2)(d), we conclude that entitlement to a "308(2)(d)" attorney fee also requires that counsel take a position, based on a "material, substantial" interest of the claimant, which advocates that a particular employer or insurer is the responsible party. Absent the taking of a position, counsel's participation, though active, is not "meaningful." See Harley J. Gordineer, 48 Van Natta 80 (1996); Paul R. Huddleston, 48 Van Natta 4, recon 48 Van Natta 203 (1996).

Turning to the merits of this case, we find that claimant's counsel effectively took a position advocating that EBI was responsible for claimant's CTS condition. Counsel began by filing hearing requests contesting both insurers' denials, thus protecting claimant's right to compensation from either insurer. Counsel requested medical and claim documents from EBI, corresponded with claimant on numerous occasions and responded to EBI's attorney's request for a list of claimant's past treating physicians. Counsel also prepared claimant for the insurer-arranged medical examination by Dr. Jewell. As a result of that examination, Dr. Jewell issued a report stating that, as between claimant's employment exposures with Lumbermens' insured and EBI's insured, the exposure with EBI's insured was more injurious in advancing claimant's CTS condition. (Ex. 19-4).

Claimant's counsel represents that he verbally assured Lumbermens' attorney on several occasions that, upon acceptance of the claim by EBI, the hearing request concerning Lumbermens' denial would be dismissed. EBI does not dispute counsel's representation. We are persuaded, therefore, that claimant's counsel took the position that EBI is the responsible insurer. Furthermore, based on records showing that claimant's temporary total disability rate is higher under the EBI claim than it would have been under the Lumbermens claim, (Exs. 9, 16), we are persuaded that counsel's position protected and advanced claimant's material interest in receiving maximum benefits for his condition.

Finally, we acknowledge that claimant's counsel's position was not documented on the hearing "record." However, inasmuch as a hearing was not convened in this matter, we look to pre-hearing pleadings and negotiations for evidence that claimant's counsel advocated a position regarding the responsibility issue. In that context, counsel's verbal assurances to Lumbermens' attorney that the appeal of Lumbermens' denial would be withdrawn upon EBI's acceptance of the claim, rose to the level of advocacy required to be "meaningful" under ORS 656.308(2)(d). Accordingly, we affirm the ALJ's fee award.

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[5] At the time Keenon was decided, responsibility disputes were resolved by arbitration under former ORS 656.307.

Inasmuch as attorney fees are not compensation, claimant's attorney is not entitled to an assessed fee for services on review defending the ALJ's attorney fee award. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated November 9, 1996 is affirmed.

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May 6, 1997 Cite as 49 Van Natta 582 (1997)

In the Matter of the Compensation of
**CORDELL R. SOULE, Claimant**
WCB Case No. 96-06533
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside the SAIF Corporation's denial of claimant's current low back condition. On review, the issue is compensability.

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

Claimant has an accepted 1977 claim for lumbar strain. A 1978 Determination Order awarded 5 percent unscheduled permanent disability. After the claim reopened in 1978, a 1980 Determination Order awarded only temporary disability. A subsequent Stipulated Order, however, awarded claimant an additional 10 percent unscheduled permanent disability.

In June 1996, SAIF denied compensation for spondylolisthesis and spina bifida oculta. Citing ORS 656.225, the ALJ upheld the denial. The ALJ further concluded that SAIF was not precluded from denying the conditions by Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).

Claimant's treating osteopath, Dr. Luke, reported that claimant's current low back pain "is an exacerbation of the original injury on 10/07/77." (Ex. 21).

Examining orthopedic surgeon, Dr. Shapiro, described claimant's 1977 injury as "a lumbosacral strain superimposed upon his underlying spondylolisthesis." (Ex. 24-5). Dr. Shapiro further reported that "the spondylolisthesis is the major problem, as far as the ongoing duration of [claimant's] symptoms" and the 1977 strain would have resolved. (Id.)

Examining neurologist, Dr. Mayron, diagnosed "bilateral chronic sacroiliitis" and was "not convinced" that the spondylolisthesis contributed to claimant's current condition. (Ex. 26-4). Dr. Mayron subsequently indicated that claimant's 1977 injury was a material contributing cause to claimant's current low back condition. (Ex. 28).

Finally, consulting surgeon, Dr. Colley, indicated that claimant's 1977 injury was the major contributing cause of his current need for treatment. (Ex. 27). Dr. Colley subsequently expressed disagreement with Dr. Shapiro's opinion, stating that Dr. Colley could not "conclusively agree with [Dr. Shapiro's] assessment that [claimant's] current condition and need for treatment are due to his pre-existing condition." (Ex. 29).

Although the record shows that the accepted injury is a material contributing cause of claimant's current need for treatment, (Exs. 21, 28), only Dr. Colley indicated that the accepted condition was the major contributing cause of the need for treatment of the combined condition. We agree with the ALJ, however, that the complete absence of explanation why the 1977 compensable injury is the major contributing cause greatly reduces the persuasiveness of Dr. Colley's opinion. See Somers v. SAIF, 77

Or App 259 (1986). Thus, we find Dr. Colley's opinion to be no more persuasive than the remaining medical evidence and, consequently, the medical opinions are in equipoise. Therefore, we conclude that claimant did not carry his burden of proving compensability of his current low back condition.

ORDER

The ALJ's order dated November 5, 1996 is affirmed.

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May 7, 1997 Cite as 49 Van Natta 583 (1997)

In the Matter of the Compensation of
**DAN A. STURTEVANT, Claimant**
WCB Case No. 96-05158
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Stoel Rives LLP, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's occupational disease claim for osteoarthritis of the lumbosacral spine and left L5-S1 foraminal stenosis. No briefs were filed on review. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Because the employer initiated Board review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel may be entitled to an assessed fee under ORS 656.382(2). No respondent's brief was filed on review; however, claimant's counsel wrote a letter advising that claimant would not be filing a respondent's brief and that the Board should proceed with its review based on the record. Claimant's counsel's letter shows that "legal representation" services were rendered on Board review. Therefore, claimant's counsel is entitled to an assessed fee. See Shirley M. Brown, 40 Van Natta 879, 882 (1988) (counsel may provide "legal representation" short of filing a brief to warrant an assessed fee award on Board review). 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 services on review is $150, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response letter), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 29, 1996 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $150, to be paid by the self-insured employer.

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In the Matter of the Compensation of
**ELVIA H. HILLNER, Claimant**
WCB Case No. 96-11311
SECOND ORDER DENYING MOTION TO DISMISS
Moscato, Skopil, et al, Defense Attorneys

On May 1, 1997, we denied the self-insured employer's motion to dismiss claimant's request for Board review. We have now received the employer's "reply" to claimant's response to the employer's dismissal motion. In light of such circumstances, we interpret the employer's recent submission as a motion for reconsideration of our May 1, 1997 order.

As noted in our prior order, claimant has requested Board review of an Administrative Law Judge's (ALJ's) order which dismissed claimant's hearing request. The ALJ's dismissal order issued in response to claimant's attorney's letter withdrawing claimant's hearing request. Because claimant's hearing request had been withdrawn, the employer asserted that we lacked appellate jurisdiction to review the ALJ's order. We disagreed. Finding that claimant timely appealed the ALJ's order, we concluded that we are authorized to examine the propriety of the ALJ's decision to dismiss claimant's hearing request. In reaching our conclusion, we relied on ORS 656.289(3), ORS 656.295(2), Mike D. Sullivan, 45 Van Natta 990 (1993), and Donald L. Lowe, 41 Van Natta 1873 (1989).

In its reply, the employer contends that any confusion or disagreement claimant may have concerning her counsel's withdrawal of her hearing request are not adequate grounds for altering the ALJ's dismissal order. In support of this assertion, the employer cites Gilbert O. Garcia-Ortega, 48 Van Natta 2201 (1996).

As with the employer's previous citation to Karen D. Maloney, 47 Van Natta 436 (1995), the Garcia-Ortega holding does not stand for the proposition that we lack appellate review authority to consider a timely appeal of an ALJ's dismissal order. To the contrary, as with Maloney, the Garcia-Ortega decision is inapposite to the employer's contention because the propriety of the ALJ's dismissal order was likewise addressed in Garcia-Ortega.

In conclusion, the Garcia-Ortega rationale may eventually prove to be applicable to the substantive question of whether the ALJ properly dismissed claimant's hearing request. Nonetheless, since claimant has timely and properly requested Board review of the ALJ's order, resolution of that substantive question must await completion of the parties' briefing schedule and our formal review.

Accordingly, on reconsideration, as supplemented herein, we republish our May 1, 1997 order denying the employer's motion to dismiss. In light of these circumstances, the briefing schedule shall again be revised. Since claimant has already submitted her appellant's brief (her written argument explaining why she disagrees with the ALJ's decision), the employer's respondent's brief shall be due 21 days after the mailing date of this order.[1] Claimant's reply brief shall be due 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] Enclosed with the employer's copy of this order are copies of claimant's April 28, 1997 letter and accompanying submissions. For future reference, claimant is reminded to also send copies of any written materials submitted to the Board to the employer's attorney.

In the Matter of the Compensation of
**MIR ILIAIFAR, Claimant**
WCB Case No. 96-05052
ORDER ON RECONSIDERATION
Rex Q. Smith, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our April 17, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which set aside the SAIF Corporation's denial of his low back injury claim. Specifically, claimant argues that we erred in concluding that his injury did not occur within the course and scope of his employment, where he was injured in an automobile accident while driving to the employer's premises in a "demonstrator" vehicle furnished by his employer to deliver a physician's "off-work" authorization.

On reconsideration, claimant raises several "assignments of error." In his first and second points, claimant argues that he was acting in furtherance of the employer's business (and therefore within the "special errand" exception to the "going and coming rule") because (1) he was injured while driving the "demonstrator" vehicle to the employer's premises and (2) the employer had an interest in seeing him in person to determine his condition when he had a physician's authorization to be off work.

In our prior order, we expressly concluded that these facts did not render claimant's injury per se compensable. We explained that claimant was not acting in furtherance of the employer's *business* (the sale of automobiles) nor was he acting on the employer's behalf at the time he was injured. We found that claimant made the trip primarily for his own benefit; i.e., to secure his entitlement to continued temporary disability benefits. We also noted that claimant was not under the employer's control at the time of his injury. Although claimant was driving a "demonstrator" vehicle furnished by the employer, claimant had been released from work and the employer did not control the time, manner of travel, or route to be taken on this particular trip to the employer's premises.[1]

In his third assignment of error, claimant challenges our determination that the "special errand" exception did not apply because he was not traveling to the employer's premises to perform work. In the order, we found it significant that claimant was already on a medically-approved release from work at the time of his injury. We held that in order for the "going and coming" rule and the "special errand" exception to apply, the worker must be going from or coming to "work" (as in the performance of services for which he or she is compensated) and must be injured while performing (or proceeding to perform) a special task or mission for the employer. We declined to apply the "special errand" exception by analogy because we found no Oregon cases to support such an approach. We were also mindful of the Oregon Supreme Court's "traditionally narrow approach" to applying the exceptions to the going and coming rule. See Krushwitz v. McDonald's Restaurants, 323 Or 520, 529 (1996). On reconsideration, we continue to find that the "special errand" exception to the going and coming rule is inapplicable to the circumstances of this case.

We further conclude that the remaining "assignments of error" set forth in claimant's request for reconsideration were adequately addressed in our prior order.

In conclusion, we adhere to our determination that claimant's December 29, 1995 injury did not occur within the course and scope of his employment. Accordingly, our April 17, 1997 order is withdrawn. On reconsideration, as supplemented above, we republish our April 17, 1997 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] There was no evidence that claimant was a "traveling employee" or that travel was a part of his service to the employer.

In the Matter of the Compensation of
**LAWRENCE B. HOWARD, Claimant**
WCB Case No. 95-10028
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's L5-S1 disc condition. On review, the issue is compensability.

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

On review, claimant argues that the ALJ erred by stating that claimant's family physician, Dr. Anderson, had submitted only one report. Claimant contends that, on page 3 of the Opinion and Order, the ALJ mistakenly referred to a medical opinion as "Exhibit 22A," which was authored by Dr. Miller. Claimant argues that the exhibit referenced by the ALJ is actually Exhibit 22B, and was generated by Dr. Anderson.

After reviewing the record, we agree with claimant that the Opinion and Order contains an incorrect reference. The exhibit described is actually Exhibit 22B, which is a chartnote written by Dr. Anderson, rather than Dr. Miller. Accordingly, we modify the ALJ's Findings of Fact to reflect that correction.

With respect to the merits of the case, claimant argues that the dispositive issue is whether the incident of June 6, 1995 (claimant's operation of a dumpster door at work) was a heavy or significant incident which involved pulling and twisting. Claimant argues that under such circumstances, compensability is established, as Dr. Miller agreed that such "torquing" action could have independently caused the disc to herniate.

After reviewing the record, we conclude that the contemporaneous evidence does not support a finding that claimant's activity on June 6, 1995 involved a heavy or significant torquing or lifting incident.[1] For example, on the day of the incident, claimant gave a history of closing the dumpster door and "he twisted slightly as the door came closed." (Ex. 2). Also see Exs. 5-2, 6, 7.

Accordingly, we agree with the ALJ that the record does not establish that a "significant" event occurred on the date in question. Under the circumstances, the medical evidence does not support compensability of the herniated disc. We, therefore, affirm the ALJ's order.

ORDER

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

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[1] After reviewing claimant's testimony regarding the incident, we find it to be equivocal. For example, claimant first testified that the kind of exertion he used to close the dumpster was "about medium force." (Tr 16). However, claimant then agreed that the force needed would be "excessive," as the doors were "pretty heavy." (Tr. 16). Other witnesses testified that the doors did not require a lot of stress or strain on the arms or back when they were being opened. (Tr. 27, 35, 36). Accordingly, in light of the inconsistent nature of the testimony, we are more persuaded by the contemporaneous medical histories which describe the incident.

In the Matter of the Compensation of
**DAVID D. INFAUSTO, Claimant**
WCB Case No. 96-00293
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) awarded additional temporary partial disability compensation from January 1, 1994 to July 21, 1995; and (2) awarded 5 percent (16 degrees) unscheduled permanent disability for claimant's tinnitus condition, whereas the Order on Reconsideration awarded no permanent disability. On review, the issues are temporary disability and extent of unscheduled permanent disability. We modify in part and reverse in part.

## FINDINGS OF FACT

On April 19, 1993, claimant began work as a truck driver with the employer. (Ex. A-5). In June 1993, claimant experienced the onset of a compensable tinnitus condition. (Ex. 1). Claimant was treated by Dr. Egan, otolaryngologist; Dr. Black, otologist; and Dr. Lilly, audiologist.[1] Dr. Black released claimant to regular work on October 26, 1993. (Exs. 3, 9). On November 17, 1993, Dr. Hodgson, otologist, evaluated claimant's hearing loss and tinnitus conditions for the employer. (Id.).

On January 14, 1994, claimant sought treatment for his tinnitus condition from Dr. McMenomey, Assistant Professor of Otolaryngology at Oregon Health Sciences University. (Exs. AA, A-9). The insurer issued an August 22, 1995 Notice of Closure (with September 21, 1995 and October 5, 1995 corrections not relevant to this case), which declared claimant medically stationary on July 21, 1995, awarded temporary partial disability benefits from August 20, 1993 through October 26, 1993, and no permanent partial disability benefits. (Ex. 3).

On October 20, 1995, claimant requested reconsideration, raising issues of temporary and permanent disability. (Ex. 9). Dr. Mettler performed an arbiter examination on November 21, 1995. (Ex. 8). A January 3, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects. Claimant requested a hearing on the Order on Reconsideration, raising the same issues.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability

Relying on Dr. McMenomey's October 24, 1995 opinion that noise claimant experienced in trucks prevented him from working as a truck driver from the time his tinnitus condition began, the ALJ concluded that claimant had established entitlement to additional temporary disability benefits from January 1, 1994 to July 21, 1995. On review, the insurer argues that claimant is not entitled to additional temporary disability compensation because he failed to prove he was disabled as a result of the compensable injury. Specifically, the insurer contends that Dr. McMenomey attributed some of claimant's tinnitus to a noncompensable sensorineural hearing loss. Alternatively, the insurer argues that, because claimant was medically stationary on June 24, 1994, the ALJ erred in awarding temporary disability beyond that date.[2] Claimant contends that he is entitled to temporary disability compensation from August 20, 1993 through July 21, 1995.

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[1] The record contains no medical reports from Drs. Egan, Black or Lilly.

[2] The insurer also requests remand, alleging that the ALJ failed to properly explain his application of the law to the facts regarding the temporary disability issue. Application of the correct law is a fundamental element of the Board's deliberative process which need not be expressly raised by the parties. E.g., John E. Means, 43 Van Natta 2331 (1991). We accordingly decline to remand in this case.

We begin with claimant's assertion that he should receive temporary disability compensation from August 20, 1993 through July 21, 1995.[3] We agree, based on the following rationale.

Inasmuch as claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits, Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992), which is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that claimant was at least partially disabled due to the compensable injury before being declared medically stationary. ORS 656.210; 656.212; Kenneth P. Bundy, 48 Van Natta 2501 (1996) (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); see also SAIF v. Taylor, 126 Or App 658 (1994); Esther C. Albertson, 44 Van Natta 521, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992).

In his October 24, 1995 letter, Dr. McMenomey, claimant's treating otolaryngologist, stated that the level of noise claimant experienced in the trucks prevented him from working as a truck driver from the time that the tinnitus began. (Ex. 4A-4). We generally 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 no persuasive reasons to do otherwise.

Claimant first sought treatment for tinnitus in June 1993, about six weeks after being assigned an extremely noisy truck as his permanent vehicle. (Exs. A-57, -64). Claimant complained of increased tinnitus symptoms, particularly after driving a truck all day. He also experienced increased symptoms when he wore earplugs. (Ex. A-52 through -58). Claimant was partially disabled from his regular work as a truck driver due to his compensable tinnitus condition beginning August 20, 1993. (Exs. 3, 4, 5). On October 26, 1993, claimant was released to regular work. On November 8, 1993, claimant was laid off by the employer.

On November 17, 1993, Dr. Hodgson, who examined claimant for the insurer, opined that claimant could return to his regular work with hearing protection, although he might experience annoying symptoms. Dr. Hodgson also commented that, if loud noise is "aggravating to [claimant's] ringing [tinnitus], then a different truck should be used." (Ex. A-66).

In January 1994, claimant sought additional treatment for his tinnitus condition from Dr. McMenomey. (Ex. AA). Claimant continued to complain of increasing sensitivity to noise as the day progressed, particularly as a result of riding in any vehicle. (Ex. A, 59-60). On March 11, 1994, Dr. McMenomey opined that it was inadvisable for claimant to return to work as a truck driver or to any other job which exposed him to significant and dangerous noise levels. (Ex. AA).

Subsequently, in a March 28, 1994 deposition, Dr. McMenomey continued to opine that claimant should work in a nonnoisy environment. (Ex. A-48). On April 14, 1994, Dr. McMenomey noted that claimant continued to have multiple symptoms of tinnitus. (Ex. B-1). On April 28, 1994, Dr. McMenomey placed PE tubes in claimant's ears, which resolved his clicking and pressure complaints. (Id.) Claimant also received hearing aids, which provided masking for his remaining tinnitus symptoms. (Ex. B-1, -2). On July 24, 1995, Dr. McMenomey declared claimant medically stationary as of July 21, 1995[4] and released him to work, stating that claimant should use "hearing precautions." (Ex. 2).

The evidence shows that claimant was partially disabled as of August 20, 1993. Although Dr. Hodgson opined that claimant could return to regular work with hearing protection, he also opined that claimant should not return to his regular work if loud noise aggravated his tinnitus. We are not persuaded by Dr. Hodgson's opinion that claimant could return to his regular work as a truck driver,

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[3] Claimant was awarded temporary partial disability from August 20, 1993 to October 26, 1993 by an August 22, 1995 Notice of Closure, which was affirmed by a January 3, 1996 Order on Reconsideration. This portion of the award is not in dispute.

[4] Although the insurer argues that claimant became medically stationary on June 24, 1994, (Appellant's Brief at 9), the insurer declared claimant medically stationary as of July 21, 1995 in its August 22, 1995 Notice of Closure, as corrected. (Exs. 3, 4, 5). The issue of medically stationary date was not raised, and could not be raised, for the first time at hearing, as it was not raised on reconsideration. ORS 656.283(7); William T. Masters, 48 Van Natta 1788 (1996). Accordingly, we are barred from considering it for the first time on review.

particularly in light of the subsequent medical evidence which indicates that claimant continued to be disabled from working as a truck driver because of noise during the time he treated with Dr. McMenomey. Moreover, even though claimant's condition began to improve with the insertion of the PE tubes, Dr. McMenomey did not release claimant to regular work at any time prior to July 21, 1995, when he declared claimant medically stationary.

Consequently, based on the preponderance of the evidence in the entire record, we conclude that claimant was disabled from his regular work as a result of his compensable tinnitus[5] until he was declared medically stationary on July 21, 1995. Therefore, claimant is entitled to temporary disability benefits from August 20, 1993 to July 21, 1995.

Unscheduled Permanent Disability

The ALJ concluded that claimant was entitled to 5 percent unscheduled permanent disability based on an impairment value of 5 percent for tinnitus. The insurer contends that claimant is not entitled to an award of permanent disability for his tinnitus condition, as he has not proven that his tinnitus requires job modification. We agree.

Claimant must prove that he incurred a permanent loss of earning capacity due to his compensable injury. Barrett v. D. & H. Drywall, 300 Or 325 (1985), aff'd on recon 300 Or 553 (1986).

OAR 436-035-390(7)(b)[6] allows a value of 5 percent unscheduled permanent disability for "[t]innitus which by a preponderance of medical opinion requires job modification."

The ALJ concluded that Dr. McMenomey's March 11, 1994 and Dr. Hodgson's November 17, 1993[7] reports establish that claimant's job was modified because of his tinnitus. The insurer contends that these reports are not persuasive because they addressed claimant's condition from one to two years prior to claimant's medically stationary date. We agree.

Although both Dr. Hodgson and Dr. McMenomey initially opined that claimant should avoid dangerous noise levels, claimant's tinnitus condition subsequently improved. (Ex. B). In his July 1995 report finding claimant medically stationary, Dr. McMenomey stated that claimant should take "noise precautions." (Ex. 2). Subsequently, Dr. McMenomey advised that claimant needed to wear noise protection and avoid exposure to loud noises "which could further damage his hearing and * * * lead to an increased likelihood of worsened tinnitus." Dr. McMenomey's statement regarding possible future damage to claimant's hearing is speculative and therefore not persuasive. Moreover, his statement that claimant's tinnitus condition might worsen in the future if claimant experiences additional hearing loss is insufficient to establish that claimant suffers from a permanent impairment due to his compensable tinnitus.

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[5] The insurer also argues that claimant's disability was not due to the compensable tinnitus, but to a noncompensable tinnitus related to claimant's hearing loss. We disagree.

Claimant has a noncompensable sensorineural hearing loss. Although Dr. McMenomey attributed the cause of claimant's tinnitus to noise exposure and hearing loss, the tinnitus is compensable in its entirety. (Ex. 1). Moreover, Dr. McMenomey opined that claimant's work at the employer did not have an effect on claimant's preexisting hearing loss. (Ex. A-29). Consequently, we conclude that claimant's work restrictions are due to the compensable tinnitus and not to the noncompensable hearing loss.

[6] WCD Admin. Order 96-072, which became effective February 15, 1997, provides that, for workers medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268, disability rating standards in effect on the date of issuance of the Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C) shall apply. OAR 436-035-0003(2). In addition, the provisions of OAR 436-035-0270(4), 436-035-0310(6) and (8) apply to all claims closed on or after March 13, 1992, for workers medically stationary on or after June 1, 1990, where the rating for permanent disability is not final by operation of law. OAR 436-035-0003(3). Claimant became medically stationary July 21, 1995, and his claim was closed by an August 22, 1995 Notice of Closure which has not become final. Consequently, in addition to those standards contained in WCD Admin. Orders 6-1992 and 93-056, the provisions of OAR 436-035-0270(4), 436-035-0310(6) and (8) apply to claimant's claim.

[7] The insurer contends that Dr. Hodgson's report was not admitted into the record. We disagree. Dr. Hodgson's November 17, 1993 report was included as a part of Exhibit A, a March 28, 1994 deposition of Dr. McMenomey on behalf of the insurer, as Deposition Exhibit 5. (See Ex. A-10).

In addition, Dr. Mettler, the medical arbiter, found claimant's tinnitus condition inconsistent at the time of his examination, which is in accord with Dr. McMenomey's findings that claimant had questionable bilateral tinnitus on July 27, 1995. (Exs. B-3; 8).

Accordingly, we conclude that claimant's compensable tinnitus condition does not require job modification. See Gary R. Peyton, 45 Van Natta 2288 (1993) (a physician's recommendation to wear more effective hearing protection at work is a safety measure that does not affect a worker's duties or the performance of his regular work). Claimant is, therefore, entitled to no unscheduled permanent disability for his tinnitus condition. Former OAR 436-035-390(7)(b).

Inasmuch as the insurer requested review and claimant's temporary disability compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on Board review regarding the temporary disability issue is $700, 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, his counsel's statement of services, and the insurer's objections), the complexity of the issue, and the value of the interest involved.[8]

ORDER

The ALJ's order dated April 16, 1996 is modified in part and reversed in part. That portion of the ALJ's order awarding 5 percent (16 degrees) unscheduled permanent disability (and an "out-of-compensation" attorney fee) is reversed. In addition to the ALJ's award of temporary partial disability from January 1, 1994 to July 21, 1995, claimant is awarded temporary disability benefits from August 30, 1993 to December 31, 1995, less amounts already paid and time worked. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total "out-of-compensation" attorney fees awarded by the ALJ's order and this order shall not exceed $3,800. For services on review, claimant's counsel is awarded $700, to be paid by the insurer.

[8] The insurer contends that claimant's attorney fee request is excessive and should be awarded in the amount of $1,000. Because claimant prevailed on one issue only, and we considered the factors in OAR 438-015-0010(4), a fee of $700 is reasonable in this case.

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In the Matter of the Compensation of
**RANDY R. KACALEK, Claimant**
WCB Case No. 95-13897
ORDER OF ABATEMENT
Burt, Swanson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our April 11, 1997 order that dismissed his request for hearing for lack of jurisdiction. Citing SAIF v. Shipley, 147 Or App 26 (1997), we concluded that this case involved a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6). Claimant argues that, unlike Shipley, he sought benefits for an aggravation of his 1991 injury which required reopening for surgery. He asserts that SAIF's denial included a denial of the condition resulting in the need for treatment and disability. Therefore, claimant contends that Shipley does not apply to this case and the Board has jurisdiction.

In order to consider this matter, we withdraw our April 11, 1997 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Claimant's reply must be filed within 14 days from the date of mailing of SAIF's response. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
**GREGORY C. PECK, Claimant**
WCB Case No. 96-04998
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
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) Stephen Brown's order that set aside its denial of claimant's claim for a cervical condition. In his brief, claimant seeks reversal of that portion of the ALJ's order that upheld SAIF's denial of his aggravation claim for a low back injury. On review, the issues are compensability and aggravation.

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

The ALJ found that claimant sustained a compensable C5-6 disc herniation while performing physical therapy for his accepted low back condition. Although claimant had preexisting cervical degenerative disease, the ALJ found that the physical therapy activity was the major contributing cause of the need for treatment of the combined condition (C5-6 disc herniation).

SAIF asserts that Dr. Henderson's medical opinion (relied on by the ALJ) is unpersuasive because his opinion fails to address the relative contribution of the degenerative disc disease and the injury. We disagree. Dr. Henderson was aware of and specifically considered the degenerative condition and concluded that claimant's nerve injury and loss of function in his shoulder were not related to cervical degenerative disease alone. (Ex. 50). Dr. Henderson based his opinion on the acute loss of function which followed the injury. Thus, we are persuaded that Dr. Henderson considered the degenerative disc condition and concluded that the injury, as opposed to the degenerative condition, was the major contributing cause of the cervical condition and need for treatment.

SAIF also argues that Dr. Henderson was unable to state to a reasonable medical probability that the physical therapy excercise was such that it could have caused the herniated disc. We disagree. Based on his deposition testimony, Dr. Henderson did not know the exact mechanism of the injury and considered the case "unusual," but was convinced that the physical therapy activity caused the herniated disc. He based his opinion not only on claimant's history, but on the sudden onset of weakness and the progressive atrophy that occurred subsequent to the incident. (Ex. 55-66). Dr. Henderson also explained that he did not believe that the C5-6 disc could have been present prior to the physical therapy incident and have been asymptomatic. Under such circumstances, we are persuaded that Dr. Henderson believed to a reasonable medical probability that the physical therapy activity caused the herniation.

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 of the cervical condition is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 11, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

In the Matter of the Compensation of
**JACK W. VANDOLAH, Claimant**
WCB Case No. 96-06390
ORDER ON REVIEW
Johnson, Cram & Associates, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that directed it to recalculate claimant's rate of temporary disability benefits. On review, the issue is the rate of temporary disability benefits. We modify.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In finding #3, we omit footnote 1. We change finding #6 to read:

> "Claimant testified that mileage varied between 7 to 13 miles per gallon, depending on the size and age of the unit. Average fuel cost was $1.12 per gallon."

## CONCLUSIONS OF LAW AND OPINION

Claimant is a transport driver who drives recreational vehicles from the manufacturer to the dealer or between dealers. Claimant and his partner traveled over the entire United States. They towed a vehicle to transport them between dispatches. They slept in the recreational vehicle they were driving and did not incur lodging expenses.

Claimant testified that he was paid a different rate per mile, ranging from 36 cents to 44 cents, depending on the type of rig or the manufacturer. (Tr. 7). He was taxed on 10 cents per mile. (Id.) The remaining amount was characterized as either "nontaxable income" or "reimbursable expenses." (Tr. 7, 8). From the "reimbursable expenses," claimant paid his expenses, including fuel and food. (Tr. 10). Claimant estimated that he was able to keep 62 to 63 percent of the "reimbursable expenses" for his personal use. (Tr. 19). He was not required to submit receipts in order to obtain the "reimbursable expense" payments. (Tr. 9).

Claimant was also reimbursed for toll charges, phone charges and repair expenses based on his actual expenditures. (Tr. 11). He had to submit receipts for those expenses. (Id.) If a breakdown occurred or the driver's departure was delayed due to the manufacturer's fault, claimant was paid extra. (Tr. 13). Claimant was reimbursed for the number of hours of "down time." (Tr. 14).

Claimant was paid to wash the vehicle, from $5 to $20, depending on the manufacturer. (Tr. 11). Some dealerships provided all the materials for washing the vehicles. (Tr. 16). Claimant also testified that he was paid a "set" amount for trailer or motorhome "pickup," which was not directed to any specific expense incurred. (Tr. 12, 13, 17). If someone else picked up the unit for him, the "pickup" payment was deducted. (Tr. 19, 20).

Claimant testified that he regularly received a monthly "safe driver bonus" at the rate of 2 cents of mile. (Tr. 12).

Claimant was injured on August 30, 1994. Although claimant was originally paid the maximum compensation rate, his wages were recalculated in November 1995, which significantly reduced the rate of temporary disability benefits. (Ex. 2-1). The parties were unable to agree on a reasonable wage and submitted the dispute to the Director for resolution. Claimant contended that the actual rate of compensation ranged from 36 to 40 cents per mile, rather than the 10 cents per mile reported by the employer on claimant's W-2 and tax statement. Claimant wanted the additional sums of money to be used to calculate his temporary disability benefits. The Director's order issued on May 14, 1996, finding that the documentation provided did not provide "proof of earnings that would be classified as a similar advantage received from the employer" that would allow an increase in claimant's temporary total disability (TTD) rate. (Ex. 2-2). Claimant's TTD rate was to be calculated based on the mileage reported by the employer at 10 cents per mile. (Id.) Claimant requested a hearing.

Relying on David C. McKee, 47 Van Natta 2028 (1995), the ALJ concluded that the employer should recalculate claimant's TTD rate to include, in addition to the 10 cents per mile previously paid: (a) 50 percent of "reimbursable expenses" paid historically over the 52 weeks prior to injury; (b) a safety bonus of 2 cents per mile paid over the previous 52 weeks; and (c) truck wash and trailer pickup, net, averaged.

On review, the employer contends that the Director's order should be reinstated. The employer argues that, even if its flat rate payment of reimbursable expenses is characterized as "per diem," it cannot be considered part of claimant's wage pursuant to former OAR 436-60-025(5)(b).

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. Here, claimant was injured on August 30, 1994 and, therefore, 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.
>
> "(b) For workers paid salary plus considerations (e.g. rent, utilities, food, etc.) insurers shall compute the rate on salary only if the considerations continue during the period the worker is disabled due to the injury. If the considerations do not continue, the insurer shall use salary plus a reasonable value of those considerations. Expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage." (Emphasis added).

We have not yet decided any cases applying former OAR 436-60-025(5)(b) (WCD Admin. Order 94-055). However, in David C. McKee, we referred to that rule in dicta. In that case, the claimant's job required constant travel doing advertisements. The claimant's employment contract with the employer provided that the claimant would receive a weekly salary of $350 plus a "weekly per diem of $189" for "personal expenses such as meals, laundry, telephone calls, personal transportation and tips." In addition to the weekly salary, the employer also paid the lodging costs of its employees. The Director found that the claimant's TTD rate should be calculated based on his weekly salary of $350, plus a reasonable value for lodging, which the Director determined was $238. The Director declined to include a $189 per week per diem allowance.

In McKee, the ALJ included the $189 weekly "per diem" payment in the calculation of the claimant's wages. The employer argued that those expenses were merely reimbursement for expenses caused by the work-related travel. On review, we reasoned that the employment contract provided for the $189 payment for "personal expenses" and indicated that the money could be used for such things as "meals, laundry, telephone calls, personal transportation and tips." We noted that the $189 was paid to the claimant in advance and the claimant was not required to submit receipts or to establish that the money was spent only on work-related or travel expenses. No restrictions were placed on the use of the money. Given those facts, we were not persuaded that the $189 "per diem" was merely a reimbursement for work-related or travel expenses. Instead, we concluded that it was compensation for the claimant's services. Therefore, we agreed with the ALJ that the $189 "per diem" should be included in the calculation of the claimant's TTD rate. 47 Van Natta at 2030.

In dicta, we noted that former OAR 436-60-025(5)(b) (WCD Admin. Order 94-055) did not apply to the McKee case. However, we noted that, even assuming that the rule applied, we would still conclude that the $189 "per diem" payment should be included in the claimant's wages for temporary disability. 47 Van Natta at 2030 n.2. We found that the "per diem" paid by the employer was not intended as a "reimbursement" for expenses incurred on the job. Since no limitations were placed on the use of the money and the money was paid in advance with no restrictions, we concluded that the "per diem" was part of the claimant's remuneration for his services and was not a reimbursement of expenses incurred on the job. Id.

Unlike McKee, former OAR 436-60-025(5)(b) (WCD Admin. Order No. 94-055) applies to this case. Claimant contends, however, that the rule does not apply to his additional payments, characterized by the employer as "reimbursable expenses," because the payments were fixed and not dependent on actual expenses incurred.

Former OAR 436-60-025(5)(b) provides, in part: "Expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage." Because the rule does not define "reimbursed," we turn to the dictionary definition. "Reimburse" is defined as:

> "1 : to pay back (an equivalent for something taken, lost or expended) to someone : REPAY (costs shall be ... *reimbursed* from such funds - *U.S. Code*)
>
> "2 : to make restoration or payment of an equivalent to (as a person) : INDEMNIFY (~government employees for travel expenses)." Webster's Third New Int'l Dictionary 1914 (unabridged ed 1993).

Thus, "reimburse" means to repay an equivalent amount already expended. Under former OAR 436-60-025(5)(b), if the worker's expenses are incurred due to the job and repaid in an equivalent amount, they are not considered part of the wage.

Here, claimant receives several categories of payments. Claimant testified that he is reimbursed for toll charges, phone charges and repair expenses based on his actual expenditures. (Tr. 11). Claimant must submit receipts for those expenses and he is repaid an amount equivalent to his actual expenditure. We conclude that the toll charges, phone charges and repair expenses are expenses "incurred due to the job and reimbursed by the employer" pursuant to former OAR 436-60-025(5)(b), and, therefore, are not considered part of claimant's wage for purposes of calculating temporary disability.

The more difficult question concerns claimant's "reimbursable expenses" for which he does not have to submit receipts. Claimant testified that he was paid a different rate per mile, ranging from 36 cents to 44 cents, depending on the type of rig or the manufacturer. (Tr. 7). Claimant was taxed on 10 cents per mile. (Id.) The remaining amount was characterized as either "nontaxable income" or "reimbursable expenses." (Tr. 7, 8). From the "reimbursable expenses," claimant paid his expenses, including fuel and food. (Tr. 10). Claimant estimated that he was able to keep 62 to 63 percent of the "reimbursable expenses" for his personal use. (Tr. 19). He was not required to submit any receipts showing actual expenses in order to obtain the "reimbursable expense" payments. (Tr. 9). No restrictions were placed on claimant's use of the "reimbursable expense" payments. (Tr. 9, 10). Although claimant paid for some of his trip expenses with those payments, he was not required to do so. (Tr. 10).

The employer contends that the flat rate expense reimbursement paid to claimant was intended to be reimbursement for expenses incurred in performing his job duties. However, former OAR 436-60-025(5)(b) applies only to expenses incurred due to the job and repaid in an equivalent amount. Claimant testified that he paid his fuel and food expenses incurred due to the job from the "reimbursable expenses" and his unrebutted testimony establishes that he was able to keep 62 to 63 percent, averaged as 62.5 percent, of the "reimbursable expenses" for his personal use. (Tr. 19). Thus, we find that the remainder of 37.5 percent of the "reimbursable expenses" were actually "reimbursed," i.e., used to repay an equivalent amount already expended. Based on former OAR 436-60-025(5)(b), we conclude that 37.5 percent of claimant's "reimbursement expenses" are not considered part of his "wage."

On the other hand, we find that 62.5 percent of the "reimbursable expenses" are considered part of claimant's "wage." The calculation of temporary total disability benefits is based on the replacement of wages lost as a result of a compensable injury or disease. See ORS 656.210(1); former OAR 436-60-025; Cutright v. Weyerhaeuser Co., 299 Or 290, 298 (1985). Under ORS 656.005(29), "wages" are defined, in part, 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[.]" Here, we find that, based on claimant's unrebutted testimony, 62.5 percent of the "reimbursable expenses" were part of his remuneration for his services and constituted "wages." Those payments, in addition to the 10 cents per mile previously paid, should be included in the calculation of claimant's TTD rate.

Claimant also contends that the employer should calculate his time loss by including an amount based on payments made to him for washing the recreational vehicles and "trailer pickup" during the 52 weeks prior to his injury.

Claimant was paid to wash the recreational vehicles, from $5 to $20, depending on the manufacturer. (Tr. 11). He was paid a "set" amount for trailer or motorhome "pickup," which was not directed to any specific expense he incurred. (Tr. 12, 13, 17). If someone else picked up the unit for him, the "pickup" payment was deducted. (Tr. 19, 20). The documentation of claimant's payments includes payments for "wash" and payments or deductions for "trailer pick up." (Ex. 1). We conclude that claimant's payments for washing the vehicles and his net payment for trailer or motorhome "pickups" should be included in calculating his TTD rate.

Finally, claimant argues that the employer should include his "safe driver bonus" in calculating TTD. Claimant testified that he regularly received a monthly "safe driver bonus" at the rate of 2 cents of mile. (Tr. 12). The bonus was contingent on having no accidents. (Id.) Former OAR 436-60-025(5)(f) provides:

> "Bonus pay shall be considered only when provided as part of the written or verbal employment contract as a means to increase the worker's wages. End-of-the-year and other one time bonuses paid at the employer's discretion shall not be included in the calculation of compensation."

Here, claimant's unrebutted testimony established that he had regularly received a monthly "safe driver bonus" at the rate of 2 cents of mile. We agree with the ALJ that claimant is entitled to have bonus pay considered in calculating his TTD rate. See Kenneth L. Stevenson, 47 Van Natta 1310 (1995) (the claimant's unrebutted testimony established that his contract of hire included a 2 cents per mile bonus; the claimant's bonus pay was considered in calculating his temporary disability rate).

Claimant's counsel is entitled to an attorney fee of 25 percent, not to exceed $3,800, of any increased compensation that results from the recomputation of his temporary total disability benefits. See ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated October 30, 1996 is modified. The self-insured employer is directed to recalculate claimant's temporary disability compensation consistent with this order and to pay claimant the additional compensation resulting from that recalculation. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

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May 9, 1997 Cite as 49 Van Natta 595 (1997)

In the Matter of the Compensation of
**LEONA M. PRICE, Claimant**
WCB Case Nos. 96-09629 & 95-10229
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Claimant has requested reconsideration of our April 11, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which had set aside the self-insured employer's denial of claimant's claim for a consequential upper extremity fibromyalgia condition. Specifically, claimant contends that we erred in evaluating the opinion of Dr. Keller, claimant's treating physician.

In order to further consider this matter, we withdraw our April 11, 1997 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 take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
**ROBERT L. HANSEN, Claimant**
WCB Case No. 96-07609
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Schultz' order that upheld the SAIF Corporation's denial of his occupational disease/injury claim for bilateral knee conditions. On review, the issue is compensability. We reverse in part and affirm in part.

## FINDINGS OF FACT

Claimant, a plasterer, had been working for 6 weeks on the construction of a bookstore, when, on April 27, 1996, he was required to work half a day on his hands and knees because of the arrangement of scaffolding. (Trs. 11, 19). Claimant did not notice anything unusual after completing his work that day, but the next morning he noticed that his knees were quite stiff, especially the left side. (Tr. 20). Claimant had not experienced any prior knee problems during the course of this employment.[1]

Claimant sought treatment from Dr. Hardiman, an orthopedic surgeon, on May 2, 1996, complaining of left knee pain. Dr. Hardiman diagnosed possible internal derangement of the left knee. (Ex. 4). An MRI scan of the left knee was performed and revealed a medial meniscus tear. (Ex. 5).

Because of insurance coverage problems, claimant transferred his care to another orthopedic surgeon, Dr. Hoppert, on May 22, 1996. Dr. Hoppert diagnosed bilateral knee pain, which he suspected was patellofemoral compression syndrome or chondromalacia. (Ex. 7). Noting the imaging evidence of a left medial meniscus tear, Dr. Hoppert described the condition as "minimally symptomatic." (Ex. 7). Claimant was treated conservatively.

On June 5, 1996, claimant reported that his left knee was essentially asymptomatic. Dr. Hoppert noted that claimant's meniscus tear was probably "pre-existent." (Ex. 9). However, Dr. Hoppert opined that treatment was unnecessary since the meniscus tear was stable and asymptomatic. Id.

Dr. McKillop, an examining physician, evaluated claimant on July 8, 1996 and opined that claimant's patellofemoral disease was "preexisting and predisposing." (Ex. 10-2). According to Dr. McKillop, claimant's April 27, 1996 occupational exposure had probably combined with the preexisting condition to "bring about symptoms that led [claimant] to seek medical care." (Ex. 10-3). Dr. McKillop also opined that the major contributing cause of the "combined condition" was the preexisting patellofemoral disorder. Id. With respect to claimant's torn medical meniscus, Dr. McKillop stated there was no way of determining when it occurred, but that preexisting degenerative disease of the meniscus was the major contributing cause of the condition, even though work activity was a "material" cause in bringing about symptoms. Id.

Based on Dr. McKillop's report, SAIF denied bilateral patellofemoral syndrome and the left medial meniscus tear on July 11, 1996. (Ex. 11). Claimant requested a hearing.

Dr. Hoppert disagreed with Dr. McKillop's report on July 18, 1996. (Ex. 13). After a bone scan which demonstrated increased "uptake" in claimant's right knee, Dr. Hoppert diagnosed possible associated immune mediated disease. (Ex. 15). He recommended a rheumatological consultation.

In response to an inquiry from claimant's counsel, Dr. Hardiman stated that he did not know when claimant tore his medial meniscus. (Ex. 17). Noting that claimant had become symptomatic because of work activities when he had not been significantly symptomatic before, Dr. Hardiman opined that the major contributing cause of claimant's "knee difficulty" was his employment. Id.

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[1] Claimant had previously injured his right knee in 1966 or 1967, an injury that bothered claimant for a couple of years but was not causing problems prior to April 27, 1996. (Tr. 18).

Dr. Hoppert was deposed on November 5, 1996. He testified that he was unable to state that claimant's work activities pathologically worsened the patellofemoral condition. (Ex. 19-5). However, claimant's work activities were probably the major contributing cause of the condition, although Dr. Hoppert was reluctant to give a definitive opinion pending the outcome of claimant's rheumatological consultation. (Ex. 19-33, 34). Dr. Hoppert also testified that claimant's work activity combined with his preexisting bilateral knee condition to cause symptoms for which treatment was provided. (Ex. 19-32). Regarding claimant's left medial meniscus, Dr. Hoppert stated he did not know what caused the condition. (Ex. 19-27). However, Dr. Hoppert opined that the medial meniscus tear was not contributing to claimant's symptoms or need for treatment and that claimant's medical treatment was not provided for that condition. (Ex. 19-28).

## CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial, first determining that the claim should be analyzed as an occupational disease because claimant's symptoms arose after several weeks of crawling and kneeling on the job. The ALJ then concluded that claimant had failed to sustain his burden of proof under ORS 656.802(2). In reaching this conclusion, the ALJ found that claimant has a preexisting bilateral knee condition. However, the ALJ reasoned that, although claimant's work activity was the major contributing cause of his symptoms that led to his medical treatment, the medical evidence did not establish that it had caused a pathological worsening of claimant's preexisting bilateral knee condition.

On review, claimant contends that his bilateral knee claim should be analyzed as an industrial injury, rather than as an occupational disease, because it developed over a short, discrete time period. Therefore, claimant asserts that, while his alleged bilateral knee injury may have combined with a preexisting condition or predisposition, he need not prove a pathological worsening of his knee condition under ORS 656.005(7)(a)(B). Arguing that the medical evidence establishes that his work activity on April 27, 1996 was the major contributing cause of his bilateral knee condition, claimant contends that the ALJ should have set aside the SAIF's denial.

We first address the issue of whether the claim should be analyzed as an occupational disease claim. For the following reasons, we conclude that it should be analyzed as an injury claim.

In determining the appropriate standard for analyzing compensability, we focus on whether the development of claimant's bilateral knee condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset of claimant's knee problems was sudden or gradual. Mathel v. Josephine County, 319 Or 235 (1994); James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261 (1983), rev den 296 Or 350 (1984). As the court noted in Crowe v. Jeld-Wen, 77 Or App 81, 85-86 (1985) (citing White v. State Ind. Acc. Com., 227 Or 306 (1961)): "An occupational disease is stealthy and steals upon its victim when he is unaware of its presence and approach. Accordingly, he cannot later tell the day, month or possibly even the year when the insidious disease made its intrusion into his body."

Although there was no specific incident of injury, claimant's bilateral knee problems occurred after performing work activity during a short, discrete period of time on April 27, 1996. In addition, claimant knew precisely when his knee symptoms began: The day following his work activities on April 27, 1996, which required substantial kneeling and crawling. See Joseph R. Huff, 47 Van Natta 731 (1996) (left shoulder condition that developed suddenly and unexpectedly on a specific date was properly characterized as accidental injury). Thus, we conclude that the claim should be categorized as one for an accidental injury.

Absent evidence that a preexisting condition combined with his April 1996 work injury, claimant need only establish that his work injury was a material contributing cause of his disability and need for treatment. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); see also Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition). However, we agree with the ALJ's reasoning that claimant had a preexisting condition in his knees that combined with his April 27, 1996 injury to cause disability or a need for treatment. Therefore, we conclude that the major contributing cause standard of ORS 656.005(7)(a)(B) applies in determining compensability. Thus, the ALJ properly applied the major contributing cause standard to the claim.

The ALJ also determined that claimant had failed to sustain his burden of proving compensability because he failed to establish a pathological worsening of either the patellofemoral or the medial meniscus condition pursuant to ORS 656.802(2). Inasmuch as we have determined that claimant's bilateral knee claim should be categorized as injury, rather than as an occupational disease, under ORS 656.005(7)(a)(B), claimant must show that his April 1996 injury was the major contributing cause of the disability of the combined condition or of the need for medical treatment of the combined condition. Claimant need not establish a pathological worsening under ORS 656.005(7)(a)(B) to prove a compensable claim. Robert C. Train, 45 Van Natta 2329 (1993).

We agree with the ALJ's conclusion that claimant proved that his work activity on April 27, 1996 was the major contributing cause of his need for medical treatment for his combined condition. Dr. Hoppert, claimant's attending physician, opined that claimant's work activity was the most significant factor in causing claimant's need for treatment of his bilateral patellofemoral condition. (Ex. 34-19). 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 no persuasive reason to do otherwise. Therefore, we conclude that claimant has established the compensability of his bilateral patellofemoral condition under ORS 656.005(7)(a)(B).[2] However, Dr. Hoppert also opined that claimant did not require medical treatment for his medial meniscus condition. (Ex. 19-28). Based on Dr. Hoppert's persuasive medical opinion, we conclude that claimant failed to prove the compensability of his torn left medical meniscus.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of his bilateral patellofemoral knee condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 31, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF's denial of claimant's bilateral patellofemoral syndrome is reversed. SAIF's denial insofar as it pertained to that condition is set aside and the claim is remanded to SAIF for processing in accordance with law. The remainder of SAIF's denial is upheld. For services on review and at hearing, claimant's attorney is awarded an assessed attorney fee of $3,500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

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[2] In this regard, we note Dr. McKillop's opinion that claimant's occupational exposure on April 27, 1996 brought about his symptoms that required medical care. (Ex. 10-3). In addition, Dr. Hardiman opined that claimant's work exposure was the major contributing cause of claimant's knee difficulty. (Ex. 17). We conclude that these opinions support a finding that the April 27, 1996 injury was the major factor in claimant's need for treatment of his bilateral patellofemoral condition.

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In the Matter of the Compensation of
**EDWARD G. BRUNEAU, Claimant**
WCB Case No. 96-07970
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

Claimant has a compensable claim for low back strain as a result of a September 1994 industrial injury. Claimant challenges the employer's denial of his low back degenerative disc disease and diagnosed disc herniation.

First, we agree with the ALJ that Dr. Franks, a neurosurgeon who treated claimant, provided the only opinion supporting claimant's position. Dr. Franks explained that a back disc is like a "very 'tense grape'" which becomes "squashey" with age, making it more vulnerable to herniation if loaded or stressed. (Ex. 37-1). According to Dr. Franks, claimant's September 1994 injury "was a very significant clinical event that made his back condition become manifest" and constituted the major contributing cause of claimant's need for treatment "even though he did have probably an underlying problem of some desiccation of the disc making the disc more 'squashey' and also the facet degenerative changes that have been alluded to on his neuroimaging studies." (Id. at 1-2).

We interpret Dr. Franks as indicating that claimant had a preexisting low back condition that combined with his September 1994 injury. Consequently, claimant must show that the compensable injury was the major contributing cause of the combined condition. ORS 656.005(7)(a)(B). In this regard, although Dr. Franks explains how a disc degenerates and becomes vulnerable to herniation, he provides no reasoning why the industrial injury was the major contributing cause, as opposed to a precipitating event that caused the condition to "become manifest." For this reason, as well as those provided by the ALJ, we agree with the ALJ that Dr. Franks' opinion is not sufficient to carry claimant's burden of proof.

ORDER

The ALJ's order dated December 20, 1996 is affirmed.

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May 13, 1997 Cite as 49 Van Natta 599 (1997)

In the Matter of the Compensation of
**NEAL L. JACQUES, Claimant**
WCB Case No. 96-06988
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the self-insured employer's denial of claimant's bilateral carpal tunnel syndrome condition and left ulnar neuropathy condition. On review, the issue is compensability.

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

We modify "December 1998" in the first paragraph of the "Findings of Fact" to "December 1988."

Claimant contends that he proved a compensable occupational disease claim for bilateral carpal tunnel syndrome and left ulnar neuropathy. The record contains opinions from treating orthopedist Dr. Ellison and examining neurologist Dr. Wilson that address causation. Dr. Wilson found that claimant's work activities only aggravated claimant's conditions without constituting the major contributing cause. (Ex. 26-6). Dr. Ellison first expressed concurrence with Dr. Wilson's report. (Ex. 28). Dr. Ellison subsequently indicated that, after reexamining Dr. Wilson's report, he realized he had "made a mistake as far as agreeing" since he believed that "the work activities are the major contributing cause of [claimant's] problem." (Ex. 30).

We agree with the ALJ that Dr. Ellison's opinion is not sufficiently persuasive to carry claimant's burden of proof. Along with the defect discussed by the ALJ, Dr. Ellison gives no explanation or reasoning for his opinion. Dr. Ellison also was a consulting physician who had seen claimant only twice before rendering his opinion. Consequently, we find no basis for finding Dr. Ellison's opinion persuasive. See Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983).

Finally, we note the ALJ's conclusion that claimant was not required to attend an independent medical examination (IME) scheduled after the employer issued its denial. On review, the employer disputes this portion of the ALJ's order only if we find that claimant proved compensability. Inasmuch as we have agreed with the ALJ that claimant did not establish compensability, we have not addressed, and express no concurrence or disagreement, with that portion of the ALJ's order concerning the post-denial IME matter.

ORDER

The ALJ's order dated November 22, 1996 is affirmed.

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In the Matter of the Compensation of
**ANNE M. WALKER, Claimant**
WCB Case Nos. 96-07915 & 96-00676
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of claimant's injury claim for a right knee popliteal cyst condition. The insurer cross-requests review of that portion of the order that set aside its "back up" denial of claimant's injury claim for a right medial meniscus tear. On review, the issue is compensability.

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

Claimant argues that the ALJ erred in evaluating the right knee cyst condition, because he did not apply ORS 656.225. We disagree.

ORS 656.225, entitled "Compensability of certain preexisting conditions," 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) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

We have previously noted that application of the above statute is limited by its terms to "disability solely caused by or medical services solely directed to a worker's preexisting condition." See Linda F. Hansen, 48 Van Natta 2560 (1996).

Here, the persuasive medical evidence establishes that claimant's popliteal cyst (and arthritic degeneration) preexisted her work injury and combined with the work injury, resulting in the cyst's rupture. Thus, although the cyst contributed to claimant's right knee disability and need for treatment, it was not the sole cause. (See Exs. 50, 55-17-19, -22). Accordingly, ORS 656.225 does not apply. See Paul E. Hargreaves, 48 Van Natta 1676 (1996) (Where the current condition is a "combined condition," ORS 656.225 is not germane).

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

ORDER

The ALJ's order dated December 6, 1996, as amended December 27, 1996, is affirmed. For services on review regarding the torn right medial meniscus condition, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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In the Matter of the Compensation of
**CHARLES J. WILLIAMS, Claimant**
WCB Case Nos. 96-04776 & 96-01206
ORDER ON REVIEW
Susan L. Frank, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) upheld Liberty Northwest Insurance Company's denial, on behalf of R&B Furniture (R&B), of compensability and responsibility for claimant's right foot injury; and (2) upheld Liberty Northwest's denial, on behalf of Alliance Corporation (Alliance), for the same injury. In his reply brief, claimant moves to strike Alliance's respondent's brief on the ground that it was not served upon all parties to the hearing. On review, the issues are compensability, responsibility and motion to strike.

We affirm and adopt the ALJ's order with the following supplementation concerning the motion to strike.

Claimant moves to strike Alliance's respondent's brief because Alliance failed to serve its brief on claimant's attorney on appeal.

Our rules of procedure do not expressly provide that a brief not served on all other parties may be stricken. See OAR 438-011-0020(2). However, it is well established that such a remedy is implied and is within our discretion. E.g., James M. Kleffner, 38 Van Natta 1413 (1986).

The record indicates that Alliance timely mailed a copy of its respondent's brief to the attorney who represented claimant at hearing, rather than to the attorney representing him on review. Yet claimant obviously obtained a copy because he filed a reply brief specifically addressing the arguments raised in Alliance's respondent's brief. Thus, claimant has not been prejudiced by Alliance's failure to mail its brief to claimant's attorney on review. Under these circumstances, we conclude that Alliance's respondent's brief should not be stricken. Accordingly, the motion to strike Alliance's respondent's brief is denied.

ORDER

The ALJ's order dated November 20, 1996 is affirmed.

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In the Matter of the Compensation of
**YANN YOU, Claimant**
WCB Case Nos. 96-02010 & 95-11718
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's occupational disease claim for a low back condition. The employer argues that the ALJ erred in granting claimant's motion for a continuance to admit Exhibit 28, a "post-hearing" medical report. On review, the issues are evidence and compensability. We reverse.

## FINDINGS OF FACT

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

At hearing, claimant requested a continuance for admission of an anticipated "post-hearing" medical report from Dr. Kim, treating physician. (Tr. 6). The employer objected to claimant's motion. (Tr. 6-7). The ALJ granted the motion, stating that Dr. Kim's "post-hearing" report would be subject to cross-examination, if the employer wished. (Tr. 9-11).

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established that his work activities for the employer were the major contributing cause of his low back degenerative disc disease, based on the opinion of Dr. Kim, treating physician.[1] (See Exs. 21A-3, 27, 28).

The only evidence arguably supporting the claim is provided by Dr. Kim. Although we generally rely on the opinion of a worker's treating physician, we do not do so when we find persuasive reasons to discount that opinion. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find such reasons.

On several occasions, Dr. Kim acknowledged the possibility that claimant's work activities "could" or "may" have been a major cause of claimant's degenerative disease. (Exs. 21A-3, 22, 25, 27). Finally, after the hearing, Dr. Kim checked a box indicating concurrence with a statement that those activities probably were the major cause of claimant's condition. (Ex. 28).

We find Dr. Kim's ultimate (post-hearing) opinion regarding causation unpersuasive because it changed substantially from his previous opinions without explanation. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Michael A. Bracken, 45 Van Natta 2126, 2127 (1993) (When a doctor finds a condition work-related, without explaining away previously expressed doubts, the ultimate conclusion is not persuasive). We find his opinion "as a whole" similarly unpersuasive because it lacks adequate explanation for its variations. Id. Under these circumstances, we conclude that the claim must fail. See Somers v. SAIF, 77 Or App 259 (1986).

## ORDER

The ALJ's order dated November 4, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee is reversed.

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[1] The employer argues that the ALJ abused his discretion in granting claimant's motion for a continuance (over the employer's objection) for the purpose of admitting Exhibit 28, a "post-hearing" concurrence letter signed by Dr. Kim. See OAR 438-006-0091; OAR 438-006-0081. We need not determine whether the ALJ abused his discretion in this regard, because we find that the claim fails even if the evidence was properly admitted.

In the Matter of the Compensation of
**VICKI L. DAVIS, Claimant**
WCB Case No. 96-01884
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board en banc.[1]

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the SAIF Corporation's partial denial of claimant's degenerative arthritis and degenerative disc disease conditions involving the low back; and (2) affirmed an Order on Reconsideration, as reconsidered, that awarded no permanent disability for a lumbar strain and rib contusion injury. On review, the issues are validity of the partial denial and extent of unscheduled 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 ultimate finding of fact relating to SAIF's January 10, 1996 partial denial.

## CONCLUSIONS OF LAW AND OPINION

We begin by summarizing the relevant facts. On March 15, 1995, claimant was injured at work and SAIF accepted the claim for lumbar strain and rib contusion. (Exs. 9, 10, 12, 13). An x-ray taken the day after the injury indicated mild degenerative disc disease throughout claimant's lumbosacral spine. (Ex. 11). Dr. Hodulik, attending physician, provided conservative treatment for the lumbar strain.

On September 8, 1995, Dr. Hodulik found claimant medically stationary and stated that the lumbar strain had resolved. (Ex. 18). That same date, Dr. Hodulik responded to several questions from SAIF regarding the relationship between the accepted lumbar strain condition and the preexisting degenerative disc disease/degenerative arthritis condition. (Exs. 17, 19). Specifically, Dr. Hodulik opined that the degenerative conditions were not caused or worsened by the work injury. However, he stated that claimant's symptoms following the work injury were caused by that trauma and the treatment provided claimant related to the work injury, not the degenerative conditions. He also stated that claimant had recovered from the lumbar strain and the compensable injury would not result in any permanent impairment. (Ex. 19). He opined that, if there was any further disability, "it very well may be related to [claimant's] pre-existing degenerative arthritis," although he doubted claimant would have further problem unless there was further injury. (Ex. 19-1). Finally, he noted that, due to the nature of degenerative arthritis, claimant would "from time to time, suffer waxing and waning of symptoms of low back pain," although he did not expect this to result in time loss, unless there was further injury or trauma. (Ex. 19-2).

On November 30, 1995, Drs. Neumann, orthopedist, and Platt, neurologist, examined claimant on behalf of SAIF. Their diagnoses included "pre-existing early degenerative arthritic changes and degenerative disc disease in the spine." (Ex. 20-5). They opined that claimant would suffer waxing and waning of her low back condition as a result of her degenerative arthritis rather than the March 15, 1995 lumbar strain injury. (Ex. 20-6). Dr. Hodulik concurred with their report. (Ex. 23).

On January 10, 1996, SAIF issued a denial of claimant's degenerative arthritis and degenerative disc disease of the low back as unrelated to claimant's accepted injury claim. (Ex. 24). On January 12, 1996, SAIF closed the claim with a Notice of Closure which awarded temporary disability, but no permanent disability.

Claimant requested reconsideration and appointment of a medical arbiter. Dr. Coletti, orthopedist, served as medical arbiter. (Ex. 26). On May 15, 1996, an Order on Reconsideration issued awarding claimant five percent unscheduled permanent disability based on Dr. Coletti's lumbar extension measurement. (Ex. 26A-4). SAIF requested reconsideration.

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[1] Board Member Moller has recused himself from participation in this review. See OAR 438-011-0023.

The Department requested clarification from Dr. Coletti, noting that the initial information it provided him did not mention SAIF's denial of disability resulting from degenerative conditions of the low back. (Ex. 27). The Department requested that Dr. Coletti indicate if the reduced lumbar range of motion resulted from the accepted conditions or the denied conditions. Id. Dr. Coletti responded that claimant had no valid measurement for loss of range of motion in the lumbar spine. (Exs. 27, 28). Relying on this information, the Department issued a June 25, 1996 Order on Reconsideration which awarded no unscheduled permanent disability and affirmed the Notice of Closure in all respects. (Ex. 29). Claimant requested a hearing raising issues of validity of SAIF's partial denial and extent of permanent disability.

Validity of the Partial Denial

Relying on Reynolds Metals v. Mendenhall, 133 Or App 428 (1995), the ALJ upheld SAIF's partial denial, essentially finding that SAIF could reasonably believe that the medical record as a whole constituted a claim for the lumbar degenerative conditions. At hearing and on review, claimant challenges SAIF's partial denial, contending that the denial was premature because she did not make a claim for the degenerative conditions. For the following reasons, we agree with claimant.

In 1995, the legislature amended the process by which a claimant could make a claim for a new medical condition after claim acceptance. Specifically, the legislature added ORS 656.262(7)(a), which 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 claim at any time."

Subsequent to the ALJ's decision, we decided Ramona E. Hamilton, 48 Van Natta 2438 (1996), in which we applied ORS 656.262(7)(a) to facts similar to those in the present case. There, the claimant compensably injured her low back. Subsequent diagnostic studies and medical reports indicated degenerative arthritis and vascular conditions. The claimant made no request for written acceptance of these conditions. Following the first claim closure, the insurer denied the compensability of the degenerative and vascular conditions. The claimant requested a hearing challenging that denial, contending that the denial was procedurally improper under ORS 656.262(7)(a) because she had filed no claim for the degenerative and vascular conditions. The ALJ rejected claimant's contention and upheld the denial.

On review, we held that pursuant to ORS 656.262(7)(a), in order to assert a "new medical condition" claim, a claimant "must clearly request formal written acceptance of a condition." 48 Van Natta at 2439. Because the claimant made no "clear request" for written acceptance of either her degenerative arthritis or her vascular condition, we found no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Furthermore, since a denial issued in the absence of a claim is a nullity, we found that the insurer's denial had no legal effect. Id. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Larry J. Bergquist, 46 Van Natta 2397 (1994).

Moreover, we rejected the insurer's reliance on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), in contending that it should be able to issue a "precautionary " denial to avoid a Determination Order that might award impairment for unaccepted conditions. We held that, if a Determination Order awarded permanent disability for an unaccepted condition, the insurer's remedy is to appeal the award of permanent disability, not to issue a denial before a new medical condition claim is made. 48 Van Natta at 2439, ORS 656.214(2), (5).

Here, SAIF accepted claimant's injury claim for lumbar strain and rib contusion. (Exs. 9, 10, 12, 13). Thereafter, neither claimant nor her physician[2] made a "clear request" of a "formal written acceptance" of any degenerative conditions. SAIF does not contend otherwise. Therefore, we find no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Finally, since a denial issued in the absence of a claim is a nullity, we find that SAIF's denial has no legal effect. Altamirano v. Woodburn Nursery, Inc., 133 Or App at 19-20.

Here, too, SAIF relies on Messmer to argue that it should be allowed to issue a "precautionary" denial of the degenerative conditions in order to exclude those conditions from consideration in the rating of permanent disability. As discussed above, we rejected that argument in Hamilton. Here, SAIF availed itself of the remedy discussed in Hamilton; namely, SAIF appealed the award of permanent disability made by the Order on Reconsideration. Thus, contrary to SAIF's argument, it has a remedy. However, that remedy does not include issuing a denial of a new medical condition for which no claim was made under ORS 656.262(7)(a).

In addition, SAIF relies on Weyerhaeuser Co. v. Warrilow, 96 Or App 34, rev den 308 Or 184 (1989), in support of its argument that its "precautionary" denial is appropriate. In Warrilow, the carrier accepted all conditions related to a work accident, without identifying the specific conditions accepted. At the same time, the carrier denied specific degenerative conditions as unrelated to the injury. The court found the partial denial was proper, reasoning that such a denial avoided the possibility that the preexisting conditions might later be determined to be encompassed in the acceptance of the claim.[3] In reaching this decision, the court stated that it knew "of no reason why an employer should not be permitted to deny the compensability of a condition that it reasonably interprets to be encompassed in a claim and which it believes to be noncompensable." 96 Or App at 38. Given the fact that the employer's partial denial clearly specified the condition denied, the court found that it met the requirements of a valid partial denial under Johnson v. Spectra Physics, 303 Or 49 (1987).

For the following reasons, we find that the reasoning in Warrilow is no longer applicable. At the time Warrilow and Mendenhall were decided, 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). As discussed in Warrilow, under such circumstances, to prohibit a carrier from partially denying a condition it did not consider compensable could place the carrier in a precarious position. In other words, as the court explained:

> "To refuse to allow the partial denial would require the employer either to accept the claim and risk the result in [Georgia-Pacific v.] Piwowar, [305 Or 494 (1988),] or neither to accept nor deny the claim until all of the possible medical evidence concerning the cause of the condition is available, at which time the employer may be subject to a penalty for a late acceptance or denial." 96 Or App at 37.

Given these circumstances, the court concluded that the employer's partial denial was procedurally proper and did not represent a premature denial. Id. at 38. Thus, the premise of the decision in Warrilow was based on the possibility of a new medical condition claim being made by the mere mention of the condition in a medical report.[4]

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[2] To the contrary, Dr. Hodulik specifically stated that the degenerative conditions were not caused or worsened by the work injury. (Ex. 19).

[3] We note that Reynolds Metals v. Mendenhall, 133 Or App at 434, a case relied on by the ALJ in the present case, relied on the reasoning in Weyerhaeuser Co. v. Warrilow, 96 Or App at 36-38, to find that a partial denial issued in that case was proper in that the carrier could reasonably interpret the denied condition to be included in the claim and the carrier believed that the denied condition was not compensable.

[4] In addition, we note that the 1995 legislature added a provision that requires a worker to communicate in writing to a carrier if he or she believes that a condition has been incorrectly omitted from a notice of acceptance, or the notice is otherwise deficient. ORS 656.262(6)(d). The worker may initiate such a written objection at any time. Id. The carrier has 30 days from receipt of the communication to revise the notice or otherwise respond in writing. Id. Thus, ORS 656.262(6)(d) provides further protection to the carrier that was not available at the time Warrilow and Mendenhall were decided. In this regard, before the 1995 amendments, a worker could allege a "de facto" denial of a condition without first requesting written clarification of the acceptance. Such circumstances provided another basis for precautionary denials. However, with the addition of ORS 656.262(6)(d), this basis for a precautionary denial was removed.

However, pursuant to ORS 656.262(7)(a), this premise for allowing a "precautionary" denial after claim acceptance no longer exists. Specifically, ORS 656.262(7)(a) explicitly requires a "clear request" for "formal written acceptance" of a new medical condition after claim acceptance and provides that new medical condition claims "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." (Emphasis added).

Accordingly, for all of the above reasons, we find the analysis in Warrilow and Mendenhall inapplicable to the circumstances of the present case.[5]

We also note that the ALJ cited ORS 656.268(16) in support of his conclusion that SAIF's partial denial was procedurally proper. ORS 656.268(16) provides that "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied." However, on this record, ORS 656.268(16) is not applicable. Specifically, Dr. Hodulik opined that claimant's preexisting degenerative disc disease/degenerative arthritis condition were not caused or worsened by the work injury. (Ex. 19). In other words, Dr. Hodulik did not indicate that the arthritis/degenerative conditions originated from the accepted conditions; instead, he separated the arthritis/degenerative conditions from the accepted conditions and found no relationship between the two. Thus, claimant's arthritis/degenerative conditions are not "direct medical sequelae" of the accepted lumbar strain and rib contusion conditions. Therefore, ORS 656.268(16) does not apply to the facts of this case.

Finally, we find that SAIF's preclosure denial is not procedurally proper under ORS 656.262(7)(b), which provides: "[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." We have interpreted ORS 656.262(7)(b) as applying only where the accepted condition, whether voluntary or by litigation, is a combined condition. Robin W. Spivey, 48 Van Natta 2363 (1996). Here, there is no evidence that the accepted condition is a combined condition. To the contrary, SAIF accepted a lumbar strain and rib contusion. (Ex. 13). Therefore, ORS 656.262(7)(b) does not apply to the present claim.[6]

Here, as discussed above, SAIF'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 SAIF's denial.

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). Ramona E. Hamilton, 48 Van Natta at 2440; 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 1933 (1995) (same).

Extent of Unscheduled Permanent Disability

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

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[5] To the extent that this holding is inconsistent with the reasoning expressed in the following post-1995 amendment cases which relied on the Warrilow analysis, these cases are disavowed: Loreta C. Sherwood, 48 Van Natta 992 (1996); Alton D. Simons, 48 Van Natta 860 (1996); Barbara Cooper-Townsend, 47 Van Natta 2381 (1995); Kenneth E. Beglau, 47 Van Natta 2038 (1995); and Ronald L. Tipton, 47 Van Natta 1493 (1995).

[6] Furthermore, where ORS 656.262(7)(b) does not apply, a carrier is not required to issue a preclosure denial before it may argue that a preexisting condition, rather than the accepted condition, is the major cause of disability. Robin W. Spivey, 48 Van Natta at 2366. Therefore, any unintended effects of Messmer may be limited by the carrier in an accepted combined condition claim by issuing a preclosure denial under ORS 656.262(7)(b) and in an accepted noncombined condition claim by arguing that a preexisting condition, rather than the accepted condition, is the major cause of disability. Of course, the merits of such an argument will be determined by the evidence in the record.

For the purpose of rating disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter, 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). Furthermore, if there is no measurable permanent impairment under the standards caused by the accepted injury, no award of unscheduled permanent disability is allowed. Former OAR 436-35-007(1); 436-35-270(2).

Claimant sustained a compensable lumbar strain and rib contusion. Dr. Hodulik, claimant's attending physician at claim closure, opined at the time he declared claimant medically stationary that the compensable injury would not result in any permanent impairment. (Exs. 18, 19). Dr. Hodulik also concurred with the opinion of Drs. Neumann, examining orthopedist, and Platt, examining neurologist, who opined that claimant sustained no permanent disability as a result of the compensable injury. (Exs. 20-5, 23).

Dr. Coletti, medical arbiter, found claimant had normal strength and no chronic condition due to the compensable injury. (Ex. 26-3). He noted that claimant had no impairment due to the compensable rib contusion. (Ex. 26-4). Regarding the lumbar range of motion findings, he noted "[t]he sum of the sacral angles measures 24 degrees (validity criteria are not met)." Id.

Based on Dr. Coletti's range of motion measurement for lumbar extension, the Appellate Reviewer awarded claimant five percent unscheduled permanent disability in a May 15, 1996 Order on Reconsideration. (Ex. 26A-4). SAIF requested reconsideration and the Department abated its order. The Appellate Reviewer requested further information from Dr. Coletti regarding whether the decreased lumbar ranges of motion were due to the accepted lumbar strain and rib contusion or the degenerative low back conditions denied by SAIF. (Ex. 27). Dr. Colletti responded that "the validity criteria was not met for flexion and extension," noting that "[n]either the sprain nor the degenerative disc disease . . . could cause such striking loss." (Ex. 27, 28). He also noted the lateral bending was not limited. Id.

Notwithstanding any issue regarding the validity of SAIF's partial denial, on this record, we agree with the ALJ that the preponderance of the medical evidence does not establish any impairment due to the compensable injury.

## ORDER

The ALJ's order dated October 21, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the SAIF Corporation's partial denial of claimant's degenerative arthritis and degenerative disc disease conditions involving the low back is reversed. SAIF's denial of these conditions is set aside as a nullity. The remainder of the order is affirmed.

**Board Chair Hall specially concurring.**

Although bound by principles of stare decisis, I refer the parties to my dissent in William C. Becker, 47 Van Natta at 1935-36. In accordance with the reasoning in my dissent in Becker, 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 SAIF 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 SAIF'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 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, claimant's attorney is not entitled to an assessed fee. See Robert W. Stephenson, 48 Van Natta 2442 (1996) (Board Chair Hall specially concurring).

In the Matter of the Compensation of
**CLAYTON W. FINCHER, Claimant**
Own Motion No. 94-0171M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney.

Claimant requests review of the SAIF Corporation's January 29, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from March 7, 1994 through January 17, 1997. SAIF declared claimant medically stationary as of January 17, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Claimant further requests "assistance in my goal to become rehabilitated and placed in a new career." In the alternative, claimant requests a "cash settlement."

Premature Closure

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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 January 29, 1997 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 a March 27, 1997 letter, we requested that SAIF submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. SAIF submitted its response on March 22, 1997, however, no further response has been received from claimant. Therefore, we will proceed with our review.[1]

In a January 17, 1997 medical report, Dr. Versteeg, claimant's treating orthopedic physician, opined that claimant was medically stationary. Dr. Versteeg's opinion is unrebutted.

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

Entitlement to Vocational Rehabilitation

Under ORS 656.278(1), the Board may authorize the payment of temporary disability compensation in those claims where aggravation rights have expired, and where the claimant's compensable injury requires surgery or hospitalization. When the Board reopens an Own Motion claim, the injured worker is entitled to temporary disability compensation until the worker's condition becomes medically stationary. However, pursuant to Senate Bill 369, amended ORS 656.278(2) now prescribes that:

> "Benefits provided under subsection (1) of this section do not include vocational assistance benefits under ORS 656.340."

Therefore, the Board, in its Own Motion authority, does not have jurisdiction to consider vocational issues. Thus, we are unable to grant claimant's request for vocational assistance under his 1974 injury claim with SAIF.

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[1] This matter was apparently set for hearing in error. On April 18, 1997, because the Hearings Division does not have jurisdiction over Own Motion claims, Administrative Law Judge (ALJ) Mongrain dismissed claimant's hearing request in WCB Case No. 97-02019. Claimant's request for review of SAIF's closure of his claim is properly before the Board under its Own Motion authority. ORS 656.278.

Entitlement to Permanent Disability Compensation

Claimant requests a "cash settlement" for his compensable injury.[2] We treat claimant's request as a request for additional permanent disability benefits for his compensable injury. However, claimant's entitlement to permanent disability benefits ended when his aggravation rights expired on August 4, 1980. That means that, although claimant is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future disability compensation is restricted to time loss benefits under ORS 656.278(1). 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). Accordingly, we are not authorized to grant claimant's request. See Charles H. Jones, 47 Van Natta 1546 (1995); David L. Grenbemer, 48 Van Natta 195 (1996).

Accordingly, we affirm SAIF's January 29, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] If claimant is requesting that the Board approve a settlement agreement between the parties, we do not find that such a document has been submitted to the Board by the parties for approval. Therefore, no "cash settlement" may be approved, as there is no signed agreement existing between the parties.

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May 14, 1997 Cite as 49 Van Natta 609 (1997)

In the Matter of the Compensation of
**SIRIJEET S. JOHNSON, Claimant**
Own Motion No. 96-0236M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest, Insurance Carrier

Claimant requests review of the insurer's March 21, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from May 22, 1996 through January 8, 1997. The insurer declared claimant medically stationary as of January 8, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Claimant further requests temporary disability compensation from March 5, 1997 through March 19, 1997, and asks the insurer (or the Board) to "reopen" his claim.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 21, 1997 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 a January 8, 1997 medical report, Dr. Blum, claimant's treating orthopedic physician, opined that claimant's compensable left knee condition was medically stationary. On that date, Dr. Blum released claimant to modified work, with restrictions. We conclude that claimant was medically stationary on January 8, 1997. However, the insurer did not close the claim on January 8, 1997.

In a March 14, 1997 medical report, Dr. Blum noted that claimant had "the development of swelling in his left knee a few weeks ago for no apparent reason." Dr. Blum recommended that claimant should perform quadriceps strengthening exercises regularly, keep his left knee wrapped with an Ace bandage until the swelling went away, and use anti-inflammatory medication. Furthermore, Dr. Blum opined that "[t]his is an ominous sign and indicates that [claimant's] knee may in fact not be stable but may be deteriorating." We treat Dr. Blum's opinion as a recantation of his previous opinion that claimant's compensable knee condition was medically stationary. See Gerald D. Duren, 49 Van Natta 162 (1997).

Here, it appears that, although claimant's compensable condition became medically stationary on January 8, 1997, it did not remain so.[1] Moreover, although a worsening prior to claim closure does not preclude a finding that a worker is medically stationary if no material improvement is reasonably expected from medical treatment or the passage of time, that is not the case here. See ORS 656.005(17). In his March 14, 1997 report, Dr. Blum clearly prescribes further treatment for claimant's knee, and notes that claimant's condition is probably not stable, but, rather, may be deteriorating. Dr. Blum's report is unrebutted, and, therefore, persuasive. Finally, the treatment prescribed by Dr. Blum was initiated prior to claim closure, establishing that claimant was still in the process of undergoing / receiving further treatment for his compensable condition when the insurer closed his claim. See Michael T. Alioth, 49 Van Natta 54 (1997). On this record, we are persuaded that claimant's compensable knee condition was not medically stationary on March 21, 1997, the date the insurer closed the claim.

Claimant requests that his claim be "reopened," and that he be paid temporary disability for the weeks of March 5, 1997 through March 19, 1997.[2] Because we have concluded that claimant was not medically stationary on the date his claim was closed, he is eligible for temporary disability compensation recommencing with the date that the insurer terminated the payment of those benefits. Those benefits, less any wages claimant should receive during this period, shall continue until claimant is medically stationary and the claim is properly closed.

Accordingly, we set aside the insurer's March 21, 1997 Notice of Closure as premature. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] We have previously found that no "worsening" of a compensable injury is required to establish a non-medically stationary status in a reopened claim. See Christi L. McCorkle, 48 Van Natta 1766 (1996). Although we agree that Dr. Blum had declared claimant medically stationary on January 8, 1997, that date is not the relevant inquiry for purposes of premature closure. See Larry R. Comer, 47 Van Natta 1574 (1995). Dr. Blum opined that claimant was not medically stationary on March 14, 1997, prior to the time that claimant's claim was closed. Furthermore, because claimant's claim was in reopened status at the time he became non-medically stationary, claimant only need establish that he was not medically stationary at claim closure (or that he did not remain medically stationary prior to claim closure). Christi L. McCorkle, 48 Van Natta at 1766.

[2] Claimant is apparently under the impression that he must re-apply to reopen his claim for the payment of temporary disability compensation. However, because we have concluded that claimant was not medically stationary at claim closure, he is not required to establish a worsening of his compensable injury, as the claim remains reopened. ORS 656.005(17); 656.278(1); Larry R. Comer, 47 Van Natta at 1574; Esther M. Anderson, 47 Van Natta 16 (1995).

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In the Matter of the Compensation of
**THOMAS J. KOLLEN, Claimant**
WCB Case No. 96-03549
THIRD ORDER ON RECONSIDERATION
Flaxel & Nylander, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 28, 1997 Second Order on Reconsideration which: (1) set aside a Director's "Proposed and Final Order on Weekly Wage for Computing Temporary Disability Rate"; and (2) recalculated claimant's temporary total disability rate. SAIF requests that we reconsider the attorney fees awarded under ORS 656.382(2).

In our December 13, 1996 Order on Review, we awarded claimant's attorney an assessed fee of $750 pursuant to ORS 656.382(2) for services on review. In our February 7, 1997 Order on Reconsideration, we awarded claimant's attorney an assessed fee of $500 pursuant to ORS 656.382(2) for services on reconsideration. SAIF asserts that, under the Board's holding, claimant's temporary total disability rate has been reduced and, therefore, he is no longer entitled to an attorney fee pursuant to ORS 656.382(2).

Claimant contends that SAIF has been attempting to have the entire amount of time loss as determined by the ALJ disallowed. He asserts that the Board made a minor modification in the calculation of the time loss, which was consistent with his alternative argument in his response to SAIF's first request for reconsideration. According to claimant, attorney fees awarded on original review and first reconsideration should be affirmed. We disagree.

Claimant does not dispute SAIF's assertion that, as a result of our Second Order on Reconsideration, his temporary total disability (TTD) rate has been reduced from $296.79 to $266.64. 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. We agree with SAIF that, as a result of our Second Order on Reconsideration, claimant's TTD rate has been reduced. Consequently, claimant is no longer entitled to an attorney fee pursuant to ORS 656.382(2). We vacate the $750 fee awarded in our December 13, 1996 Order on Review and the $500 fee awarded in our February 7, 1997 Order on Reconsideration.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our December 13, 1996 order, as reconsidered on February 7, 1997 and April 28, 1997. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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May 14, 1997 Cite as 49 Van Natta 611 (1997)

In the Matter of the Compensation of
**THOMAS J. LIDAY, Claimant**
Own Motion No. 97-0174M
OWN MOTION ORDER
Myrick, Seagraves, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left medial meniscus tear injury. Claimant's aggravation rights expired on April 9, 1987. SAIF opposes reopening of the claim for the payment of temporary disability compensation, 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.

In a January 10, 1997 report, Dr. Duncan, claimant's treating physician, recommended that claimant undergo a 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 contends that claimant was not in the work force at the time of disability because he has provided "conflicting information" and inconsistent work force evidence. Claimant contends that he was working in an adult foster care facility until mid-November 1996, when he was "laid off." Claimant has the burden of proof on this issue and must provide persuasive evidence that he was in the work force during the relevant time.

Claimant's claim was reopened under the Board's Own Motion authority for an October 1995 surgery, and remained reopened until August 2, 1996, when SAIF closed his 1978 injury claim. Therefore, by virtue of claimant's eligibility for time loss benefits during that time, we conclude that he has established that he was in the work force until August 2, 1996, at claim closure. See Harry Bostwick, 49 Van Natta 490 (1997); Michael C. Johnstone, 48 Van Natta 761 (1996).

Claimant submitted a 1996 W-2 Wage and Tax Statement which indicates that he worked for Faith Adult Foster Home, Inc. in 1996. Although a W-2 form indicates that a worker received wages during that tax year, the form does not indicate during which months the wages were earned. However, claimant submitted an affidavit, in which he attests that he worked for the foster care home providing maintenance and cooking services from July 28, 1996 until "around November 15, 1996." Claimant further stated that, after his wife was injured, they were laid off since the foster care home required a "couple" to provide services to its clients. Thus, although SAIF contends that claimant's evidence and testimony exhibit "inconsistencies" (SAIF submitted a January 10, 1997 work history questionnaire and an occupational injury report allegedly completed by claimant which state that claimant last worked in November 1994, as well as a telephone conversation with claimant on February 19, 1997, in which claimant allegedly stated that he had not returned to sedentary work after his claim closed on August 2, 1996), the above evidence persuades us that claimant was in the work force at the time of disability.[1]

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 claimant 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.

[1] SAIF further contends that Directory Assistance does not have a listing for Faith Adult Foster Home Inc. However, the 1996 W-2 form submitted by claimant clearly indicates that he was paid wages by that establishment. Because the information contained on the W-2 form is furnished by the Internal Revenue Service, we find it persuasive evidence that claimant received wages from an employer during calendar year 1996.

May 14, 1997 Cite as 49 Van Natta 612 (1997)

In the Matter of the Compensation of
**MARCIA G. WILLIAMS, Claimant**
WCB Case No. 96-06746
ORDER ON RECONSIDERATION
Cole Cary & Wing PC, Claimant Attorneys
John M. Pitcher, Defense Attorney

On April 16, 1997, we withdrew our March 25, 1997 order that reversed the Administrative Law Judge's (ALJ's) order that affirmed the Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability for claimant's mental condition. We took this action to consider claimant's contention that, since the accepted psychological condition is a consequential condition, the holdings in Boyd K. Belden, 49 Van Natta 59 (1997), and Robin W. Spivey, 48 Van Natta 2363 (1996), apply to this case. Citing ORS 656.268(16), claimant argues that she is entitled to a permanent disability award for her Class II, minimal range impairment since this impairment is due to her depression, which is a direct medical sequelae of the original accepted condition that has never been denied. Having received the self-insured employer's response and claimant's reply, we now proceed with our reconsideration.

Citing ORS 656.268(8), the employer argues that claimant failed to raise the issue regarding the possible application of ORS 656.262(7)(b), or any other procedural issue, when she requested reconsideration of the Notice of Closure.

Claimant did not raise the arguments regarding ORS 656.262(7)(b) or ORS 656.268(16) at hearing or on review. We generally do not review issues which were not raised at hearing and are being raised for the first time in a request for reconsideration. Claimant raised those issues for the first time on 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); Annette E. Farnsworth, 48 Van Natta 508 (1996). In Dixie L. Stanton, 49 Van Natta 295 (1997), the claimant argued for the first time on review that the employer's denial was procedurally improper under ORS 656.262(6)(c) and ORS 656.262(7)(b). Since the claimant did not raise those arguments at hearing, we did not address them on review. Here, since claimant did not raise the arguments regarding ORS 656.262(7)(b) or ORS 656.268(16) at hearing or on review, we are not inclined to consider those arguments on reconsideration.[1]

Even if we assume, without deciding, that claimant's argument under ORS 656.262(7)(b) is raisable and the employer's failure to deny the claim under that statute precludes it from arguing that claimant's disability as rated by Dr. Burt was not "due to" the accepted condition, the result would be the same because claimant has not established entitlement to unscheduled permanent disability under this claim. See Vincent S. Roberts, 49 Van Natta 15 n.1 (1997). Similarly, since claimant has not established her entitlement to unscheduled permanent disability, ORS 656.268(16) does not apply.

We are not persuaded by Dr. Burt's opinion that claimant's current function is in the Class 2, minimal range. Dr. Burt reported that he would classify claimant as having function in the "Class 2, minimal range," based "primarily on her depressive symptoms, and her increased thoughts of suicide off the Paxil, [as] well as some decrease in her pursuit of pleasurable activities[.]" (Ex. 31-11). Dr. Burt's Axis I diagnosis included "[m]ajor depression - recurrent versus dysthymia." (Id.) Nevertheless, in another part of his report, Dr. Burt said that claimant's underlying depressive symptoms "currently do not meet criteria for major depression." (Ex. 31-8). Thus, Dr. Burt diagnosed major depression, despite the fact that claimant's depressive symptoms did not currently meet the criteria for major depression. We adhere to our earlier conclusion that Dr. Burt's opinion is, at best, inconsistent and confusing and is insufficient to establish that claimant is entitled to an unscheduled permanent disability award. We are not persuaded by Dr. Burt's opinion that claimant's function is in the Class 2, minimal range.

Accordingly, on reconsideration, as supplemented herein, we republish our March 25, 1997 order. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In light of our conclusion that claimant did not raise the arguments regarding ORS 656.262(7)(b) at hearing or on review, we do not address the employer's argument that claimant was required to raise the issue of ORS 656.262(7)(b) on reconsideration with the Department.

In the Matter of the Compensation of
**TAMITHA A. BARENDRECHT, Claimant**
WCB Case No. 96-07545
ORDER ON REVIEW
Doblie, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that dismissed the insurer's hearing request regarding an Order on Reconsideration. Claimant seeks sanctions for an allegedly frivolous hearing request and attorney fees under ORS 656.382(2). The insurer moves to strike those portions of claimant's brief that refer to matters not admitted into evidence. On review, the issues are the insurer's motion to strike and the propriety of the ALJ's dismissal order.

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

The insurer requested a hearing on August 14, 1996 concerning a July 25, 1996 Order on Reconsideration. The matter was scheduled for hearing on November 13, 1996. On the day of the hearing, before the hearing had convened, the insurer withdrew its hearing request. That same day, claimant's counsel wrote the ALJ, asserting that, as a result of the insurer's hearing request, claimant had been denied temporary disability to which she was entitled by the July 25, 1996 reconsideration order. Alleging that the insurer's hearing request was unreasonable, claimant requested that the ALJ's dismissal order award sanctions for a "frivolous" hearing request pursuant to ORS 656.390.[1] Claimant did not seek the admission of any exhibits or request that a hearing be convened.

The ALJ entered an Order of Dismissal on December 3, 1996. The ALJ stated that there was no basis for imposing sanctions under ORS 656.390 because no evidence was admitted and claimant did not cross-request a hearing.

In contending on review that the ALJ should have imposed sanctions, claimant refers to matters not in evidence. Inasmuch as we are limited to the record developed by the ALJ, see Brian A. Haskie, 47 Van Natta 2171(1995), and because no record was developed in this case, we do not consider those references on review. Moreover, because no evidence was admitted and no record was developed, we agree with the ALJ that there is no basis on which to impose sanctions pursuant to ORS 656.390.[2]

Finally, claimant also contends that she is entitled to an attorney fee pursuant to ORS 656.382(2). However, claimant did not raise this issue in her November 13, 1996 letter. Therefore, we do not the consider the issue on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).[3]

ORDER

The ALJ's order dated December 3, 1996 is affirmed.

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[1] ORS 656.390(1) allows an ALJ or the Board to impose an appropriate sanction against an attorney who files a frivolous request for hearing or review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see Westfall v. Rust International, 314 Or 553, 559 (1992) (defining "frivolous" under former ORS 656.390).

[2] In her reply brief, claimant requests that the matter be remanded to the ALJ. However, we find no "compelling" reason to remand given claimant's failure to seek development of an evidentiary record below to support her request for sanctions. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

[3] Moreover, even if we addressed the issue, we would conclude that claimant is not entitled to an attorney fee under ORS 656.382(2) since the ALJ made no decision on the merits of the issues raised in claimant's hearing request. See Terlouw v. Jesuit Seminary, 101 Or App 493 (1990); Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Timothy L. Williams, 46 Van Natta 2274 (1994).

In the Matter of the Compensation of
**DENNIS L. BARNES, Claimant**
WCB Case No. 96-04745
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that affirmed an Order on Reconsideration which awarded permanent total disability. On review, the issue is permanent total disability.

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

SAIF argues that the ALJ's reliance on Dr. Burt's opinion regarding claimant's mental and emotional condition was misplaced.[1] Specifically, SAIF argues that Dr. Burt based his opinion on claimant's inability to work full time and did not address claimant's "malingering" concerning his physical disabilities. SAIF also argues that Dr. Burt did not attribute claimant's inability to work to his cognitive and emotional problems.

We disagree with SAIF's assertion that Dr. Burt's opinion was based solely on claimant's inability to work full time. Dr. Burt indicated that claimant's ability to perform regular, suitable and gainful employment was "significantly impaired." He also indicated that in claimant's current work environment (working on his parents' farm), claimant is able to work for brief periods of time in a very supportive environment which is likely the best type of work environment within which claimant could operate. Dr. Burt further opined that claimant was probably operating at maximum capacity working on his parents' farm.

Although Dr. Burt stated that any attempt to return claimant to "full time" work would result in failure, we read his opinion, as summarized above, to be that claimant is incapable of regularly performing gainful and suitable employment. We agree with the ALJ's assessment that claimant's current employment on his parents' farm is akin to a sheltered workshop with a sympathetic employer. Thus, regardless of whether claimant is capable of performing his current chores full or part time, we find that claimant is not currently able to sell his services on a regular basis in a hypothetically normal labor market. See Harris v. SAIF, 292 Or 683, 695 (1982). The references throughout the medical record to the residuals of claimant's head injury, including cognitive deficits, mood lability, verbal aggression and inappropriate behavior, support the conclusion that claimant is not currently employable.

Regarding claimant's exaggeration of his physical disabilities, it is apparent from the record that claimant's main obstacle to employment is his mental and emotional condition and not his physical disabilities. We are not persuaded that claimant's alleged exaggeration of his physical disability detracts from the persuasiveness of Dr. Burt's assessment of claimant's mental impairment or that claimant was also able to exaggerate his cognitive and mental disabilities.

We reject SAIF's argument that Dr. Burt did not relate claimant's inability to work to his cognitive and emotional problems. In fact, claimant's belief that he was unable to work was only one basis for Dr. Burt's opinion. Dr. Burt also cited claimant's significant cognitive impairment, an emotional disorder related to his dementia and claimant's concreteness and mental inflexibility as factors impacting claimant's employability.

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

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[1] SAIF also contends that the Board's precedent regarding the placement of the burden of proof was wrongly decided. See Earl D. Lesperance, 45 Van Natta 2133 (1993). We decline SAIF's request to re-examine our prior holding in Lesperance. Moreover, we are not persuaded that the placement of the burden of proof is a decisive factor in this case.

ORDER

The ALJ's order dated December 5, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**PAULA M. BROWNING-VANBURGER, Claimant**
WCB Case No. 96-05361
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Stoel Rives LLP, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) declined to reopen the record for admission of an additional medical report from her treating surgeon; and (2) upheld the self-insured employer's denial of claimant's C6-7 herniated disc condition. On review, the issues are the ALJ's evidentiary ruling and compensability.

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

The ALJ closed the evidentiary record on September 16, 1996, the day of the hearing. The hearing was continued, however, on October 21, 1996 for closing argument, at which time claimant sought admission of a medical report dated September 16, 1996 from Dr. Golden, her attending surgeon. Claimant's counsel explained that Dr. Golden's report was written to his request in August 1996 that Dr. Golden respond to the August 6, 1996 medical report (Ex. 72) of an examining physician, Dr. Rosenbaum. (Tr. II-3).

Noting that the evidentiary record had been closed on September 16, 1996, the date of the hearing, the ALJ declined to admit Dr. Golden's report into evidence. The ALJ reasoned that, since the employer would be entitled to cross-examination of Dr. Golden, it would be inappropriate for reasons of "judicial economy" to reopen the record. (Tr. II-4).

On review, claimant contends that the ALJ abused his discretion in not admitting Dr. Golden's September 16, 1996 report. Claimant asserts that it is a crucial piece of evidence that is necessary for a fair hearing. We disagree with claimant's assertions.

We review an ALJ's evidentiary rulings for abuse of discretion. Mary J. Richards, 48 Van Natta 390 (1996) (citing James D. Brusseau II, 43 Van Natta 541 (1991)). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice).

In this case, claimant did not object to closure of the record at the time of the September 16, 1996 hearing. In fact, claimant had already submitted a September 4, 1996 report from Dr. Golden. (Ex. 73). Chronologically, this report was the last exhibit admitted into evidence. Claimant gave no indication at the September 16, 1996 hearing, which was continued for the sole purpose of closing arguments, that an additional medical report had been requested from Dr. Golden. Under these circumstances, we do not find that the ALJ abused his discretion in declining to admit Dr. Golden's September 16, 1996 report.

In any event, even if we considered Dr. Golden's September 16, 1996 report, we would still conclude that claimant failed to sustain her burden of proving that her C6-7 disc herniation was compensable. In his September 16, 1996 report, Dr. Golden stated that, based on claimant's history, the alleged injury of June 4, 1995 was responsible for claimant's neck and left arm pain and need for cervical

surgery. That history included claimant's assertion that she experienced radicular quality pain shortly after she allegedly injured her neck transferring a patient from a wheelchair. (Ex. 74). However, claimant did not testify that she experienced upper extremity pain shortly after the alleged incident. In fact, she testified that she did not develop tingling in her left hand until October 1995. (Tr. 55). In addition, Dr. Rosenbaum, an examining physician, also recorded a history that claimant's upper extremity symptoms did not begin until October 1995, at the earliest. (Ex. 72-7). Inasmuch as Dr. Golden's opinion in his September 16, 1996 report is based, at least in part, on an inaccurate history, we would not find that report persuasive, even if we considered it on the causation issue. See Miller v. Granite Construction Co., 128 Or App 473 (1977) (causation opinion based on unreliable and inaccurate history is unpersuasive).

Because we agree with the ALJ's reasons for finding the C6-7 cervical herniated disc condition noncompensable based on the record without consideration of Dr. Golden's September 16, 1996 report, and because we would not find that report persuasive even if we considered it on review, we conclude that the ALJ properly upheld the employer's denial. We, therefore, affirm.

## ORDER

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

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May 15, 1997 Cite as 49 Van Natta 617 (1997)

In the Matter of the Compensation of
**ROBERT S. CEBALLOS, Claimant**
WCB Case No. 96-05366
ORDER ON REVIEW
John E. Snarskis, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Hoguet's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

## FINDINGS OF FACT

Pursuant to an April 12, 1996 Disputed Claim Settlement, claimant agreed to accept a lump sum payment of $2,500, less medical bills of $454.54, in full settlement of his denied claim for a low back injury. In consideration of this payment, the insurer's April 10, 1996 denial of claimant's low back injury claim was upheld.

By letter dated June 4, 1996, claimant requested a hearing, contesting the approved settlement agreement. A hearing was scheduled for September 4, 1996. Just before this scheduled hearing date, claimant retained an attorney. As a result, the hearing was rescheduled for February 26, 1997.

By letter dated December 11, 1996, claimant's attorney informed the Board that, "[o]n behalf of the claimant, the Request for Hearing is withdrawn and the matter may be dismissed." On December 19, 1996, the ALJ dismissed claimant's hearing request. By letter dated January 24, 1997, counsel advised the Board that he no longer represented claimant.

On January 13, 1997, the Board received a request for review from claimant. In this correspondence, claimant notes that he continues to have problems with his back injury. Claimant also submits a copy of a prescription for physical therapy regarding his low back.

## CONCLUSIONS OF LAW AND OPINION

The issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order was appropriate.

By letter dated December 11, 1996, claimant's attorney informed the Board that, on behalf of claimant, he was withdrawing the pending hearing request and that the request may be dismissed. Thus, the record establishes that claimant, through his attorney, withdrew his request for hearing. Claimant does not dispute his attorney's authority to act on his behalf,[1] nor does he dispute the fact that the ALJ dismissed his request for hearing on this claim in response to his 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 dismissal order.

ORDER

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

[1] If claimant could present evidence suggesting that his attorney lacked authority to act on his behalf, we might reconsider this decision. Since our authority to conduct such a reconsideration expires 30 days from the date of this order, claimant should present any such evidence as soon as possible. (Claimant should also send copies of any such evidence to the insurer's attorney).

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May 15, 1997 Cite as 49 Van Natta 618 (1997)

In the Matter of the Compensation of
**JAMES P. DILLON, Claimant**
WCB Case No. 95-10688
ORDER ON REVIEW
Susan D. Isaacs, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

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

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

On review, claimant contends that his request for hearing is timely. We disagree. As explained by the ALJ, pursuant to the court's decision in Weyerhaeuser v. Purdy, 130 Or App 322 (1994), claimant's recourse following the "post-vocational training" Determination Order was through former ORS 656.268(9), which provides that a party may request a hearing under ORS 656.283 on a determination within 180 days after the order is mailed.[1]

Here, rather than requesting a hearing, claimant first requested reconsideration. Subsequently, following an Order Denying Request for Reconsideration, claimant filed a request for hearing more than 180 days after the mailing date of the Determination Order. Inasmuch as the reconsideration process does not apply to "post-ATP" Determination Orders under former ORS 656.268(5), it necessarily follows that the "stay" provision in ORS 268(6)(b) is likewise not applicable. See Purdy, 130 Or App at 325 (enrollment in authorized training program triggers "entirely separate" review process from what is described in ORS 656.268(5)). Therefore, claimant's request for hearing concerning the Determination Order was untimely.

Claimant also argues that the Determination Order incorrectly gave appeal rights which provided that, "Any party to the claim has the right to request a reconsideration or a hearing for a period of 180 days from the mailing date of this determination order." Claimant contends that he was misled by the appeal language and, rather than requesting a hearing, he relied on the language and requested reconsideration.

[1] ORS 656.268(9) was amended in 1995 by Senate Bill 369. Because claimant became medically stationary before the effective date of the Act, the amended statutes do not apply to this claim. 1995 Or Laws, Ch 332, Sec. 66(4) (SB 369). Amended ORS 656.268(9) effectively overrules Purdy for claims in which a claimant becomes medically stationary after the effective date of SB 369.

While the statement on the Determination Order was misleading, it cannot modify the express language of the controlling statute. That is, an incorrect statement of appeal rights cannot confer jurisdiction on a forum that has no statutory jurisdiction over the matter. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). It is conceivable that a "corrected" Determination Order may have been warranted. Nevertheless, since neither we nor the ALJ are authorized to render such a ruling under these particular circumstances, claimant's remedy rests with another forum; i.e. contesting the Department's Order Denying Request for Reconsideration. See ORS 656.704(2), the Administrative Procedures Act (ORS 183), and OAR 436-030-0008(6).

Finally, to the extent that claimant is requesting a hearing concerning the Department's Order Denying Reconsideration, as opposed to the Determination Order, we have previously held that the Hearings Division lacks jurisdiction to consider a claimant's appeal from a Director's Order Denying Reconsideration. James W. Jordan, 48 Van Natta 2602 (1996). In Jordan, we noted that under ORS 656.268(6)(f) a dissatisfied party had 30 days in which to request a hearing from a "reconsideration order." However, because the Department denied reconsideration, we found that claimant's hearing request did not pertain to a "reconsideration order." 48 Van Natta at 2603. We found further support for this conclusion in 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.).

Consequently, as noted above, claimant's remedy in this regard would have been to request a hearing before the Director concerning the Order Denying Reconsideration and then, subsequently to appeal the Director's order directly to the court. For these reasons, we agree with the ALJ that claimant's request for hearing should be dismissed.

ORDER

The ALJ's order dated February 23, 1995 is affirmed.

**Chair Hall specially concurring.**

Although I am bound by the principle of *stare decisis*, I continue to disagree with the conclusion that the Hearings Division lacks jurisdiction over a request for hearing concerning a Director's Order Denying Reconsideration for the reasons set forth in my dissent in James W. Jordan, 48 Van Natta 2602 (1996).

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May 15, 1997 Cite as 49 Van Natta 619 (1997)

In the Matter of the Compensation of
**HOWARD L. BROWNE, Claimant**
Own Motion No. 96-0211M
OWN MOTION ORDER OF ABATEMENT
Michael M. Bruce, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 15, 1997 Own Motion Order, in which we authorized reopening of claimant's 1982 injury claim for the payment of temporary disability compensation, commencing May 28, 1996, the date he was hospitalized for multilevel back surgery. Specifically, SAIF contends that, at the time of the response to the Own Motion request, claimant was still employed, but by the time of claimant's surgery, claimant had retired from the workforce.

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.

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In the Matter of the Compensation of
**ROLANDO M. GARCILAZO, Claimant**
WCB Case No. 94-10343
ORDER ON REVIEW
Judy Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Tenenbaum's order which declined his request for postponement and dismissed his request for hearing. On review, the issues are postponement and dismissal. We affirm.

## FINDINGS OF FACT

On August 22, 1994, claimant requested a hearing. The matter was initially scheduled for hearing on November 23, 1994, but was postponed and reset for hearing on July 7, 1995. That hearing was postponed so that claimant could obtain legal counsel. The matter was again set for hearing on January 19, 1996. The hearing was once again postponed on the ground that claimant needed more time to obtain legal counsel. Claimant was advised that no more postponements would be granted for the purpose of securing legal counsel.

The matter was again scheduled for hearing on May 10, 1996. Claimant was granted another postponement, this time in order to obtain an interpreter. The claim was again set for hearing on November 26, 1996 at 9 a.m. in Salem.

Neither claimant nor a legal representative were present when the hearing convened some time after 9 a.m. on November 26, 1996. The SAIF Corporation moved to dismiss the hearing request based on claimant's failure to appear at hearing. The ALJ orally granted the motion.

Before an order had been published, claimant appeared later that day at the Hearings Division in Salem at around 12:30 p.m. The ALJ advised SAIF's counsel of claimant's appearance, but was informed that SAIF's attorney could not return to the Hearings Division that afternoon. However, SAIF's attorney agreed to allow the ALJ to go back on the record to determine claimant's reasons for not appearing at the time of the hearing.

Claimant stated that he was aware that the hearing was scheduled for that day, but had not appeared at 9 a. m. because he believed that the hearing was set to convene at 1 p.m. It appears that claimant had lost the hearing notice, but did not call to verify the time of the hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ declined to postpone the hearing, finding that being mistaken as to the time of a hearing did not constitute "extraordinary circumstances" sufficient to justify another postponement. The ALJ reasoned that claimant should have confirmed the time of the hearing and that claimant's conduct had caused numerous delays in the proceedings over the previous two years. Consequently, the ALJ concluded that there were no grounds to postpone the hearing. Because claimant had not appeared at the appointed time for the hearing, the ALJ dismissed claimant's hearing request.

Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-006-0071(2). An ALJ shall dismiss a request for hearing if the party that waives appearance is the party that requested the hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. Id. OAR 438-006-0081 provides that a "scheduled hearing shall not be postponed except by order of a referee upon finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement."

In this case, claimant is the party that requested the hearing. The issue is whether the ALJ properly dismissed claimant's hearing request when he failed to attend the scheduled hearing. The resolution of this issue in turn depends on whether "extraordinary circumstances" justified a postponement in this case.

In Lynette K. Norton, 42 Van Natta 621 (1990), we stated that, although former OAR 438-06-081 (since renumbered to OAR 438-006-0081) allowed postponements only in extraordinary circumstances, the rule must not be applied with unforgiving rigidity. We noted that the rule listed a number of circumstances that did not justify postponement. We observed that a claimant's mistake concerning the time of, and late arrival at the hearing, was not one of those exclusions. Therefore, we reasoned that the justification for a postponement under such circumstances must be considered in light of the facts of the particular situation. Under some circumstances, we explained, a failure to appear at a hearing on time may warrant postponement.

Having noted our previous comments in Norton, we, nevertheless, conclude that the circumstances in this case did not warrant postponement. As the ALJ observed, the hearing in this matter has been postponed on numerous occasions in the past to accommodate claimant. Even assuming that claimant's mistake as to the time of the hearing was due to a good faith belief that it was scheduled for 1 p.m., rather than 9 a.m., the fact remains that claimant should have been aware of the importance of arriving to attend the hearing at the appropriate time. This should have prompted him to call the Hearings Division to confirm the time of the hearing after apparently losing his hearing notice. While we adhere to our reasoning in Norton that the postponement rule should not be inflexible, we conclude that, under the circumstances of this case, the ALJ properly declined to allow a postponement.

Because neither claimant nor an attorney appeared on his behalf at the scheduled time of the hearing, and because we have concluded that no "extraordinary circumstances" justified postponement of the hearing, we affirm the ALJ's dismissal of claimant's hearing request. OAR 438-006-0071(2).

ORDER

The ALJ's order dated December 5, 1996 is affirmed.

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May 15, 1997 Cite as 49 Van Natta 621 (1997)

In the Matter of the Compensation of
**RICHARD L. HENLEY, Claimant**
WCB Case No. 95-09346
ORDER ON REVIEW
Barnes, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's partial denial of claimant's injury claim for diabetes and carbuncle conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Ultimate Findings of Fact," with the following correction.

The first two sentences of the third paragraph are corrected as follows:

"At the time of his compensable injury and prior to July 1984, claimant lived in Oregon. In July 1984 claimant moved to Phoenix, Arizona (Ex. 22-1, Tr. 22)."

In addition, we supplement as follows:

About thirty days before the injury, claimant had a physical examination which revealed no health problems and normal cholesterol and triglyceride levels. (Ex. 75-2).

Upon hospital admittance after the injury, claimant had elevated glucose. (Ex. 1).

On December 4, 1990, claimant was determined to be permanently and totally disabled. (Ex. 73).

On July 24, 1995, SAIF issued a partial denial of claimant's diabetes mellitus and related carbuncle conditions and acknowledged its acceptance of the fractured right femur, sacrum and L5, as well as paraplegia, traumatic perineal rupture, right sided colostomy, and depression. (Ex. 104).

CONCLUSIONS OF LAW AND OPINION

On January 11, 1984, claimant was injured while changing the left front fog lamp of his 18 wheel tractor trailer truck while working as a truck driver. Claimant's truck was hit from behind causing the left front wheel and at least one set of tandem wheels to run over him. He sustained extremely serious crush/fracture injuries, including evisceration, a crushed pelvis with marked separation, and fractured spine and right femur. He soon developed a perirectal abscess (which required a right upper quadrant colostomy), multiple rectovesicular fistulas, and chronic urinary tract infections. He underwent multiple surgeries (at least 20), including several operations to close perineal urethral fistulas, reanastomosis, and a hermorrhoidectomy. Additional problems associated with claimant's traumatic paraplegia have included hypertension, fistula and rectal bleeding, recurrent pelvic abscesses with bone spicules, a paracolostomy hernia, status post hepatitis-B, transient renal failure, cardiomegaly, chronic pain, chemical dependency, depression, hyperlipidemia, post-traumatic stress disorder, systemic candidiasis, and diabetes. Claimant has a partial quadriplegia, with a sensory level at approximately L4-5. (Exs. 26-2, 34-1, 48, 62, 97-1, 99-1, 100A-4, 108; see Tr. 45).

In 1994, claimant had surgery for a large thoracic diabetes-related carbuncle.

The ALJ upheld SAIF's denial of claimant's diabetes and carbuncle conditions, based on a finding that the opinions of Drs. Karl and Cook are more persuasive than those of Drs. Shelton, Heileman, and Biesbroeck. We disagree.[1] First, based on the persuasive opinions of Drs. Shelton and Heileman, we find that claimant's diabetes condition is most appropriately analyzed as an indirect consequence of his work injury and its sequelae. (See e.g., Ex. 109-14). Under these circumstances, claimant must prove that the work injury was the major contributing cause of the diabetes condition.[2] See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Considering the passage of time since the onset of claimant's diabetes and the disagreement among the medical experts regarding its etiology, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. See Barnett v. SAIF, 122 Or App 279 (1993). We rely on those 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 rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

The ALJ accorded no special deference to Dr. Shelton (who has been claimant's treating physician for over ten years) or Drs. Heileman and Biesbroeck (who each examined claimant once) over Drs. Cook and Karl (who never examined claimant), because he deemed this to be a case of expert analysis rather than expert observation. However, it is undisputed that only a small number of persons have sustained trauma like claimant's and there is no suggestion that Drs. Cook and Karl have ever examined or treated a patient with injuries like claimant's. (See Exs. 109-30, 110-32-33, 113-23). Considering Drs. Cook and Karl's lack of experience with claimant (or a patient similar to claimant), as compared with Dr. Shelton's years of direct experience, we are unwilling to conclude that this is a case

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[1] The parties agree that the carbuncle condition is a consequence of the diabetes and that the carbuncle condition is compensable only if the diabetes is compensable.

[2] There is some evidence suggesting that claimant may have been genetically predisposed (to some degree) to develop diabetes (at some time) and that such a predisposition may have combined with the injury and its sequelae to produce and/or prolong his disability and need for treatment for diabetes. (See Exs. 109-10, 110-9, 111-8; 110-41, 111-7-19, 111-25, 111-28, 111-33; Tr. 41, 59; see also Exs. 109-18-19; 109-30-33; 109-43). Such circumstances would require claimant to establish that the 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" under ORS 656.005(7)(a)(B). However, because claimant is also subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(A), we need not determine whether the aforementioned statute applies.

primarily involving expert analysis. Instead, we evaluate the medical evidence according to its persuasiveness, in light of Dr. Shelton's unique position as claimant's long-time treating physician (and considering Drs. Heileman and Biesbroeck's opportunity to examine claimant). See Somers, 77 Or App 259; Weiland, 64 Or App 810.

Drs. Cook and Karl performed file reviews for SAIF. They opined that claimant was predisposed to develop diabetes, because his mother has diabetes. Further, because claimant's clinical course was typical for Type II diabetes (also known as adult onset diabetes), which may be genetically transmitted, Drs. Cook and Karl concluded that claimant's genetic predisposition was the major contributing cause of his current diabetes condition. We find these opinions unpersuasive, for the following reasons.

The experts agree that claimant's mother's diabetes means that claimant has a 20-50 percent chance of having diabetes himself. (See Exs. 109-35, 110-32). However, this statistical prediction is not helpful in ruling out or evaluating the relative contributions of causes other than genetics with regard to claimant's current diabetes condition. Thus, to the extent that Drs. Cook and Karl rely on claimant's genetic predisposition as evidence of "major" causation, we find their opinions unpersuasive. See Mary E. Williams, 44 Van Natta 2154, 2155 (1992) (Medical opinion without a reliable factual basis to judge its validity is unpersuasive).

As we have noted, the experts also agree that claimant has "adult onset" or Type II diabetes, because his clinical course is consistent with that diagnosis. However, only Drs. Cook and Karl conclude that claimant's condition is primarily (or solely) inherited based on this consistency. We do not find these doctors' reasoning in this regard persuasive, because it assumes its conclusion without adequately considering claimant's very unusual circumstances. (See Exs. 109-31, 110-22, 113-18). See Moe v. Ceiling Systems, 44 Or App 429 (1980). Although Drs. Cook and Karl acknowledge that claimant's injury-related physical and emotional stresses could cause or at least aggravate his diabetes, they offer insufficient explanations for relegating such potential causes to minimal significance. (See Exs. 109-30-33, 110-33-34, 110-41, 113-18; compare Exs. 109-19-20, 109-23, 113-18 and Ex. 111-27-31.). Finally, because Drs. Cook and Karl failed to adequately consider (or persuasively rule out) claimant's unique circumstances, we cannot say that these opinions are based on accurate and complete histories. Under these circumstances, we conclude that the opinions of Drs. Cook and Karl are unpersuasive. See Somers, 77 Or App 259.

The evidence supporting the claim is provided primarily by Drs. Shelton and Heileman.

Dr. Heileman examined claimant and reviewed his extensive records. He opined that claimant's diabetes is "adult-onset type," a genetically predetermined disease. (Ex. 99-1). In claimant's case, however, Dr. Heileman also explained that the traumatic injury to claimant's body (not specifically to the pancreas) resulted in stress "which lead to the cascade of events producing diabetes." (Ex. 106-1; see Exs. 111-7, 111-27). Dr. Heileman specifically identified indirect sequelae of the injury as the most significant causal contributors in claimant's case, including trauma, pain, surgeries and anesthesia necessitated by the trauma, chronic infection, and pain. (Ex. 111-19). He explained persuasively how these factors acted to cause claimant's current disability and need for treatment for diabetes and why the indirect results of the injury were the major cause of claimant's diabetes. (Exs. 111-7-33). We find Dr. Heileman's opinion and conclusions persuasive.

Dr. Shelton agreed that claimant's diabetes is probably "Type II adult onset." (Tr. 59). He explained that not everyone with this diagnosis has a genetic background to become a Type II diabetic and, although genetics are usually a predominant causal factor, other factors "weigh into it." (Id). In claimant's case, Dr. Shelton explained that the crush injury[3] and its sequelae are the most significant causes for the diabetes (i.e., more significant than any genetic predisposition which claimant may have). (See Tr. 41, 51-53, 60, 64-5; Exs. 45, 46, 51, 57, 72).

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[3] Based on the mechanism of injury, Dr. Shelton opined that claimant's pancreas was directly subjected to tremendous physical pressure and trauma. (Tr. 45-6, 60). Drs. Cook, Karl, and Heileman opined that the injury did not directly damage claimant's pancreas, because they find no evidence of such damage in the record. (See Ex. 106). We need not determine whether claimant's pancreas was directly injured on January 11, 1984, because even if the pancreas survived the crush injury unscathed, claimant has established that sequelae of the work injury (indirect physical and mental stresses) contributed more to his diabetes than did any predisposition, as explained above.

We find the opinions of Drs. Shelton and Heileman[4] persuasive because they are well-reasoned and based on accurate histories. Accordingly, based on those opinions, we conclude that claimant has established that his 1984 work injury and its sequelae were the major contributing cause of his subsequent diabetes and carbuncle conditions.[5]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(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 $8,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

## ORDER

The ALJ's order dated December 6, 1996 is reversed. The SAIF Corporation'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 $8,000 attorney fee, payable by SAIF.

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[4] Dr. Biesbroeck examined claimant and opined that his diabetes results from the 1984 injury directly and indirectly. (Ex. 108). We find his opinion persuasive insofar as it is consistent with those of Drs. Shelton and Heileman.

[5] See n.1, above.

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In the Matter of the Compensation of
**RUSSELL HOWERTON, Claimant**
WCB Case No. 96-02128
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the insurer's denial of his right knee injury claim; and (2) declined to assess a penalty for an alleged discovery violation. In his brief, claimant also contends that he has made a separate claim for a right knee contusion. With his brief, claimant attaches an affidavit not submitted at the time of hearing. We treat such submissions as a motion for remand. On review, the issues are remand, compensability, and penalties and attorney fees. We deny the motion for remand and reverse on the issue of compensability.

## FINDINGS OF FACT

Claimant works for the employer as a shuttle bus driver. On October 5, 1995, claimant was getting up from the driver's seat of the shuttle to assist a passenger when his right foot became caught. Claimant fell and landed on his right knee. When he landed, claimant's right knee struck a metal divider strip on the floor. Claimant experienced right knee pain which went away at first, but then came back approximately a week later.

On October 13, 1995, claimant sought medical treatment at Kaiser for his right knee. X-rays were taken and claimant was prescribed anti-inflammatories and crutches.

Claimant continued to experience knee pain and swelling, and on November 27, 1995, an orthopedic examination was performed by Dr. Montgomery, who reported an exam and history consistent with a lateral meniscal tear.

On December 5, 1995, a right knee MRI showed findings consistent with a meniscal tear, joint effusion, and abnormalities consistent with osteonecrosis.

On December 7, 1995, claimant treated with Dr. Koski, who diagnosed probable osteonecrosis. Dr. Koski recommended further bone scan testing and restrictions on weight bearing activity. A December 13, 1995 bone scan showed a hyperemic process consistent with healing phase of avascular necrosis, trauma, or infection.

On December 28, 1995, claimant completed a change of attending physician form, and named Dr. Noall as his attending physician.

On February 7, 1996, claimant was examined by Dr. Mandiberg on behalf of the insurer. Dr. Mandiberg diagnosed an October 5, 1995 twisting injury at work, and preexisting osteonecrosis lateral femoral condyle.

On February 22, 1996, the insurer denied claimant's October 5, 1995 right knee injury.

On February 23, 1996, Dr. Noall concurred with the findings and recommendations set forth in Dr. Mandiberg's report.

On March 8, 1996, claimant was in the process of bending over when he heard a pop in his right knee. A loose fragment was found in the lateral femoral condyle of the right knee, and claimant underwent surgery on March 13, 1996. Claimant's surgery was performed by Dr. Pelmas, an orthopedic surgeon. Following the surgery, claimant consulted with Dr. Ushman on March 19, 1996.

On February 27, 1996, claimant's counsel requested production of discovery. On May 17, 1996, claimant's counsel requested a copy of claimant's taped statement. The statement had never been transcribed, but a summary had been made on December 6, 1995. The summary was faxed to claimant's counsel on May 17, 1996.

Prior to the October 5, 1995 work incident, claimant had injured his right knee on one occasion. Claimant's prior knee injury occurred in 1990, when he slipped and twisted his right knee while working in his yard. Several weeks after the 1990 incident, claimant's knee pain completely resolved.

Prior to the October 5, 1995 incident, claimant walked on a daily basis for exercise. Claimant's walks were from three to five miles long. Claimant also went on a strenuous hike in the summer of 1995. Between the time the 1990 knee injury resolved and the October 1995 accident occurred, claimant did not experience any right knee problems.

## CONCLUSIONS OF LAW AND OPINION

### Remand

On review, claimant's counsel has submitted an affidavit not previously submitted at the time of hearing. Because our review is confined to the record developed before the ALJ, we treat claimant's submission as a motion to remand for the taking of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, claimant's affidavit contends that, during oral (unrecorded) closing argument, claimant argued that he had proven a separate right knee contusion claim, which was in addition to and distinguishable from the claim for avascular necrosis.

We conclude that claimant has not shown why the contusion issue was not raised during opening remarks, or why the contusion claim issue could not have been raised or preserved before the ALJ in some other manner. In opening remarks, claimant's counsel stated that the work injury was the "cause of the condition which is really at stake, and that condition is called osteonecrosis...." Tr. 6.

Additionally, we do not find sufficient evidence in the record to support claimant's claim for a separate contusion condition, apart from the osteonecrosis condition. Therefore, we do not find that the submitted affidavit is likely to affect the outcome of the case.

Based on the aforementioned reasons, we deny claimant's motion to remand. Moreover, in reaching our decision, we have not considered claimant's submission.

Compensability

The ALJ found that the preponderance of evidence established that claimant had a preexisting knee condition. Accordingly, the ALJ applied ORS 656.005(7)(a)(B), and found that claimant had not shown that the work injury was the major contributing cause of the disability and need for treatment of the combined condition. However, on review, claimant argues that the correct standard is ORS 656.005(7)(a), and he is only required to prove that the injury was a "material contributing cause." Alternatively, claimant argues that he has also proven his case under the major contributing cause standard.

In order to determine the proper legal standard, we first examine the expert medical opinions. See, e.g., Daniel S. Field, 47 Van Natta 1457 (1995). As the ALJ explained, the medical opinions are divided. Dr. Mandiberg, who examined claimant on behalf of the insurer, believed that claimant's osteonecrosis condition was a preexisting condition which probably dated back to the 1990 right knee injury. Dr. Mandiberg reported that the "x-ray findings that we see today on plain films predate the injury by many months to years." (Ex. 24-3). Consequently, Dr. Mandiberg concluded that claimant's work injury was not the major cause of his osteonecrosis. In a "check-the-box" concurrence, Dr. Noall agreed with Dr. Mandiberg's findings and recommendations. (Ex. 26). Dr. Ushman agreed that claimant's condition most likely preexisted the October 1995 injury. (Ex. 29).

Dr. Pelmas, who performed claimant's knee surgery, reported in March 1996, that claimant had a "five-month history of osteonecrosis." (Ex. 26ac-1). Dr. Pelmas subsequently opined that claimant's right knee injury of October 5, 1995, was the major contributing cause of his disability and need for treatment. Dr. Pelmas based her conclusion on the fact that the October 13, 1995 x-ray was essentially normal, which did not support a finding that the osteonecrosis was a long-standing problem. Finally, Dr. Pelmas reported that claimant's history of being free of pain, despite regular strenuous activity before October 5, 1995, indicated that the osteonecrosis was not present at that time. (Ex. 33).

Dr. Koski, who initially treated claimant for his right knee condition, reported that he was aware of claimant's injury which occurred in 1990. However, Dr. Koski reported that if claimant's 1990 injury had induced the osteonecrosis, claimant would have experienced an acute progression of symptoms at that time, and the condition would not have been "released" by the subsequent October 1995 injury. Dr. Koski found that the "progression of [claimant's] symptoms and x-ray findings of 10/13/95, 11/27/95, 12/19/95, 3/6/96, and again on 3/11/96 clearly show progression of events wholly consistent with osteonecrosis of the lateral femoral condyle from an inciting event of 1995." (Ex. 28).

The ALJ found that Dr. Mandiberg had provided the most thorough and well-reasoned opinion. Accordingly, the ALJ found that claimant failed to meet his burden of proof. We disagree.

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). For the following reasons, we conclude that Drs. Pelmas and Koski have provided the best-reasoned opinions.

First, we give the appropriate deference to the opinion of Dr. Pelmas, claimant's treating surgeon, who had a first-hand opportunity to observe claimant's knee condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Drs. Pelmas and Koski both examined the x-rays and concluded that claimant's osteonecrosis condition did not preexist the October 5, 1995 injury. They also based their conclusions on the fact that, prior to the 1995 work incident, claimant did not have any symptoms following the 1990 injury. The doctors also considered the fact that claimant performed regular, strenuous activity, without experiencing right knee symptoms. Finally, the doctors considered the progression of both the findings on the x-rays and claimant's symptoms, in concluding that the October 5, 1995 work incident was the major cause of claimant's necrosis condition.

After reviewing the record, we find that the opinions of Drs. Pelmas and Koski are consistent with both the medical record and with claimant's history. Furthermore, we find that the opinions are well-reasoned and based on accurate history.

On the other hand, Dr. Mandiberg stated that claimant's x-rays taken shortly after the October 5, 1995 work incident showed degeneration within the femoral condyle. Dr. Pelmas, however, found that the October 13, 1995 x-ray was normal. The x-ray report of October 13, 1995 provides that the x-ray was taken to "check for degenerative changes." However, the findings included only a "tiny spur" of the patella, "minimal spurring" of the tibial spines, and "no significant joint space narrowing." (Ex. 3). The record does not show an x-ray finding of osteonecrosis until December 1995. (Ex. 11). Accordingly, without more explanation from Dr. Mandiberg, we do not find his opinion persuasive.

Dr. Mandiberg also based his opinion regarding a preexisting condition on the fact that claimant had injured his right knee in 1990. However, both Drs. Pelmas and Koski have persuasively explained that, if claimant's osteonecrosis had arisen as a result of the 1990 injury, claimant would not have been free of symptoms for five years, and would not have been able to perform the type of routine strenuous exercise described at hearing. Consequently, for this additional reason, we find that Dr. Mandiberg's opinion is not persuasive.

Next, we conclude that, although Dr. Noall concurred with Dr. Mandiberg's opinion, his concurrence took place in a "check-the-box" format, with no reasoning to support his conclusion. We do not find such an opinion persuasive. See Marta I. Gomez, 46 Van Natta 1654 (1994). Furthermore, because Dr. Noall indicates agreement with Dr. Mandiberg's "findings," which we have above rejected, we similarly reject Dr. Noall's opinion.

Finally, we give little weight to Dr. Ushman's opinion that claimant has a preexisting condition. Dr. Ushman saw claimant on one occasion and did not examine him at that time. Dr. Ushman's first impression was that the osteonecrosis condition was "probably" the result of an industrial injury. (Ex. 26c). However, Dr. Ushman later indicated in a "check-the-box" response that claimant had a preexisting condition. Dr. Ushman's response contains no reasoning to support his conclusion. Moreover, there is no evidence that he reviewed claimant's prior x-rays before providing a response. (Ex. 29).

Accordingly, we find no persuasive medical evidence that claimant has a preexisting condition. Therefore, we agree with claimant that the case is properly analyzed pursuant to ORS 656.005(7)(a). Furthermore, based on the opinions of Drs. Pelmas and Koski, we conclude that claimant has established the compensability of his osteonecrosis condition under either a standard of major or material contributing cause. Therefore, we reverse the ALJ's order on the issue of compensability.

Penalties and Attorney Fees/Discovery Violation

The ALJ found that the insurer conceded that its discovery was untimely. However, because the ALJ found the claim not compensable, he also found that there were no "amounts due" upon which to base a penalty.

Because no reason has been provided for the insurer's untimely disclosure, we agree that the insurer's untimely production of documents was unreasonable. However, inasmuch as the insurer's denial preceded the discovery violation, there was no compensation due at the time of the violation. Therefore, there were no "amounts then due" at the time of the 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); Janice A. Talevich, 48 Van Natta 2318 (1996).

Notwithstanding our conclusion that there is no basis for a penalty, we find that, because of our compensability decision regarding claimant's knee condition, an attorney fee pursuant to ORS 656.382(1) is appropriate. 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 an attorney fee award under ORS 656.382(1) provided the 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 the insurer's concession, that the failure to provide the document was unreasonable. Inasmuch as the document was important to the compensability issue, we conclude that the insurer unreasonably resisted the payment of compensation after it issued its denial of compensability. Accordingly, we assess an attorney fee under ORS 656.382(1). Talevich, 48 Van Natta at 2321; Betty V. West, 46 Van Natta 1469 (1994) (No penalty available for discovery violation because no amounts "then due." However, some conduct may amount to unreasonable resistance to the payment of compensation supporting assessment of an attorney fee under ORS 656.382(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 the insurer's discovery violation is $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), the complexity of the issue, and the value of the interest involved.

Attorney Fees

Claimant is entitled to an assessed attorney fee for finally prevailing against the insurer's 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 assessed attorney fee for claimant's counsel's services at hearing and on review regarding the compensability of the osteonecrosis condition is $5,800. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellant briefs, and counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated. We note that no attorney fee is available for services devoted to the contusion claim and that claimant's counsel is being separately compensated for services devoted to the discovery issue.

ORDER

The ALJ's order dated October 1, 1996 is reversed. The insurer's February 22, 1996 denial is set aside and the claim is remanded to the insurer for acceptance and processing according to law. For its unreasonable discovery violation, the insurer is assessed an attorney fee of $500, to be paid to claimant's counsel. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $5,800, to be paid by the insurer.

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May 15, 1997 Cite as 49 Van Natta 628 (1997)

In the Matter of the Compensation of
**JOHNNY R. JOHNSON, Claimant**
WCB Case No. 96-04174
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) declined to set aside the self-insured employer's denial of a medical bill; and (2) did not award an attorney fee pursuant to ORS 656.386(1). In its brief, the employer argues that the Board lacks jurisdiction over this medical services dispute. On review, the issues are jurisdiction, and, if jurisdiction, compensability and attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim with the employer for a 1992 low back injury. In February 1996, claimant filed an aggravation claim which the employer denied on April 22, 1996. On June 20, 1996, the employer sent a letter to Portland Orthopedic Clinic indicating that a medical bill, which had been

submitted for medical services performed on March 26, 1996, would not be paid because the claim had been denied. (Ex. 69). After a hearing on claimant's challenge of the denial, the ALJ upheld the aggravation denial and neither party contests this portion of the ALJ's order.

At hearing, claimant also sought to have the employer's denial of the medical bill set aside. In response, the employer's counsel asserted that the employer did not dispute the bill on the ground that the treatment was not causally related to the compensable low back claim. (Tr. 9). Instead, the employer contended that it objected to the medical bill on grounds over which the Hearings Division lacked jurisdiction. The ALJ found that the disputed medical bill was for treatment for the denied aggravation claim and "found no fault in rejecting a billing for treatment under the aggravation claim." On that basis, the ALJ upheld the employer's denial of the medical bill.

On review, claimant seeks to have the denial of the medical bill set aside and seeks an attorney fee under ORS 656.386(1) for overcoming a denial of a "denied claim." Claimant acknowledges that although the aggravation claim was denied, the 1992 claim remains accepted. The employer asserts that it does not dispute the causal relationship between the medical treatment and the 1992 compensable injury. Instead, the employer disputes that claimant's medical treatment is compensable under ORS 656.245.

In SAIF v. Shipley, 147 Or App 26 (1997), the claimant suffered a compensable knee injury in 1989. The claim was closed with an award of temporary and permanent disability. Thereafter, the claimant experienced an off-the-job injury and began receiving treatment. Claimant did not seek benefits for time loss. Nevertheless, the carrier issued a letter denying that the claimant had experienced a worsening of his compensable condition and denying a request to reopen the claim. In rejecting the claimant's contention that this " * * * is not a case that concerns only the compensability of medical services," the court stated:

> "As the ALJ and the Board found, and as the parties appear to agree, claimant has never sought benefits for an aggravation of his 1989 injury. He has never sought to establish the compensability of a new consequential condition. He seeks only treatment of his current condition, contending that the treatment is compensable under ORS 656.245 because it is materially related to the 1989 injury. The fact that SAIF's denial encompassed more than what claimant was seeking does not enlarge the scope of this dispute beyond the scope of the claim. This is and has always been a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6). The Board lacked jurisdiction to consider the matter." (Emphasis added).

Here, unlike in Shipley, claimant did file a claim for aggravation and the processing agent denied that aggravation claim. The parties litigated the aggravation denial. The ALJ upheld the denial and the parties do not dispute that part of the Opinion and Order. However, in this case, the processing agent also denied payment of a medical bill. This bill was not encompassed within claimant's aggravation claim and, thus, was likewise not encompassed within the employer's aggravation denial. In light of such circumstances, the medical bill dispute which pertained to medical services for an accepted condition is subject to the jurisdiction of the Director pursuant to ORS 656.245(6). Because this matter is within the Director's jurisdiction, the ALJ likewise lacked authority to award attorney fees. ORS 656.385(5).

## ORDER

The ALJ's order dated September 20, 1996 is vacated in part and affirmed in part. That portion of the ALJ's order which addressed the medical services denial is vacated. The remainder of the order is affirmed.

In the Matter of the Compensation of
**WANDA S. McCLAIN, Claimant**
WCB Case No. 95-07628
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order which: (1) determined that the self-insured employer's partial denial was procedurally proper; (2) upheld the employer's denial of claimant's claim for his right shoulder and arm conditions; and (3) declined to award penalties and attorney fees for the employer's allegedly unreasonable denial. On review, the issues are the procedural propriety of the employer's denial, claim processing, compensability, penalties and attorney fees.

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

On November 21, 1991, claimant, a bus driver, sustained a compensable injury when a passenger fell, landing on claimant's right arm, right shoulder and neck. The employer accepted the claim as a "nondisabling" claim for cervical strain, thoracic strain, and paresthesia of the right hand. (Ex. 6). The claim was eventually reclassified to "disabling" in October 1993. (Ex. 27). A Notice of Closure was issued on April 18, 1995, which awarded temporary disability for various periods from August 6, 1993 to January 23, 1995. (Ex. 50).

On May 1, 1995, the employer issued a partial denial of several right shoulder and arm conditions on the ground that they were not related to the compensable injury. (Ex. 52). Claimant requested a hearing.

At hearing, claimant contended that the employer's denial was procedurally improper and that the denied conditions were compensable. The ALJ determined, however, that the employer's denial was procedurally proper and that the denied conditions were not compensable. We agree with the ALJ's reasoning, but address the contention that the employer's reclassification of the claim in October 1993 to "disabling" status operated as an acceptance of claimant's right shoulder impingement condition and related surgery in November 1993.

Claimant reasons that, since the employer reclassified her claim to "disabling" more than a year after her compensable November 1991 injury, it necessarily accepted an "aggravation" claim in October 1993. See former ORS 656.277(2).[1] Claimant further argues that, because the employer did not specify what condition was accepted, an examination of the circumstances surrounding the acceptance is necessary to determine the nature of the employer's acceptance. See SAIF v. Tull, 133 Or App 449 (1992). Noting that she received medical treatment and temporary disability for her right shoulder condition when her claim was reclassified, claimant asserts that the employer accepted the right shoulder condition in October 1993 when it reclassified the claim.

Claimant's contentions notwithstanding, we are not persuaded that the employer accepted an "aggravation" claim in October 1993 when it voluntarily reclassified claimant's claim to "disabling." Insofar as this record establishes, claimant made no request for reclassification of her claim. Moreover, the medical records contemporaneous with the employer's reclassification do not support a finding that an "aggravation" claim was made. To the contrary, although claimant was receiving medical treatment for the right shoulder impingement condition, the medical records do not indicate that claimant was experiencing a worsening of her right shoulder condition when her claim was reclassified. (Exs. 24, 25, 26). Dr. Kaesche, claimant's attending physician, specifically stated that claimant was "fit for employment." (Exs. 24, 26).

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[1] At the time this claim was reclassified, former ORS 656.277(2) provided that "[a] claim that a nondisabling injury 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." The current version of ORS 656.277(2) does not differ from the former version in any way material to this claim.

It appears that the employer apparently authorized right shoulder surgery in November 1993. (Ex. 31). However, this was after the employer had reclassified the claim in October 1993. In addition, the record does not establish that the employer authorized the surgery in response to an aggravation claim. (Exs. 28, 29, 30). While claimant received temporary disability as a result of the employer's voluntary reclassification of the claim, payment of compensation does not constitute acceptance of a condition. ORS 656.262(10).

In conclusion, we agree with the ALJ that the employer's reclassification of the claim in October 1993 did not result in acceptance of claimant's right shoulder condition. Accordingly, we affirm.[2]

ORDER

The ALJ's order dated October 18, 1996 is affirmed.

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[2] In Jean B. Rogers, 48 Van Natta 1307 (1996), the employer accepted the claimant's claim as a compensable aggravation. Inasmuch as the aggravation claim was made pursuant to ORS 656.277(2) as a request for reclassification of the claimant's injury claim, we held that the employer's acceptance of the claim necessarily required it to reclassify the claim as "disabling." However, we do not construe our decision in Rogers as compelling a finding that the reclassification of the claim to "disabling" in this case necessarily means that an "aggravation" claim was made. Moreover, in Rogers, there was no dispute that the claimant's claim was an "aggravation" claim made more than one year after the date of injury pursuant to ORS 656.277(2). In contrast to Rogers, we have determined that the record here does not establish the existence of either an aggravation claim or a request for reclassification prior to the employer's voluntary reclassification in October 1993. Alternatively, even if the employer's reclassification operated as an acceptance of an "aggravation" claim, we would conclude that this did not result in acceptance of claimant's right shoulder condition. To the contrary, acceptance of an aggravation claim would only constitute an admission that claimant's previously accepted conditions (cervical strain, thoracic strain and right hand paresthesia) had compensably worsened, not that a noncompensable condition had been accepted.

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In the Matter of the Compensation of
**MELBA D. MOORE, Claimant**
WCB Case No. 96-06632
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order which: (1) declined to award interim compensation from June 13, 1996 through August 30, 1996; and (2) declined to award penalties and attorney fees for the insurer's allegedly unreasonable failure to pay interim compensation. On review, the issues are interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ declined to award claimant interim compensation in regard to her aggravation claim, finding that the medical evidence was insufficient to trigger the insurer's duty to pay interim compensation pursuant to ORS 656.273(6). On review, claimant contends that interim compensation was due from June 13, 1996, the date her attending physician, Dr. Teal, authorized temporary disability. We disagree.

In an aggravation claim, the first installment of interim compensation shall be paid no later than the 14th day after the insurer had notice or knowledge of a medically verified inability to work in the form of a medical report that constitutes prima facie evidence of a compensable worsening under ORS

656.273(1). ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993). Medical verification of an inability to work so as to trigger the insurer's obligation to begin paying interim compensation must come from claimant's attending physician. SAIF v. Christensen, 130 Or App 346, 348 (1994).

A compensable worsening under ORS 656.273(1) is a worsened condition established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. In SAIF v. Walker, 145 Or App 294 (1996), issued subsequently to the ALJ's order, the court held that the term "actual worsening" was not intended to include a symptomatic worsening, but rather it was intended to require proof of a pathological worsening.

In this case, Dr. Teal provided medical verification of claimant's inability to work on June 13, 1996 when he stated that claimant was "permanently off work." (Exs. 17, 17A). However, Dr. Teal's medical reports provided no "prima facie" evidence of a compensable worsening before the insurer began voluntarily paying temporary disability on August 31, 1996. In other words, Dr. Teal's medical reports contained no evidence that claimant's compensable condition had pathologically worsened. (Exs. 17A, 17B, 20a, 22).

Accordingly, we agree with the ALJ that claimant was not entitled to payment of interim compensation during the period in dispute. We, therefore, affirm.[1]

ORDER

The ALJ's order dated October 25, 1996 is affirmed.

[1] It follows from our decision that the insurer's failure to pay interim compensation was not unreasonable. Thus, we also decline claimant's request that we award penalties or attorney fees.

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May 15, 1997 Cite as 49 Van Natta 632 (1997)

In the Matter of the Compensation of
**PHILIP UNICH, Claimant**
WCB Case No. 96-04794
ORDER ON REVIEW
Dennis H. Henninger, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that assessed a 25 percent penalty for its allegedly unreasonable denial of claimant's injury claim for a herniated cervical disc condition. On review, the issue is penalties.

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

On review, the employer contends that its denial was reasonable based on all of the evidence available at the time of the denial. We disagree. A penalty may be assessed when a carrier unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The standard for determining whether the carrier's denial was unreasonable, is whether the carrier had a legitimate doubt as to its liability for the claim. See Brown v. Argonaut Insurance Co., 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier at the time of its denial. Id.; Ginter v. Woodburn United Methodist Church, 62 Or App 118, 122-23 (1983).

In February 1996, claimant filed a claim for left neck and upper back pain which developed following a discrete period of physically strenuous work activities (i.e., installing panels) in January 1996. The pain was ultimately diagnosed to be due to a herniated disc at C6-7 on the left. The medical

evidence revealed a preexisting degenerative condition (spondylosis) in the cervical spine, which combined with the work exposure to produce the disc herniation, resulting in his subsequent disability and need for treatment, including surgery.

On May 14, 1996, the employer denied claimant's claim for the herniated cervical disc condition on grounds that the preexisting cervical condition was the major cause of the disc herniation and need for surgery. At the time of the denial, the employer had in its possession medical opinions by Drs. Wright and Hutchinson. On April 2, 1996, Dr. Wright, consulting neurosurgeon, opined that work conditions were responsible for claimant's symptoms. (Ex. 18). On May 2, 1996, claimant was examined by Dr. Hutchinson, orthopedic surgeon, at the employer's request. Dr. Hutchinson opined that the "[work] injury [was] the major contributing cause (51% or more) of his current condition and need for treatment." (Ex. 21-9). He reasoned that, although the disc herniation would not have occurred but for the preexisting degenerative condition, claimant was able to perform his work activities until the work exposure caused a significant change in his condition. (Ex. 21-10).

The employer argues that the doctors' opinions were insufficient to carry claimant's burden of proof under the "major contributing cause" standard. We disagree. We are persuaded that both doctors weighed the relative contributions of the preexisting condition and work exposure and concluded that the work exposure was the primary cause. See Dietz v. Ramuda, 130 Or App 397, 401 (1994). They gave reasoned opinions to support their conclusions, and their opinions were sufficiently persuasive to establish compensability. The employer's assertions regarding deficiencies in their opinions, if valid, would only go to the weight of their opinions vis-a-vis opinions that supported noncompensability. Here, there were no such contrary opinions. In addition, we have not reviewed evidence generated after the date of the denial, because, as we stated above, the reasonableness of the employer's denial is judged based on the evidence available to the employer prior to issuance of the denial. See Brown, 93 Or App at 591; Ginter, 62 Or App at 122-23.

Thus, at the time of the employer's denial, the medical opinions supported the compensability of the cervical disc condition under the "major contributing cause" standard, and there was no medical evidence to the contrary. Based on this record, we agree with the ALJ's finding that the employer had no legitimate doubt that it was liable for the claim. Accordingly, the penalty was properly assessed.

Claimant's attorney is not entitled to an assessed fee award under ORS 656.382(2) for services rendered on review in defense of the ALJ's penalty assessment. See SAIF v. Saxton, 80 Or App 631 (1986).

## ORDER

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

In the Matter of the Compensation of
**SUZANNE N. GIBERT, Claimant**
WCB Case No. 96-04126
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that awarded claimant 20 percent (64 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration awarded no permanent disability. In her respondent's brief, claimant challenges the ALJ's decision to admit Exhibit 25a, a medical report which employer did not timely disclose to claimant. On review, the issues are evidence and extent of unscheduled permanent disability.

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

At hearing, claimant objected to the admission of Exhibit 25a, a letter signed by claimant's attending physician indicating her concurrence with the findings and recommendations of the insurer-arranged medical examiners. Claimant argued that the report should be excluded pursuant to the Board's discovery rules because it was not timely disclosed to her.[1] Noting that the concurrence letter was part of the record on reconsideration (and even specifically referenced in the reconsideration worksheet), the ALJ elected to admit the exhibit over claimant's objection.

We need not resolve the question regarding the propriety of the ALJ's ruling because we concur with the ALJ's determination that neither the findings of the insurer-arranged medical examiners nor the concurrence of Dr. Thomasson were persuasive evidence on the issue of claimant's permanent impairment. Consequently, regardless of whether the disputed exhibit was considered, we would agree with the ALJ's conclusion regarding claimant's permanent disability.

Claimant's attorney is entitled to an assessed fee for services on review with regard to the employer's appeal of her unscheduled permanent disability award. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, 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 her counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 29, 1996, as reconsidered December 3, 1996, is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the employer.

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[1] If there is material prejudice to a party resulting from the other party's failure to comply with the disclosure requirements of OAR 438-007-0015, the ALJ has the discretion to remedy the untimely disclosure by continuing the hearing or by excluding the documents at hearing. See OAR 438-007-0018(4); see also OAR 438-007-0015(5).

In the Matter of the Compensation of
**JENNIFER L. BROWN, Claimant**
WCB Case No. 96-06872
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's hyperventilation syndrome claim. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

While working, claimant experienced headache, nausea, and difficulty breathing. At that time, construction was being performed and there was the presence of paint fumes. An ambulance transported claimant to the hospital emergency room, where Dr. Sandberg, M.D., treated claimant. Dr. Sandberg diagnosed toxic fume exposure and hyperventilation syndrome. (Ex. A-1).

The ALJ found that claimant proved that work exposure was at least a material contributing cause of the need for medical services and that claimant had established compensability. SAIF objects to the ALJ's order, first arguing that, under ORS 656.802(1)(a)(A), the claim should be analyzed as one for occupational disease and, alternatively, claimant failed to prove that work conditions were even a material contributing cause of her hyperventilation syndrome. Claimant responds that medical evidence is not necessary to prove the claim because it is not complicated.

In order to determine if expert medical evidence of causation is necessary, the following factors are considered: (1) whether the situation is not 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 is any expert testimony that the alleged precipitating event could not have been the cause of the injury. E.g., Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). We find that, under these factors, this case is complicated. First, symptoms did not appear immediately; claimant's headache developed about 45 minutes after she began working and the paramedics were not called until about four hours after claimant's arrival at work. (Ex. A-2, Tr. 22). Dr. Sandberg also explained it is difficult to decide whether an external factor causes hyperventilation since the process has a "snowballing effect" due to anxiety combining with overbreathing. (Ex. 9-18). We find such evidence shows that hyperventilation is a complicated situation. Finally, Dr. Sandberg indicated only a possibility that the paint fumes were a cause of claimant's hyperventilation. (Id. at 13, 19). Thus, there is expert medical evidence that paint fumes could not have been the cause of the hyperventilation.

Based on these factors, we conclude that this case is complex and requires medical evidence of causation. As discussed above, Dr. Sandberg provided only that the paint fumes possibly were a material contributing cause of claimant's hyperventilation syndrome. Thus, whether the claim is one for accidental injury or occupational disease, claimant did not prove compensability. ORS 656.005(7)(a), 656.802(2); Gormley v. SAIF, 52 Or App 1055 (1981). Therefore, we reverse the ALJ's order.

## ORDER

The ALJ's order dated January 7, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
**WENDY R. BYE, Claimant**
WCB Case No. 96-10356
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order which upheld the self-insured employer's denial of her occupational disease claim for bilateral ulnar neuropathy and bilateral anterior scalene syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding the compensability of the bilateral anterior scalene syndrome.

The ALJ upheld the employer's denial, finding that the medical opinion of the only physician to address the causation of claimant's bilateral anterior scalene syndrome, Dr. Peterson, failed to establish that claimant's work activity as a grocery checker was the major contributing cause of this condition or its worsening. On review, claimant contends that Dr. Peterson's opinion establishes that the symptoms of bilateral anterior scalene syndrome are the disease and that her work activity was the major contributing cause of this condition. For the following reasons, we disagree with claimant's contentions.

To establish a compensable occupational disease, claimant must prove that her work activities were the major contributing cause of her bilateral anterior scalene syndrome. See ORS 656.802(2)(a). Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. See Weller v. Union Carbide, 288 Or 27 (1980). However, if the medical evidence establishes that claimant's symptoms are the disease, a worsening of symptoms that is caused, in major part, by work conditions may be compensable. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

Here, claimant cites Dr. Peterson's deposition testimony that anterior scalene syndrome is normally diagnosed by its symptoms, that treatment is provided for the "constellation" of symptoms, and that the symptoms of the syndrome cause disability. (Ex. 65-20). However, we are not persuaded that Dr. Peterson's medical opinion establishes that the symptoms of bilateral anterior scalene syndrome are the disease.

First, Dr. Peterson never expressly stated that symptoms of bilateral scalene syndrome are the disease. See Donald M. Lewis, 48 Van Natta 950 (1996) (physician's opinion unpersuasive when he did not conclude that the claimant's symptoms were the disease). Moreover, in her September 14, 1995 report, Dr. Peterson concluded that claimant's work activity of reaching over a scanner for groceries contributed to the "symptoms" of the condition, but that it did not result in the worsening of the "underlying pathology." (Ex. 62-2). In her deposition, Dr. Peterson reiterated her opinion that claimant's work activities did not worsen the underlying pathology of the bilateral scalene syndrome. (Ex. 65-24, 25).

In light of the distinction Dr. Peterson has drawn between the symptoms of bilateral scalene syndrome and the underlying disease or pathology, we are not persuaded that this record proves that the symptoms of this condition are the disease. See Matthew R. Ross, 47 Van Natta 698 (1995) (where distinction drawn between carpal tunnel symptoms and the underlying condition, the symptoms were not the disease). Moreover, because Dr. Peterson's testimony establishes that claimant's work activity only affected the symptoms of her condition, we further conclude that claimant has failed to sustain her burden of proving that her occupational disease claim is compensable. Weller v. Union Carbide. Accordingly, we affirm.

ORDER

The ALJ's order dated December 18, 1996 is affirmed.

In the Matter of the Compensation of
**KAREN S. CARMAN, Claimant**
WCB Case No. 96-07089
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial of a right shoulder condition. On review, the issue is compensability.

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

Claimant compensably injured her right shoulder as a result of work-related incidents on June 15, 1995 and June 22, 1995. SAIF accepted the claim for a disabling right shoulder strain, right subacromial bursitis, and right shoulder impingement syndrome.

On May 6, 1996, claimant requested that SAIF accept right shoulder peritendinitis calcarea and calcific tendinitis of the rotator cuff.[1] (Ex. 18). SAIF denied the claim on September 20, 1996, on the ground that the compensable injury did not pathologically worsen or accelerate the preexisting condition. (Ex. 29). Claimant requested a hearing.

On October 16, 1996, SAIF accepted the disputed right shoulder condition as part of a "combined condition" pursuant to ors 656.005(7)(a)(B). (Ex. 31). SAIF's acceptance noted that the combined condition was accepted so long as and to the extent that the otherwise compensable injury was the major contributing cause of the disability and need for treatment of the combined condition. Id. SAIF did not withdraw any part of its prior denial.

At hearing, the issue was whether SAIF's amended acceptance of a "combined condition" and its prior denial of the preexisting right shoulder condition could coexist, or whether SAIF's acceptance of the disputed right shoulder condition as part of a "combined condtion" required that its prior denial be set aside.[2] Upholding SAIF's denial, the ALJ determined that both SAIF's denial and its acceptance could coexist. We agree.

Here, claimant formally requested acceptance of claimant's preexisting right shoulder condition in and of itself. (Ex. 18). Inasmuch as the medical evidence established that the compensable injury did not pathologically worsen the right shoulder condition, SAIF's denial was appropriate. However, the medical evidence also established that the compensable injury "combined" with the preexisting right shoulder condition to cause disability or a need for treatment. ORS 656.005(7)(a)(B) does not require a pathological worsening of a preexisting condition, see Robert C. Train, 45 Van Natta 2329 (1993), only that the otherwise compensable injury is the major contributing cause of the disability and need for treatment of the "combined condition." consequently, SAIF's acceptance of a "combined condition" is both logically and legally correct under the current statutory scheme.

We, therefore, agree with the ALJ that SAIF's acceptance of a combined condition does not require that its prior denial be set aside. Accordingly, we affirm.

ORDER

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

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[1] Claimant's attending physician, Dr. Tilson, indicated that these diagnoses are synonymous. (Ex. 26A-1). We, therefore, consider the disputed right shoulder claim to consist of only one condition, described either as peritendinitis calcarea or as calcific tendinitis of the rotator cuff.

[2] The ALJ found, the parties do not dispute, and we find that the disputed right shoulder condition preexisted the compensable June 1995 injury; the disputed right shoulder condition "combined" with the compensable injury to cause or prolong disability or a need for treatment; and the compensable right shoulder injury did not pathologically worsen the disputed right shoulder condition.

In the Matter of the Compensation of
**JANICE K. GONZALEZ, Claimant**
WCB Case No. 95-06243
ORDER ON REVIEW
Charles D. Beshears, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that awarded claimant's counsel an extraordinary attorney fee under ORS 656.308(2)(d) of $7,265 for prevailing over the insurer's responsibility denial. On review, the issue is attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial of responsibility for claimant's low back claim and awarded claimant's counsel an assessed attorney fee pursuant to ORS 656.308(2)(d). The ALJ found that claimant had shown extraordinary circumstances to justify an attorney fee award of $7,265 for his counsel's services at hearing.

On review, the insurer argues that the case did not present extraordinary circumstances and the ALJ's attorney fee award should not have exceeded the $1,000 statutory limit set forth in ORS 656.308(2)(d). Specifically, the insurer contends that the length of the hearing, the number of witnesses and the number of exhibits do not comprise "extraordinary circumstances."

We agree with the ALJ's conclusion that claimant has established extraordinary circumstances sufficient to justify an attorney fee in excess of the $1,000 statutory limit. Although we agree with the insurer that the length of the hearing (approximately two hours), the number of witnesses (3) and the number of exhibits (95) would not normally justify extraordinary circumstances, see Steve H. Salazar, 48 Van Natta 2389 (1996) on recon 49 Van Natta 5 (1997), there are additional factors present which support the extraordinary fee award.

Here, as claimant has explained, the case involved complex issues beyond that of the ordinary case. For example, claimant was required to prepare to litigate issues involving timeliness, the retroactive application of the responsibility statute, the constitutionality of the statute, and to defend against the insurer's "back-up responsibility denial" defense. Accordingly, we find that the record, including claimant's counsel's affidavit and statement of services, support an extraordinary attorney fee award. See Harley I. Gordineer, 48 Van Natta 80 (1996).

Finally, the insurer alternatively argues that, even if claimant is entitled to a fee in excess of $1,000, the ALJ's attorney fee is, nevertheless, excessive. The insurer again contends that the hearing, length of the record, and number of witnesses in this case does not justify such a fee. The insurer argues that, although claimant's counsel documented extensive research time on his statement of services, the Board has awarded a less substantial attorney fee in cases where similar research would have been required. The insurer also "speculates" that the size of the fee must have been increased due to the fact that there was no basis for a penalty or attorney fee award for other claims processing issues.

Claimant, on the other hand, argues that the value of her case is substantial, the case involved complex issues requiring significant research, and the case was difficult to prepare, due to numerous additional medical records which were not necessarily part of the submitted exhibits. Claimant's counsel also contends that, due to claimant's memory difficulties, additional time was required to prepare her for the hearing and to prepare the "equitable estoppel" issue.

Based on our review of the record and claimant's counsel's affidavit and statement of services, we conclude that the ALJ's attorney fee award is appropriate. We find absolutely no indication in either the ALJ's order, or in claimant's counsel's statement of services, that any portion of the fee is being claimed or was awarded for an unavailable penalty or fee issue. Additionally, the factors cited by the insurer to support its contention that this was a "standard" responsibility case have been previously discussed and rejected. Again, we point to the fact that numerous complex procedural issues were involved which required research on behalf of claimant's counsel.

Moreover, the insurer has not identified any particular portion of the statement of services to allege that certain services were duplicative, unnecessary, or excessive, nor do we find such circumstances on review. Although the insurer has raised the issue of time spent on research, the insurer has not shown that the researched subjects were not relevant or were issues that had been previously conceded. Additionally, the insurer has also not challenged claimant's counsel's hourly attorney fee rate ($125), which we find to be reasonable considering the particular circumstances present in this case. See Schoch v. Leupold & Stevens, 325 Or 112 (1997) (Where the Board's attorney fee award was less than the amount requested by the claimant's counsel pursuant to a statement of services, the Board's order was inadequate for "substantial evidence" review because it lacked a rationale for the disparate award).

Based on the foregoing reasoning, we find that claimant is entitled to an extraordinary attorney fee under ORS 656.308(2)(d) of $7,265. See OAR 438-015-0010(4). In particular, we have considered the time devoted to the case (as represented by claimant's counsel's affidavit and statement of services and the record, including the insurer's objections), the complexity of the issues, and the nature of the proceeding.

Although claimant has provided a respondent's brief on review, we note that no attorney fee award is available, as the only issue on review was attorney fees. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Finally, we note that, on review, claimant argues that he is entitled to a carrier-paid attorney fee pursuant to ORS 656.386(1). We are not inclined to consider claimant's argument, as it has been raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). However, even if claimant had previously raised such an issue, we would not find an entitlement to such a fee, as the insurer's denial denied responsibility only (Ex. 51), and the parties agreed at hearing that the issue was one of responsibility. (Tr. 2, 3).

ORDER

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

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May 19, 1997 Cite as 49 Van Natta 639 (1997)

In the Matter of the Compensation of
**TERESA KERSEY-SHERBINA, Claimant**
WCB Case No. 96-06593
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

On April 30, 1997, we issued an Order on Review which affirmed an Administrative Law Judge's order that: (1) determined that the self-insured employer's partial denial issued in response to claimant's objection to a Notice of Acceptance was not premature; and (2) upheld the employer's partial denial of claimant's L5 spondyloysis and L5-S1 disc herniation with left S1 nerve root involvement. On our own motion, we withdraw our prior order and replace it with the following order.

In our previous order, we reasoned that, while the statutory language in ORS 656.262(6)(d) appears to allow a carrier to respond to a claimant's objection to an acceptance notice in a manner other than a formal claim denial, it also does not prevent a carrier from issuing a "written clarification" in the form of a denial. Therefore, we concluded that the employer's denial was a legally permissible response under ORS 656.262(6)(d) to claimant's "objection" to a Notice of Acceptance.

We did not, however, refer to OAR 438-005-0050(2), which provides:

"In the event that the insurer or self-insured employer disagrees with all or any portion of a worker's objections to a notice of claim acceptance under ORS 656.262(6)(d), the insurer's or self-insured employer's written response shall specify the reasons for the disagreement, and shall contain a notice, in prominent or bold-face type, as follows:

"IF YOU DISAGREE WITH THIS DECISION, YOU MAY FILE A LETTER WITH THE WORKERS' COMPENSATION BOARD, 2250 McGILCHRIST STREET, S.E., SALEM, OREGON 97310. YOUR LETTER SHOULD STATE THAT YOU WANT A HEARING, YOUR ADDRESS, THE DATE OF YOUR INJURY, AND YOUR CLAIM NUMBER.

"IF YOUR CLAIM QUALIFIES, YOU MAY RECEIVE AN EXPEDITED HEARING WITHIN 30 DAYS. YOUR REQUEST CANNOT, BY LAW, AFFECT YOUR EMPLOYMENT. YOU MAY BE REPRESENTED BY AN ATTORNEY OF YOUR CHOICE AT NO COST TO YOU FOR ATTORNEY FEES. IF YOU HAVE QUESTIONS YOU MAY CALL THE BENEFITS SECTION TOLL FREE IN OREGON 1-800-452-0288 OR IN SALEM OR FROM OUTSIDE OREGON AT (503) 945-7585."

The administrative rule does not expressly provide for a "denial" as a permissible response to an objection to a Notice of Claim Acceptance. It merely states that the carrier's "written response" shall state the reasons for disagreement with a claimant's "objection." However, neither the rule nor any other statutory or administrative requirement precludes a carrier from also responding to an objection to an acceptance notice by means of a denial. Under such circumstances, we do not find the administrative rule inconsistent with our holding that a denial is a legally appropriate response to an objection to an acceptance notice.

In reaching this conclusion, we recognize that the appeal rights recited in OAR 438-005-0050(2) differ from those that accompany a denial. However, the purpose of the appeal rights that accompany both a denial and a carrier's disagreement is to advise a claimant of the right to request a hearing (Pursuant to ORS 656.319(1)(a), a claimant has 60 days within which to request a hearing from a denial, whereas there is no time limit for requesting a hearing from a disagreement with an objection to an acceptance notice). Since the primary objective under both devices is to enable the parties to seek resolution of their disputes, we conclude that the appeal rights that accompanied the employer's denial satisfied the notice requirements of OAR 438-005-0050(2).

Accordingly, we withdraw our April 30, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our April 30, 1997 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
**CHRISTOPHER L. MILLER, Claimant**
WCB Case No. 96-02390
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that set aside its partial denial of claimant's claim for a left wrist condition. On review, the issue is compensability.

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

On review, the insurer first argues that it has not been established that claimant's preexisting left wrist fracture combined with the compensable injury. We disagree. At the time of his deposition, Dr. Buehler, the surgeon who operated on claimant's left wrist, testified that the preexisting condition had combined with the work injury. (Ex. 27). Accordingly, we conclude that the ALJ correctly analyzed the claim pursuant to ORS 656.005(7)(a)(B).

The insurer also contends that, in concluding that the work injury was the major contributing cause of the combined condition, Dr. Buehler has relied solely on the fact that claimant's preexisting condition was asymptomatic prior to the work incident. The insurer argues that, pursuant to Board and court cases, a "but for" or "precipitating cause" analysis is not sufficient in a case involving a combined condition. See Dietz v. Ramuda, 130 Or App 397 (1994); Alec Snyder, 47 Van Natta 838 (1995).

After reviewing Dr. Buehler's opinion in its entirety, we disagree that the opinion is based solely on a "but for" or "precipitating cause" analysis. The asymptomatic nature of claimant's preexisting condition prior to the work injury was a factor considered by Dr. Buehler. However, Dr. Buehler also explained that when the work injury combined with the preexisting condition, the "fibrous union became disrupted leading to motion at the fracture site and discomfort." Dr. Buehler further testified that the work injury of March 1, 1995 would have broken apart or disrupted the fibrous union. (Ex. 27-8).

We conclude that Dr. Buehler's opinion is persuasive as it considers the preexisting condition and the contribution of the work injury, and explains why the work injury is the major cause of the combined condition. Moreover, there is no contrary medical opinion which rebuts Dr. Buehler's opinion. Based on Dr. Buehler's testimony, we agree with the ALJ that claimant has established the compensability of his left wrist condition.

Claimant's attorney 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 conclude that a reasonable attorney fee for services on review is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 20, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
**JOSEPH S. ORLOW, Claimant**
WCB Case No. 96-05721
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

## FINDINGS OF FACT

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

On January 26, 1996, claimant experienced a left shoulder injury at work for which he sought medical treatment. On April 15, 1996, claimant filed a formal claim for his injury. On May 22, 1996, claimant filed a request for hearing alleging that SAIF "de facto" denied the claim on the basis that the employer had knowledge of the injury in January 1996, and requesting an attorney fee under ORS 656.386(1). On July 25, 1996, SAIF formally accepted claimant's claim.

At hearing, claimant raised as an alternative theory supporting an attorney fee for a "de facto" denial SAIF's failure to timely accept or deny the claim.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that the employer did not have knowledge of claimant's compensable shoulder injury in January 1996. The ALJ also found that claimant's May 22, 1996 request for hearing was premature and there was no additional request for hearing asserting a "de facto" denial based on SAIF's failure to accept or deny the claim within 90 days. Accordingly, the ALJ declined to award an attorney fee because claimant had failed to perfect his claim.

On review, claimant contends that SAIF is liable for an attorney fee for the "de facto" denial of the shoulder injury arising out of the employer's knowledge of the claim, or, alternatively, for the "de facto" denial resulting from SAIF's failure to accept or deny timely. We conclude that claimant's request for an attorney fee based on SAIF's untimeliness was properly before the ALJ.[1] Nevertheless, whether the "de facto" denial arose from the employer's knowledge of the claim or from SAIF's failure to accept or deny timely, we find that claimant is not entitled to an attorney fee under ORS 656.386(1).

Under amended ORS 656.386(1), which is applicable in this case, a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation."

Here, there is no contention that any benefits for claimant's shoulder condition have been unpaid. Moreover, the record does not establish that the employer refused to pay compensation on the express ground that the shoulder condition was not compensable or did not give rise to an entitlement to compensation. Therefore, under these circumstances, no "denied claim" has been established and no

[1] We agree with the ALJ's finding that claimant's hearing request was apparently premature with respect to the issue of a "de facto" denial based on SAIF's failure to accept or deny timely. A premature request for hearing is ineffective and void. Syphers v. K-W Logging, Inc., 51 Or App 769 (1981); Michael A. Dipolito, 44 Van Natta 981 (1992). However, here, SAIF acknowledged that its acceptance was late, thereby admitting that it had eventually "de facto" denied the claim. (Tr. 6). Thus, even if claimant's hearing request on the "de facto" denial issue was premature, that infirmity was cured at hearing by SAIF's admission that its acceptance was late. See OAR 438-006-0031 (new issues may be raised during the hearing, if supported by the evidence); Deborah K. Atchley, 44 Van Natta 1435 (1992).

attorney fee is warranted under amended ORS 656.386(1). See Michael Galbraith, 48 Van Natta 351 (1996) (no "denied claim" where carrier paid all benefits for the compensable condition and did not expressly contend the condition was not compensable); Jerome M. Baldock, 48 Van Natta 355 (1996) (no attorney fee authorized where carrier did not "refuse to pay" compensation).

ORDER

The ALJ's order dated November 25, 1996 is affirmed.

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In the Matter of the Compensation of
**JOYCE L. REEDY, Claimant**
WCB Case Nos. 96-03323 & 95-10848
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its compensability and responsibility denials for claimant's lumbar spondylosis and degenerative disc disease conditions; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) compensability and responsibility denials of claimant's aggravation claim 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 except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks to prove the compensability for her lumbar spondylosis and degenerative disc disease at L4-5 and L5-S1. She has sustained four compensable low back injuries. Claimant compensably injured her low back in June 1986. On July 3, 1986, SAIF accepted an acute lumbosacral sprain/strain. (Ex. F). On July 11, 1986, Dr. Bachhuber performed a 2-level laminectomy at L4-5 and L5-S1. (Ex. G). A May 13, 1987 Determination Order awarded 10 percent unscheduled permanent disability. (Ex. L).

On February 9, 1988, claimant again compensably injured her low back. On April 11, 1988, SAIF accepted a lumbosacral strain. (Ex. 10). On September 29, 1988, Dr. Mason performed a lumbar laminectomy at L4-5. (Ex. 25). A June 12, 1989 Determination Order awarded claimant 29 percent unscheduled permanent disability. (Ex. 46). An Opinion and Order dated February 16, 1990 increased claimant's unscheduled permanent disability award to 51 percent, which was reduced by the previous 10 percent award. (Ex. 60).

On June 12, 1991, claimant was injured after slipping on a wet floor at work. Liberty accepted a left buttock contusion. (Tr. 15). Claimant did not sustain any permanent disability as a result of the June 1991 injury. (Exs. 74, 75).

On March 14, 1992, claimant injured her tailbone, head and neck after slipping on a wet floor at work. Liberty accepted a sacral contusion and cervical strain on May 15, 1992. (Ex. 91). A May 27, 1992 Notice of Closure did not award any permanent disability. (Ex. 92).

Claimant returned to Dr. Mason on June 9, 1995 for treatment of low back and leg pain. SAIF and Liberty subsequently issued denials of compensability and responsibility. Claimant requested a hearing on the denials.

The ALJ rejected claimant's argument that SAIF's acceptance of the 1986 and 1988 injuries encompassed lumbar spondylosis and degenerative disc disease. The ALJ concluded that the February 9, 1988 injury resulted in the pathological worsening and acceleration of claimant's degenerative lumbar condition and was the major contributing cause of her treatment in June 1995 and thereafter. The ALJ determined that SAIF was responsible for claimant's lumbar spondylosis and degenerative disc disease.

Although we agree with the ALJ that SAIF is responsible for claimant's lumbar spondylosis and degenerative disc disease, we base our decision on the following reasoning.

Citing Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996), claimant and Liberty argue that SAIF is responsible for claimant's lumbar spondylosis and degenerative disc disease as a result of SAIF's acceptance of her 1986 and 1988 injury claims, the subsequent surgeries and unappealed awards of permanent disability.

In Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) ("Messmer I"), an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that, although an employer's payment of compensation, by itself, did not constitute acceptance of the degenerative condition, the employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. In Messmer I, the court reasoned that the result was not that the degenerative condition had been accepted; it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id at 258.

In Deluxe Cabinet Works v. Messmer, ("Messmer II"), the court reexamined the Messmer case in light of Senate Bill 369. The court found that amended ORS 656.262(10) said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court noted that the amended statute provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability. Consequently, the court held that the amended statute, ORS 656.262(10), did not overrule its prior decision in Messmer I.

Here, claimant seeks to prove the compensability for her lumbar spondylosis and degenerative disc disease at L4-5 and L5-S1. SAIF never formally accepted or denied those conditions in connection with claimant's 1986 and 1988 injury claims. However, SAIF did not appeal the May 13, 1987 Determination Order, which awarded 10 percent unscheduled permanent disability, or the February 16, 1990 Opinion and Order, which increased her unscheduled permanent disability award to 41 percent. Thus, in accordance with Messmer, we examine the issue of whether SAIF is precluded from denying claimant's lumbar spondylosis and degenerative disc disease as part of its accepted 1986 and 1988 claims.

We first examine claimant's 1986 low back injury claim. Claimant injured her low back in June 1986 while lifting a storefront gate. On July 3, 1986, SAIF accepted an acute lumbosacral sprain/strain. (Ex. F). Dr. Bachhuber performed a 2-level laminectomy at L4-5 and L5-S1 on July 11, 1986. (Ex. G). Dr. Bachhuber reported on January 8, 1987, that claimant's condition was medically stationary, noting that she had "minimal impairment as a residual of L4-5 nerve root compression, surgically treated." (Ex. K). A May 13, 1987 Determination Order awarded 10 percent unscheduled permanent disability. (Ex. L). The evaluator's worksheet attached to the Determination Order indicated that the impairment value of "6" was for "laminectomy x 2" and "discectomy." (Ex. L-2). SAIF did not appeal the May 13, 1987 Determination Order.

Dr. Bachhuber's closing report that claimant had "minimal impairment as a residual of L4-5 nerve root compression, surgically treated" indicated that her impairment was related to the surgery, not for any degenerative conditions. Similarly, the evaluator's worksheet indicated that her impairment was for the laminectomy and discectomy. Under these circumstances, we are not persuaded that claimant's 1987 award of unscheduled permanent disability was related to lumbar spondylosis and degenerative disc disease. See Darrold D. Willis, 48 Van Natta 1782 (1996). Consequently, we conclude that claimant has failed to prove that the May 13, 1987 Determination Order awarded permanent disability for lumbar spondylosis and degenerative disc disease under her 1986 compensable low back injury claim.

On February 9, 1988, claimant compensably injured her low back. An MRI on March 15, 1988 revealed a transitional type vertebra at the lumbosacral junction, evidence of partial sacralization on the right of L5, mild degenerative changes of the facet joints in the lower lumbar region, disc degeneration with mild to moderate extradural defect centrally and on the left at L4-5, and degenerated disc with minimal central protrusion at L5-S1. (Ex. 8). On April 11, 1988, SAIF accepted a lumbosacral strain. (Ex. 10).

On May 15, 1988, Dr. Rabie reported that claimant's symptoms had significantly worsened and he diagnosed "[d]isc disease superimposed on lumbosacral strain." (Ex. 14). He noted that claimant had been followed "for bilateral disc disease at 2 separate levels in her lumbar spine." (Id.) Dr. Mason examined claimant on July 28, 1988 and recommended surgery. (Ex. 17). A myelogram performed on August 10, 1988 showed a left L4-5 extradural defect with left L5 nerve root and nerve root sheath impingement. (Ex. 20). On September 29, 1988, Dr. Mason performed a lumbar laminectomy at L4-5. (Ex. 25).

Although claimant initially did well after the surgery, by December 1988 she began to experience increased low back pain. (Ex. 21). On January 24, 1989, Dr. Mason admitted claimant to the hospital for conservative treatment. (Ex. 28). A CT scan on January 31, 1989 showed a small protuberance of disk material at L4-5 and a central bulge of the central L5-S1 disc. (Ex. 29). A lumbar myelogram on the same date showed a deviation of the left L5 root at the level of the L4-5 interspace. (Ex. 30). On March 10, 1989, Dr. Mason wrote to SAIF to recommend physical therapy because it "would be likely to result in significant improvement in her continuing lumbar discomfort, secondary to her spondylosis and muscle spasms." (Ex. 34).

A June 12, 1989 Determination Order awarded claimant 29 percent unscheduled permanent disability. (Ex. 46). The evaluator's worksheet attached to the Determination Order indicated that the impairment value of "23" was related to "ROM 16", "disc 5 L4-5", and "bulge 4 L5-S1." (Ex. 46-2).

An Opinion and Order dated February 16, 1990 increased claimant's unscheduled permanent disability award for the 1988 injury to 41 percent. (Ex. 60). The ALJ noted that an "MRI showed an extradural defect centrally and on the left at L4-5 that appeared to be related to the presence of a disc protrusion, and a minimal central disc protrusion at L5-S1." (Ex. 60-1). The ALJ concluded that claimant was entitled to 16 percent impairment for loss of range of motion, 5 percent for her laminectomy and discectomy, 4 percent for her unoperated disc bulge, and 5 percent for a chronic condition limiting the repetitive use of her back. (Ex. 60-2). SAIF did not appeal the February 16, 1990 Opinion and Order.

Based on the February 16, 1990 Opinion and Order, as well as the underlying medical evidence, we conclude that claimant's unappealed 41 percent unscheduled permanent disability award for the 1988 injury included an award for lumbar spondylosis and degenerative disc disease. See Judy A. Tucker, 48 Van Natta 2391 (1996); Carolyn A. Morrison, 48 Van Natta 1690 (1996); Dennis L. Keller, 47 Van Natta 734 (1995). An MRI on March 15, 1988 revealed degenerative changes at L4-5 and L5-S1. (Ex. 8). Dr. Rabie reported on May 15, 1988 that claimant had been followed "for bilateral disc disease at 2 separate levels in her lumbar spine" and he diagnosed "[d]isc disease superimposed on lumbosacral strain." (Ex. 14). After claimant's September 29, 1988 lumbar laminectomy at L4-5, a CT scan on January 31, 1989 showed a small protuberance of disc material at L4-5 and a central bulge of the central L5-S1 disc. (Ex. 29). Dr. Mason indicated on March 10, 1989 that claimant needed physical therapy because it would improve her "continuing lumbar discomfort, secondary to her spondylosis and muscle spasms." (Ex. 34).

SAIF did not challenge the February 16, 1990 Opinion and Order that awarded 16 percent impairment for loss of range of motion, 5 percent for her laminectomy and discectomy, 4 percent for her unoperated disc bulge, and 5 percent for a chronic condition limiting the repetitive use of her back. (Ex. 60-2). In light of the medical evidence relating claimant's lumbar surgeries and disc bulge to her lumbar spondylosis and degenerative disc disease conditions, we conclude that February 16, 1990 unscheduled permanent disability award was based, at least in part, on those conditions. That order became final by operation of law. The medical evidence establishes that claimant's current problems are caused by lumbar spondylosis and degenerative disc disease. (Exs. 97, 99, 103, 104, 106). Based on both Messmer cases, we conclude that SAIF's failure to challenge the February 16, 1990 Opinion and Order on the

ground that it included an award for the noncompensable lumbar spondylosis and degenerative disc disease conditions, precludes it from denying that those conditions were part of the 1988 claim. See Judy A. Tucker; Carolyn A. Morrison; Dennis L. Keller. The result is not that SAIF has accepted claimant's lumbar spondylosis and degenerative disc disease conditions; rather, it is that SAIF is barred by claim preclusion from denying that those conditions are part of her 1988 injury claim.[1] Messmer I, 130 Or App at 258.

Citing Mary L. Miller, 46 Van Natta 369 (1994), SAIF argues that claimant's failure to appeal its August 16, 1991 denial establishes that her low back condition was not compensable as to SAIF as of the date of the denial. SAIF asserts that claimant's current low back claim as to SAIF is properly characterized as a claim for a worsening of a preexisting noncompensable condition. We disagree.

As we have discussed, SAIF is barred by claim preclusion from denying that claimant's lumbar spondylosis and degenerative disc disease conditions are part of her 1988 injury claim. Therefore, contrary to SAIF's argument, claimant's current claim is not for a worsening of a "noncompensable" condition. Moreover, the case of Mary L. Miller is inapposite. In Miller, the claimant failed to appeal a 1991 denial of her carpal tunnel syndrome (CTS) claim. Over a year later, the claimant filed a second claim for CTS, which was also denied. We found that, because the claimant did not appeal the 1991 denial, her CTS condition was not compensable as of the date of the denial. However, we concluded that her current CTS claim was properly characterized as a claim for a worsening of a preexisting noncompensable condition. 46 Van Natta at 370.

Here, on August 16, 1991, SAIF issued a denial of claimant's condition, which was "diagnosed as low back pain." (Ex. 72A). SAIF's denial stated, in part:

> "Information in your file indicates that you suffered a new and separate injury to your low back on June 12, 1991. It is our position that your back strain of February 9, 1988 had resolved and that the major contributing cause of your current condition is the slip and fall you suffered on June 12, 1991. It is also our understanding that Liberty Northwest has assumed responsibility for your current condition." (Id.)

SAIF's August 16, 1991 denial referred only to claimant's June 12, 1991 injury. The denial did not mention claimant's lumbar spondylosis or degenerative disc disease conditions. Therefore, SAIF's denial did not advise claimant that her lumbar spondylosis and degenerative disc disease conditions were not compensable and the denial did not put her on notice that she must act on the denial to preserve her right to compensation for those conditions. Compare Mary L. Miller; Brian M. Lundquist, 45 Van Natta 358, 360 (1993) (the carrier's denial notified the claimant that his CTS claim was not compensable and thereby notified him that he must act on the denial to preserve his right to compensation for that condition). Moreover, SAIF's denial acknowledged that Liberty had assumed responsibility for the June 12, 1991 injury. Under these circumstances, claimant's failure to appeal SAIF's August 16, 1991 denial has no preclusive effect concerning its responsibility for claimant's lumbar spondylosis and degenerative disc disease conditions.

Citing Bonni J. Mead, 46 Van Natta 1185 (1994), SAIF argues that, even if it is deemed to have accepted claimant's preexisting disease under Messmer, responsibility for claimant's entire low back condition shifted to Liberty when it accepted claimant's low back condition involving the same preexisting condition in 1991.

In Bonni J. 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 the 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 those circumstances, we found that Liberty remained responsible under ORS 656.308(1) for future compensable medical services and disability for the compensable condition.

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[1] In light of our conclusion that SAIF is barred by claim preclusion from denying that claimant's lumbar spondylosis and degenerative disc disease conditions are part of her 1988 injury claim, we need not address the argument from SAIF and Liberty that the ALJ erred in concluding that claimant's current low back condition is compensable.

Here, we disagree with SAIF's argument that Liberty's acceptance of claimant's 1991 injury involved the same low back condition as the 1988 injury claim. As we have discussed, SAIF is barred by claim preclusion from denying that claimant's lumbar spondylosis and degenerative disc disease conditions were part of her 1988 injury claim. As a result of claimant's June 12, 1991 injury, Liberty accepted a left buttock contusion. (Tr. 15). Claimant did not sustain any permanent disability as a result of the June 1991 injury. Unlike Bonni J. Mead, Liberty's acceptance of a left buttock contusion was for a different condition from the 1988 injury claim with SAIF. See Craig D. Smith, 48 Van Natta 1624, 1625 & n.1 (1996). In addition, Liberty's acceptance of a sacral contusion and disabling cervical strain on May 15, 1992 (Ex. 91) was for a different condition. Therefore, ORS 656.308(1) does not apply and our holding in Mead is distinguishable.

In summary, we conclude that SAIF is responsible for claimant's lumbar spondylosis and degenerative disc disease at L4-5 and L5-S1, based on the preclusive effect of Messmer.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 17, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the SAIF Corporation.

**Board Chair Hall specially concurring.**

I write separately to express my agreement with the ALJ's conclusion that claimant's February 9, 1988 injury resulted in the pathological worsening and acceleration of her degenerative lumbar condition and was the major contributing cause of her need for treatment in June 1995 and thereafter. Because I agree that, in any event, SAIF is responsible for claimant's lumbar spondylosis and degenerative disc disease at L4-5 and L5-S1, I specially concur.

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In the Matter of the Compensation of
**LARRY V. TUCKER, Claimant**
Own Motion No. 96-0251M
OWN MOTION ORDER
Bischoff, Strooband, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right shoulder strain injury. Claimant's aggravation rights expired on May 9, 1995. SAIF denied the compensability of and responsibility for claimant's current condition on May 16, 1996. SAIF issued an amended denial of the compensability of and responsibility for claimant's current degenerative disc disease at the C5-6/C6-7 level on June 28, 1996. In addition, SAIF opposed reopening of the claim on the grounds that: (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 with the Hearings Division. (WCB Case No. 96-04740).

On July 5, 1996, we consolidated the Own Motion matter with the above hearing in this claim. On October 24, 1996, Administrative Law Judge (ALJ) Poland issued an Opinion and Order in WCB Case No. 96-04740, setting aside SAIF's May 16, 1996 and June 28, 1996 denials, to the extent that they denied claimant's C6-7 disc protrusion. The ALJ issued a separate recommendation finding that claimant was in the work force at the time of his current disability. SAIF requested Board review of the ALJ's Opinion and Order. On March 20, 1997, the Board affirmed the ALJ's 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 13, 1996, Dr. Belza, claimant's treating physician, recommended that claimant undergo a two-level anterior cervical discectomy with interbody fusion using autologous bone grafting and instrumentation. 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).

In our July 5, 1996 Own Motion Order Referring for Consolidated Hearing, we requested that, if SAIF was found to be responsible for claimant's current condition, the ALJ take evidence on the issue of whether claimant was in the work force at the time of disability. Because the Board, in its Own Motion authority under ORS 656.278, has sole jurisdiction to reopen claimant's claim for the payment of temporary disability compensation, on April 2, 1997, we requested the parties' positions regarding the work force issue.[1]

In its May 16, 1996 recommendation to the Board, SAIF contended that it was "unsubstantiated" whether claimant was in the work force at the time of disability. It is unclear whether SAIF sent page three of the recommendation form to claimant (as required) because no copy of that page of the form was submitted to the Board for our record.[2]

Claimant contends that he was in the work force at the time of disability. Claimant has the burden of proof on this issue and must provide evidence that he was in the work force during the relevant time. In the ALJ's October 24, 1996 Own Motion Recommendation, the ALJ concluded that the documentary evidence and testimony supported a finding that, at the time of his compensable worsening, claimant had not left the work force for reasons unrelated to his compensable injury. The hearing transcript supports the ALJ's recommendation that claimant left a vocational program in February of 1995 because he could not comprehend or adjust to that type of rehabilitation program. (See Transcript of August 15, 1996 Hearing, page 15). Claimant further testified at hearing that he was unable to return to work, but had attempted to do so, because of his compensable shoulder injury. There is no contrary evidence in the record. Furthermore, SAIF only offers that claimant's time loss should be denied because it does not have employment records establishing that claimant was in the work force.

On this record, we are persuaded that claimant has established that he was willing to work, but unable to work because of the compensable injury at the time of disability.

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

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[1] Although the ALJ made a recommendation regarding whether claimant was in the work force at the time of disability, the Hearings Division does not have jurisdiction over that issue. Furthermore, the Board's Order on Review did not address the work force issue, as it, too, lacks jurisdiction to consider the matter. ORS 656.278.

[2] If a carrier disputes the work force issue, it is required to forward a copy of page three of the Carrier's Own Motion Recommendation form to claimant. OAR 438-012-0020; 438-012-0030, 438-012-0035. Page three of the recommendation form contains the criteria under which a claimant may establish that the claimant was in the work force at the time of disability. Dawkins v. Pacific Motor Trucking, 308 Or at 254. Here, SAIF did not specifically disagree in its recommendation to the Board that claimant was in the work force; however, it did not agree that he was either. SAIF's response to that inquiry was that the issue was "unsubstantiated." (See May 16, 1996 Carrier's Own Motion Recommendation form). Furthermore, there is no indication that SAIF sent the work force letter to claimant to advise him of the criteria he must meet. See Rodney D. Sullivan, 48 Van Natta 1143 (1996). Therefore, we referred the matter to the Hearings Division for taking of evidence and argument. The ALJ made a recommendation to the Board after considering evidence and argument presented at hearing.

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.

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May 20, 1997 Cite as 49 Van Natta 649 (1997)

In the Matter of the Compensation of
**BARBARA J. LLOYD, Claimant**
WCB Case No. 94-00752
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Lloyd v. K-Mart Corp., 146 Or App 384 (1997). The court has reversed our prior order, Barbara J. Lloyd, 48 Van Natta 219 (1996), which had upheld the self-insured employer's denial of claimant's right knee condition. Citing Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996), the court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of his finding that the 1986 left foot injury was the major contributing cause of claimant's current right knee condition.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's accepted left foot injury in 1986 was the major contributing cause of her need for right knee surgery, and therefore concluded that the right knee condition was a compensable consequence of the 1986 injury.

On review, we reversed the ALJ's order, finding that the medical evidence did not establish that the 1986 left foot condition was the major contributing cause of claimant's need for right knee surgery. We then turned to claimant's contention that the employer was precluded from denying the right knee condition because it failed to appeal a 1987 Determination Order awarding permanent disability for the right knee condition. Based on our interpretation of amended ORS 656.262(10), we concluded that the employer's payment of a prior Determination Order award for the right knee condition did not bar it from denying claimant's degenerative right knee condition.

Citing its opinion in Messmer, 140 Or App 548 (Messmer II), the court has remanded for reconsideration. In Messmer II, the court concluded that ORS 656.262(10) did not overturn its prior decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) rev den 320 Or 507 (1995) (Messmer I). In Messmer I, the court held that an employer's failure to challenge a permanent disability award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that that condition was not part of the compensable claim.

In the present case, the employer failed to challenge a November 1987 Determination Order which awarded 5 percent scheduled permanent disability for claimant's right knee condition. The medical evidence at the time from Dr. Bachhuber indicated that the knee condition involved degenerative disease. Claimant's 1993 right knee condition which necessitated total knee replacement surgery also involved degenerative disease.

Under such circumstances, applying the court's holdings in Messmer I and II, we conclude that the employer's failure to appeal the Determination Order award precludes it from now contesting compensability of claimant's current right knee condition and need for treatment. Thus, we affirm the ALJ's order setting aside the employer's denial of claimant's current (1993) right knee condition and awarding a $3,000 attorney fee.

We now turn to the question of attorney fees for claimant's counsel's services on Board review and before the court. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or Board, the Administrative Law Judge, Board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(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 on review and before the Court of Appeals is $3,000, 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.

Accordingly, the ALJ's order dated October 18, 1994 is affirmed. For services at the Board and court levels, claimant's attorney is awarded a reasonable attorney fee of $3,000. This fee is in addition to that awarded by the ALJ, resulting in a total award for services rendered before all prior forums of $6,000, to be paid by the employer.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ELIZABETH A. BERGIN, Claimant**
WCB Case No. 95-13542
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of her left cervical strain, left trapezius strain and C6-7 herniated disk. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first full paragraph on page 2, we adopt only the first six sentences and insert the following paragraph:

> "On August 11, 1995, claimant returned to her chiropractor, Dr. Gittins, complaining of mild, intermittent left neck pain extending into the upper left trapezius. (Ex. 17). Claimant told Dr. Gittins that she had been "doing very well over the past several months with minimal to no symptoms." (Id.) Dr. Gittins treated claimant for general musculoskeletal symptoms. (Id.)"

In the second full paragraph on page 2, we change the date in the first sentence to "September 3, 1995."

In the third full paragraph on page 2, we omit the last sentence and we also omit the first sentence of the fourth full paragraph. We replace the first sentence of the fourth full paragraph with the following: "Claimant began seeing Dr. Hill on September 15, 1995. Dr. Hill noted that claimant's lifting activities as an EMT sometime after September 6, 1995, also seemed to have increased claimant's left neck pain. (Ex. 9)." In the second sentence of the fourth full paragraph on page 2, we change "At that point" to read "On September 15, 1995."

In the fourth full paragraph on page 3, we change the second sentence to read: "On that basis, claimant's stretching injury of November 16, 1995, was caused directly by an injury at work with the employer."

We do not adopt the last paragraph of the findings of fact or the findings of ultimate fact.

## CONCLUSIONS OF LAW AND OPINION

On December 4, 1994, claimant injured her head and neck in a non-work related injury. She was initially diagnosed with a mild neck strain. (Ex. 1). On September 3, 1995, she struck her head on a wall cabinet while working for the employer. She was diagnosed with a cervical/trapezius strain. As part of her treatment, Dr. Hill recommended a home exercise program. While performing those exercises on November 16, 1995, claimant sustained a herniated disk at C6-7.

The ALJ found that claimant's December 1994 cervical/trapezius strain was not completely resolved in September 1995. The ALJ concluded that claimant's September 3, 1995 work injury was not compensable under ORS 656.005(7)(a)(B). Based on that conclusion, the ALJ then determined that claimant's C6-7 herniated disk was not a consequential condition.

Claimant contends that her December 1994 cervical/trapezius strain was resolved in September 1995. She asserts that, even if the previous trapezial strain had not resolved completely, the medical evidence establishes that the September 3, 1995 work injury was the major contributing cause of her disability and need for treatment in the Fall of 1995. Furthermore, she argues that the November 1995 C6-7 disk herniation was the direct result of reasonable and necessary treatment for the September 1995 cervical/trapezius strain.

### September 1995 Cervical/Trapezius Strain

The initial question is whether claimant's December 1994 cervical/trapezius strain had resolved by September 1995. We briefly review claimant's medical history.

On December 4, 1994, claimant sustained a non-work-related injury when she was loading some furniture into her car. She noticed immediate head and neck symptoms. On December 8, 1994, Dr. Patricelli reported that claimant had left-sided neck pain ranging from the occiput down into the trapezius muscle and he diagnosed a mild neck strain. (Ex. 1-1). On January 10, 1995, Dr. Patricelli reported that claimant was "approximately 50% better." (Ex. 1-2). He prescribed physical therapy.

On April 5, 1995, claimant was examined by Dr. Jackson, who reported that claimant's discomfort in the left neck/shoulder area had returned. Dr. Jackson diagnosed "[t]rapezius trigger point cervical neck strain/sprain, chronic, with acute exacerbation." (Ex. 2-3). He prescribed physical therapy. On April 6, 1995, Dr. Lindquist reported that claimant's neck was "quite a lot better" than the previous day. (Ex. 2-4). On April 20, 1995, Dr. Lindquist reported that claimant had been seeing a chiropractor for her neck, which was better. (Ex. 2-5). Claimant was also using a TENS unit.

Claimant was treated with physical therapy for her neck strain from April 5, 1995 through June 2, 1995. (Ex. 4). The June 2, 1995 chart note indicated that claimant was doing much better and the chiropractor had been very helpful. (Ex. 4-6).

Claimant also received chiropractic treatments for her neck from Dr. Gittins, who diagnosed "[c]hronic traumatic cervical strain/sprain with mild radiculitis into the left lateral arm" and "[c]hronic cervical and thoracic myofascitis." (Ex. 17). Dr. Gittins treated claimant from April 4, 1995 through June 20, 1995. (Exs. 3, 17). Dr. Gittins reported that claimant traveled to Spain for one month and returned to his office on August 11, 1995, "complaining of mild, intermittent left neck pain extending into the upper left trapezius." (Ex. 17). Claimant told Dr. Gittins she had been doing very well over the past several months with minimal to no symptoms. (Id.) Dr. Gittins treated claimant for general musculoskeletal symptoms. Although Dr. Gittins instructed her to return for a closing examination, claimant did not do so, and he assumed that her condition had resolved. (Id.)

On September 3, 1995, claimant struck her head on a wall cabinet while working for the employer. She noticed headache and accompanying neck strain symptoms. On September 5, 1995, she experienced increased symptoms after teaching a CPR class at another employment.

On September 6, 1995, claimant was examined by Dr. Jansen, who diagnosed a probable neck strain/sprain after impacted trauma to the head. (Ex. 9, 9A). Dr. Jansen noted that claimant's December 1994 neck strain had "resolved without problems." (Ex. 9A). Dr. Jansen recommended physical therapy, work restrictions and medication.

Claimant began seeing Dr. Hill on September 15, 1995. Dr. Hill noted that claimant had exceeded her work restrictions that day and had experienced an increase in her left neck pain. (Ex. 9). Dr. Hill diagnosed "[c]ervical strain injury, with evidence of irritation to the left upper trapezius muscle; work-related." (Ex. 9-2). Dr. Hill instructed claimant in a home stretching program and recommended that she continue physical therapy. Dr. Hill examined claimant on October 16, 1995 and November 8, 1995, and told her to continue physical therapy and the home stretching program. (Exs. 13A, 13B).

On November 22, 1995, claimant was examined by Dr. Weller, who reported that on the previous Thursday (November 16, 1995), claimant had been doing her home exercise program when she turned her head to the right side and back. (Ex. 13C). Claimant had increased pain at that time, and the next morning she was in excruciating pain with increased headache, pain in her neck and upper back and numbness in her left arm down to her fingers. (Id.) An MRI showed a central disk herniation at the C6-7 level. (Id.)

The insurer contends that claimant's December 1994 cervical/trapezius strain had not resolved by September 1995. We disagree.

Dr. Gittins' chart notes in June 1995 noted that claimant's neck was "much improved" and "feeling pretty good." (Ex. 3-4). Dr. Gittins' June 20, 1995 chart note indicated that claimant was to return for a check-up after her trip to Spain. (Id.) In addition, the June 2, 1995 physical therapy chart note indicated that claimant was doing much better and the chiropractor had been very helpful. (Ex. 4-6).

Claimant testified that she did not have any problems with her neck while she was in Spain, even though she was involved in several activities, including horseback riding. (Tr. 7). When she returned, she went back to teaching CPR classes. (Tr. 6, 7). Claimant went to see the chiropractor after she returned from the trip to "make sure everything was still okay." (Tr. 7). She said that the trip had ended badly and she was quite tense. (Id.) The flare-up was in the same location as the December 1994 injury, but the symptoms were not as severe. (Tr. 16). On August 11, 1995, Dr. Gittins reported that she complained of mild, intermittent left neck pain extending into the upper left trapezius. (Ex. 17). Claimant did not return for any further treatment.

Claimant testified that when she started work for the employer, her neck and shoulder symptoms from the December 1994 injury had resolved and she was able to perform her duties without problems. (Tr. 15, 16). In an earlier statement, claimant said that her neck and shoulder symptoms had "pretty much resolved" after six months of treatment, although she had residual symptoms of dizziness and a sore jaw from the December 1994 injury. (Ex. 13BB-14, 15).

Claimant's testimony that her December 1994 injury had resolved by September 1995 is consistent with the medical reports. The chart notes from Dr. Gittins and the physical therapy clinic indicated that, by June 1995, claimant's neck symptoms were minimal. (Exs. 3, 4). Dr. Gittins treated claimant on only one more occasion on August 11, 1995 for a mild flare-up after she returned from her trip. (Ex. 17).

Dr. Jansen reported on September 6, 1995 that claimant's December 1994 neck strain had "resolved without problems." (Ex. 9A). Similarly, Dr. Hill reported that claimant's 1994 muscle strain injury had resolved. (Ex. 19). Dr. Hill noted that claimant had "returned to quite vigorous activities, and this would not have been possible if the muscle strain had not resolved." (Id.) In a deposition, Dr. Hill explained that claimant "was back to vigorous activities, including horseback riding, and those [December 1994] symptoms had essentially resolved when her new symptoms started in September 3." (Ex. 23-8). Dr. Hill was aware that claimant had returned to Dr. Gittins on August 11, 1995 and based on Dr. Gittins' report, Dr. Hill felt that claimant was "doing pretty good" at that time. (Ex. 23-9).

Based on claimant's testimony and the medical reports from Drs. Hill, Gittins, Jansen and the physical therapy clinic, we conclude that claimant's December 1994 cervical/trapezius strain had resolved by September 1995.

The insurer argues that the claimant had a preexisting cervical/trapezius strain that combined with the September 3, 1995 injury to cause the disability or need for treatment. We need not resolve whether there was a "combined condition," because even if the major contributing cause standard of ORS 656.005(7)(a)(B) applies, we find that the medical evidence satisfies that legal standard.

We give the most weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we are most persuaded by the opinion of claimant's treating physician, Dr. Hill.

Dr. Hill concluded that claimant had sustained a new, acute left trapezius strain on September 3, 1995 while she was at work.[1] (Ex. 19). In a deposition, Dr. Hill explained that claimant had suffered a new muscle strain injury in the same area as the December 1994 injury. (Ex. 23-12, -14, 18). Dr. Hill felt that claimant's CPR activities on September 6, 1995 served to increase her symptoms temporarily, but did not cause the trapezius strain. (Ex. 19). Dr. Hill explained that patients generally report more neck pain a day or two after the incident, especially with a trapezius strain. (Ex. 23-39).

Dr. Weller examined claimant on one occasion. Dr. Weller commented on the causation of claimant's C6-7 disk herniation and the annular tear, but she did not discuss the causation of claimant's left trapezius strain injury in September 1995, except to indicate that claimant's cervical and neck pain were "work-related." (Ex. 13C-2). In light of the conclusory nature of Dr. Weller's report, we do not assign it much probative weight in deciding the causation of claimant's September 1995 left trapezius strain.

Based on Dr. Hill's opinion, we conclude that claimant's work injury on September 3, 1995 was the major contributing cause of a new, acute left trapezius strain.

November 1995 C6-7 Herniated Disk

Claimant contends that her C6-7 herniated disk was caused while performing reasonable and necessary medical treatment for the trapezial strain injury. We agree.

When a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). Robinson v. Nabisco, Inc., 143 Or App 59, 65-66 (1996); Barrett Business Services v. Hames, 130 Or App 190, 193, rev den 320 Or 492 (1994).

In Barrett Business Services v. Hames, 130 Or App at 195, the claimant sustained an injury to his right ulnar nerve during physical therapy for his compensable shoulder injury, and the court found that the ulnar nerve injury flowed "directly and inexorably" from the shoulder injury. In Martin J. Fowler, 47 Van Natta 614 (1995), the claimant sustained a herniated disk at C6-7 during the course of a weightlifting activity prescribed to treat his compensable right hip injury. Based on the treating doctor's characterization of the weightlifting activity as an "integral part" of the claimant's "recovery" from the original hip injury, we found persuasive evidence that the weightlifting activity was reasonable and necessary treatment for the compensable hip injury. We noted that "[t]he weightlifting activity was directed and overseen by the physical therapist rather than performed on claimant's own initiative." 47 Van Natta at 614. We concluded that the claimant had established the compensability of his cervical condition under ORS 656.005(7)(a)(A).

In contrast, in Bradley B. Rogers, 48 Van Natta 1849 (1996), we concluded that the claimant's home exercise program did not constitute "medical treatment" for his compensable low back injury. The claimant's exercises were not prescribed as a curative treatment to aid his "recovery," but as a preventative measure, to maintain flexibility and avoid recurrent pain after he became medically stationary. The claimant was performing the exercises several months after claim closure and without any direct medical supervision. Under those circumstances, we found the causal relationship between the claimant's compensable low back injury and his cervical injury too tenuous and indirect to be compensable under ORS 656.005(7)(a)(A).

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[1] In a deposition, Dr. Hill explained that his references to cervical strain and trapezius strain were basically interchangeable. (Ex. 23-20, 21). The more specific diagnosis was left upper trapezius strain. (Ex. 23-28).

We find this case to be analogous to Barrett Business Services v. Hames, and Martin J. Fowler. Here, Dr. Hill prescribed physical therapy and a home stretching program for claimant's strain injury. On September 15, 1995, Dr. Hill instructed claimant in a home stretching program. (Ex. 9). On October 16, 1995 and November 8, 1995, Dr. Hill instructed claimant to continue physical therapy and the home stretching program. (Ex. 13A, 13B). Dr. Hill testified that the home exercise program was prescribed to work out the tightness in the left upper trapezius. (Ex. 23-29). Dr. Hill explained that claimant was given some home stretches by him as well as the physical therapist. (Id.)

Claimant testified that she was doing the prescribed exercises one evening in November 1995 and was following instructions and performing an exercise that involved turning her head to the side and then pulling it back. (Tr. 8). She felt a "pop" and the next morning she woke up in excruciating pain. (Id.) On November 22, 1995, Dr. Weller reported that the previous Thursday (November 16, 1995), claimant had been doing her home exercise program when she turned her head to the right side and back. (Ex. 13C). Dr. Weller reported that claimant had increased pain at that time, but the next morning she was in excruciating pain with increased headache, pain in her neck and upper back and numbness in her left arm down to her fingers. (Id.) An MRI showed a central disk herniation at the C6-7 level. (Id.)

Dr. Hill concluded that claimant had sustained a disk herniation at C6-7 while performing stretching exercises as instructed. (Ex. 19). Dr. Hill testified that claimant's home exercises were the major contributing cause of the disk herniation at C6-7. (Ex. 23-40, -41). Similarly, although Dr. Weller felt that claimant had first torn the annulus of the disk in December 1994, she concluded that claimant's stretching during the home exercise program was the major contributing cause of the herniated disk. (Ex. 21).

Since claimant's home exercise program was prescribed by Dr. Hill to treat the trapezius strain and she was performing the stretching exercises as instructed, we conclude that the home exercise program was reasonable and necessary treatment for claimant's trapezius strain injury. See Martin J. Fowler, 47 Van Natta at 614. Unlike Bradley B. Rogers, where the claimant was performing the exercises several months after claim closure, as a preventative measure claimant in this case was performing the exercises as curative treatment to aid her recovery. Furthermore, we conclude that claimant's consequential C6-7 disk herniation was a direct result of performing prescribed exercises for treatment of the compensable trapezius strain injury and the herniation flowed "directly and inexorably" from the compensable condition. See Barrett Business Services v. Hames, 130 Or App at 195; Martin J. Fowler, 47 Van Natta at 615. Therefore, claimant has established that the C6-7 disk herniation is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $7,500, 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 November 4, 1996 is reversed. The insurer's denial of claimant's left cervical/trapezius strain and C6-7 disk herniation is reversed 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 $7,500, payable by the insurer.

In the Matter of the Compensation of
**TERI S. CALLAHAN, Claimant**
WCB Case No. 96-02777
ORDER ON RECONSIDERATION
Bischoff, Strooband, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our April 28, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which had increased claimant's unscheduled permanent disability award from 26 percent (83.2 degrees), as awarded by an Order on Reconsideration, to 44 percent (140.8 degrees). Claimant argues that we erred in evaluating the medical evidence regarding claimant's residual functional capacity. In response, the self-insured employer asserts that claimant's motion should be denied.

Claimant relies on Dr. Peterson's "Return to Work Recommendations" forms, contending that Dr. Peterson's opinion as a whole supports a conclusion that claimant has work restrictions and therefore less than medium residual functional capacity. (See Exs. 41, 42, 51).

On August 10, 1995, Dr. Peterson filled out a "Return to Work Recommendations" form, indicating that claimant was limited to lifting and carrying 10 pounds or less frequently, completely precluded from bending, twisting and kneeling, and limited to reaching, sitting, climbing stairs, standing, walking, squatting, and driving occasionally. Dr. Peterson also opined that claimant should be able to stand or walk a total of 3 hours and sit a total of one hour (both with a break every half hour) during a regular work day. (Exs. 41, 42).

On September 29, 1995 (the date of claimant's closing examination), Dr. Peterson annotated an identical form with "No change" and "Restrictions as before." (Ex. 51). Also on September 29, 1995, Dr. Peterson stated in his "Closing Examination Evaluation," "I have recommend that this patient seek employment which allows her to change positions frequently and avoid any heavy lifting or bending. It is also important for her to avoid any employment which would require prolonged sitting or driving." (Ex. 52-2).

Thus far, Dr. Peterson's recommendations would support a finding of restrictions under OAR 436-35-310(3)(l)(A). However, on October 26, 1995, Dr. Peterson expressly stated that claimant "has been to released regular work without restrictions." (Ex. 53). Then, without explanation, Dr. Peterson amended his closing examination on November 3, 1995 and opined that claimant should not "engage in anything more than occasional bending and lifting of objects up to 50 pounds." (Ex. 54).

Considering the variety of Dr. Peterson's return to work recommendations (specifically, whether claimant's work activities should be restricted beyond lifting limits), we continue to conclude that the record is insufficient to establish that claimant has ratable restrictions under the applicable standards.[1] Consequently, we adhere to our prior conclusions regarding claimant's residual functional capacity and the extent of his permanent disability under the Director's disability standards.

Accordingly, our April 28, 1997 order is withdrawn. On reconsideration, as supplemented herein, we republish our April 28, 1997 order in its entirety, 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] In other words, on this record, we cannot say that claimant is restricted from frequently performing at least two of the activities listed under OAR 436-35-310(3)(l)(C) or from sitting, standing, or walking less than two hours at a time, based on the opinions of Drs. Peterson or Neumann. (See Ex. 58-6).

In the Matter of the Compensation of
**ALAN L. HINES, Claimant**
WCB Case Nos. 94-04038 & 93-06474
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) upheld the SAIF Corporation's partial "de facto" denial of claimant's February 18, 1993 injury claim for brain and spinal cord trauma and psychological conditions; (2) declined to award a penalty for SAIF's allegedly unreasonable failure to process the claim; (3) affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's conditions; (4) upheld SAIF's denial of claimant's March 17, 1993 injury claim for dysthymic disorder, concussion, and post-concussion syndrome conditions; (5) declined to award a penalty for an allegedly unreasonable denial; and (6) awarded a $2,500 attorney fee for his counsel's services in overcoming the denial of the March 17, 1993 head contusion. SAIF cross-requests review of that portion of the order that set aside its denial of claimant's claim for a March 17, 1993 head contusion. With its brief, SAIF argues that the ALJ erred in: (1) addressing claimant's request for permanent total disability compensation, because the issue was not properly raised on reconsideration; and (2) in admitting evidence on the permanent total disability issue not contained in the reconsideration record. On review, the issues are compensability, scope of review, evidence, extent of permanent disability (including permanent total disability), penalties, and amount of attorney fees.

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

In evaluating claimant's claims for permanent disability benefits, including PTD, we have not considered evidence outside the reconsideration record.[2] See George D. Koskela, 49 Van Natta 529 (1997) (ORS 656.283(7)'s evidentiary limitation is not constitutionally defective in PTD cases).

Claimant contends that the ALJ's $2,500 attorney fee for services related to prevailing on the claim for a March 17, 1993 head contusion is inadequate. In this regard, claimant argues that a long hearing and extensive preparation was required to establish that the March 1993 injury occurred and that her necessary services included review of massive medical records, several doctors' depositions, and questioning of an accident reconstructionist and claimant's divorce attorney. SAIF objects generally to claimant's fee request.

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 head contusion claim is $2,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's representation of services rendered), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review in reply to SAIF's appeal of the head contusion 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 this issue is $1,000, payable by SAIF. In reaching this

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[1] However, we do not decide whether the PTD issue was raised on reconsideration or, if it was not, whether the ALJ erred in addressing that issue, because claimant does not have injury-related permanent disability.

[2] Claimant argues that the prohibition against "post-reconsideration" evidence does not apply in this case because such evidence was submitted before June 7, 1995, when Senate Bill 369 was enacted and amended ORS 656.283(7) went into effect. However, because only evidence previously and properly admitted at a hearing is excepted from retroactive application of amended ORS 656.283(7), we do not consider "post-reconsideration" evidence of claimant's disability in this case. See Precision Castparts Corp. v. Plummer, 140 Or App 227, 231 (1996).

conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief on review, claimant's attorney's statement of services, and SAIF's response to claimant's fee request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's undated order, as corrected on August 20, 1996 and reconsidered on September 6, 1996, is affirmed. For services on review related to the March 17, 1993 injury claim for a head contusion, claimant is awarded a $1,000 attorney fee, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**BILL J. SLACK, Claimant**
WCB Case No. 96-02784
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that affirmed an Order on Reconsideration that awarded claimant 11 percent (35.2 degrees) unscheduled permanent disability for a respiratory condition. On review, the issue is extent of unscheduled permanent disability.

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

The insurer accepted claimant's claim for an acute exacerbation of chronic bronchitis, which was eventually classified as disabling. This claim was closed by Determination Order on November 8, 1995, which awarded only temporary disability. Claimant requested reconsideration, contesting the rating of unscheduled permanent disability. With his request for reconsideration, claimant submitted a January 11, 1996 report from Dr. Gotchall, treating physician, discussing claimant's permanent impairment. Relying on this report, a February 13, 1996 Order on Reconsideration awarded claimant 11 percent unscheduled permanent disability for claimant's respiratory condition. The ALJ affirmed this award.

On review, the insurer argues that Dr. Gotchall's January 11, 1996 report represents a conclusory, unexplained change of opinion and, as such, is not persuasive evidence of permanent impairment due to the compensable injury. We disagree with the insurer's interpretation of Dr. Gotchall's opinion.

On January 20, 1995, claimant was examined by Dr. Lewis, pulmonary specialist, on behalf of the insurer. (Ex. 5). Dr. Lewis opined that claimant's work exposure to dust was the major cause of claimant's symptoms resulting from an acute exacerbation of chronic bronchitis. Dr. Lewis noted that claimant was no longer working for the insured employer; however, he recommended that claimant not return to that job and avoid any jobs which might expose him to undue amounts of inorganic or organic dust. (Ex. 5-6). He also stated "[t]here is no permanent impairment." (Ex. 5-7).

On March 6, 1995, Dr. Gotchall concurred with Dr. Lewis' report. (Ex. 7). On September 6, 1995, Dr. Gotchall noted that he did not believe that claimant had "any permanent impairment related to his dust associated airway disease." (Ex. 9-1). However, he also noted that claimant was advised to avoid intense dust exposures, which was a permanent work restriction. Id. He noted that his opinion relating to claimant's impairment status only applied to the work-related respiratory symptoms, and not any work-related back injury for which claimant was apparently treating with another physician. (Ex. 9-1-2).

Finally, on January 11, 1996, Dr. Gotchall responded to claimant's attorney's request for clarification of his opinion regarding impairment related to claimant's workers' compensation claim.

(Ex. 11A-4, -5). This request included recitation of former OAR 436-35-385(5) and 436-35-450. Dr. Gotchall indicated that, under these rules, claimant had 8 percent impairment. Dr. Gotchall explained that claimant's respiratory symptoms represented an irritant or inflammatory response, not necessarily an allergic or immunologic response, which was a technical point and unrelated to claimant's impairment evaluation. (Ex. 11A-5). He opined that claimant "should permanently avoid dusty work environments; his impairment permanently precludes some work activity." Id.

We disagree with the insurer's contention that Dr. Gotchall's January 11, 1996 report represents a conclusory, unexplained change of opinion. All along Dr. Gotchall opined that claimant was permanently limited from working in dusty environments subsequent to his work exposure. (Exs. 5-6, 7, 9). His prior concurrence included Dr. Lewis' opinion that claimant avoid working in dusty environments. (Exs. 5-6, 7). Therefore, Dr. Gotchall opined claimant had a permanent restriction, notwithstanding his statement/concurrence that there was no permanent impairment. When informed that such a permanent restriction could result in impairment under the standards, Dr. Gotchall explained why he found that claimant had such permanent impairment. (Ex. 11A-5). Thus, we find that Dr. Gotchall's clarification of his opinion regarding impairment is not a conclusory, unexplained change of opinion.

Furthermore, we find this opinion relates the permanent impairment to the compensable respiratory condition. 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, such findings may be construed as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550 (1997). However, where the treating physician or medical arbiter attributes the claimant's impairment to causes other than the compensable injury, the opinion is not considered persuasive evidence of injury-related impairment. Marcia G. Williams, 49 Van Natta 313 (1997); Julie A. Widby, 46 Van Natta 1065 (1994).

Here, with citation to the appropriate administrative rule regarding permanent impairment, claimant's attorney inquired of Dr. Gotchall about impairment related to claimant's workers' compensation claim for his respiratory condition. (Ex. 11). In responding to this inquiry, Dr. Gotchall did not indicate that any impairment was due to causes other than the compensable injury. (Ex. 11-2). Moreover, the impairment due to permanent restriction from dust exposure appears consistent with claimant's accepted respiratory condition. Given the fact that Dr. Gotchall did not attribute the findings to causes other than the compensable condition and given that he rated impairment in response to a specific inquiry regarding claimant's impairment, those findings are construed as being due to the condition. Danboise, 147 Or App at 550.

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 $250, 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 letter), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated October 23, 1996, as amended on November 22, 1996 and December 12, 1996, is affirmed. For services on review, claimant's attorney is awarded a fee of $250, payable by the insurer.

In the Matter of the Compensation of
**GERALD R. BALCOM, Claimant**
WCB Case No. 95-09867
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Bethlahmy's order that set aside its denial of claimant's injury claim. On review, the issue is whether claimant's injury arose out of and in the course of his employment.

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

On review, SAIF agrees that, "[a]s a traveling employee, claimant would normally be covered by workers' compensation insurance in his travels to and from the employer's jobsite in Salem." Appellant's Brief, pg. 4 (Emphasis in the original). SAIF also acknowledges that claimant was typically reimbursed for mileage for business use of his personal vehicle. Appellant's Brief, pg. 1. Nevertheless, SAIF contends that, because claimant was injured on his return trip to Portland after picking up a vehicle that claimant and the employer had agreed to fix up and sell, claimant was on a personal mission unrelated to his employment. As authority, SAIF relies on Underwood v. Pendleton Grain Growers, 112 Or App 170 (1992).

In Underwood, the claimant was asked to drive a coworker home, transport tires from the employer's store to a store in another city, and to call on customers on his sales route. The claimant and the coworker, however, consumed alcohol and stopped at two taverns over a two and a half hour period that afternoon. After dropping the coworker off, the claimant was involved in an auto accident. The court held that, under the facts of the case, the claimant had abandoned his job for that work day as, at the time of the injury, the claimant was on his way home from a tavern. Underwood, 112 Or App at 174.

Although SAIF acknowledges that the facts in this case did not involve such "egregious activities" as those in Underwood, SAIF contends that claimant abandoned his employment when he undertook the personal task of transporting the vehicle to Portland. We disagree.

We find the facts of the present case to be more analogous to the ones presented in Savin Corp. v. McBride, 134 Or App 321 (1995). In Savin, the claimant, a traveling employee, had completed her assignment and was told by the employer that she was released for the day. Rather than returning directly to her home town, however, the claimant stopped at a bank to conduct some personal business. The claimant then returned to her car and began driving to her home. On the way home, the claimant was involved in an auto accident. The court disagreed with the employer's argument that the claimant's errand to the bank was a "distinct" departure from her employment. Rather, the court found that the departure was minimal in terms of both time and space, and could be disregarded as insubstantial. Savin, 134 Or App at 325.

Here, regardless of whether claimant returned from Salem in the purchased vehicle or with the employer, claimant would have returned to the employer's shop following a day at the Salem work site. Moreover, the ALJ accepted claimant's testimony that he was going to bid on jobs (on behalf of the employer) after picking up the vehicle and prior to returning to the shop. Finally, the employer did not object to claimant's returning home in the purchased vehicle, and it was the employer who dropped claimant off to pick up the vehicle after working at the Salem site. Additionally, we do not find the length or nature of claimant's deviation to have taken him outside the course and scope of his employment, as contrasted with the facts in Underwood, supra.

Accordingly, we agree with the ALJ that claimant was injured in the course of his employment and his claim is, therefore, compensable.

Claimant's counsel is entitled to an assessed attorney fee for prevailing over SAIF's 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 $1,000, to

be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as reflected by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The ALJ's order dated October 28, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**BOBBI J. BLAKELY, Claimant**
Own Motion No. 96-0530M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

On March 17, 1997, we withdrew our February 13, 1997 Own Motion Order, as reconsidered on April 9, 1997, in which we authorized the reopening of claimant's 1977 injury claim for the payment of temporary disability compensation. We took this action to consider the SAIF Corporation's contention that claimant provide information on her work activities since August 1994, when the Social Security Administration Disability Section informed claimant that she no longer qualified for social security disability benefits (SSDI) because she had "once again performed substantial work." Having received claimant's response, we proceed with our reconsideration.

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

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

In our April 9, 1997 order, we concluded that claimant had established that she was in the work force at the time of disability, because a March 5, 1997 letter from the Social Security Administration (SSA) notified her that she was no longer entitled to social security benefits. That letter indicated that, beginning in August 1994, claimant "once again performed substantial gainful work." In reaching this conclusion, we reasoned that, although a claimant's receipt of social security benefits might not establish that the claimant was disabled due to a compensable injury, the disqualification of a claimant for those benefits because the SSA had determined that the claimant was performing substantial work, indicated that the claimant was in the work force by virtue of performing that work. See Bobbi J. Blakely, 49 Van Natta 463 (1997); Lowell D. Armon, 48 Van Natta 2416 (1996); Kenneth C. Felton, 48 Van Natta 725 (1996).

Furthermore, claimant's surgery was performed in November 1996. Because the SSA's letter was issued on a "contemporary" date (March 5, 1997) and stated that claimant was "not entitled to payments beginning August 1994," we concluded that the letter indicated that the SSA had determined that claimant was ineligible for SSDI beginning in August 1994 through the date of the letter. On that basis, we concluded that claimant was engaged in gainful employment at the time of disability. Bobbi J. Blakely, 49 Van Natta at 463.

In response to SAIF's request for evidence of employment at the time of disability, claimant submitted child care payment notices, which establish that she was a child care provider since 1995. The most recent voucher indicates that claimant provided child care from May 1, 1996 through May 31, 1996.

Although claimant's surgery was in November 1996, a September 5, 1996 "Notice of Claim for Aggravation of Occupational Injury or Disease" form establishes that Dr. Mohler, claimant's treating physician, opined that claimant's compensable condition worsened requiring surgery several months earlier.

On this record, we conclude that claimant has established that she was in the work force at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 13, 1997 order, as reconsidered on April 9, 1997, 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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May 23, 1997 Cite as 49 Van Natta 661 (1997)

In the Matter of the Compensation of
**JAMES R. BURRES, Claimant**
WCB Case No. 96-02026
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury claim. On review the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

The employer had two fixed places of business in Oregon at the time of claimant's injury, one in Portland and one in Rice Hill.

CONCLUSIONS OF LAW AND OPINION

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

ORS 656.027(5) provides, in relevant part:

> "All workers are subject to [the Workers' Compensation Law] except those nonsubject workers described in the following subsections:
>
> "* * * * *
>
> "(5) A worker engaged in the transportation in interstate commerce of goods, persons or property for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business in this state."

In this case, claimant was engaged in interstate transportation of goods by truck for the employer at the time of his injury. However, he does not qualify as a nonsubject worker under the above statute, because the employer has two fixed places of business (including employees at those locations) in this state. (See Tr. 4, 11, 15, 34, 39, 50, 57; Exs. 4-10-11, 4-18-19, 4-23). See Giltner v. Commodore Con. Carriers, 14 Or App 340, 345 (1973); compare Charles R. Fritz, 43 Van Natta 403, 405 (1991) (Where employer had no truck terminal or full time employees in Oregon, it had no fixed place of business in the state).

In addition, because we agree with the ALJ that claimant was a permanent Oregon employee at the time of his injury (under the permanent employment relation test), we also agree with the ALJ's conclusion that claimant was an Oregon subject employee under ORS 656.126 at the time of his otherwise 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 $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 23, 1996 is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the self-insured employer.

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In the Matter of the Compensation of
**SPIRO CHALKIOPOULOS, JR., Claimant**
WCB Case No. 96-07546
ORDER ON REVIEW
Floyd Shebley, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

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

FINDINGS OF FACT

Claimant, age 26, worked for the employer as a mail room clerk. His duties included occasional loading of boxes of paper onto pallets and delivery to various locations in the building. From about December 1995/January 1996 to April 19, 1996, claimant complained at work about back aches, but failed to report any injury to his employer. During the same period, claimant sought no medical treatment and lost no time from work due to his back.

On April 8, 1996, after two verbal discussions, claimant's supervisor gave him a written warning regarding excessive tardiness and absences. (Ex. 2). On April 19, 1996, at an early afternoon meeting, claimant was formally placed on probation for disruptive behavior. (Ex. 1, Tr. 62). Later the same day, claimant sought treatment for upper back pain from Dr. Andren. (Exs. 3, 4). Claimant reported to Dr. Andren that he had injured his back in a lifting incident at work on January 23, 1996, which was still painful. On April 22, 1996, claimant notified his supervisor that he had injured his back on the job on January 23, 1996. Claimant's supervisor provided claimant with a form 801, and, on April 24, 1996, claimant filed a written claim for his injury.

On June 5, 1996, claimant was asked by his supervisors to justify eight absences during the previous seven weeks, which he had attributed to the on-the-job injury, to avoid being placed on probation for excessive absenteeism. (Exs. 15, 17). Dr. Andren concluded that there was no medical justification for claimant's absences. (Ex. 16).

On June 3, 1996, Dr. Scheinberg examined claimant for the insurer. (Ex. 14).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant compensably injured his upper back on or about January 23, 1996, while lifting a heavy box of paper at work. On review, the employer contends that claimant has not carried his burden of proof to establish that this unwitnessed injury occurred on the job. Specifically, the insurer argues that causation turns on claimant's credibility, and claimant is not credible.

The ALJ made no credibility finding. However, we infer that the ALJ found claimant credible because his findings of fact are based in large part on claimant's testimony. See Erck v. Brown Oldsmobile, 311 Or 519, 527 n. 7 (1991) (by crediting the testimony of the claimant, the ALJ implicitly found her testimony to be credible). In the absence of an express credibility finding by the ALJ in this case, we make the necessary credibility finding based on the substance of the witness' testimony, and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Following our de novo review of the record, we find claimant not to be credible.

Claimant contends that he was injured in a lifting incident at work on January 23, 1996, which he reported to his supervisor "two or three" weeks later. We do not find claimant's contentions convincing.

On April 19, 1996, claimant reported to Dr. Andren that he felt a sharp pain in his left upper back on January 23, 1996, after lifting a heavy box. Claimant admitted he made up the date of injury, which, according to his varying reports, occurred as early as December 12, 1995, or sometime in early January, when holiday decorations were still up. (Ex. 28; Tr. 10, 16, 64, 65, 89, 96). Claimant also stated that he reported his injury to his supervisor, Vicky Vandehey, sometime in February or March 1996 (Tr. 42); inconsistently, he also stated that he did not file a claim prior to April 23, 1996, because he was afraid of his supervisor.[1] Claimant also testified that he reported his work injury to Ms. Vandehey when she was helping him to select a doctor about a week before his appointment. (Tr. 120).

The record reveals that claimant failed to report any specific work-related injury to his supervisors prior to April 22, 1996. Marilyn Kickner, department manager, testified that she was aware that claimant had a doctor's appointment, but did not know its purpose, on April 19, 1996, when she and Ms. Vandehey met with claimant to formally place him on probation for disruptive behavior. Ms. Vandehey testified that claimant had frequently complained of back aches and stomach aches, but that he never mentioned any work-related cause of his back problems until April 22, 1996, when he told her he was filing a workers' compensation claim.

Moreover, the record also reveals that, although claimant complained to others of a sore back, there is no evidence to corroborate his story. Mr. Russell, a coworker, did not witness claimant's alleged injury. Mr. Russell reported that claimant told him his back hurt sometime in January 1996, but Mr. Russell did not remember any details regarding an injury, aside from claimant telling him that claimant was delivering paper. Mr. Tolonen, also a coworker, testified that claimant mentioned that he had pain in the back from general lifting at work, but did not report a specific injury to him.

Furthermore, claimant neither sought medical treatment nor missed any work due to his injury prior to April 19, 1996. (Tr. 57). When asked to describe how his back complaints progressed between January and April 1996, he said: "Well, I -- I can't tell you. I can't say what was the progression. It's just that it hurts . . . ." In addition, when claimant reported the alleged injurious incident to Dr. Andren, he described the box as weighing approximately 30 pounds. (Ex. 4). He informed Dr. Scheinberg that the box weighed 60 to 70 pounds. (Ex. 14).

In summary, we do not find the substance of claimant's testimony credible. For that reason, we give little weight to the opinions of Dr. Andren or Dr. Scheinberg, who each attributed claimant's upper back pain to his work-related injury by history. Miller v. Granite Construction Co., 28 Or App 473 (1977) (a medical opinion is no better than the history on which it is based), and conclude that claimant has failed to establish a compensable claim.

## ORDER

The ALJ's order dated November 22, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[1] We note that claimant admitted at hearing that the last time he injured himself on the job was on August 9, 1994, and that he filed his workers' compensation claim the next day (Tr. 72), which indicates that he was familiar with the claims process. We also note that claimant sought treatment and filed the current claim after his supervisor placed him on written counseling for excessive absenteeism and on probation for disruptive behavior, which belies his excuse that he failed to file a claim before April 22, 1996 because he feared his supervisor. These incidents weigh against finding claimant credible, as does his medically unsupported failure to show up for work for eight days after telling his supervisor that his absences were due to his back condition. (Exs. 15, 16).

In the Matter of the Compensation of
**LINDA M. GREENHAW, Claimant**
WCB Case No. 96-04113
INTERIM ORDER
Malagon, Moore, et al, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Claimant requested review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of claimant's occupational disease claim for right carpal tunnel syndrome. Prior to the completion of the briefing schedule, a procedural issue has arisen. Inasmuch as our review cannot proceed without resolution of this disputed issue, we have suspended the briefing schedule and allowed the parties an opportunity to address this procedural matter.

Having considered their respective positions and the applicable points and authorities, we hold that the insurer is responsible for the costs of copying Exhibit 17 (a videotape of a consulting physician's deposition, which was arranged at the insurer's request) and providing that copy to claimant's counsel. Our conclusion is based on the following reasoning.

The parties' hearing was continued for, among other reasons, the deposition of Dr. Thayer, a physician who had examined claimant and reviewed her x-rays shortly before the scheduled hearing. The insurer scheduled the deposition, which was both transcribed and videotaped. During the deposition, Dr. Thayer demonstrated the amount of force on a wrist required to produce a torn ligament. At the reconvened hearing, a copy of the deposition transcript and the videotape were admitted into the record. Although both parties had copies of the deposition transcript, neither had a copy of the videotape.

Following conclusion of the hearing and the closure of the record, the ALJ issued his order. In upholding the insurer's denial, the ALJ found Dr. Thayer's opinion that claimant's condition was work-related to be unpersuasive. In reaching this conclusion, the ALJ reasoned that claimant's demonstration of the work incident involving her right wrist "does not match Dr. Thayer's demonstration on the videotape."

Prior to the commencement of the briefing schedule concerning her appeal of the ALJ's order, claimant sought a Board ruling entitling her to a copy of the admitted videotape to be provided at the insurer's expense. Responding that claimant's counsel was present at the deposition and that claimant had received a copy of the deposition transcript, the insurer asserted that requiring it to pay for a copy of the videotape was an unnecessary expense.

Within 15 days of mailing a copy of a hearing request to the carrier, a claimant is entitled to, without cost, originals or legible copies of all medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim. OAR 438-007-0015(1). Documents acquired after the initial exchange of discovery shall be provided to the other parties within 7 days after the disclosing party's receipt of the documents. OAR 438-007-0015(4). Video tapes are encompassed within the term "documents" for purposes of this rule. See Ashwani K. Grover, 42 Van Natta 2340 (1990); William E. Wood, 41 Van Natta 2123 (1989).

Here, it is undisputed that the insurer offered Exhibit 17, a videotape of Dr. Thayer's deposition, as evidence and did not provide a copy of the admitted exhibit to claimant's counsel. Inasmuch as videotapes are subject to the aforementioned disclosure rule, it follows that claimant is entitled, without cost, to a copy of the admitted exhibit.[1]

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[1] We recognize that the insurer has provided claimant with a copy of the deposition transcript. In most cases, such an action would constitute compliance with a party's disclosure obligations. Nonetheless, in this particular case, a videotape of the deposition has also been produced and admitted into the record and the ALJ's decision has been at least partially based on the physician's demonstrations recorded by that videotape. Under such circumstances, to require claimant to proceed with her appellate arguments without a copy of the admitted exhibit would not be consistent with our understanding of substantial justice.

Moreover, the costs for cross-examination of a claimant's attending or consulting physician shall be paid by the carrier. OAR 438-007-0005(3). Consistent with that administrative rule, responsibility for the payment of costs associated with a deposition are generally borne by the party requesting the deposition. See Senters v. SAIF, 91 Or App 704 (1988).

Application of these points and authorities likewise results in a conclusion that the insurer is responsible for the charges associated with copying the admitted videotape. In other words, since it is also uncontested that the insurer requested the deposition for purposes of cross-examining claimants' consulting physician, the costs associated with that deposition must be borne by the insurer.

In conclusion, because the deposition arranged by the insurer was videotaped and since that tape was admitted into the record as an exhibit, claimant is entitled to a copy of that videotape to be provided by the insurer at its cost. Furthermore, because the admitted exhibit cannot leave our possession and since we have the capabilities to copy the videotape, we will proceed with that reproduction, provide the copy to claimant's counsel, and bill the insurer for those copying charges. Once the videotape has been reproduced, the copy will be forwarded to claimant's counsel and a revised briefing schedule will be implemented.

Finally, since this is an interim order, we retain jurisdiction to eventually address the substantive issues arising from claimant's appeal of the ALJ's order; i.e., compensability and remand. This order will eventually be incorporated into our final, appealable order.

IT IS SO ORDERED.

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May 23, 1997 Cite as 49 Van Natta 665 (1997)

In the Matter of the Compensation of
**BARTON MORRIS GROVER, Claimant**
Own Motion No. 96-0403M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's January 22, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from November 21, 1996 through January 8, 1997. SAIF declared claimant medically stationary as of December 31, 1996. Claimant does not dispute that he was medically stationary when his claim was closed. Rather, claimant contends, specifically, that the rate of temporary disability benefits which SAIF paid was incorrect. In addition, claimant requests a penalty for SAIF's allegedly unreasonable failure to pay the correct benefits.

## FINDINGS OF FACT

Claimant was awarded permanent total disability benefits subsequent to a January 26, 1979 bilateral knee industrial injury, currently administered by EBI Companies. Claimant sustained another compensable injury to the L4-5 level of his low back on December 23, 1980. That claim is insured by SAIF and is the subject of this review.

On August 7, 1996, claimant underwent a laminectomy at L2-3 and L3-4, a medial facetectomy and diskectomy, and L4-5 "redo" laminectomy. On August 28, 1996, SAIF denied claimant's current L2-3 and L3-4 conditions and resulting treatment. Claimant did not appeal that denial.

On November 21, 1996, we issued an Own Motion Order, which authorized the reopening of claimant's 1980 injury claim with SAIF for the payment of temporary disability compensation, beginning the date claimant underwent surgery. We concluded, however, that SAIF was currently responsible only for claimant's disability which resulted from treatment for the compensable L4-5 portion of the procedure. In reaching this conclusion, we reasoned that we had no Own Motion authority to authorize temporary disability compensation for claimant's noncompensable (denied) conditions.

Our November 21, 1996 order further found that claimant was in the work force at the time of disability by virtue of his permanent total disability status in his 1979 workers' compensation injury claim. In reaching that conclusion, we reasoned that, pursuant to the court's decision in Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989), claimant had met the standard for the third criterion in Dawkins required for qualifying as a member of the work force. We concluded that claimant was unable and unavailable to work or to seek work because he is permanently and totally disabled due to a compensable injury.[1] See Id.; William L. Halbrook, 46 Van Natta 79 (1994). Finally, our order noted that, if claimant was due any concurrent temporary disability compensation as a result of our order, SAIF could petition the Workers' Compensation Division for a *pro rata* distribution of payments. OAR 436-060-0020(8) and (9); Michael C. Johnstone, 48 Van Natta 761 (1996); William L. Halbrook, 46 Van Natta at 79.

On December 19, 1996, SAIF petitioned the court for judicial review of our November 21, 1996 order. On January 22, 1997, SAIF closed claimant's claim, declaring him medically stationary as of December 31, 1996. On the Notice of Closure, SAIF indicated that it paid time loss compensation from November 21, 1996 through January 8, 1997 and noted that:

> "SAIF began paying disability from 11/21/96, the date of the Board's order concerning time loss. We have appealed the order of 11/21/96. Furthermore the amount paid has been reduced by 2/3, based on footnote #3 in the Board's 11/21/96 order and Dr. Schleusener's Letter of 12/3/96."

On February 12, 1997, the Benefits Section of the Workers' Compensation Division issued a ProRata Order Designating Paying Agents Pursuant to ORS 656.307. In that order, the Director concluded that there was no concurrent temporary disability due claimant, and that "[t]here is only one claim in which temporary total disability is due, therefore, the Division is unable to designate [a paying agent]."

On February 14, 1997, claimant requested review of SAIF's January 22, 1997 Notice of Closure. Claimant further requested that we issue an order compelling SAIF to pay 100 percent of his temporary total disability benefits for that period of time that he was disabled by his L4-5 disc surgery. Finally, claimant requested that we assess a penalty for SAIF's alleged failure to correctly calculate and pay those benefits.

On March 14, 1997, SAIF responded that it paid temporary disability compensation pursuant to our order, specifically, within the application of footnote number three on page four of our November 21, 1996 order. SAIF further contended that claimant's treating physician indicated "that one-third of his temporary disability is due to the compensable L4-5 stenosis."

## CONCLUSIONS OF LAW AND OPINION

### Calculation of Temporary Disability Compensation

Claimant requests that we require SAIF to fully comply with our November 21, 1996 Own Motion Order, and to pay claimant temporary total disability at 100 percent of the appropriate rate. We proceed with our review of the appropriateness of the rate of temporary disability compensation SAIF paid to claimant.[2]

Our November 21, 1996 order reopened claimant's claim for the payment of temporary disability compensation. Our order noted that claimant underwent a laminectomy at L2-3 and L3-4, a medial facetectomy and diskectomy, and L4-5 "redo" laminectomy. We, therefore, concluded that claimant's compensable L4-5 condition worsened requiring a portion of that surgery.

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[1] 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).

[2] Although SAIF has requested judicial review of our November 21, 1996 order, we conclude that we have the authority to proceed with our review of its January 22, 1997 Notice of Closure pursuant to OAR 438-012-0050 and 438-012-0060. In any event, we have previously found that we are not required to hold Own Motion matters in abeyance pending a claimant's petition for judicial review. See Patrick G. Mahlberg, 49 Van Natta 165 (1997).

In its August 28, 1996 denial of claimant's L2-3 and L3-4 conditions, SAIF stated that:

> "SAIF Corporation will continue to provide medical benefits related to [claimant's] accepted low back strain with subsequent L4/5 laminectomy. SAIF Corporation agrees to pay that portion of your recent medical treatment and hospitalization as it relates to [claimant's] accepted claim."

In footnote number one on page two of our order, we advised that:

> "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."

As SAIF had previously advised us that claimant is permanently and totally disabled subsequent to another compensable injury claim, we noted in our order that, if any concurrent temporary disability compensation is due claimant as a result of our November 21, 1996 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). Our order further advised that we authorized "the reopening of claimant's claim to provide temporary disability compensation beginning August 7, 1996, the date [claimant] was hospitalized for surgery." Denoted at the end of that sentence, footnote number three on page four of our order advised that:

> "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."

Here, although SAIF may have interpreted our footnote as authorization to reduce claimant's temporary disability compensation by two-thirds of the amount to which claimant may be entitled, our notations regarding SAIF's responsibility for the portion of temporary disability to which claimant was entitled due to his L4-5 condition, merely reiterate the Board's authority. In other words, we may only authorize temporary disability compensation for claimant's whose aggravation rights have expired and for those conditions accepted by the carrier from the surgery date until those conditions are medically stationary. ORS 656.278. Stated another way, our authority pertains to "time periods" of temporary disability (from the disability date to the termination date), rather than to "percentage" of temporary disability as SAIF apparently interpreted our order. If SAIF was unsure (as it alleges it was) of the intent of our statement, it could have sought reconsideration or clarification of our order. It did neither.

SAIF further contends that Dr. Schleusener indicated that only one-third of claimant's temporary disability was due to the compensable L4-5 stenosis. Although claimant's treating physician may have opined that claimant was entitled to one-third of the TTD authorized by the Board, our order did not authorize SAIF to pay only one-third of the temporary disability compensation due claimant. Claimant was temporarily disabled due to his compensable L4-5 condition and resulting surgery until he was medically stationary with respect to that condition. Thus, even though claimant may have been disabled from other non-compensable conditions, as long as he was disabled from his compensable L4-5 condition, he was entitled to full TTD until the L4-5 condition was medically stationary. See Morris B. Grover, 48 Van Natta 486 (1996); Michael C. Johnstone, 48 Van Natta at 761; William L. Halbrook, 46 Van Natta at 79.

Instead of paying TTD to claimant to compensate for his disabled status and work missed, SAIF chose to pay one-third of the amount, or what is tantamount to temporary partial disability, until his compensable condition was medically stationary. Furthermore, SAIF applied to the Department for a *pro rata* distribution of temporary disability compensation, and was advised (by order dated February 12, 1997) that, because there was only one claim in which temporary disability was due, the Department was unable to designate a paying agent. The Department, therefore, denied SAIF's request to pay partial compensation.

Claimant is entitled to the full amount of temporary total disability beginning the date of surgery until his compensable L4-5 condition was medically stationary.[3] Therefore, because SAIF's Notice of Closure indicates that "the amount paid has been reduced by 2/3," we conclude that claimant's temporary disability compensation was improperly calculated and paid by SAIF. Claimant is entitled to 100 percent of the temporary disability rate for those dates of eligibility indicated in SAIF's January 22, 1997 Notice of Closure.

Penalties

Claimant requests a penalty for SAIF's allegedly unreasonable failure to pay the appropriate compensation in his claim. We hold that a penalty is warranted.

Under ORS 656.262(11)(a), if the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, the carrier is liable for an additional amount of 25 percent of the amounts "then due." The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991); Castle & Cook Inc. v. Porras, 103 Or App 65 (1990). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 12, 126 n. 3 (1985).

SAIF contends that it did not intentionally miscalculate claimant's TTD. Rather, SAIF asserts that "[i]f an error was made in the payment of claimant's temporary disability benefits, the error was done within the application of foot note #3 found on page 4 of 5 of the Board's [November 21, 1996] order." Furthermore, in a March 14, 1997 letter, SAIF's claims examiner asks: "Was it the Board's intention to order temporary disability for the duration, or that period of time, the claimant was disabled by his compensable L4-5 surgery?"

Here, SAIF has agreed (and has so noted in its Notice of Closure) that it paid claimant only one-third of temporary disability compensation (for the L4-5 level stenosis) that it would have paid for disability due to the entire surgery. SAIF further states that "[t]here was no intent to unreasonably withhold payment." However, we find no point or authority which would support SAIF's interpretation of our order, and, thus, supports its decision to, unilaterally reduce claimant's compensation by two-thirds. Furthermore, SAIF did not seek reconsideration of our November 21, 1996 order nor did it request clarification before it reduced claimant's temporary disability payments. Finally, SAIF offers no explanation as to why it did not direct the question it posed in its March 14, 1997 letter to the Board soon after our November 21, 1997 order issued, and before it unilaterally reduced claimant's TTD. Therefore, we do not find that SAIF had a "legitimate" doubt about its liability when it withheld compensation due to claimant. We conclude that claimant is entitled to a penalty of 25 percent of the amount of the compensation awarded by this order, payable in equal shares to claimant and his attorney.

Accordingly, we modify SAIF's January 22, 1997 Notice of Closure to award claimant full temporary total disability compensation for the dates listed in its January 22, 1997 Notice of Closure. Claimant is entitled to a penalty in this matter, payable as previously described.

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.

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[3] We again note that we are only authorized to award TTD for the compensable L4-5 condition. ORS 656.278. That authorization was effective as of August 7, 1996, the date of the entire surgery until claimant's compensable L4-5 condition was medically stationary. Morris B. Grover, 48 Van Natta 2325 (1996).

In the Matter of the Compensation of
**JACK B. HOOPER, Claimant**
WCB Case No. 96-03400
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Neal's order that dismissed its hearing request from an Order on Reconsideration that granted claimant permanent total disability benefits. The employer requests that this matter be remanded for a hearing. In his Respondent's and Cross-Appellant's brief, claimant seeks sanctions under ORS 656.390 for the employer's allegedly frivolous appeal. On review, the issues are jurisdiction, remand, and sanctions.

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

We begin with a brief summary of the relevant facts. On April 3, 1993, claimant compensably injured his back and leg in a fall at work. On July 14, 1995, the employer closed the claim by Notice of Closure, awarding claimant 23 percent unscheduled permanent disability. Claimant requested reconsideration of the Notice of Closure. On April 2, 1996, the Department issued an Order on Reconsideration that granted claimant permanent total disability. On April 4, 1996, the employer requested a hearing.

Jurisdiction / Remand

At hearing, claimant moved for dismissal of the employer's hearing request, contending that the employer did not timely appeal the April 2, 1996 Order on Reconsideration. The ALJ found that, pursuant to former ORS 656.268(6)(b),[1] the employer's request for hearing was untimely. Specifically, the ALJ found that, because the mailing date of the Order on Reconsideration is not counted in calculating the timeliness of a hearing request regarding a reconsideration order, the employer had until April 3, 1996, to appeal the April 2, 1996 Order on Reconsideration. Thus, the ALJ concluded the employer's April 4, 1996 request for hearing was untimely and dismissed the employer's hearing request.

On review, the employer argues that it is raising the issue of subject matter jurisdiction regarding the validity of the April 2, 1996 Order on Reconsideration. While we agree with the employer that the issue of subject matter jurisdiction may be raised at any time during the course of litigation, under the circumstances of this case, that fact does not further the employer's position. Schlecht v. SAIF, 60 Or App 449 (1982).

The employer argues that the Department was without subject matter jurisdiction to issue the April 2, 1996 Order on Reconsideration because claimant did not properly request reconsideration before expiration of 180 days from the mailing date of the Notice of Closure. Specifically, the employer argues that claimant's request for reconsideration, made by facsimile on the 180th day from the mailing date of the Notice of Closure, did not meet the filing requirements of a request for reconsideration. See ORS 656.726(3)(a); former OAR 436-30-115(1) (WCD Admin. Order 95-059); former OAR 436-01-155 (WCD Admin. Order 95-054). Therefore, the employer argues, because the Department was without subject matter jurisdiction, the April 2, 1996 Order on Reconsideration can be collaterally attacked and was void ab initio.

We disagree with the employer's underlying premise that the Department was without subject matter jurisdiction to issue the Order on Reconsideration. Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute. SAIF v. Roles, 111 Or App 597 (1992). In this

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[1] Because claimant's claim became medically stationary before June 7, 1995, former ORS 656.268(6)(b) applies to his claim. Or Laws 1995, ch 332, § 66(4). We note that, although the ALJ correctly applied former ORS 656.268(6)(b), she inadvertently stated the relevant date as June 7, 1996. We correct that clerical error.

case, the Department clearly had the authority under ORS 656.268 and ORS 656.704 to address the issue in dispute. The employer's allegations regarding claimant's untimely/improper request for reconsideration, even if true, do not divest the Department of its subject matter jurisdiction to decide the issue in dispute. Therefore, contrary to the employer's argument, the reconsideration order was not void ab initio and cannot be collaterally attacked due to lack of subject matter jurisdiction. Furthermore, as addressed below, because the employer failed to timely request a hearing regarding the reconsideration order, it lost its opportunity to "directly" attack the reconsideration order through the hearings process.

We agree with the ALJ's reasoning and conclusions regarding the untimeliness/dismissal of the employer's request for hearing, with the following supplementation.

On review, the employer argues that its hearing request should not have been dismissed because its request for determination of whether the Department had subject matter jurisdiction to issue the April 2, 1996 Order on Reconsideration was a "matter concerning a claim" pursuant to ORS 656.283(1). Therefore, the employer argues, pursuant to ORS 656.283(1), the Hearings Division had subject matter jurisdiction to determine whether the April 2, 1996 Order on Reconsideration was "void ab initio" due to the Department's alleged lack of subject matter jurisdiction. Furthermore, because its hearing request was dismissed, the employer requests that the matter be remanded to the Hearings Division for admission of relevant evidence regarding the issue of the Department's subject matter jurisdiction to issue the April 2, 1996 Order on Reconsideration.

ORS 656.283(1) provides, in relevant part, that "[s]ubject to ORS 656.319, any party . . . may at any time request a hearing on any matter concerning a claim[.]" A "matter concerning a claim" is defined as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3). While the employer may be correct in its assertion that the validity of the April 2, 1996 Order on Reconsideration is a "matter concerning a claim" in that it involves claimant's right to receive compensation, the employer overlooks the explicit statement in ORS 656.283(1) that its provisions are "[s]ubject to ORS 656.319."

Former ORS 656.319(4)[2] provides:

> "With respect to objections to a reconsideration order under ORS 656.268, a hearing on such objections shall not be granted unless a request for hearing is filed within 180 days after the copies of the determination or notice of closure were mailed to the parties."

As the ALJ found, the employer's request for hearing on the reconsideration order occurred more than 180 days after the Notice of Closure was mailed. Therefore, pursuant to former ORS 656.319(4), a hearing on any objections to the reconsideration order "shall not be granted," notwithstanding the fact that the request for hearing would otherwise constitute a "matter concerning a claim" under ORS 656.283(1). Therefore, we do not find the ALJ erred in dismissing the employer's hearing request.

Because we find that the ALJ properly dismissed the employer's hearing request, we need not address the employer's request for remand for development of the record regarding the issue of the Department's subject matter jurisdiction to issue the reconsideration order. In any event, as discussed above, even if we addressed that issue, we would find that the Department had subject matter jurisdiction to issue the reconsideration order.

Sanctions

Claimant seeks a sanction under ORS 656.390, based on the employer's allegedly frivolous request for Board review regarding the ALJ's order. Specifically, claimant contends that Raymond A. Baker, 47 Van Natta 309 (1995), a case relied on by the ALJ, "is identical to the fact situation in the case at bar" and the employer had no reasonable prospect of prevailing on review. Claimant's Respondent's and Cross-Appellant's Brief, page 5.

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[2] Because claimant's claim was medically stationary before June 7, 1995, former ORS 656.319(4) applies to his claim. Or Laws 1995, ch 332, § 66(4).

ORS 656.390(1) gives the ALJ and the Board authority to impose an appropriate sanction against an attorney who filed a frivolous request for hearing or review. "Frivolous" means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing. ORS 656.390(2); see Westfall v. Rust International, 314 Or 553 (1992) (defining "frivolous" under former ORS 656.390).

In this case, we find that the employer's request for review was not "frivolous" within the meaning of the statute. In reaching this conclusion, we note that, contrary to claimant's contention, Raymond A. Baker is not factually identical to the present case in that there was no contention in Baker that the claimant's initial request for reconsideration was untimely/improper. Furthermore, the employer raised colorable arguments regarding the jurisdiction issue that were sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Donald M. Criss, 48 Van Natta 1569 (1996). While we ultimately concluded these arguments did not prevail, we cannot say that the employer's request for review was "frivolous." Accordingly, claimant's request for sanctions is denied.

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 employer's appeal is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to such services (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated August 7, 1996, as reconsidered on September 10, 1996, is affirmed. For services on review regarding the self-insured employer's appeal, claimant's attorney is awarded $1,200, payable by the employer.

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May 23, 1997 Cite as 49 Van Natta 671 (1997)

In the Matter of the Compensation of
**CHERYL D. McLAUGHLIN, Claimant**
WCB Case No. 96-08931
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the insurer's denial of claimant's bilateral carpal tunnel condition claim. On review, the issue is compensability.

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

On review, claimant acknowledges that she has a preexisting bilateral carpal tunnel condition which combined with the bilateral carpal tunnel symptoms that arose out of her work for the employer. However, claimant disagrees with the ALJ's conclusion that she must prove that work activities are both the major contributing cause of the combined condition and the pathological worsening of the disease. ORS 656.802; 656.005(7)(a)(B).

We have previously held that, where an occupational disease claim is brought pursuant to ORS 656.802(2)(b), it is no longer sufficient for the worker to prove that work conditions were the major contributing cause of the worsening of the preexisting disease; he or she must also prove that work conditions were the major contributing cause of the "combined condition" itself. Carolyn A. Miller, 48 Van Natta 785 (1996); Dan D. Cone, 47 Van Natta 2220, 2221 (1995). Consequently, in the present case, we conclude that the ALJ applied the correct legal standard. Amended ORS 656.802(2)(b).

Finally, for the reasons stated in the ALJ's order, we conclude that the opinion of Dr. Teal, claimant's attending physician, is not persuasive. Accordingly, because that is the only expert medical opinion in the record which supports compensability, we conclude that claimant has failed to meet her burden of proof. Therefore, the ALJ's order is affirmed.

ORDER

The ALJ's order dated January 17, 1997 is affirmed.

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May 23, 1997 Cite as 49 Van Natta 672 (1997)

In the Matter of the Compensation of
**TERESA L. PUCKETT, Claimant**
WCB Case No. 96-01948
ORDER ON REVIEW
David C. Force, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of claimant's occupational disease claim for an L5-S1 disc herniation. In its brief on review, the employer contests the ALJ's ruling that claimant filed a timely hearing request from the employer's denial. On review, the issues are timeliness of the hearing request and compensability of the occupational disease claim.

We adopt the ALJ's order subject to the following corrections, substitute findings of fact and supplemental analysis.

The fifth sentence of the first paragraph of the ALJ's order identifies the record at hearing as Exhibits 1 through 48, 46A and 49. The hearing record also includes the April 12, 1996 affidavit of Gayle L. Mitchell, which the ALJ admitted as Exhibit 50.

FINDINGS OF FACT

Claimant was 36 years old at the time of hearing. She injured her low back while performing laundry work for the employer on March 2, 1994. Claimant had previously injured her low back in a sledding accident in Alaska in or around 1980. Since that incident, claimant has experienced episodes of temporary low back and left thigh pain which resolved within a few months.

At the time of the March 2, 1994 work injury, claimant complained of low back pain radiating down her left leg into her toes. She sought treatment from Dr. Joll, M.D., who diagnosed a lumbar strain. By early April 1994, claimant's symptoms had improved with conservative treatment and limited physical activity, and she was able to return to modified work for the employer folding towels. Claimant subsequently experienced an exacerbation of low back and left thigh pain after playing baseball in early May 1994. Claimant's symptoms improved with time off work and further conservative treatment, and she returned to full-time regular work for the employer.

Claimant experienced a further exacerbation of her low back and left leg pain in July 1994. Claimant associated this increase in symptoms with the bending, twisting and tugging maneuvers she engaged in at work in removing twisted blankets from laundry bins. Dr. Joll authorized physical therapy, and claimant's symptoms had improved when Dr. Joll reexamined claimant on August 13, 1994. However, at Dr. Joll's follow-up examination on August 25, 1994, claimant complained of persistent back and left leg pain. In addition, claimant demonstrated a positive left straight leg raise, whereas she had previously had a normal neurological examination. An MRI performed on the same day documented an L5-S1 disc herniation causing displacement of the left S1 nerve root.

In the interim between Dr. Joll's August 13, 1994 and August 25, 1994 examinations, claimant continued performing her regular, full-time work for the employer, which included pulling twisted blankets out of laundry bins. Claimant did not perform any similar off-work activity during this time period. Nor did she sustain any discrete injuries to her low back either on or off-the-job.

Dr. Gallo, neurosurgeon, assumed responsibility for claimant's care on August 31, 1994. At that time, claimant reported radiating pain into the left buttock, thigh and calf, with tingling in the ball of the left foot. Dr. Gallo performed a left total sacral microdiskectomy on September 12, 1994.

The employer denied claimant's injury claim for the March 2, 1994 work incident, and claimant requested a hearing. The matter proceeded to litigation before ALJ Livesley in November 1994. (WCB Case No. 94-09830). ALJ Livesley found the diagnosed lumbar strain compensable, but concluded that the herniated L5-S1 disc was not compensably related to the March 2, 1994 injury. ALJ Livesley's order was not appealed and became final as a matter of law.

The processing of the March 2, 1994 injury claim subsequently became a subject of litigation in WCB Case No. 95-03202, which was scheduled for hearing on June 7, 1995. Prior to that hearing, claimant filed a timely occupational disease claim for the L5-S1 disc herniation. The aforementioned June 1995 hearing in the injury claim was then postponed so that the employer's pending denial of the occupational disease claim could be consolidated for litigation.

On June 9, 1995, the employer issued its formal denial of claimant's occupational disease claim. On June 23, 1995, claimant's attorney completed and signed a request for hearing from the employer's June 9, 1995 denial. Copies of that hearing request were mailed and received by claimant and counsel for the employer. However, there is no record that the Board ever received the original hearing request.

Meanwhile, the employer had closed the compensable injury claim, the closure had been set aside on reconsideration, and the employer had filed a May 31, 1995 hearing request challenging the reconsideration order. The Board assigned new WCB Case No. 95-06443 to this hearing request, consolidated the matter with WCB Case No. 95-03202, and scheduled a hearing for February 22, 1996. The Board did not assign a new case number to claimant's hearing request from the occupational disease denial or otherwise process that hearing request. Nevertheless, the parties assumed that the occupational disease claim would be litigated at the February 22, 1996 hearing. Towards that end, the parties took the deposition of Dr. Joll on December 20, 1995, and the deposition of Dr. Gallo on February 15, 1996.

When the February 22, 1996 hearing convened, the parties discovered that the Board had not processed claimant's June 23, 1995 hearing request and did not have any record of that request. Accordingly, the occupational disease denial was not litigated at the February 22, 1996 hearing. Claimant, instead, filed a copy of the June 23, 1995 hearing request with the Board. That copy was date stamped by the Board on February 22, 1996, and the matter was assigned new WCB Case No. 96-01948. It is this matter that is presently before the Board.

## FINDINGS OF ULTIMATE FACT

On June 23, 1995, the legal assistant for claimant's attorney placed the original hearing request from the employer's occupational disease denial in the U.S. Mail, properly addressed to the Board's offices in Salem. Copies of the hearing request were mailed at the same time to claimant and counsel for the employer.

## CONCLUSIONS OF LAW AND OPINION

### Timeliness of Hearing Request

We adopt the ALJ's conclusion and opinion regarding the timeliness of claimant's hearing request, including the opinion set forth in the fourth paragraph of the ALJ's Findings of Fact.

### Compensability of Occupational Disease Claim

The date appearing in the last line of page five of the ALJ's order should read March 2, 1994 rather than March 2, 1995. We otherwise adopt the ALJ's conclusion and opinion on the compensability issue, including the opinion set forth in the eighth and ninth paragraphs of the ALJ's Findings of Fact.

## ORDER

The ALJ's order dated October 30, 1996 is affirmed.

In the Matter of the Compensation of
**LINDA M. WILSON, Claimant**
WCB Case No. 96-08793
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that found that the insurer's September 30, 1996 denial was a denial of claimant's "current condition." On review, the issue is the propriety of the September 30, 1996 denial.

We adopt and affirm the ALJ's order, with the exception of the last paragraph, and with the following supplementation.

The insurer's November 1996 "Amended Partial Denial" specifies that the insurer "wishes to clarify the scope of [its] prior denial dated September 19, 1996 and September 30, 1996." The November letter further specifies that the "amended partial denial is [in] lieu of the [earlier] denials." The letter specifically denies claimant's "chronic pain syndrome" condition on the basis that it is idiopathic or of an unknown etiology, and states that the insurer will continue to pay all benefits related to the original accepted condition, but will not pay for medical treatment and disability related to the current chronic pain syndrome. Based on such language, we find that the third letter is intended to substitute for the two earlier denials by expressly stating that the third letter is in lieu of the two earlier letters and to specifically limit the scope of the denial to claimant's current chronic pain syndrome. Thus, we conclude that the third letter is most reasonably construed as effectively subsuming the first two denials to clarify that the scope of the insurer's denial is limited to the compensability of claimant's current chronic pain syndrome. Lillian M. Aman, 47 Van Natta at 1637.

In light of our conclusion that the November 1996 denial letter has subsumed the September 30, 1996 letter, we reject claimant's argument that the September 30, 1996 letter is an improper "backup" denial.

ORDER

The ALJ's order dated January 7, 1997 is affirmed.

In the Matter of the Compensation of
**DARREL L. ALLEN, Claimant**
WCB Case No. 96-04235
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of claimant's low back injury claim; and (2) awarded a $4,000 attorney fee. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order. See Steven L. Reeves, on recon 48 Van Natta 1698 (1996). In addition, we offer the following supplementation regarding the attorney fee issue.

The employer argues that the ALJ's $4,000 assessed attorney fee is unreasonable because the issues in this case are not particularly complex and there were no frivolous issues or defenses asserted.

Claimant responds that the fee is reasonable because the value of the interest involved is very high and above average time was involved, due to a post-hearing deposition (which also involved out of town travel) and written closing arguments. Claimant also contends that the compensability issue is medically complex and that the risk that claimant's counsel would go uncompensated is high, because claimant must prove that his work injury was the "major contributing cause" of his current combined low back condition, under current law.

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 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 issue in dispute was the compensability of claimant's low back injury, including a combined condition involving preexisting congenital spondylolysis with some spondylolisthesis.

Approximately 22 exhibits were received into evidence, with at least one generated and submitted by claimant. The record also includes a "post-hearing" deposition of 49 pages, which required out of town travel. The hearing transcript consists of approximately 56 pages. Two witnesses, including claimant, testified. Claimant submitted nine pages of written argument to the ALJ. The case involved issues of medical complexity greater than those generally submitted for Board consideration. The claim's value and the benefits secured are significant, because substantial medical services (including surgery) are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated, considering the medical complexity of the case and claimant's burden of proof.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,000 is a reasonable and appropriate attorney fee for services at the hearings level in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and evaluating claimant's counsel's submission in light of the employer's objection), the medical complexity of the case, the value of the interest involved, 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 $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted

to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services related to the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 1986).

ORDER

The ALJ's order dated December 10, 1996 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

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May 28, 1997 Cite as 49 Van Natta 676 (1997)

In the Matter of the Compensation of
**RALPH E. MELINE, Claimant**
Own Motion No. 97-0251M
OWN MOTION ORDER
Scott McNutt, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable left knee synovitas and plica injury. Claimant's aggravation rights expired on February 13, 1994. SAIF recommends that we authorize the payment of temporary disability compensation.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning April 1, 1997, the date claimant was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.[1]

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.

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[1] Claimant is currently receiving timeloss in another OM claim (# 4803262A). Therefore, we note that an injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). If any concurrent temporary disability compensation is due claimant as a result of this order, SAIF may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a pro rata distribution of payments. OAR 436-060-0020(8) and (9); Michael C. Johnstone, 48 Van Natta 761 (1996); William L. Halbrook, 46 Van Natta 79 (1994).

In the Matter of the Compensation of
**LENNE R. BUTCHER, Claimant**
Own Motion No. 93-0415M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
EBI Companies, Insurance Carrier

Claimant requests review of the insurer's January 30, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from August 4, 1993 through January 11, 1997. The insurer declared claimant medically stationary as of November 15, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the January 30, 1997 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 a March 13, 1997 letter, we requested the parties to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on March 20, 1997. Claimant was granted a 30-day extension of time within which to submit evidence and argument, however, no further response has been received from claimant. Therefore, we will proceed with our review.

In an October 28, 1996 chart note, Dr. Gulick, claimant's treating physician, opined that:

> "I don't feel that [claimant's] depression has any meaningful chance of improvement if he doesn't go through this pain center program, especially in light of the fact that he is taking more pain medicines than he told me about. I feel strongly that it should be in-patient at this point as well. I certainly feel that if he won't go through this program that he is not likely to get better w/further passage of time or medications, and therefore would be medically stationary."

In an October 30, 1996 Northwest Occupational Medicine Center Comprehensive Pain Evaluation, the physicians evaluating claimant for treatment for his accepted chronic mild-to-moderate depression condition, opined that "the most appropriate course of action would appear to be treatment in an interdisciplinary pain management program."

In a December 11, 1996 response, Dr. Brent, clinical psychologist, agreed with the recommendation proposed in the pain evaluation. Dr. Brent further agreed that, should claimant not agree to attend the multidisciplinary program as recommended, claimant would be medically stationary from a psychological perspective.

In a December 20, 1996 response, Dr. Gulick agreed that claimant was physically able to participate in the pain center program as of November 20, 1996. Dr. Gulick further agreed that, if claimant refused to participate in the program, he was medically stationary as of November 15, 1996.

In a January 6, 1997 letter to claimant, the insurer notified him that the pain center program was recommended, and that his physicians had agreed that he was able to participate in the pain center program. The insurer further notified claimant that, if he or his doctor did not respond within two weeks from the date of the January 6, 1997 letter, "we will assume that you have recovered to the point where your physical condition is the same as it was before you were injured, and we will proceed to close your claim." No further response from claimant or his physician is in the record.

We do not find evidence that claimant agreed to participate in the pain center program, and, thus, the opinions of the physicians and psychiatrists treating and evaluating claimant are unrebutted. On this record, we are not persuaded that claimant has established that he was not medically stationary at claim closure. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's January 30, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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May 29, 1997 Cite as 49 Van Natta 678 (1997)

In the Matter of the Compensation of
**LORETTA R. DOLAN, Claimant**
WCB Case No. 96-06882
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Nancy Meserow, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's sciatica condition. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

On June 30, 1995, claimant slipped and fell at work. Claimant was taken to the hospital emergency room; the examining physician recorded that claimant hit the back of her head and left elbow when she fell. (Ex. 2). The physician diagnosed cervical strain, left elbow contusion, occipital contusion and left knee scrape. (Id.)

Claimant sought follow-up treatment from physician's assistant Laurie Smith, who worked with Dr. Foutz, claimant's treating general practitioner. On July 12, 1995, Dr. Foutz declared claimant medically stationary and released her to full duty. (Exs. 8, 9, 12). The employer accepted "contusion with related bursitis" and "left elbow and pain with contusion on the left hip." (Ex. 13). On September 6, 1995, the employer issued a Notice of Closure. (Ex. 14).

On September 14, 1995, claimant saw Ms. Smith for right hip and groin pain. (Ex. 15). In October 1995, Dr. Foutz referred claimant to orthopedic surgeon Dr. Kendall, whose diagnosis included right sciatica "secondary to June 30 injury." (Ex. 18-4). Dr. Kendall also found that claimant was not medically stationary and released her from work. (Id.) The employer accepted right quadriceps femoris muscle sprain. (Ex. 23). The employer issued a partial denial, however, of degenerative lumbar spondylolisis[1] and right sciatica. (Ex. 28).

## CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the denial of right sciatica, finding that claimant's testimony was not consistent with the documentary record and that Dr. Kendall's opinion supporting causation was not sufficient to carry claimant's burden of proof. Claimant requested review of the ALJ's order.

Examining physicians Dr. McCormack and Dr. Emmons found that the June 30, 1995 incident injured claimant's left hip and left elbow and that, as of the date of their February 1996 examination, such conditions had resolved. (Ex. 24-6). The panel further found that claimant exhibited symptoms of degenerative lumbar spine disease. (Id.) The panel discounted the June 1995 incident as a factor in the condition since claimant had not reported low back pain following the event and Dr. Foutz had declared claimant medically stationary with no permanent impairment and released her to regular work. (Id.)

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[1] Claimant did not contest the denial of lumbar spondylolisis.

Dr. Foutz concurred with the panel's report. (Ex. 26). When asked to review the report, Dr. Kendall first indicated "I ignore," then, after a second request, stated that "my impressions regarding [claimant] are being disregarded and I don't intend to participate in justifying your IME conclusions." (Exs. 25, 27).

Dr. Kendall eventually concurred with a letter written by claimant's attorney stating that claimant's June 1995 fall "combined with her pre-existing spondylosis to cause the right sciatica" and the industrial injury "was the major contributing cause of her sciatica[.]" (Ex. 30-1). The letter further stated that the delay in low back pain was not inconsistent with the injury since "the body becomes tense and begins to spasm" following such an event. (Id.)

In evaluating medical opinions, we defer to the treating physician absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Kendall's opinion. First, Dr. Foutz, who saw claimant soon after the June 1995 event, concurred with the examining panel's report that claimant's low back pain could not be attributed to the industrial injury. Dr. Kendall's opinion also is conclusory and offers no explanation as to how the fall caused right sciatica; Dr. Kendall's reasoning instead is limited to providing a reason for the delay in onset of low back pain.

Consequently, we agree with the ALJ that Dr. Kendall's opinion is inadequate to carry claimant's burden of proof and that she did not establish compensability. See ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated November 22, 1996 is affirmed.

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May 27, 1997 Cite as 49 Van Natta 679 (1997)

In the Matter of the Compensation of
**ANTHONY J. McKENNA, Claimant**
WCB Case Nos. 95-07570, 95-02480 & 94-07262
SECOND ORDER ON RECONSIDERATION
Jerome P. Larkin (Saif), Defense Attorney
Bottini, et al, Defense Attorneys

On May 2, 1997, we republished our January 31, 1997 Order on Review that: (1) directed Safeco to accept claimant's injury claim for an "L4-5 disc derangement/bulge" condition; (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition; (3) upheld Safeco's denials of claimant's aggravation and occupational disease claims for the same condition; (4) denied claimant's motions to remand and strike Safeco's Cross-Reply Brief; and (5) declined to award interim compensation or assess penalties or sanctions. Asserting that our order contains a typographical error, Safeco seeks correction of our order.

After reviewing the portion of our order in question (Page 4, footnote 4), we agree that the last sentence in that footnote contains a clerical error. Specifically, the word "not" has been inadvertently omitted in the phrase "claimant has proven an aggravation claim." To correct this oversight, we replace the aforementioned sentence with the following sentence: "On reconsideration, we continue to find that claimant has not proven an aggravation claim, because he has not established that his compensable condition actually worsened. See SAIF v. Walker, 145 Or App 294 (1996)."

Accordingly, we withdraw our prior orders. On reconsideration, as corrected herein, we republish our prior orders, 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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In the Matter of the Compensation of
**KATHRYN B. HENSON, Claimant**
Own Motion No. 97-0051M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant, *pro se*, requests reconsideration of our February 18, 1997 Own Motion Order in which we declined to reopen her 1978 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she remained in the work force at the time of disability. With her request for reconsideration, claimant submitted W-2 wage slips for 1995 and 1996.

Concluding that claimant had demonstrated good cause for her late request for reconsideration of our order, on April 16, 1997, we abated our February 18, 1997 order, and allowed SAIF 14 days in which to file a response to the motion. We have received SAIF's response. SAIF contends that claimant was not in the work force at the time of the current disability. SAIF further contends that claimant did not have good cause for her untimely appeal of our order. Claimant has not further responded to SAIF's contentions. Therefore, we proceed with our review of the record.

Inasmuch as we find that claimant is not entitled to temporary disability benefits, we need not resolve the "good cause" issue. We base this conclusion on the following reasons.

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

Claimant underwent surgery for her compensable right knee strain injury on February 26, 1997. Thus, as in our prior order, 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 the current disability. Claimant has the burden of proof on this issue and must provide persuasive evidence that she was in the work force during the relevant time.

Claimant provided W-2 wage slips for 1995 and 1996. Those wage forms indicate that claimant worked at some time during 1995 and 1996, and reflect that claimant earned $1962.04 and $602.17 during those respective years. In an April 28, 1997 letter, SAIF's claims examiner stated that she spoke with claimant on January 27, 1997. The claims examiner stated that she had provided to claimant two requests for documentation which would verify that she was in the work force during the relevant time, and that claimant finally responded by telephone. In that conversation, SAIF alleges that claimant stated that she worked for a few weeks in "early 1996," however that claimant also stated that she now considered herself retired and would not be claiming timeloss benefits for her upcoming surgery.

Although claimant submitted W-2 forms, claimant has submitted no evidence that she was in the work force during the relevant time. Claimant's 1996 W-2 wage form indicates that claimant worked at some time during 1996, however, her surgery occurred in February 1997. Therefore, claimant must establish that she was in the work force during the time prior to her surgery. See Daniel Martushev, 48 Van Natta 1033 (1996) (the claimant's submission of check stubs or wage-withholding statements which reflect dates of work were sufficient for our review). Furthermore, SAIF contends that claimant has retired. Claimant does not refute that contention, nor does she refute that her income in 1996 was generated early in that year, rather than during the latter part of the year. See Fred Vioen, 48 Van Natta 2110 (1996) (because the claimant retired prior to surgery, he was not in the work force at the time of disability). On this record, we are not persuaded that claimant has met her burden of proving that she was in the work force at the time of her 1997 disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 18, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JIMMIE J. LAMB, Claimant**
WCB Case No. 96-08905
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant request review of that portion of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's cervical condition. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant relies on his written closing argument to the ALJ. In that argument, claimant contended that the ALJ erred in not admitting his testimony regarding extent of disability. However, we have previously addressed this issue and adhere to our decision in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996). In that case, we held that any evidence submitted following reconsideration (including a claimant's testimony) which was not previously submitted during the reconsideration process and made a part of that record, is not admissible, pursuant to amended ORS 656.283(7). See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996); Dean J. Evans, 48 Van Natta 1092, on recon 48 Van Natta 1196 (1996). Accordingly, we conclude that the ALJ did not err in excluding claimant's testimony.

Claimant next argues that the ALJ incorrectly found that there was no "objective evidence" to support claimant's claim for permanent impairment. However, the ALJ correctly noted in his "Findings of Fact," that the medical arbiter, Dr. Laycoe, reported that he had not found objective findings to support an inability to repetitively use the cervical spine. Furthermore, regardless of whether Dr. Laycoe correctly believed that there were no "objective findings," the ALJ did not reject the arbiter's opinion on that basis. Rather, the ALJ deferred to the treating doctor who had treated claimant for over a year. The ALJ discounted the arbiter's opinion, due to the arbiter's conclusory and unexplained statement that the findings were due to the accepted strain.

Finally, claimant contends that the ALJ should have accepted the arbiter's loss of range of motion findings, as those were the only measurements in the record that followed the Director's Bulletin No. 242. We disagree.

We have previously noted that 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). Rather, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. Here, due to the fact that claimant's treating doctor and others had found that claimant's degenerative process was causing the stiffness and loss of cervical motion (Exs. 43-7; 44), we find that the arbiter's report, which does not discuss either the contrary opinions or the degenerative condition, is conclusory and unpersuasive. We, therefore, agree with the ALJ's deference to the opinion of claimant's treating doctor. See Weiland v. SAIF, 64 Or App 810 (1983).

Accordingly, because claimant has not proven that his permanent impairment is due to the industrial injury, we agree with the ALJ that there is no basis for an award of unscheduled permanent disability. ORS 656.214(2); ORS 656.266.

ORDER

The ALJ's order dated January 30, 1997 is affirmed.

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May 29, 1997 Cite as 49 Van Natta 682 (1997)

In the Matter of the Compensation of
**WARREN F. RUSHLOW, Claimant**
WCB Case Nos. 96-07063 & 96-05910
INTERIM ORDER OF DISMISSAL
John Motley (Saif), Defense Attorney
Safeco Legal, Defense Attorney

Claimant requested review of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld Safeco Insurance Company's denial of claimant's aggravation claim lumbar disc condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. Claimant and Safeco have submitted a proposed "Disputed Claim Settlement Stipulation and Order," which is designed to resolve all issues raised between them.

Pursuant to the settlement, claimant and Safeco agree that Safeco's denial "shall remain in full force and effect." The settlement further provides that claimant withdraws his request for Board review of the ALJ's order insofar as it pertains to the case involving Safeco's denial. Finally, claimant stipulates that his request for review insofar as it concerns his claim with Safeco "will be dismissed with prejudice."

We have approved the settlement, thereby fully and finally resolving the dispute between claimant and Safeco. Consequently, those issues will not be further addressed on review. In approving this settlement, we emphasize that claimant is accepting the possibility that he will not receive compensation from the remaining carrier (SAIF). See Lorna I. Young, 46 Van Natta 703 (1994).

Finally, since claimant's request for Board review concerning the case involving SAIF's denial remains pending, we retain jurisdiction. In other words, following completion of the briefing schedule, we shall proceed with our review of the remaining issues. Accordingly, this order is interim and will be eventually incorporated into our final, appealable order.

Enclosed with claimant's and the insurers' attorneys' copies of this order are copies of the hearing transcript. In addition, the following briefing schedule has been implemented. Claimant's appellant's brief (his written argument explaining why he disagrees with the ALJ's order and what action he wants the Board to take) must be filed within 21 days from the date of this order. SAIF's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of SAIF's brief. (If Safeco wishes to submit a brief, it should do so within 14 days from the date of mailing of SAIF's brief.) Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MICHAEL D. SAHM, Claimant**
Own Motion No. 96-0434M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorney
Saif Legal Department, Defense Attorney

On November 21, 1996, we issued our Own Motion Order on Reconsideration, in which we declined to authorize the payment of temporary disability compensation because claimant had not established that he was in the workforce at the time of disability. That order republished our September 23, 1996 Own Motion Order, which denied reopening of the claim on the grounds that claimant had not established that: (1) his current condition required surgery or hospitalization; and (2) he was in the work force at the time of disability.

On May 8, 1997, the SAIF Corporation submitted claimant's counsel's April 22, 1997 letter and attached documentation, which was provided to SAIF by claimant to support his contention that he was in the work force at the time of disability. We treat SAIF's submission as a request for reconsideration of our November 21, 1995 order. Because neither SAIF nor claimant offer explanation for this late request, we deny the request for reconsideration. See OAR 438-012-0065(2).

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666; see also Brown v. EBI Companies, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." See Larry P. Karr, 48 Van Natta 2182 (1996); Jay A. Yowell, 42 Van Natta 1120 (1990).

Here, claimant's / SAIF's request for reconsideration was received on May 12, 1997, more than 60 days after the issuance of our November 21, 1996 reconsideration order. Moreover, neither claimant nor SAIF offer an explanation for this untimely filing. SAIF does not submit a new recommendation to reopen this claim. Rather, it relies on its September 18, 1996 Carrier's Own Motion Recommendation form, in which it opposed reopening on the grounds that: (1) no surgery had been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) claimant was not in the work force at the time of disability.

Finally, neither party represents that there are extraordinary circumstances to warrant the reconsideration of our prior order. Even if they had, the current record would not support such a finding.

In reaching this conclusion, we note that, when claimant previously requested reconsideration of our September 23, 1996 order, he failed to provide any documentation that he was in the work force at that time. Because claimant now submits payroll information for the periods of 1995 and 1996, we further conclude that this information was available to claimant "with due diligence" within 60 days after the issuance of our November 21, 1996 order.[1] See Larry P. Karr, 48 Van Natta 2182 (1996).

Therefore, we find no extraordinary circumstances exist to persuade us that an exception outside the deadlines imposed by OAR 438-012-0065(2) is appropriate, particularly since claimant has provided no explanation for his lack of due diligence in timely offering work force documentation either pursuant to our October 22, 1996 order of abatement or during the 30-day period following issuance of our November 21, 1996 order. Charles Kurnick, 46 Van Natta 2501 (1994); Jay A. Yowell, 42 Van Natta at 1120.

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[1] Claimant submitted documentation which establishes that: (1) he sustained a compensable injury in September 1995 while another insurer was on the risk; (2) he was receiving temporary disability compensation through April 1996; (3) he returned to modified work in May 1996; and (4) on July 31, 1996, Dr. Bald requested authorization to perform claimant's right total knee replacement.

Accordingly, we deny the request for reconsideration of our prior orders.

IT IS SO ORDERED.

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May 29, 1997 Cite as 49 Van Natta 684 (1997)

In the Matter of the Compensation of
**BARBARA A. SCHILTHUIS, Claimant**
WCB Case No. 96-07920
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) denied claimant's motion to continue the hearing to allow her an opportunity to further develop the record to respond to the insurer's alleged amendment of its denial of claimant's aggravation claim for a right forearm (wrist) condition; and (2) upheld the insurer's denial. On review, the issues are the ALJ's procedural ruling and aggravation.

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

Claimant asserts that the only issue raised by the insurer's denial is whether she has established "objective findings of a worsening." Assuming *arguendo* that claimant's assertion is correct, we would still find that claimant has not established an aggravation of her right forearm condition.[1]

In a May 29, 1996 chartnote, Dr. Stewart, claimant's attending physician, reported that claimant had diffuse tenderness along the ulnar border of the right forearm, but not at the wrist. (Ex. 43). Dr. Stewart further noted that claimant had excellent range of motion in her wrist and full extension of her fingers and stated that claimant had "no objective findings." (Id.). In a subsequent concurrence letter from claimant's counsel, Dr. Stewart agreed that a forearm overuse syndrome typically does not have objective findings and indicated that it was possible that findings of ulnar tenderness were reproducible. (Ex. 47). However, Dr. Stewart also indicated that such tenderness may be the result of a waxing and waning of the forearm condition. (Id.)

Even if we accept Dr. Stewart's opinion as establishing objective findings, his opinion does not indicate that these findings represent an actual worsening of claimant's compensable right forearm injury. At best, Dr. Stewart's opinion establishes that the tenderness in claimant's right forearm represents a possible waxing and waning of her compensable condition. This is not sufficient to prove "objective findings of an actual worsening" as required by ORS 656.273(1). See Russell D. Parker, 49 Van Natta 83 (1997); Helen M. Callendar, 48 Van Natta 2409 (1996). Consequently, we agree with the ALJ that claimant was not established an aggravation of her compensable right forearm condition.

ORDER

The ALJ's order dated January 6, 1997 is affirmed.

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[1] In light of this conclusion, we need not resolve the question of whether the ALJ properly denied claimant's continuance motion based on the insurer's alleged "at-hearing" amendment of its aggravation denial.

In the Matter of the Compensation of
**DANIEL I. VANWECHEL, Claimant**
WCB Case No. 96-05694
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to direct the self-insured employer to reclose claimant's right knee injury claim as a result of a "post-closure acceptance" of an ACL tear and femoral condyle fragmentation; and (2) imposed a $500 sanction against claimant's counsel pursuant to ORS 656.390 for an allegedly frivolous request for hearing. On review, the issues are claim processing and sanctions. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation and exception. We do not adopt the ALJ's findings of ultimate fact. The ACL tear and femoral condyle fragmentation were accepted "post-reconsideration."

## CONCLUSIONS OF LAW AND OPINION

### Preliminary Matter

Due to a computer error, the ALJ's order contained an incomplete paragraph. The parties have stipulated to the language that the ALJ indicated he intended to include in this paragraph. Accordingly, we review the ALJ's order as corrected by the parties' stipulation.

### Claim Processing

We summarize the pertinent facts. Claimant injured his right knee at work in January 1993. He sought treatment from Dr. Bowman, who suspected a medial meniscus tear and recommended surgery. Dr. Bowman performed arthroscopic surgery on claimant's right knee in March 1993. The post-operative diagnosis was "small tear of anterolateral cruciate bundle and ligamentum synovium, chondral fracture of medial femoral sulcus with loose body in the lateral compartment posteriorly." In March 1993, the employer accepted a disabling right knee meniscus tear.

Claimant's claim was closed by a February 1994 Determination Order with an award of 5 percent scheduled permanent disability for a chronic condition limiting repetitive use of the right knee. The "accepted" condition listed on the "Evaluator's worksheet" was "R knee meniscus tear." (Ex. 9-2). Claimant requested reconsideration and a July 13, 1994 Order on Reconsideration affirmed the Determination Order. The "accepted condition" listed on the Appellate Unit "worksheet" was "right knee." (Ex. 11-3). The closing medical exam referred to on the worksheet was that performed by Dr. Bowman on February 3, 1994. The closing report of February 3, 1994 does not reflect the condition subject to the closing exam. (Ex. 8).[1]

On October 7, 1994, the employer amended its acceptance to include "right knee anterior cruciate tear and fragmentation of the medial femoral condyle." Claimant requested a hearing seeking an attorney fee for obtaining acceptance of the ACL tear and femoral condyle fragmentation conditions. Claimant also appealed the Order on Reconsideration, seeking an increased scheduled permanent disability award for the right knee.

In an order dated August 31, 1995, a prior ALJ awarded an attorney fee, but affirmed the July 13, 1994 Order on Reconsideration. Claimant's appeal of the prior ALJ's order was later dismissed by the Board after claimant withdrew his request for review.

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[1] In a letter to claimant's counsel on February 16, 1996, a Disability Determination Specialist of the Workers' Compensation Division stated that "all accepted conditions had already been addressed by prior orders." (Ex. 25).

Claimant subsequently requested a hearing in the present matter raising the issue of a failure to process the claim for the newly accepted right knee conditions to closure. The employer filed a cross-request for hearing raising the issue of sanctions for a frivolous request for hearing under ORS 656.390.

The ALJ concluded that all of claimant's right knee conditions, including those accepted post-closure, were medically stationary and properly rated when the claim was initially closed. On this basis, the ALJ held that the employer did not have a legal duty to reclose the claim even though the employer had accepted the new conditions after the original claim closure. The ALJ also imposed sanctions against claimant's attorney for a frivolous appeal. We disagree with the ALJ's reasoning and reverse.

Subsequent to the ALJ's order, we held that where the carrier has accepted additional conditions after issuance of an Order on Reconsideration, the proper procedure at hearing on the Order on Reconsideration is to rate the conditions accepted at the time of the Order on Reconsideration and remand the later accepted conditions to the carrier for processing according to law. Anthony J. Telesmanich, 49 Van Natta 49 (1997), on recon 49 Van Natta 166 (1997); see also Bernard G. Hunt, 49 Van Natta 223 (1997).[2] Depending on the circumstances and the medical evidence, the processing of these "post-reconsideration" accepted conditions may, or may not, involve the "reopening" of the claim and a redetermination of extent of permanent disability. If the claimant objects to the carrier's subsequent processing of the claim, we have held that he may request a hearing at the appropriate time. Patricia A. Dropinski, 49 Van Natta 206, 212 (1997).

Here, as previously noted, the employer accepted claimant's ACL tear and femoral condyle fragmentation conditions after issuance of the reconsideration order. Consistent with the Telesmanich and Dropinski holdings, and contrary to the Division's February 1996 letter, these "post-reconsideration" conditions could not be properly rated during the reconsideration proceeding regarding the previously accepted right knee meniscus tear. Instead, in accordance with the rationale expressed in Telesmanich and Dropinski, the ACL tear and femoral condyle fragmentation conditions must be processed by the employer according to law. This "processing" may or may not involve the "reopening" and "re-rating" of the claim. In any event, if claimant disagrees with the employer's subsequent processing of the claim, he may seek another hearing.

Sanctions

The ALJ found that claimant's request for hearing was frivolous and imposed a sanction under ORS 656.390. We do not find that a sanction under ORS 656.390 is warranted.

ORS 656.390(1) provides that if a party requests a hearing and an ALJ finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the ALJ may impose an appropriate sanction upon the attorney who filed the request for hearing. "Frivolous" means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing. ORS 656.390(2); Sheri A. Wheeler, 48 Van Natta 1780 (1996).

As previously discussed, subsequent to the ALJ's order, we recently held that when there is a "post-closure" or "post-reconsideration" acceptance of new conditions, a carrier is required to process the later accepted conditions as required by law, including payment of any additional compensation to which the claimant may be entitled. Anthony J. Telesmanich, 49 Van Natta at 166. We further held that the processing of these later accepted conditions may or may not include a reopening of the claim and extent determination. Id. Moreover, we reasoned that, if the claimant disagreed with the carrier's eventual processing of the claim, he could request a hearing challenging the processing. Id.

In addition, we also find that the law was unclear and unsettled at the time the hearing request was filed regarding how to process new conditions accepted after claim closure. The ALJ noted that Hutson v. Precision Construction, 116 Or App 10 (1992) appeared to be authority contrary to claimant's

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[2] In Hunt, we acknowledged that we had previously ruled in other cases that consideration of "post-closure" compensable conditions was appropriate in determining the extent of a claimant's permanent disability. See, e.g., Hutson v. Precision Construction, 116 Or App 10 (1992). However, we distinguished those prior cases on the ground that they had been decided prior to the 1990 and 1995 legislative amendments which significantly limited the record regarding impairment and claim closure issues that could be reviewed at hearing and by the Board. Specifically, we noted that under ORS 656.283(7) and ORS 656.295(3) and (5), no issues could be raised and no evidence admitted at hearing or on review regarding a notice of closure or determination order that were not raised or submitted at the reconsideration proceeding under ORS 656.268.

position. However, as we explained in Bernard G. Hunt, 49 Van Natta at 224-225,[3] Hutson and its progeny were decided prior to the 1990 and 1995 legislative amendments which significantly limited the record regarding impairment and claim closure issues that could be reviewed at hearing and by the Board. Specifically, we noted that under ORS 656.283(7) and ORS 656.295(3) and (5), no issues can be raised and no evidence admitted at hearing or on review regarding a notice of closure or determination order that were not raised or submitted at the reconsideration proceeding under ORS 656.268. Hunt, 49 Van Natta at 224-225.

Consistent with the Telesmanich and Hunt decisions, we find that these statutory changes made it unclear whether Hutson remained good law after the 1995 amendments. These changes also made it unclear how claims for new medical conditions, which were accepted post-closure, were to be processed by carriers.

Under the circumstances, because of the uncertainty after the 1995 amendments regarding the processing of claims for conditions accepted post-reconsideration and because of our current case law which allows a claimant to challenge a carrier's processing of conditions accepted "post-reconsideration," we find that claimant's hearing request raised a colorable argument that the carrier should reclose his claim. Thus, we do not find that claimant's hearing request was initiated without reasonable prospect of prevailing. Accordingly, we reverse that portion of the ALJ's order which imposed sanctions against claimant's attorney.

ORDER

The ALJ's order dated October 29, 1996 is reversed. The ACL tear and condyle fragmentation conditions are remanded to the employer for processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation, if any, resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

[3] Hunt was also issued subsequent to the ALJ's order.

May 29, 1997 Cite as 49 Van Natta 687 (1997)

In the Matter of the Compensation of
**JERRY L. RUISE, Claimant**
WCB Case No. 96-05354
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Priscilla M. Taylor, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's "de facto" denial of chronic lumbar sprain, chronic lumbar strain syndrome and lumbar spine nerve impingement. The insurer has moved the Board for an order dismissing claimant's request for review based on his failure to file an appellant's brief. On review, the issues are motion to dismiss and compensability.

We deny the insurer's motion and adopt and affirm the ALJ's order with the following supplementation regarding the motion to dismiss.

Although the insurer has moved the Board for an order dismissing claimant's request for review based on claimant's failure to file an appellant's brief, the filing of briefs is not jurisdictional. OAR 438-011-0020(1). Consequently, we have jurisdiction to conduct our review of the ALJ's order. The insurer's motion is, therefore, denied. See Robert G. Edwards, 47 Van Natta 795 (1995); Bonnie A. Heisler, 39 Van Natta 812 (1987).

ORDER

The ALJ's order dated January 3, 1997 is affirmed.

In the Matter of the Compensation of
**MICHAEL T. ALIOTH, Claimant**
Own Motion No. 95-0128M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
C. David Hall, Claimant Attorney
VavRosky, et al, Defense Attorneys

Claimant requests review of the self-insured employer's March 20, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from September 8, 1995 through March 6, 1997. The employer declared claimant medically stationary as of November 25, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 20, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

Claimant submitted a May 17, 1996 medical report from Dr. Bryne, and a June 3, 1996 report from Dr. Quarum for consideration. Both of these reports indicated that surgery on claimant's foot might be beneficial. However, those reports refer to claimant's condition nearly one year prior to the current closure, and rely on Dr. Johansen's recommendations and opinions rendered at, and prior to, that time. Therefore, we are not persuaded by the opinions of Drs. Bryne and Quarum, as these physicians did not examine claimant on or near the March 20, 1997 closure.

On December 11, 1996, Dr. Johansen indicated that he did not agree that claimant was medically stationary because he had prescribed further treatment consisting of evaluation for orthotics. See Michael T. Alioth, 49 Van Natta 54 (1997).

In a February 11, 1997 chart note, Dr. Johansen, claimant's treating physician, opined that:

> "[Claimant] comes in today with a painful toe 2nd left foot. [Claimant] has his custom made shoes with AFO which he states allows [him] to walk still with pain but better. [Claimant] has pain in his 2nd digit left foot. Digit looks normal[;] no signs of pathology, swelling or trauma. Tender all over toe out of proportion. Long discussion held with [claimant] on the above. I have treated [claimant] for about 2 years[;] history of 10 y / o crush injury to his right foot. I feel I have done every thing for [claimant] that I can and am not sure that he may ressolve [sic] above in future. Feel that neurology consult may benifit [sic] him. [Claimant] would like the 2nd toe taken off completely. Discussed all above with [claimant]. Waiting on possible insurance in future. Return PRN for above."

In a March 3, 1997 response, Dr. Johansen agreed that, as of November 25, 1996, there was no further curative treatment that he could offer claimant that would improve his condition, and it was not medically probably that claimant's condition would improve with the passage of time.

Claimant submitted a copy of a State of Oregon Parking Permit to support his contention that he continues to be disabled due to the compensable injury. The permit indicates that he is allowed to park in disabled parking spaces until June of 1997. However, the definition of medically stationary outlines the criteria by which a physician must determine a claimant's medically stationary status. See ORS 656.005(17). Therefore, although claimant may be allowed preferential parking privileges, we are bound by statute to consider whether his condition will improve with further treatment or the passage of time, and thus, whether he was "medically stationary" pursuant to that statute at claim closure.

In an April 28, 1997 letter, Dr. Johansen noted that, in November of 1996, he had discussed with claimant that there was not much left that he could do to help him, other than to refer him for a neurological consult, which might "come up with a plan that might benefit [claimant]." Dr. Johansen further noted that he examined claimant on December 16, 1996 and February 11, 1997, for problematic painful second left toe. Dr. Johansen indicated that claimant wanted the toe amputated, but "I am not sure if right now that would be the proper procedure, in that I would like to know what is causing the pain first, thus, the [the need for the] neurology consult." Because Dr. Johansen examined claimant at closure, we conclude that his April 28, 1997 letter relates to claimant's condition at claim closure. Scheuning v. J.R. Simplot & Co., 84 Or App at 622.

On February 11, 1997, Dr. Johansen noted that claimant had received the prescribed custom shoes, and, although he related that his foot felt better, he also indicated that it was still painful. On February 11, 1997 and on April 28, 1997, Dr. Johansen opined that he had done everything he could for claimant's foot. Dr. Johansen expressed the opinion that he was doubtful that claimant's pain would resolve in the future. There is no contemporary surgery recommendation in the record; at best, Dr. Johansen opined that he was unsure if removal of claimant's toe was the proper procedure. Even so, he felt that a neurology consult "may" benefit claimant.

In his April 28, 1997 letter, Dr. Johansen did not prescribe any further treatment (other than the "consult"), nor did he recant his February 11, 1997 opinion that claimant's pain would probably not resolve in the future, nor his March 3, 1997 opinion that it was not medically probable that claimant's foot condition would improve with the passage of time. Dr. Johansen further noted that, in November 1996, "I did not feel [claimant] was necessarily medically stationary, other than at that time there was nothing else I could do for [claimant] under my care." Dr. Johansen noted that there were possibly other specialists who may be able to evaluate claimant and come up with a plan that may benefit him. However, in his March 3, 1997 response to the insurer's inquiry, Dr. Johansen agreed that there was no further treatment he could offer, nor would claimant's foot probably improve with time.

We recognize that the use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986); Austin v. SAIF, 48 Or App at 7. Nonetheless, in light of his other comments, Dr. Johansen's opinion that a neurological consult may provide a treatment plan or that the plan may be of benefit, is insufficient to allow an inference that, at claim closure, there was a reasonable medical expectation of material improvement in claimant's condition with treatment or the passage of time. See ORS 656.005(17).

Based on this record, we are not persuaded that claimant has met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the employer's March 20, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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May 30, 1997 Cite as 49 Van Natta 689 (1997)

In the Matter of the Compensation of
**NANCY A. BIRCH, Claimant**
WCB Case No. 94-06201
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that: (1) upheld the insurer's partial denial of her low back condition; (2) declined to assess a penalty for an allegedly untimely denial; and (3) affirmed an Order on Reconsideration that awarded claimant 7 percent (22.4 degrees) unscheduled permanent disability for a neck injury. On review, the issues are compensability, penalties, and extent of unscheduled permanent disability.

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

Inasmuch as we agree with the ALJ's conclusion that claimant has not established the compensability of her low back condition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation. Therefore, assuming *arguendo* that the insurer's denial was untimely, neither a penalty nor related attorney fee can be assessed. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

Finally, claimant's assertion that she is entitled to additional unscheduled permanent disability benefits is based entirely on her "at-hearing" testimony regarding her job duties. Inasmuch as claimant's testimony was not part of the reconsideration record, it cannot be considered. See Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996)("Post-reconsideration" evidence on an issue regarding a determination order or notice of closure is inadmissible at hearings held after June 7, 1995).

ORDER

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

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May 30, 1997 Cite as 49 Van Natta 690 (1997)

In the Matter of the Compensation of
**PATRICIA A. EPPERSON, Claimant**
WCB Case No. 95-09984
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the self-insured employer's denial of claimant's abdominal strain injury claim; (2) found noncompensable claimant's diagnostic surgery regarding a possible hernia condition; (3) awarded "time loss" compensation from August 23, 1995, through October 31, 1995 for claimant's lumbosacral condition; and (4) declined to assess a penalty for an allegedly unreasonable failure to pay interim compensation from August 23, 1995, through October 31, 1995, for claimant's lumbosacral condition. The employer cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's lumbosacral condition. On review, the issues are compensability, interim compensation, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of the Lumbosacral Strain Condition

We adopt and affirm the ALJ's reasoning and conclusions regarding this issue with the following supplementation.

Regarding the lumbosacral condition, claimant exhibited palpable muscle spasms and reduced ranges of motion, among other symptoms, when initially examined by Dr. Bowman, treating physician for the low back condition. (Exs. 8, 40-7-8, -22-23). Dr. Bowman opined that claimant's initial presentation demonstrated valid, objective findings that were consistent with the history of the work injury. (Exs. 40-30, -32, -37). He also opined that the major contributing cause of claimant's need for treatment regarding her low back was the work injury. (Ex. 40-36). However, he did not know whether her subsequent examinations continued to show objective findings, noting that he was not able to find any muscle spasms again and he did not repeat the other tests performed during the initial examination. (Exs. 40-30, -31-32).

On review, the employer argues that the lumbosacral strain injury is not established by objective findings, as required by ORS 656.005(19), because the objective findings demonstrated in Dr. Bowman's initial examination were not "reproducible." We disagree with this argument.

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."

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." Here, claimant exhibited two of the "objective findings" explicitly listed in ORS 656.005(19) -- reduced range of motion and palpable muscle spasm. These findings are observable and/or measurable. Thus, on this record, the requirements of ORS 656.005(19) have been met. Claimant need not also prove the findings are "reproducible."

Compensability of the Abdominal Strain Condition

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

Relying on Iairo J. Garcia, 48 Van Natta 235 (1996), the ALJ found that claimant had not established the requisite "objective findings" pursuant to ORS 656.005(19) to prove a compensable abdominal strain injury claim. We agree.

In Garcia, we concluded that only a physician's indication that the worker experiences pain is not sufficient to constitute "objective findings." 48 Van Natta at 237. Subsequent to the ALJ's decision, we addressed the question of whether a worker's subjective responses to clinical testing can constitute "objective findings" under ORS 656.005(19). Tony D. Houck, 48 Van Natta 2443 (1996). After examining the legislative history, we concluded that, although the legislature rejected a physician's mere adoption of a worker's complaint of pain as satisfying the "objective findings" requirement, it intended that a physician's interpretation of a worker's subjective responses to clinical testing be relied on, provided they were "reproducible, measurable or observable." Id. at 2448.

In Houck, the treating physician relied on the claimant's subjective responses to clinical testing to diagnose bilateral carpal tunnel syndrome and left epicondylitis conditions. Specifically, the physician relied on the claimant's positive Tinel's and Phalen's test results and his increased pain in the medial epicondyle with resisted wrist extension and flexion. In relying on these test results for his diagnoses, the physician explained that few patients are sophisticated enough in anatomical matters to "fake" positive test results regarding these tests. On the record presented, we found that the claimant's responses to the clinical testing constituted "verifiable indications of disease" under ORS 656.005(19) which were "reproducible." Id. at 2449. Therefore, we concluded that the claimant had established compensable conditions supported by "objective findings." Id.

Here, Dr. McBee served as claimant's treating physician regarding her abdominal condition and initially examined claimant on or about September 19, 1995. (Ex. 21). He noted both that claimant had experienced abdominal pain since the July 1995 low back injury and that the examination showed "no evidence of intra-abdominal pathology." Id. Dr. McBee ordered an abdominal CT scan to rule out a hernia because he thought that claimant's obesity would obscure a hernia of the abdominal wall. Id. On October 3, 1995, Dr. McBee noted continuing complaints of pain and recommended abdominal wall surgical exploration and probable hernia repair. (Ex. 26). Dr. McBee found that the CT scan suggested a thin abdominal wall fascia in the area above the umbilicus, but no frank herniation. (Exs. 23, 38-1). He also noted that a fascial defect or hernia can usually be palpated; however, claimant's obesity did not allow for confirmation of a hernia in that manner. (Ex. 38-1). Dr. McBee performed the exploratory surgery and found no evidence of hernia. In addition, the fascia in the region was entirely intact, with no sign of infection, neoplasm or hernia. Id.

Following this surgery, Dr. McBee opined that "[i]t is only conjecture that an abdominal wall muscle strain would account for [claimant's] pain, however I believe that the clinical history she gave me is consistent with an abdominal wall muscle strain. Her morbid obesity contributes to the problem almost certainly." (Ex. 38-1). Dr. McBee concluded that claimant's problem was related to muscle strain and "very likely related to the lifting or pulling episode at work." (Ex. 38-1, -4).

Finally, in his deposition, Dr. McBee explained that his ultimate diagnosis of abdominal strain related to the work incident was variously based on: (1) complaints of pain and no physical findings that would otherwise account for the pain (Ex. 41-5); (2) no specific test on clinical exam, just the clinical course of claimant's pain complaint resolving over time (Id.); and (3) some tenderness on both sides in the distribution of the rectus abdominis muscle with deep palpation, which would be consistent with an abdominal strain and with a hernia (Ex. 41-6). When asked whether claimant could discern which particular muscle she should indicate was tender in order to obtain a diagnosis of an abdominal muscle strain, Dr. McBee responded that anyone could do that because the abdominal muscles are usually controlled by one's own volition and cover such a large area, with the rectus abdominis muscles being "a set of muscles on each side of the midline extending from the breastbone down to the pubic bone and going around the belly button." (Ex. 41-8). However, he believed claimant's examination results of tenderness in that muscle group to be realistic and accurate. Id. Dr. McBee also noted he did not recall performing another possible clinical test which involved having claimant attempt to raise her neck or legs while laying down. (Ex. 41-6).

On this record, we do not find that claimant has established a compensable abdominal strain injury supported by "objective findings." First, Dr. McBee's initial opinion that claimant had an abdominal strain injury was based on conjecture and he does not explain his change of opinion that claimant had, in fact, sustained an abdominal strain injury at work. See Gormley v. SAIF, 52 Or App 1055 (1981) (possibility is insufficient to meet burden of proof); Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). Second, Dr. McBee's opinion does not establish the requisite "objective findings" pursuant to ORS 656.005(19). Dr. McBee primarily relied on claimant's clinical course of reported pain resolving over time to conclude that claimant had sustained an abdominal strain at work. Such reliance on reported pain no longer meets the requirements of "objective findings" under ORS 656.005(19). Jairo J. Garcia, 48 Van Natta at 237.

Claimant argues that the CT scan, the exploratory surgery and the tenderness on palpation constitute "objective findings" of an abdominal strain. We disagree. Neither the CT scan nor the exploratory surgery showed any evidence of an abdominal strain. These procedures were performed to rule out a hernia. In fact, Dr. McBee denied that either procedure could establish an abdominal strain. (Ex. 41-5). As for the tenderness on palpation, we find such findings closer to the reliance on reported pain, an analysis rejected in Garcia, than the verifiable subjective response to clinical testing that was relied on in Houck. In this regard, Dr. McBee acknowledged there was no independent method to verify tenderness in palpation of the abdomen because the abdominal muscle is so large.[1] (Ex. 48-1). Therefore, Dr. McBee simply relied on claimant's report of tenderness. As noted above, such reliance on reported pain no longer meets the requirements of "objective findings" under ORS 656.005(19). Jairo J. Garcia, 48 Van Natta at 237. Therefore, we agree with the ALJ that claimant failed to establish a compensable abdominal strain.

Compensability of Medical Services/Abdominal Diagnostic Surgery

We adopt and affirm the ALJ's reasoning and conclusions regarding this issue, with the following supplementation.[2]

Dr. McBee, treating physician for the abdominal condition, suspected that claimant's abdominal pain may be due to a hernia. However, due to claimant's obesity, Dr. McBee was unable to determine through physical examination or a CT scan whether claimant actually had a hernia. Therefore, he performed diagnostic, exploratory surgery to determine if a hernia was present and, if so, to repair it. The surgery revealed no hernia.

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[1] To the extent that there was an independent method to verify an abdominal strain, i.e., having claimant attempt to raise her neck or legs while laying down, Dr. McBee stated that he did not recall performing it and, if he performed it, he did not record the results. (Ex. 41-6).

[2] We note that the court has held that the Director has jurisdiction over disputes that concern only the compensability of medical services. ORS 656.245(6); SAIF v. Shipley, 147 Or App 26 (1997). However, here, the dispute concerned the employer's compensability denial of the underlying abdominal strain claim. (Ex. 15). Accordingly, we have jurisdiction over this dispute.

On review, claimant acknowledges that, if her abdominal muscle strain is not compensable, then the exploratory surgery is not compensable as a diagnostic procedure. We agree. ORS 656.245 does not provide for payment for diagnostic services if the claimant has not suffered a work-related injury or injurious exposure. See Genevieve V. Brooks-Bishop, 47 Van Natta 759 (1995). As the ALJ found, the diagnostic abdominal surgery did not relate to the lumbosacral strain, the only condition found compensable. Furthermore, because claimant has not established a compensable abdominal injury, medical services related to any abdominal condition are not compensable.

Interim Compensation

The ALJ found the lumbosacral condition compensable and awarded claimant "time loss" regarding that condition for the period from August 23, 1995, to October 31, 1995. On review, claimant argues that, if we reverse the ALJ's decision regarding the compensability of her lumbosacral condition, she is entitled to interim compensation for that condition for the period from August 23, 1995, the date the employer denied claimant's abdominal condition and stopped paying interim compensation regarding that condition, to October 31, 1995, the date the employer denied claimant's lumbosacral condition. However, claimant concedes that, if we find her lumbosacral condition compensable, we need not decide whether claimant is also entitled to interim compensation for the same period. In response, the employer argues only that the lumbosacral condition is not compensable and allows that the ALJ's order "as it is written reflects the time loss due and owing if the claim is compensable." Respondent's/Cross-Appellant's Opening Brief, page 9. Given the parties' positions and the fact that we find the lumbosacral condition compensable, we need not address the interim compensation issue.

Penalties

The work incident that allegedly caused the abdominal strain and lumbosacral strain injuries occurred on July 29, 1995. The employer paid interim compensation for the abdominal claim from July 29, 1995 to August 23, 1995, the date the employer denied the abdominal claim. The employer paid no interim compensation from August 23, 1995 through October 31, 1995, the date the employer denied the lumbosacral claim.

At hearing and on review, claimant argues that she is entitled to a penalty for the employer's unreasonable failure to pay interim compensation for the period from August 23, 1995 through October 31, 1995. The ALJ declined to assess a penalty, reasoning that the employer would not be obligated to pay interim compensation on the lumbosacral strain claim until that claim was filed and finding that claimant failed to establish when she filed a claim for her lumbosacral strain. We disagree.

ORS 656.262(4)(a) requires the carrier to begin payment of interim compensation "no later than the 14th day after the subject employer had notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." A claim "means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). "Knowledge of an injury" should include enough facts as to lead a reasonable employer to conclude that worker's compensation liability is a possibility and that further investigation is appropriate. See Argonaut Ins. Co. v. Mock, 95 Or App 1, 5 (1989); David Hernandez, 46 Van Natta 423 (1994).

The parties do not dispute that the attending physician authorized payment of temporary disability compensation for the period in question. Instead, the dispute focuses on when claimant made a claim for the lumbosacral condition and the effect of the employer's August 23, 1995 denial. Specifically, claimant argues that she filed a claim for the lumbosacral strain condition with Exhibits 1 and 3, which were received by the employer in August 1995. We agree.

Exhibit 1 is an 827 form entitled "First Medical Report For Workers' Compensation Claims" in which claimant reported the incident at work and the treating physician diagnosed abdominal and lumbosacral strain. This form was received by the employer on August 11, 1995. (Ex. 1). Exhibit 3 is a chart note from Dr. Ortiz, treating physician, in which he records claimant's report of the incident at work and notes that claimant denied suffering any other accident. Following examination of claimant, Dr. Ortiz diagnosed "[a]cute LS arthritis, possible from straining." (Ex. 3). This chart note was received by the employer on August 7, 1995. Id.

We find that these documents included enough facts to lead the employer to conclude that workers' compensation liability for the lumbosacral strain was a possibility and that further investigation was appropriate. See Argonaut Ins. Co. v. Mock, 95 Or App at 5. Therefore, they constitute knowledge of a lumbosacral injury possibly related to work and trigger the employer's claims processing duties regarding that claim, including payment of interim compensation.

On review, the employer does not argue that claimant failed to establish that she filed a claim for lumbosacral strain. Instead, relying on Lloyd Monroe, 47 Van Natta 1307 (1995), it argues that its August 23, 1995 denial included the lumbosacral claim. Therefore, the employer argues, its obligation to pay interim compensation terminated upon issuance of that denial. We disagree.

In Lloyd Monroe, we found that the carrier's denial of the claimant's "injury" as not arising in the course and scope of his employment applied to any conditions, including the claimant's later claimed sternal fracture. Therefore, we found that the claimant was not entitled to additional interim compensation beyond the date of the carrier's denial. 47 Van Natta at 1309.

Here, the employer's August 23, 1995 denial did not deny claimant's "injury." (Ex. 15). Instead, it focused on claimant's "claim for an abdomen strain," denying that claim and condition. Therefore, we find Lloyd Monroe distinguishable on its facts. Given the language of the employer's August 23, 1995 denial, we do not find that it included the lumbosacral strain claim. See Tattoo v. Barrett Business Services, 118 Or App 348 (1993) (carriers bound by language of their denials). Therefore, the employer did not deny the lumbosacral strain claim until it issued its October 31, 1995 denial. Consequently, the employer should have continued paying interim compensation stet October 31, 1995.

We conclude that the employer's failure to pay interim compensation for the period in question constitutes an unreasonable refusal to pay compensation. ORS 656.262(11); Lester v. Weyerhaeuser, 70 Or App 307, 311-12, rev den 298 Or 427 (1984) (unexplained delay in paying compensation is unreasonable); Petronilo Lopez, 45 Van Natta 1136 (1993). Accordingly, we assess a 25 percent penalty based on the interim compensation due for the period from August 23, 1995 stet October 31, 1995, such penalty to be shared equally by claimant and his attorney. ORS 656.262(11)(a).

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over the employer's cross-request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability of the lumbosacral strain condition is $1,200, 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 respondent's brief and claimant's counsel's statement of services[3]), the complexity of the issue, and the value of the interest involved. Since penalties are not "compensation" for the purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for prevailing on the penalty issue. 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 June 10, 1996 is reversed in part and affirmed in part. That portion of the order that declined to assess a penalty for the self-insured employer's unreasonable failure to pay interim compensation is reversed. The employer is assessed a penalty of 25 percent of the interim compensation due from August 23, 1995 through October 31, 1995, payable in equal shares to claimant and claimant's attorney. The remainder of the order is affirmed. For services on review regarding the compensability of the lumbosacral strain condition, claimant's attorney is awarded a fee of $1,200, payable by the employer.

[3] We note that claimant's attorney submitted a Statement of Services requesting a fee of $5,900 for services at hearing and on review. We also note that the ALJ awarded claimant's attorney $4,000 for services at hearing. Our order does not change the ALJ's award. Furthermore, in determining that $1,200 is a reasonable fee for claimant's attorney's services on review, we note that the only issue claimant's attorney prevailed on that would support an attorney fee is the compensability issue regarding the lumbosacral condition. Applying the aforementioned factors in OAR 438-015-0010(4), we find $1,200 is a reasonable fee for claimant's attorney's services on review.

In the Matter of the Compensation of
**BARRY M. GRIGSBY, Claimant**
WCB Case No. 96-00182
ORDER ON REVIEW
Rasmussen, 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) Stephen Brown's order that: (1) granted the insurer's motion to continue the hearing to allow it an opportunity to submit a rebuttal report; and (2) upheld the insurer's denial of claimant's aggravation claim for his low back condition. Following the submission of claimant's reply brief, the insurer has filed a motion to strike claimant's reply brief, on the ground that the brief raises "new issues and arguments." On review, the issues are the procedural motion, the ALJ's evidentiary ruling, and compensability. We deny the motion to strike, and we affirm the ALJ's order.

## FINDINGS OF FACT

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

Claimant's low back surgery was performed on November 24, 1992, rather than 1995.

## CONCLUSIONS OF LAW AND OPINION

### Procedural motion

The insurer contends that, in its reply brief, claimant has raised new issues or arguments that were not previously raised in the appellant's brief. However, after considering the insurer's contention, we disagree that claimant has raised new "issues" in the reply brief. Claimant's arguments pertain to the compensability/aggravation issue previously litigated by the parties and discussed in the ALJ's order and appellant's brief. Furthermore, claimant's discussion of the accuracy of the opinions of Drs. Peterson and Grant has been made in direct response to the argument set forth in the respondent's brief. Resp. Brief at Pg. 5.

Finally, although the insurer argues that the issue of an evidentiary ruling made by the ALJ was not raised until claimant's reply brief, we have below affirmed the ALJ's evidentiary ruling. Consequently, we do not find it necessary to address whether the issue was properly raised. Consequently, the insurer's motion to strike claimant's reply brief is denied.

### Evidentiary ruling

At the time of hearing, claimant submitted a report from his treating doctor, Dr. Peterson. Although the insurer objected, the ALJ found that the document was disclosed within seven days after claimant had received the report. The ALJ further concluded that the remedy was for the insurer to obtain cross-examination or rebuttal. On review, claimant argues that the ALJ erred in leaving the record open in order for the insurer to obtain the rebuttal report. Claimant also contends that the ALJ did not permit his counsel to make an objection for the record with respect to the evidentiary ruling.

An ALJ "may continue a hearing...[u]pon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence..." OAR 438-006-0091(2). OAR 438-006-0091 is couched in permissive language and contemplates the exercise of authority to continue a hearing as resting within the ALJ's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991). Further, an ALJ is not bound by technical or formal rules or procedure and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7). We review the ALJ's ruling for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

Here, claimant did not provide Dr. Peterson's report until the time of hearing. Accordingly, we find that due diligence has been shown on behalf of the insurer, and the ALJ properly left open the record in order for the insurer to obtain rebuttal evidence. Claimant further contends, however, that he was not permitted to register his objection to a continuance. However, prior to claimant's objection, the ALJ had advised claimant that he would have an opportunity to have the last word or to "surrebut."

Following claimant's request to be heard on the continuance, the ALJ advised claimant that he was "ahead on points." Under the circumstances, we conclude that the ALJ did acknowledge claimant's objection and we construe his comments as overruling claimant's objection.

Finally, because the ALJ also permitted claimant to "surrebut" the insurer's evidence, we find no abuse of discretion in the ALJ's decision to admit the report and keep the record open. Under the circumstances, we affirm the ALJ's evidentiary ruling.

Compensability

We adopt the ALJ's "Opinion," with the following supplementation.

The ALJ found that the opinions of Drs. Peterson, Louie and Grant were unpersuasive. All three doctors noted that claimant had undergone a discectomy, whereas the original surgical notes provided that, because no bulging disc was found, a discectomy was not performed. (Ex. 21-2). Accordingly, the ALJ discounted the opinions of claimant's treating and operating physicians on the basis that the doctors had an inaccurate history.

On review, claimant argues that one of the doctors that referred to a discectomy was Dr. Louie, the surgeon who performed the procedure. Claimant contends that, because Dr. Louie was aware of the nature of the surgery, it is not dispositive that he has referred to the surgery as a discectomy. Furthermore, claimant argues that Drs. Grant and Peterson believe that claimant's worsened condition is due, in part, to scar tissue from the original procedure. Claimant contends that it is not important whether the doctors have correctly identified the kind of surgery, as it was the resulting scar tissue that is responsible for claimant's condition.

After considering claimant's argument, we conclude that it is not appropriate for us to substitute our lay opinion in place of a medical opinion regarding the importance of the correct identity of claimant's surgery. It is not possible to say whether the doctors' belief regarding the scar tissue would change if they were aware of the exact nature and scope of claimant's surgery. Furthermore, we cannot say with certainty that Dr. Louie purposely (rather than erroneously) used the term "discectomy" to refer to the specific procedure performed on claimant, especially when it was Dr. Louie who emphasized in the surgical report that a "diskectomy was not done." Finally, we note that Dr. Church, who was aware that a discectomy was not performed, has pointed out that the doctors had an inaccurate history and should be given a copy of the operative report to clarify their opinions. (Ex. 62-34).

Accordingly, the only doctor that has commented on the discrepancy in the description of the surgical procedures has suggested that the other physicians be made aware of the fact that a discectomy was not performed. Under such circumstances, we decline to express a lay opinion that the opinions of Drs. Grant, Louie and Peterson would have remained the same even if they had acknowledged or been cognizant of the fact that claimant did not undergo a discectomy.

Additionally, we note that the ALJ discounted the opinions of Drs. Peterson and Louie (who deferred to Dr. Peterson's opinion) for other reasons. For example, Dr. Church noted that following the compensable accident and surgery, claimant remained stable and was able to continue working until 1995. Accordingly, Dr. Church did not feel that claimant's condition would be attributable to scar tissue from the procedure which would have matured within six months. (Ex. 62-39). However, as the ALJ noted, Dr. Peterson has not provided any reasoning to rebut Dr. Church's opinion.

Finally, Dr. Church also noted that claimant's bilateral lower leg pain was first recorded on October 9, 1995. Dr. Church concluded that the right leg symptoms had nothing to do with the industrial accident of June 4, 1992. As the ALJ reasoned, however, although claimant's original injury resulted in left leg pain which continued to be symptomatic, and the right leg pain did not appear until late 1995, Dr. Peterson has not explained why the right leg symptoms are related or represent a worsening of the 1992 injury. Consequently, for these additional reasons, we find the opinion of Dr. Peterson (and, therefore, Dr. Louie), to be less than persuasive. Under the circumstances, we agree with the ALJ that claimant has failed to establish the compensability of his current condition.

ORDER

The ALJ's order dated December 13, 1996 is affirmed.

In the Matter of the Compensation of
**DAVID J. KELLER, Claimant**
WCB Case Nos. 96-05687 & 96-05654
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Thye's order which: (1) dismissed the insurer's hearing request from an Order on Reconsideration that had awarded 43 percent (64.5 degrees) scheduled permanent disability for loss of use or function of the left leg; and (2) set aside the insurer's partial denial of claimant's current left knee condition. On review, the issues are dismissal, extent of scheduled permanent disability (if the insurer's hearing request was improperly dismissed), claim processing and compensability. We reverse.

## FINDINGS OF FACT

Claimant first injured his left knee in 1978 while playing football. Dr. Harder performed surgery in April 1978 for a compression fracture of the lateral femoral condyle, medial and lateral meniscus tears, and torn medial collateral and anterior cruciate (ACL) ligaments.

Claimant, employed as a construction worker, experienced occasional left knee problems, but was able to perform heavy work, when, on November 19, 1994, he reinjured his left knee stepping off a ladder into a "mole hole." Diagnostic studies revealed tibial and fibula fractures, for which Dr. Hardiman performed an arthroscopy and open repair on November 23, 1994. Dr. Hardiman described the previously damaged ACL as "acutely shredded" as a result of the new injury. (Ex. 19-2).

Declaring claimant medically stationary on March 7, 1995, Dr. Hardiman opined that claimant had "profound disability and impairment" in the left knee. The insurer then had an examining physician, Dr. Farris, evaluate claimant's left knee condition on August 14, 1995. Dr. Farris concluded that degenerative changes in the left knee resulting from the 1978 injury and surgery were the major contributing cause of claimant's current condition. (Ex. 31). On August 16, 1995, Dr. Hardiman agreed with Dr. Harris' report. (Ex. 33).

In the meantime, on August 13, 1995, the insurer issued a Notice of Claim Acceptance for "Fracture-Lateral Tibial Plateau & Proximal Fibula Left Knee." (Ex. 32). The insurer then issued a Notice of Closure on August 31, 1995, awarding 8 percent scheduled permanent disability for claimant's left leg. (Ex. 36). The closure notice, however, incorrectly stated the number of days in the appeal period during which reconsideration could be requested. (Ex. 36-3).

On October 26, 1995, another Notice of Closure was issued, correcting the error contained in the prior closure notice. (Ex. 38). On February 15, 1996, the insurer issued another Notice of Claim Acceptance, amending its prior acceptance to include injury to the ACL. (Ex. 40). After claimant requested reconsideration of the closure notice on February 26, 1996, a panel of medical arbiters examined claimant on May 3, 1996. They concluded that 90 percent of claimant's left knee impairment was due to the preexisting left knee condition and 10 percent to the November 1994 injury. (Ex. 42-3).

On May 22, 1996, an Order on Reconsideration awarded 43 percent scheduled permanent disability for claimant's left leg. (Ex. 43). This included all impairment found by the medical arbiters because the insurer had not issued a denial of the combined condition consisting of claimant's preexisting left knee condition and his current accepted condition. (Ex. 43-6).

Following the Order on Reconsideration, on June 6, 1996, the employer issued a denial of claimant's "current" left knee condition on the ground that it was related to claimant's preexisting injury. (Ex. 45). Claimant requested a hearing on June 13, 1996, contesting the denial and the reconsideration order. The insurer requested a hearing on June 14, 1996, contesting the closure notices and the reconsideration order. The insurer's hearing request was not within the 180-day appeal period from the August 31, 1995 closure notice, but was within the appeal period from the October 26, 1995 Notice of Closure.

Claimant moved to dismiss the employer's hearing request as untimely. The employer wrote a letter to the ALJ on August 21, 1996, stating that it was withdrawing its hearing request. In its letter, the insurer requested issuance of an Order of Dismissal. (Ex. 47). On September 9, 1996, the insurer requested that the Order of Dismissal "specifically reserve the employer/insurer's right to contest the validity of the Notice of Closure." At the hearing, claimant withdrew his request for hearing on the reconsideration order.

## CONCLUSIONS OF LAW AND OPINION

Rejecting the insurer's argument that a withdrawal of a hearing request is not effective until a dismissal order is issued, the ALJ found that the insurer's withdrawal of its hearing request on August 21, 1996 was effective on the day the motion was made. Because claimant withdrew his hearing request on the reconsideration order, the ALJ further concluded that there was no timely request for hearing with respect to the closure notices or the reconsideration order. The ALJ then set aside the insurer's denial of claimant's current left knee condition. The ALJ reasoned that the insurer was barred by claim preclusion from contending that claimant's preexisting left knee condition was not part of the compensable claim because it had failed to effectively challenge the Order on Reconsideration which had awarded scheduled permanent disability based on the preexisting condition. See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).

### Dismissal

The insurer first contests the ALJ's dismissal of its hearing request. Based on the following reasoning, we reverse the ALJ's order and reinstate the employer's hearing request.

An ALJ retains jurisdiction over a matter unless and until a hearing request is dismissed via an ALJ's order. See Senetra Smith-Wampler, 48 Van Natta 593, on recon 48 Van Natta 1041 (1996) (citing Mary J. McFadden, 44 Van Natta 2414 (1992)). Here, the ALJ did not issue his dismissal order pertaining to the insurer's June 14, 1996 hearing request until he issued his November 27, 1996 Opinion and Order. However, prior to issuance of that order, on September 9, 1996, the insurer had modified its earlier request to dismiss its hearing request when it reserved its right to contest its Notice of Closure. The insurer also challenged the validity of the closure notices, as well as the reconsideration order, at the September 10, 1996 hearing. (Tr. 4).

Therefore, inasmuch as the insurer modified its August 21, 1996 withdrawal of its hearing request prior to issuance of the ALJ's dismissal order, and thereby effectively challenged the propriety of the reconsideration order, we find that the insurer's appeal of the May 22, 1996 reconsideration order remained viable. See David A. Gabilondo, 46 Van Natta 2236 (1994) (Appealing party's withdrawal of appeal of ALJ's decision regarding one issue did not prevent Board from proceeding with its review of still-appealed ALJ's order.) Accordingly, we conclude that the ALJ should have proceeded to determine the issue of whether the insurer's June 14, 1996 request for hearing was timely.

### Timeliness of Hearing Request

As previously noted, the insurer's June 14, 1996 hearing request was not within the 180-day period calculated from the August 31, 1995 Notice of Closure. However, it was within the 180-day period from the October 26, 1995 closure notice, which corrected the incorrect notice of appeal rights in the August 1995 closure notice.

In Eugenia S. Torres, 48 Van Natta 125 (1996), the carrier issued a September 29, 1993 Notice of Closure, as well as a January 17, 1994 "corrected" Notice of Closure. The corrected notice changed only the temporary disability awarded by the initial notice. Within 180 days of the corrected notice, but more than 180 days after the initial notice, the claimant requested reconsideration of the second closure notice. The claimant sought a permanent disability award.

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

Here, the "corrected" Notice of Closure modified the incorrect notice of appeal rights in the first closure notice.[1] Inasmuch as the "corrected" Notice of Closure changed the appeal rights of the first Notice of Closure and became a part of and attached to that closure notice, we conclude that the "corrected" closure notice extended the appeal rights relative to the first Notice of Closure. Eugenia S. Torres; see also Filiberto B. Rosas, 48 Van Natta 1511 (1996). Under such circumstances, we find that the 180-day appeal period for both closure notices ran from the October 26, 1995 Notice of Closure, the date of the "correction." Thus, the insurer was entitled to raise any issues addressed by either Notice of Closure. Based on this reasoning, we find that the insurer was entitled to contest the permanent disability award in the May 1996 reconsideration order.

Extent of Disability

The reconsideration order awarded scheduled permanent disability based in large part on impairment findings due to claimant's preexisting left knee condition. The Department reasoned that the insurer's failure to issue a "pre-closure" denial of a combined condition pursuant to ORS 656.262(7)(b) required a finding that all of claimant's permanent impairment was due to the compensable injury.

In Robin M. Spivey, 48 Van Natta 2363 (1996), we held that the requirements concerning a "pre-closure" denial of a combined condition pursuant to ORS 656.262(7)(b) are applicable only when a "combined condition" has been accepted, either voluntarily or by means of a litigation order. The claimant in that case had an accepted cervical strain. A medical arbiter's report indicated that 90 percent of the claimant's lost range of cervical motion was due to a preexisting degenerative condition and 10 percent due to the compensable cervical strain. Noting that the carrier had not issued a denial of the "combined condition" prior to closure under ORS 656.262(7)(b), the claimant asserted that his entire impairment must be attributed to his compensable injury.

We disagreed with the claimant's contention. Since neither the preexisting condition nor a combined condition had been accepted, we reasoned that the carrier was not precluded from asserting that a portion of the claimant's permanent disability was due to the non-accepted degenerative condition and, therefore, should not be considered in rating the claimant's permanent disability.

In this case, the insurer did not accept claimant's preexisting left knee condition, nor did it accept a "combined condition." Therefore, in accordance with the Spivey rationale, the insurer is not precluded from asserting that a portion of claimant's permanent disability is due to the non-accepted, preexisting left knee condition and that, therefore, the degenerative condition should not be considered in rating claimant's scheduled permanent disability.

As previously noted, the medical arbiter panel opined that 90 percent of claimant's left knee impairment was due to his preexisting left knee condition and that 10 percent was due to the compensable November 19, 1994 injury. 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).

In this case, we find that the panel of medical arbiters provided the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. Thus, we rely on their report in assessing claimant's scheduled permanent disability.

Pursuant to ORS 656.214(2), loss of use or function of a scheduled body part, such as claimant's left knee, must be "due to" the compensable industrial injury. See Ladonna Eagleton, 49 Van Natta 75 (1997). Accordingly, we conclude that 10 percent of claimant's total scheduled permanent disability (43

[1] The October 26, 1995 "corrected" closure notice also specifically stated that it "becomes part of and should be attached to" the August 31, 1995 Notice of Closure. (Ex. 38).

percent) is due to the compensable injury.[2] That figure (4.3 percent) is rounded to the nearest whole number for an award of 4 percent scheduled permanent disability for loss of use or function of claimant's left knee due to the compensable injury. Former OAR 436-35-007(11); Robert E. Roy, 46 Van Natta 1909, 1911 (1994). Therefore, claimant's scheduled permanent disability award is reduced.

Current Condition Denial

We now proceed to a determination of the compensability of claimant's current left knee condition. The ALJ did not address the merits of the insurer's June 1996 denial, reasoning that the insurer was precluded from contending that claimant's current knee condition was due to his preexisting left knee condition by its failure to effectively contest the reconsideration order. See Deluxe Cabinet Works v. Messmer. However, Messmer is not applicable because the insurer's hearing request challenging the permanent disability award in the reconsideration order was timely filed. We, therefore, address the merits of the insurer's June 6, 1996 denial of claimant's "current condition."

Claimant was examined by Dr. Farris on behalf of the insurer in August 1995. Dr. Farris concluded that the major contributing cause of claimant's current left knee condition was a degenerative condition resulting from the 1978 injury and surgery. (Ex. 31). Dr. Hardiman, claimant's attending physician, concurred with Dr. Farris' opinion. (Exs. 33, 46). Dr. Farris explained that claimant's November 1994 injury "combined" with the preexisting condition to cause disability and a need for medical treatment for about six months, but was not the major contributing cause of claimant's left knee condition in August 1995. (Ex. 48).

Inasmuch as the degenerative condition in claimant's left knee is a "disease" that preceded the compensable injury, it qualifies as a "preexisting condition." ORS 656.005(24). Under ORS 656.005(7)(a)(B), when the compensable injury combines with a preexisting condition, the claimant must prove that the compensable injury is the major contributing cause of the "combined condition." Charles L. Grantham, 48 Van Natta 1094 (1996).

In this case, the medical evidence from both claimant's attending physician, Dr. Hardiman, and the examining physician, Dr. Farris, establishes that claimant's compensable left knee injury is not the major contributing cause of his current left knee condition. There is no medical evidence to the contrary. Accordingly, we uphold the insurer's denial of claimant's current left knee condition.

ORDER

The ALJ's order dated November 27, 1996 is reversed. The insurer's hearing request is reinstated. The insurer's denial is also reinstated and upheld. The ALJ's attorney fee award is also reversed. The award of scheduled permanent disability in the Order on Reconsideration is modified. In lieu of the reconsideration order's award of scheduled permanent disability, claimant is awarded 4 percent (6 degrees) scheduled permanent disability for loss of use or function of the left knee due to the compensable injury.

[2] The parties stipulated that claimant's scheduled permanent disability based on the medical arbiters' report was 43 percent.

In the Matter of the Compensation of
**JUDITH K. NIX, Claimant**
WCB Case No. 93-02704
SECOND ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

On May 1, 1997, we withdrew our April 9, 1997 Order on Remand that directed the self-insured employer to pay claimant's counsel's "out-of-compensation" attorney fee (equal to 25 percent of the 12 percent "increased" unscheduled permanent disability award granted by our prior order (i.e., $960)), directly to claimant's counsel, without subjecting the fee to offset for previously overpaid compensation. We took this action to consider the employer's contention that the "increased" permanent disability award has "long ago been paid" and that we previously rejected the same request from claimant's counsel in WCB Case No. 95-02805. Having received claimant's response, we proceed with our reconsideration.

To begin, we recognize that most of the "increased" permanent disability granted by our prior order has already been paid to claimant. In fact, based on such circumstances, we previously ruled that claimant's counsel must look to claimant for recovery of most of this "out-of-compensation" attorney fee. Nonetheless, the court has rejected our prior ruling, reasoning that our decision violated OAR 438-015-0085(2). Interpreting this rule, the court has held that claimant's counsel "out-of-compensation" fee is not subject to any offset for an overpayment.

Consistent with the court's holding, we continue to determine that all of the "out-of-compensation" attorney fee (25 percent of the "increased" 12 percent unscheduled permanent disability award) must be paid by the employer directly to claimant's counsel. To the extent that such a payment results in an additional overpayment of compensation, the employer is authorized to offset this overpayment against claimant's future compensation in the manner prescribed in ORS 656.268(15).

Secondly, contrary to the employer's contention, this ruling is not inconsistent with our decision in WCB Case No. 95-02805. That decision arose from claimant's hearing request which was filed after our permanent disability award in this case. Specifically, in WCB Case No. 95-02805, claimant sought an order directing the employer to pay all of the "out-of-compensation" attorney fee granted by our prior order in this case directly to claimant's counsel. We affirmed the ALJ's order in WCB Case No. 95-02805, which declined to grant claimant's request. In doing so, we cited our then-appealed decision in this case. In essence, we concluded in WCB Case No. 95-02805 that the employer was properly processing claimant's permanent disability award in accordance with our appealed decision in this case (WCB Case No. 93-02704); i.e., because our previous decision in WCB Case No. 93-02704 had rejected claimant's counsel's request for payment of an entire "out-of-compensation" fee directly from the employer without application of an offset, the employer was under no obligation to make such a payment in accordance with claimant's counsel's request.

In contrast to our "processing / enforcement" decision in WCB Case No. 95-02805, the issue in this case (WCB Case No. 93-02704) involves the substantive question of whether we appropriately ruled that claimant's counsel must look to claimant for full payment of the "out-of-compensation" attorney fee granted by the ALJ's order and our "increased" permanent disability award. Since the court has ultimately held that our ruling violated OAR 438-015-0085(2), we are obligated to apply that holding.

Accordingly, as supplemented herein, we republish our April 9, 1997 order.[1] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[1] In light of our interpretation of our decision in WCB Case No. 95-02805, we decline claimant's alternative request to hold this matter in abeyance to await the court's anticipated remand of WCB Case No. 95-02805.

In the Matter of the Compensation of
**WILLIAM H. PAULEY, Claimant**
WCB Case No. 96-06588
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) denied claimant's request to postpone the hearing; (2) upheld the SAIF Corporation's denial of his current low back condition; and (3) denied claimant's post-hearing motion to reopen the record for the taking of additional evidence. On review, the issues are the ALJ's procedural ruling, remand and compensability.

We adopt and affirm the ALJ's order with the following supplementation on the procedural ruling / remand issue.

Claimant requested a hearing on July 1, 1996 challenging SAIF's June 26, 1996 denial of his current low back condition. On July 23, 1996, the Board mailed a Notice of Hearing to the parties and their counsel stating that the hearing was scheduled for October 9, 1996.

Claimant's counsel appeared at the hearing but claimant did not attend. Representing to the ALJ that he did not know why claimant was absent, claimant's counsel requested a postponement of the hearing. The ALJ declined to do so, finding no evidence of extraordinary circumstances beyond claimant's control to justify claimant's absence. See ORS 656.283(4); OAR 438-006-0081.

On November 4, 1996, the ALJ issued an Opinion and Order upholding SAIF's "current condition" denial. Thereafter, on December 3, 1996, claimant moved to abate the order so that he could establish good cause for his absence from the hearing. The ALJ issued an Order of Abatement the next day, giving claimant the opportunity to file his motion to reopen the record.

Claimant submitted an affidavit stating that he was out of state the day of his scheduled hearing due to his employment as a long haul truck driver. He also stated that he did not receive the Notice of Hearing or any other notification of the hearing date and was therefore not aware that his hearing had been scheduled for October 9, 1996 until he spoke with his counsel on November 1, 1996. After considering claimant's motion, the ALJ issued an order denying claimant's request to reopen the record and reinstating the original opinion and order.

On review, claimant asserts that the ALJ erred in declining to reopen the record, because he has shown extraordinary circumstances sufficient to justify his absence from the hearing. We disagree.

As noted above, OAR 438-006-0081 sets forth the Board's rule regarding postponement of a hearing. This provision provides, in pertinent part, as follows:

> "A scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon a finding of extraordinary circumstances beyond the control of the party or parties requesting postponement. 'Extraordinary circumstances' shall not include:
>
> "(2) Unavailability of a party, witness or representative due to * * * occupational, personal or professional business appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person is a worker who is temporarily working out of state and is reasonably expected to return to the state within a time certain * * * ."

While the ALJ may grant a postponement to a worker who is temporarily working out of state, the rule also requires that the circumstances be "beyond the control" of the party seeking postponement. Here, there is no evidence indicating that claimant's lack of notice or his failure to attend the hearing was beyond his control.

We have previously held that where the claimant knows that a request for hearing has been made but fails to maintain contact with his attorney or the Hearings Division, his contention that he did not receive notice of the hearing does not establish extraordinary circumstances beyond his control sufficient to justify postponement. See, e.g. Lisa Miles, 44 Van Natta 1156 (1992); Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990).

In this case, claimant requested the hearing through his counsel. His counsel appeared at the hearing and represented that claimant had been actively involved in his case until very recently but that he had not been in contact with counsel for the last two months or so. (Tr. 4). There is no explanation for claimant's failure to contact his attorney to determine the status of his hearing request or to take steps to ensure that he received his mail during this time period.[1] Because claimant did not maintain contact with his counsel or with the Hearings Division, we agree with the ALJ that he has not demonstrated "extraordinary circumstances beyond his control" to justify a postponement of the hearing or a reopening of the record.[2]

ORDER

The ALJ's order dated November 4, 1996, as reconsidered January 3, 1997, is affirmed.

[1] As the ALJ noted, claimant does not assert that the Notice of Hearing was not mailed to, or received at, his correct mailing address or that he could not have received his mail because of his employment.

[2] OAR 438-007-0025 gives the ALJ the discretion to reopen a hearing record and reconsider the decision "upon motion of a party showing error, omission, misconstruction or an applicable statute or the discovery of new material evidence."

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In the Matter of the Compensation of
**JOSE D. RODRIGUEZ, Claimant**
WCB Case No. 96-08060
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's left wrist condition on the ground that it was procedurally improper. On review, the issue is the propriety of the employer's denial.

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

The ALJ set aside the employer's denial of claimant's left wrist condition, reasoning that, since no claim was pending at the time of the denial, the employer's denial was an improper "prospective" denial under Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). In setting aside the denial, the ALJ rejected the employer's argument that its denial was procedurally proper under ORS 656.262(7)(b).[1] The ALJ reasoned that the statute was inapplicable because the medical evidence did not establish the presence of a "combined condition."[2]

[1] 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."

[2] Based on the statute's terms, its context, and legislative history, we have held that ORS 656.262(7)(b) does not apply unless the accepted condition, whether voluntary or by litigation, is a "combined condition." Robin W. Spivey, 48 Van Natta 2363 (1996).

Citing Julia A. Watson, 48 Van Natta 1598 (1996), the employer contends that the medical evidence as a whole proves that claimant's preexisting wrist fracture and arthritis combined with his compensable left wrist sprain. Therefore, the employer asserts that its denial was procedurally proper under ORS 656.262(7)(b) because the compensable injury was no longer the major contributing cause of claimant's alleged "combined condition."

We disagree with the employer's contention that Watson is controlling with respect to the presence of a "combined condition." In Watson, the attending physician opined that the claimant's preexisting degenerative condition and compensable injury underlay her current condition and noted that the underlying degenerative condition contributed to the claimant's need for treatment. 48 Van Natta at 1598 n. 1. In this case, however, the medical evidence does not establish that claimant's preexisting wrist condition contributed to his current disability or need for medical treatment. Based on our de novo review of the record as a whole, we agree with the ALJ that there is insufficient evidence of a "combined condition." Therefore, we conclude that the ALJ properly determined that ORS 656.262(7)(b) was not applicable. Robin Spivey, 48 Van Natta at 2363.

Moreover, the record indicates that claimant's last medical treatment occurred on October 24, 1995. (Ex. 12). Although Dr. Carpenter, claimant's attending physician, speculated that wrist surgery might be performed in the future (Ex. 7), there was no request for surgery, nor were any medical services being provided, at the time of the employer's June 26, 1996 denial. In the absence of a current claimed need for medical treatment, we agree with the ALJ that the employer's denial was procedurally improper.[3] Striplin, 99 Or App at 356.

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 propriety of the employer's denial is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 23, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

[3] The employer contends that its denial was a proper "precautionary" denial under Weyerhaeuser Company v. Warrilow, 96 Or App 34, rev den 308 Or 184 (1989). That case stands for the proposition that a carrier may deny the compensability of a condition that it reasonably interprets to be encompassed in a claim. However, since Warrilow was decided, the legislature enacted ORS 656.262(7)(a), which provides that a worker must "clearly request formal written acceptance" of any new medical conditions. We need not determine the continued vitality of Warrilow in light of that statute because claimant was not seeking medical services or making a claim for his preexisting left wrist condition at the time of the employer's denial. Therefore, we do not find that the employer's prospective denial constitutes a valid "precautionary" denial, even assuming the Warrilow rationale is still viable. See William H. Waugh, 45 Van Natta 919, 920 (1993) (a denial is premature if no claim made for the denied condition).



In the Matter of the Compensation of
**TREVOR A. SMITH, Claimant**
WCB Case No. 96-08290
ORDER ON REVIEW
Quintin Estell, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order which increased claimant's scheduled permanent disability for the right knee from 17 percent (25.5 degrees), as awarded by Order on Reconsideration, to 30 percent (45 degrees). Claimant cross-requests review of the portion of the ALJ's order which refused to admit non-medical, impeachment evidence

that was not contained in the reconsideration record. On review, the issues are evidence and extent of scheduled permanent disability. We affirm the evidentiary ruling, and reverse on the merits.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, except his finding that claimant has reduced ability to walk during an eight-hour period.

## CONCLUSIONS OF LAW AND OPINION

The ALJ awarded an additional 15 percent scheduled disability based on the finding that claimant has reduced ability to walk during an eight-hour period. Specifically, the ALJ found that claimant can walk no more than one hour in an eight-hour period. On review, the insurer contends that claimant did not prove he is limited to walking no more than two hours during an eight-hour period. We agree and reverse.

The standards applicable to rating claimant's disability are set forth in WCD Admin. Order 96-051, as amended by WCD Admin. Order 96-068. OAR 436-035-0003(2). The applicable standards include OAR 436-035-0230(16) which states that "[w]hen there is an injury to the knee/leg and objective medical evidence establishes an ability to walk or stand for a cumulative total of two hours or less in an 8-hour period, the award shall be 15% of the knee/leg...."

Claimant has an accepted injury claim for an osteochondral fracture in the right knee. He underwent surgery in August 1995 and his condition became medically stationary in January 1996. His disability was rated by Dr. Strum, examining orthopedist, who wrote: "In terms of [claimant's] ability to stand or walk greater than two hours in an eight-hour period, I would expect this to be problematical after this type of an injury." (Ex. 11-6). At the same time, Dr. Strum approved, as being within claimant's restrictions, an apprentice plumber/fabricator job that requires three to six hours of walking in an eight-hour day. (Ex. 11, pp. 8-9).

Dr. Snider, claimant's attending orthopedic surgeon, agreed with Dr. Strum's assessment of claimant's condition, but questioned whether Dr. Strum's work release was consistent with the Salem Hospital's November 1995 physical capacity evaluation (PCE) that was performed by evaluator, Linda Poling. (Ex. 12). The insurer subsequently asked Ms. Poling about claimant's walking limitations. (Ex. 15). Ms. Poling responded that claimant demonstrated the ability to walk for 60 minutes, adding: "It is projected that he could tolerate 2-4 hours per day." (Ex. 16). Dr. Snider concurred with Ms. Poling's report. (Ex. 17).

The medical arbiter, Dr. Neumann, also examined claimant's right knee and wrote: "I feel [claimant] does not show a permanent preclusion from walking or standing for two hours or less, cumulatively, in an eight hour shift." (Ex. 21-5).

Based on our review of the aforementioned reports, we conclude that claimant has not carried the burden of proving he has a two-hour walking limitation. While Dr. Strum indicated that walking over two hours would be "problematical," he did not state that claimant would be unable to walk for more than two hours during an eight-hour period. On the contrary, Dr. Strum approved an apprentice plumber/fabricator job which requires three to six hours of walking in an eight-hour day. Thus, Dr. Strum's opinion, as ratified by claimant's attending physician, Dr. Snider, does not support a two-hour walking limitation.

Ms. Poling also did not state that claimant is unable to walk for more than two hours in an eight-hour day. Rather, she "projected" that claimant could walk up to four hours. Unlike the ALJ, we do not interpret Ms. Poling's use of the term "projected" as offering a prognostication of future improvement. Rather, the most reasonable interpretation is that she felt claimant currently has the ability to work at a job requiring up to four hours of walking. Therefore, Ms. Poling's opinion, as ratified by the attending physician, also does not support a two-hour walking limitation.

Finally, the medical arbiter, Dr. Neumann, does not state that claimant is unable to walk for more than two hours in an eight-hour day. He states that claimant "does not show a permanent preclusion from walking or standing for two hours or less, cumulatively, in an eight-hour shift." (Ex. 21-5). The statement says that claimant is able to walk for two hours or less in an eight-hour shift. We conclude, however, that the confusing wording of the arbiter's statement obscured his true meaning.

We find that, rather than addressing a preclusion from walking for two hours or less, the arbiter intended to address a preclusion from walking for more than two hours. In any event, the arbiter did not state that claimant is precluded from walking for more than two hours during an eight-hour period. Thus, the arbiter's opinion also does not support a two-hour walking limitation.

We conclude there is no persuasive medical opinion to support a finding that claimant is unable to walk or stand for a cumulative total of more than two hours in an eight-hour period. Absent such evidence, claimant has not carried his burden of proof in this matter, and the Order on Reconsideration shall be affirmed.

Claimant contends that we should admit and consider non-medical, impeachment evidence that was not a part of the reconsideration record. We rejected a similar argument in Tim L. Besheone, 48 Van Natta 2337 (1996). In Besheone, we held that impeachment evidence which was not submitted at the reconsideration proceeding and was not a part of the reconsideration record, is inadmissible at hearing concerning the extent of permanent disability arising from an appeal of an Order on Reconsideration. See ORS 656.268(8), 656.283(7). "Post-reconsideration" evidence, even if impeachment evidence, is inadmissible at hearing concerning extent of disability.

ORDER

The ALJ's order dated January 3, 1997 is reversed. The Order on Reconsideration is affirmed.

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May 30, 1997 Cite as 49 Van Natta 706 (1997)

In the Matter of the Compensation of
**RAYMOND J. SUEK, SR., Claimant**
WCB Case No. 95-13702
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) upheld the self-insured employer's "back-up" denial of his current low back condition; (2) awarded a $550 attorney fee for setting aside the denial of a pars defect as premature; and (3) declined to award penalties and attorney fees for the employer's allegedly unreasonable denials. The employer requests review of that portion of ALJ's order that set aside its denial of a pars defect as premature. On review, the issues are compensability, premature denial, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact on page 2, we change the fifth sentence to read: "Claimant's condition was diagnosed as low back syndrome (Ex. 9), for which he was treated conservatively." In the following paragraph, we change the date of "December 15, 1995" in the fourth sentence to "September 15, 1995."

CONCLUSIONS OF LAW AND OPINION

Back-up Denial

Claimant injured his back at work on March 15, 1994, while lifting a television set. On June 23, 1994, the employer accepted a nondisabling claim for "low back pain." (Ex. 22). On November 21, 1994, the Department of Consumer and Business Services ordered the employer to classify the claim as disabling. (Ex. 35). On December 1, 1994, the employer accepted a claim for "disabling low back pain." (Ex. 38).

On December 6, 1995, the employer accepted the March 15, 1994 injury claim as "disabling low back strain." (Ex. 49). On the same date, the employer wrote to claimant and explained that its previous acceptances were incorrect in referencing low back pain as the accepted condition. (Ex. 50).

The employer said it would "back up and deny (low back pain)" and that it had amended the Notice of Acceptance to accept a claim for low back strain. The employer also denied compensability of spondylosis at L4-5 with anterolisthesis at L4 and L5 with possible pars defect on the basis that it was not attributable to the March 15, 1994 lifting incident and his employment. (Id.) Claimant requested a hearing.

The ALJ found that, by accepting low back pain with regard to the March 15, 1994 injury, the employer's acceptance included the underlying degenerative problem at L4-5. See Georgia-Pacific v. Piwowar, 305 Or 494 (1988). The parties did not dispute that the employer's December 6, 1995 denial was a "back-up" denial. The ALJ found that the evidence relied upon by the employer was not "later obtained evidence." Rather, the ALJ reasoned that the additional medical evidence was effectively a new analysis based on the same information the employer knew, or should have known, at the time of the acceptance. Nevertheless, the ALJ concluded that the denial was proper, reasoning that the preponderance of medical evidence established that the low back strain resulting from the March 15, 1994 injury had resolved and claimant's chronic low back problem was due to the underlying degenerative problem at L4-5.

Claimant agrees with the ALJ that the employer's acceptance included the underlying degenerative problem at L4-5, but he contends that the ALJ erred by concluding that the "back-up" denial was proper. Claimant argues that, since the additional medical evidence did not constitute "later obtained evidence," the back-up denial was invalid.

We agree with the ALJ that, by accepting "low back pain" with regard to the March 15, 1994 injury, the employer's acceptance included the degenerative problem at L4-5. See Piwowar; Emmert v. City of Klamath Falls, 135 Or App 209 (1995). The employer's acceptance of "low back pain" was an acceptance of a symptom of claimant's underlying degenerative condition. Compare Granner v. Fairview Center, 147 Or App 406 (1997) (the carrier accepted a separate condition rather than a symptom of a preexisting condition).

The employer acknowledges that claimant's degenerative spondylosis at L4-5 was documented during the time he was treated for the March 15, 1994 injury. However, the employer contends that the preponderance of medical evidence establishes that, by September 1995, the effects of claimant's March 15, 1994 injury were no longer the major contributing cause of his disability and need for treatment. Citing ORS 656.262(7)(b) and ORS 656.262(6)(c), the employer contends that the ALJ properly upheld its December 6, 1995 denial of claimant's accepted low back pain condition, including spondylosis at L4-5 with anterolisthesis at L4 and L5.

By its terms, ORS 656.262(6)(c)[1] applies only to combined or consequential conditions. See, e.g., Lee J. Johnson, 48 Van Natta 2261, 2263 (1996). In Robin W. Spivey, 48 Van Natta 2363, 2365 (1996), we held that ORS 656.262(7)(b)[2] does not apply unless a condition had been accepted under ORS 656.005(7) as 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 a need for treatment.

ORS 656.005(7)(a)(B) does not apply to this case. Claimant's degenerative condition at L4-5, which preexisted the compensable March 1994 injury, is itself a compensable condition and, therefore, it does not constitute a preexisting condition for the purposes of ORS 656.005(7)(a)(B). See Lee J. Johnson, 48 Van Natta at 2263 (since the carrier's acceptance included the osteoarthritis condition, ORS 656.005(7)(a)(B) and 656.262(6)(c) did not apply); James M. King, 47 Van Natta 2563 (1995) (where

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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] 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."

coronary artery disease was ordered accepted by court, there was no "combined" condition and ORS 656.262(6)(c) did not apply); Ronald L. Ledbetter, 47 Van Natta 1461, 1462 (1995). Because there is no evidence that the compensable degenerative condition combined with any other preexisting condition, ORS 656.005(7)(a)( B) is not applicable. Furthermore, since the employer did not accept either a "combined" or consequential condition, neither ORS 656.262(6)(c) nor ORS 656.262(7)(b) is applicable.

We agree with the ALJ that the employer's December 6, 1995 denial constituted a "back-up" denial of compensability. 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.

The employer acknowledges that claimant's degenerative spondylosis at L4-5 was documented during the time he was treated for the March 15, 1994 injury. The employer contends that the medical record showed a "change" in claimant's condition in late 1994. The relevant inquiry, however, is whether the employer had "later obtained evidence" that the claim is not compensable or that it was not responsible for the claim.

The employer has not sustained its burden of proof. We agree with the ALJ that the additional medical evidence relied upon by the employer was based on the same information the employer knew, or should have known, at the time of claim acceptance.

Claimant testified that he had not suffered from any low back problems before the March 15, 1994 injury. (Tr. 13). On March 25, 1994, Dr. Bain diagnosed "low back syndrome." (Ex. 9). An x-ray taken the same day showed "L4-5 disc spondylosis which is relatively advanced by plain film criteria." (Ex. 8). On May 6, 1994, Dr. Bain reported that claimant had persistent right posterolateral thigh pain. (Ex. 16). He suspected a nerve root injury with a possible L4-5 lesion or a separate lesion at L5-S1. An MRI dated May 18, 1994 revealed, among other things, spondylolysis at L4 with secondary rotatory anterolisthesis at L4-5. (Ex. 18).

On June 8, 1994, claimant was examined by Dr. Olson, who reported that claimant's findings were consistent with a degree of radiculopathy, mild with radiculitis with claimant having a spondylolisthesis and secondary nerve irritation. (Ex. 20). Dr. Olson recommended further conservative treatment.

On June 23, 1994, the employer accepted nondisabling "low back pain." (Ex. 22). Prior to the employer's acceptance, the medical reports had consistently focused on claimant's spondylolysis, radiculopathy and radiculitis. Thus, the employer knew, or should have known, at the time of acceptance that claimant's degenerative condition was contributing to his disability and/or need for treatment.

After the employer's acceptance, claimant's degenerative conditions, including L4-5 spondylosis, continued to contribute to his disability and/or need for treatment. On October 6, 1994, Dr. Olson reported that claimant had spondylolysis at L-4 with secondary rotation and anterolisthesis at L4-5 with edema fluid at the spondylolysis defect. (Ex. 27). On November 3, 1994, Dr. Olson again reported that claimant had problems at the L4-5 level, with some secondary radiculitis being most probable. (Ex. 33). Dr. Olson felt that claimant's condition was stable and he had reached maximum medical improvement. (Id.)

Dr. Poulson examined claimant on November 30, 1994. (Ex. 37). Claimant had low back pain that radiated into the right lower extremity. Dr. Poulson reported that the MRI showed a bulging mass anterior to the L4-5 interspace and claimant had spondylolysis at both sides at L4. (Id.) Dr. Poulson subsequently discussed the possibility of a fusion at the L4-5 interspace. (Ex. 41).

On March 27, 1995, Dr. Collada examined claimant and reported that he had clear-cut degenerative changes of the spine, complicated by spondylolysis at L4-5. (Ex. 44-2). He felt that claimant's discomfort was from the degenerative changes and some instability at L4-5. (Id.)

On September 15, 1995, claimant was examined by Drs. Wilson and Duff. They diagnosed a lower back strain, related to the March 15, 1994 injury, resolved, and spondylolysis, L4-5, with anterolisthesis of L4 on L5, with possible pars defect. (Ex. 46-5). They concluded that claimant's present ongoing complaints were due to the degenerative condition at L4-5, which was unrelated to the March 15, 1994 lumbar strain. (Id.) Drs. Olson and Collada concurred with their report. (Exs. 47, 52).

After reviewing the record, we agree with the ALJ that the employer's denial was not based on "later obtained evidence." The employer's denial was based primarily on the report of Drs. Wilson and Duff, who referred to the imaging studies done before claim acceptance and did not describe any particular change in claimant's condition. Although Drs. Wilson and Duff indicated that claimant's present complaints were due to the degenerative condition, that did not constitute new evidence. We agree with the ALJ that the additional medical evidence is based on the same information the employer knew, or should have known, at the time of claim acceptance. A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). Magnuson, 119 Or App at 286. Since the employer's "back-up" denial was not based on "later obtained evidence," the denial was invalid under ORS 656.262(6)(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 concerning the "back-up" denial is $5,000, 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 appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Pars Defect Denial

The employer's December 6, 1995 letter denied compensability of a "possible" pars defect of the lumbar area. (Ex. 50). At hearing, claimant argued that since he had made no claim for a pars defect, the employer's denial of that condition was premature. The ALJ agreed with claimant, reasoning that it was speculative whether the condition existed, no treatment had been recommended and no medical services claim had been made for the condition. The ALJ set aside the employer's denial of the pars defect.

The employer cross-requests review, arguing that the denial of the pars defect should be upheld, because the possible pars defect was one of several potential causes of the combined condition, and claimant sought treatment for the combined condition. We disagree.

In Vicki L. Davis, 49 Van Natta 603 (1997), we applied ORS 656.262(7)(a) and held that a carrier's precautionary partial denial of lumbar degenerative conditions was premature because the claimant had not filed a "new medical condition" for the conditions. Prior to the closure of the claimant's accepted injury claim for lumbar strain and rib contusion, an x-ray had shown, and several physicians (attending and examining) had diagnosed, degenerative disc disease / arthritis conditions. Contending that the degenerative conditions were unrelated to the accepted lumbar strain injury, the carrier issued a "pre-closure" precautionary partial denial.

We held that the carrier's denial was premature because the claimant had not made a claim for her degenerative conditions. Relying on Ramona E. Hamilton, 48 Van Natta 2438 (1996), we reasoned that, because neither the claimant nor her physician made a "clear request" of a "formal written acceptance" of any degenerative conditions, there had not been a "new medical condition" claim under ORS 656.262(7)(a). Inasmuch as a denial issued in the absence of a claim is a nullity, we found that the carrier's denial had no legal effect.

We reach the same conclusion in this case. ORS 656.262(7)(a) requires a "clear request" for "formal written acceptance" of a new medical condition after claim acceptance and provides that new medical condition claims "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." (Emphasis added). Here,

the employer accepted "low back pain." Thereafter, neither claimant nor his physician made a "clear request" of a "formal written acceptance" of a pars defect of the lumbar area. The employer does not contend otherwise. Therefore, we find no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Finally, since a denial issued in the absence of a claim is a nullity, we find that the employer's denial of the pars defect has no legal effect. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Vicky L. Davis, 49 Van Natta at 606.

The ALJ awarded an assessed attorney fee of $550 pursuant to ORS 656.386(1) for claimant's counsel's services in setting aside the employer's "premature" pars defect 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 employer'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).[3] Vicky L. Davis, 49 Van Natta at 606; Ramona E. Hamilton, 48 Van Natta at 2440.

Penalties

Claimant contends that he is entitled to penalties for the unreasonable "back-up denial" and pars defect denial.

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).

At the time of the December 6, 1995 denial, the employer had the report from Drs. Wilson and Duff that indicated that claimant's lower back strain had resolved and his present complaints were due to the degenerative condition. (Ex. 46). Two of claimant's treating physicians, Drs. Olson and Collada, concurred with that report. (Exs. 47, 52). In light of those reports, we conclude that the employer had a legitimate doubt as to its liability for claimant's current low back condition. Therefore, we do not assess a penalty against the employer for an unreasonable "back-up" denial.

Claimant also contends that he is entitled to a penalty for the employer's unreasonable denial of the pars defect. As we mentioned earlier, we found that claimant made no "claim" for the pars defect and the employer's denial was premature and a nullity. Claimant will receive no benefits as a result of our holding. Under these circumstances, 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).

ORDER

The ALJ's order dated December 5, 1996, as amended December 6, 1996, is affirmed in part and reversed in part. That portion of the ALJ's order that upheld the employer's "back-up" denial is reversed. The denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review concerning the "back-up" denial, claimant's attorney is awarded $5,000, payable by the self-insured employer. That portion of the ALJ's order that awarded an assessed attorney fee of $550 pursuant to ORS 656.386(1) for claimant's counsel's services in setting aside the "premature" pars defect denial is reversed. The remainder of the ALJ's order is affirmed.

[3] In light of our conclusion, we do not address claimant's argument that the attorney fee for the pars defect should be increased to $1,200.

In the Matter of the Compensation of
**KRYZSZTOF ZIELINSKI, Claimant**
WCB Case No. C700845
ORDER ON RECONSIDERATION DISAPPROVING CLAIM DISPOSITION AGREEMENT
Richard F. McGinty, Claimant Attorney
Lundeen, et al, Defense Attorneys

On April 22, 1997, we issued an order approving the parties' Claim Disposition Agreement (CDA). Kryzsztof Zielinski, 49 Van Natta 524 (1997). In doing so, we noted that claimant settled his third party action for a total of $65,000 ($55,000 plus an additional $10,000 payable directly to the workers' compensation insurer from the third party insurer in satisfaction of the workers' compensation insurer's $24,200 lien). In light of such circumstances, we reasoned that the $14,200 reduction in the workers' compensation insurer's third party lien represented the total consideration for the disposition. Finally, since the body of the CDA provided that claimant's counsel's attorney fee was payable from the third party settlement, we determined that, contrary to the summary page of the CDA, no attorney fee was payable from the CDA; i.e., the $14,200 reduction in the workers' compensation insurer's third party lien.

On April 28, 1997, we received claimant's timely request for abatement and reconsideration of our April 22, 1997 order. With his request for abatement of our order, claimant submitted an addendum to the CDA which had been signed by the parties' counsels and provided: "Claimant's attorney shall receive an attorney fee from the third party settlement **and $4875 from the new money ($30,000.00) portion of this Claims Disposition Agreement.** No fee is to be taken from the additional $10,000.00 paid by [the third party insurer] to [the insurer]." (Emphasis in original).

On May 2, 1997, we abated our April 22, 1997. Kryzsztof Zielinski, 49 Van Natta 575 (1997). In our abatement order, we stated that notwithstanding the addendum's reference to $30,000 in "new money," we did not consider funds flowing from the third party insurer to claimant to be "consideration" for the release of his workers' compensation rights from the workers' compensation insurer. Rather, we continued to construe the total consideration for the CDA to be the workers' compensation insurer's apparent waiver of $14,200 of its $24,200 statutory third party lien.

Based on our interpretation of the agreement, we indicated that, in the absence of extraordinary circumstances, the maximum attorney fee payable from the $14,200 in "CDA" consideration allowed by OAR 438-015-0052(1) would be $3,295; i.e., 25 percent of the first $12,500 and 10 percent of the remaining $1,700. We noted, however, that the parties' proposed addendum provided for an attorney fee of $4,875, payable out of the CDA consideration.

Consequently, we reasoned that, absent extraordinary circumstances justifying the proposed attorney fee, the amended CDA could not receive our approval. Finally, to assist us in proceeding with our further review of the CDA, we requested that the parties submit a further addendum to the CDA describing the circumstances surrounding the settlement of claimant's third party claim, including the amount of claimant's counsel's fee arising from the third party settlement and clarification of the term "new money." We directed that the addendum be signed by claimant, his counsel and the insurer's counsel.

On May 22, 1997, we received a revised addendum to the CDA. The revised addendum amended the original CDA to provide for a lump sum of $30,000 to be paid to claimant by the workers' compensation insurer in addition to the carrier's partial release of its third party lien. The revised addendum also provided that the $4,875 attorney fee would be taken from the $30,000 lump sum payment. The proposed addendum was signed by claimant's counsel and counsel for the insurer. Although the addendum contained a signature line for claimant, the addendum did not contain his signature. Furthermore, claimant's counsel's cover letter accompanying the revised addendum indicated that claimant had declined to sign the addendum.

As a party to the agreement, claimant must execute the CDA. See OAR 438-009-0001(1); Isidro Rangel-Perez, 47 Van Natta 214 (1995); Catherine E. Evans, 45 Van Natta 1043 (1993); Edgar C. Sixberry, 43 Van Natta 335 (1991). Such a requirement is particularly important where, as here, the revised CDA provides for an attorney fee payable from the CDA consideration (funds that will directly reduce

claimant's share of the CDA proceeds). Finally, contrary to the express directive in our abatement order, the amended CDA (which significantly revised the original CDA)[1] does not contain claimant's signature. Under such circumstances, we conclude that the agreement is "unreasonable as a matter of law" and we decline to approve it. See ORS 656.236(1)(a)(A).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-150(5)(k) and (7)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

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[1] The original CDA indicated that claimant had reached a $55,000 settlement with the third party, with an additional $10,000 payable directly from the third party insurer to the workers' compensation insurer. In addition, unlike the revised CDA, the original CDA did not provide that any monies were to be paid directly from the workers' compensation carrier to claimant.

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In the Matter of the Compensation of
**MELINDA M. THOMPSON, Claimant**
WCB Case No. 96-08011
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) Hoguet's order that: (1) found that her cervical strain claim was not prematurely closed; and (2) affirmed an Order on Reconsideration which awarded no unscheduled permanent partial disability. On review, the issues are premature closure and, alternatively, extent of unscheduled permanent disability.

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

On review, although claimant acknowledges our decision in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), claimant contends that the ALJ erred by not permitting her to testify at hearing regarding the status of her attending physician. Claimant argues that her testimony would establish that her attending physician was actually Dr. Long, and Dr. Long's opinion supports her contention that her cervical claim was prematurely closed. Claimant also argues that any exclusion of her testimony constitutes a "due process" violation.

We agree with the ALJ's evidentiary ruling and his decision to decline to consider evidence not previously submitted at the time of reconsideration. In Arlie B. Tompkins, 48 Van Natta 1664 (1996), we extended our holding in Joe R. Ray to include cases involving an issue of premature closure. In other words, we concluded that, under amended ORS 656.283(7), evidence not submitted at reconsideration concerning the claimant's medically stationary status at the time of claim closure was statutorily inadmissible at a subsequent hearing. Tompkins, 48 Van Natta at 1664. Additionally, in Tomkins, we found that the amended statute did not violate the claimant's due process rights. Accordingly, we affirm the ALJ's decision on the issue of premature closure.

ORDER

The ALJ's order dated January 15, 1997 is affirmed.

In the Matter of the Compensation of
**TONIA M. CHANDLER, Claimant**
WCB Case No. 96-03404
ORDER ON REVIEW
Brownstein, Rask, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet'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 with the following supplementation.

Although finding that claimant proved an industrial injury in November 1995, the ALJ concluded that claimant failed to establish compensability. In particular, the ALJ found that the medical evidence supporting causation was not persuasive because it was based on an inaccurate history. Claimant contends that such medical opinion was based on a history that claimant had low back symptoms only during pregnancy, such history is accurate and, consequently, she carried her burden of proof.

We agree with the ALJ that the preponderance of the evidence shows that claimant had ongoing low back and leg pain before the November 1995 work incident. During a recorded statement with the insurer's claims investigator, claimant indicated that she had a "pinched sciatic nerve" which "comes and goes." (Ex. 13A-12, 13A-13). Claimant further stated that she had the most symptoms when pregnant but that several months before the November 1995 work event she had low back and leg pain. (Id. at 15, 17). Claimant explained that her symptoms prevented her from lifting heavy items at work. (Id. at 18-19). Such statements were corroborated at hearing by testimony from claimant's coworkers, who stated that claimant constantly complained of low back pain before the November 1995 incident and, as a result, she used a stool while working, was not required to lift heavy items, and had left work early on several occasions. (Tr. 54, 58-59, 66-68, 77-79).

Because the opinions supporting causation were based on a history that claimant's low back symptoms were limited to her pregnancies, we agree with the ALJ that they were not based on an accurate history. (Exs. 21, 22). Consequently, there are persuasive reasons for finding them unpersuasive. See Weiland v. SAIF, 59 Or App 810 (1983).

ORDER

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

In the Matter of the Compensation of
**HERBERT GRAY, Claimant**
WCB Case No. 95-13675
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Bock and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order which: (1) reopened the record for the admission of a "post-hearing" medical report; and (2) set aside the insurer's denial of claimant's right shoulder injury claim. On review, the issues are evidence and compensability. We vacate and remand.

Claimant allegedly injured his right shoulder on November 3, 1995. The insurer denied the injury claim on December 14, 1995. A hearing was held on March 12, 1996, which resulted in a May 17, 1996 Opinion and Order that upheld the insurer's denial.

Claimant filed a Motion for Reconsideration on June 7, 1996, in which he requested that the record be reopened for the admission of a May 31, 1996 medical report from Dr. Switlyk based on the findings of surgery he performed on May 10, 1996. (Ex. 11). After abating his original order and allowing the insurer to respond to claimant's motion, the ALJ admitted Dr. Switlyk's report and stated that he would explain his evidentiary ruling in his Order on Reconsideration.

On November 29, 1996, the ALJ issued his Opinion and Order on Reconsideration, in which he set aside the insurer's denial. However, the ALJ provided no explanation of his decision to reopen the record for admission of additional evidence. On review, the insurer argues that the ALJ's evidentiary ruling is "unreviewable" without an explanation of his decision. We agree.

It is well-settled that we review an ALJ's evidentiary ruling for abuse of discretion. See Allan Coman, 48 Van Natta 1882 (1996). However, without some explanation of the ALJ's decision to reopen the record to admit additional evidence, we are unable to review for abuse of discretion. See Janell Tackett, 47 Van Natta 1594 (1995); Ronald D. Robinson, 44 Van Natta 1232 (1992); (James D. Brusseau II, 43 Van Natta 541 (1991) (case remanded to ALJ to develop record regarding admissibility of untimely disclosed document where no findings made regarding material prejudice to carrier). Here, because the ALJ provided no explanation of his evidentiary ruling, we find this record "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(3); James D. Brusseau II.

Accordingly, the ALJ's order dated May 17, 1996 is vacated. This matter is remanded to ALJ Mills with instructions to issue a final, appealable order on remand explaining his reasons for reopening the evidentiary record. Thereafter, should either party wish to again request Board review of the ALJ's order, they may do so.

IT IS SO ORDERED.

In the Matter of the Compensation of
**DIANE H. KURCIN, Claimant**
WCB Case No. 96-03838
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) granted claimant's motion to continue the hearing for the admission of claimant's treating physician's response to the testimony of a physician called by SAIF; and (2) set aside SAIF's denial of claimant's low back injury claim. On review, the issues are the ALJ's evidentiary ruling and compensability. We affirm.

## 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

### Evidence

The ALJ continued the hearing to allow claimant an opportunity to respond to testimony provided by SAIF's expert at the time of hearing. On review, SAIF argues that the ALJ abused his discretion as claimant received advance notice that SAIF's expert would testify but had not obtained rebuttal evidence prior to the hearing.

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 that the exercise of authority to continue a hearing rests within the ALJ's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991). Further, an ALJ is not bound by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7). We review the ALJ's ruling for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

At hearing, counsel for SAIF objected to claimant's request for a continuance in order for claimant's treating physician, Dr. Calhoun, to review the expert testimony at hearing provided by Dr. Gambee. The ALJ found that claimant had exercised due diligence, and that it would not have been possible for claimant to have known the substance of Dr. Gambee's testimony prior to hearing. The ALJ further noted that claimant had the right to produce final rebuttal evidence. Finally, there was no opposition to SAIF's request to cross-examine Dr. Calhoun.

Under the circumstances, we conclude that it was not an abuse of discretion for the ALJ to continue the hearing in order for claimant to obtain final rebuttal evidence from Dr. Calhoun. Although SAIF argues, on review, that claimant should have been able to anticipate the substance of Dr. Gambee's testimony and to provide rebuttal evidence without leaving the record open, we find such an argument to be speculative. Accordingly, we conclude that the ALJ did not abuse his discretion by granting claimant's motion for a continuance.

### Compensability

On review, SAIF argues that the ALJ incorrectly applied a "material contributing cause" standard. Rather, SAIF contends that the case involves a preexisting and "combined" condition and should have been analyzed under ORS 656.005(7)(a)(B). We conclude that it is not necessary to determine whether claimant has a "combined condition," because even if the major contributing cause standard of ORS 656.005(7)(a)(B) applies, we find that the medical evidence satisfies that legal standard.

The evidence pertaining to the issue of causation is divided. Moreover, because of the various possible causes of claimant's herniation, we find that the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967). We generally afford greater weight to the opinion of claimant's attending physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Claimant's family doctor, Dr. Choong, treated claimant both before and after the December 1995 work injury. Dr. Choong reported the findings from claimant's 1996 MRI and noted that claimant had not previously mentioned any back problems prior to the December 1995 injury. Because Dr. Choong found that claimant's prior condition had stabilized, she agreed that the work incident was the major cause of claimant's present problem. (Ex. 12).

Dr. Calhoun, claimant's treating neurosurgeon, saw claimant on referral from Dr. Choong. Dr. Calhoun took a history of claimant's prior back problems and of the work injury, reviewed the MRI, and opined that the work injury was the major contributing cause of claimant's present problems. (Exs. 5, 13).

Drs. Dineen and Platt examined claimant on behalf of SAIF. The examiners diagnosed a lumbosacral strain and probable recurrent herniated disc at L4-5, due to the December 1995 injury. The examiners concluded that, although the preexisting condition may have made claimant more vulnerable to a recurrent injury, claimant had been functioning without symptoms or the need for treatment, prior to the injury. Accordingly, the examiners concluded that the December 1995 "new injury" was the major cause of claimant's disability and need for treatment. (Ex. 13B).[1]

Dr. Gambee also examined claimant on behalf of SAIF. Dr. Gambee first stated that it was "unclear" whether claimant's work or the preexisting condition was the major cause of her preexisting condition. (Ex. 9). Dr. Gambee later agreed that claimant's recurrence of her disc herniation and resultant disability and need for treatment were not related to the December work incident. (Ex. 14-2).

After reviewing the expert medical evidence, we find no persuasive reason to discount the opinion of claimant's initial treating doctor, Dr. Choong, or her treating neurosurgeon, Dr. Calhoun. Dr. Choong had an opportunity to observe and treat claimant both before and after the December 1995 incident. Furthermore, both Drs. Choong and Calhoun have considered claimant's preexisting condition and the findings shown on the MRI, and have taken an accurate history of the 1995 work incident. After considering all of those factors, both doctors have explained why the work incident is the major cause of claimant's condition and need for treatment.

We do find persuasive reasons to reject the causation opinion of Dr. Gambee. First, we note that Dr. Gambee's opinion is contrary to the remaining expert medical opinions in the record.[2] Additionally, Dr. Gambee testified at hearing that claimant's ongoing problems were due to scar tissue from the prior injury. (Tr. 38). Dr. Calhoun, however, disagreed with Dr. Gambee's statement, as his review of the MRI showed "very little scar formation...." (Ex. 16).

Moreover, Dr. Gambee testified that the disc was impinging on the thecal sac, and not the nerve root. (Tr. 50). However, Dr. Calhoun disagreed, as he explained that at every level except L5-S1, the nerve root has not exited the thecal sac at the level of the disc space. Therefore, Dr. Calhoun disagreed with Dr. Gambee's testimony, as Dr. Calhoun stated that a nerve is usually impinged upon while "still with (sic) the thecal sac." (Ex. 16).

Accordingly, because we find that Dr. Gambee's opinion is contrary to the majority of the remaining medical opinions regarding causation, and because we find that Dr. Calhoun has successfully and persuasively rebutted Dr. Gambee's opinion, we reject Dr. Gambee's opinion. Therefore, based on the persuasive medical opinions, we find that claimant has shown that the work injury was the major contributing cause of her disc herniation at L4-5.

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[1] When later contacted by SAIF, Dr. Platt agreed that he was now "not comfortable" providing an opinion regarding the major cause of claimant's condition. (Ex. 15-2).

[2] We do not consider Dr. Platt's unexplained change of opinion in reaching our conclusion on the issue of causation.

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 counsel's services on review is $1,515, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated November 26, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,515, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**DAVID J. MARTEN, Claimant**
WCB Case No. 96-08377
ORDER ON REVIEW
John C. Moore & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its partial denial of claimant's claim for a current 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 claimant suffered a lumbar sprain at work in November 1995 which did not combine with his preexisting lumbar spondylolysis and spondylolisthesis to cause his disability or need for treatment following the November 1995 accident. Finding no "combined condition," the ALJ applied the "material contributing cause" test to conclude that the current low back condition is compensably related to the accident.

On review, the insurer contends that in recorded closing arguments at hearing, claimant's attorney stipulated that claimant's current need for treatment was due to a combination of the November 1995 injury and his preexisting condition and that the "major contributing cause" test was applicable to his claim. Therefore, the insurer argues, claimant has the burden of proving, pursuant to ORS 656.005(7)(a)(B), that the November 1995 injury was the major contributing cause of the need for treatment for the "combined condition."

Assuming, without deciding, that claimant stipulated that his current need for treatment is due to a combination of the November 1995 injury and the preexisting spondylolysis and spondylolisthesis, we conclude that claimant nevertheless has carried his burden of proof under the "major contributing cause" standard. The medical evidence is divided between the opinion of claimant's treating physician, Dr. Freeman, and the examining physician, Dr. Farris.

Dr. Freeman, who treated claimant on four occasions, attributed claimant's current need for treatment to the soft tissue injury (lumbar sprain) suffered in the accident and to the residual pain which has persisted due to the "mutually synergistic" effect of muscle tension and pain after healing of the sprain. (Ex. 26). Dr. Farris, who examined claimant once at the insurer's request, opined that at the time of his examination in May 1996, claimant had recovered completely from the November 1995 accident and his residual symptoms were due entirely to the preexisting condition. (Ex. 27). Dr. Farris explained that the preexisting condition predisposed claimant to the development of low back pain and that the lumbar strain suffered in the accident should have resolved within three months after the accident. (Ex. 35).

For the reasons discussed by the ALJ, we find that Dr. Freeman's opinion is more persuasive. Those reasons include the seriousness of the November 1995 accident as compared to the relatively minor preexisting pathology, the absence of preexisting low back pain resulting in disability or a need for treatment event while claimant performed heavy work, and the persistence of low back symptoms requiring treatment since the accident. We also find that Dr. Freeman's opportunity to treat claimant over time enhanced his ability to evaluate claimant's condition since the accident, including the persistence of pain after healing of the soft tissue injury. See Weiland v. SAIF, 64 Or App 810, 814 (1983). In this regard, we reject the insurer's argument that this is a case involving expert analysis rather than expert external observation and that special credit should not be given to the treating physician's opinion. Based on Dr. Freeman's opinion, we find that the November 1995 accident was at least the major contributing cause of claimant's subsequent need for treatment. Accordingly, the ALJ's order setting aside the denial is affirmed.

Claimant's attorney is entitled to an assessed attorney fee for services on Board 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 attorney fee for claimant's attorney's services on review is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's attorney's time sheet), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 3, 1997 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,500, payable by the insurer.

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In the Matter of the Compensation of
**CAROL J. BARRETT, Claimant**
Own Motion No. 96-0424M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Peter O. Hansen, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's December 23, 1996 Notice of Closure which closed her claim with an award of temporary disability compensation from September 3, 1996 through October 14, 1996. SAIF declared claimant medically stationary as of December 12, 1996. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her 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 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 December 23, 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 a December 12, 1996 medical report, Dr. Mandiberg, claimant's treating physician, opined that claimant was medically stationary. In a December 12, 1996 Supplemental Medical Report (form 828), Dr. Mandiberg noted that claimant was released to regular work on October 1, 1996, and that she was medically stationary on December 12, 1996. Dr. Mandiberg's opinion is unrebutted.

Furthermore, claimant is not entitled to further substantive temporary disability compensation in this claim. A claimant is entitled to substantive benefits prior to claim closure if the claimant can

establish that he / she was disabled due to the compensable injury prior to being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992); Donna Anderson, 46 Van Natta 1160 (1994); Randy Boydston, 46 Van Natta 2509 (1994); Debra Dale, 47 Van Natta 2344 (1995).

Here, claimant was declared medically stationary on December 12, 1996. Therefore, claimant must establish that she was disabled between October 14, 1996, when SAIF terminated temporary disability, and December 12, 1996, her medically stationary date. The record indicates that Dr. Mandiberg released claimant to regular work on October 1, 1996. Therefore, claimant has received the benefits to which she was entitled as she has not established that she was disabled after October 1, 1996.

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

Accordingly, we affirm SAIF's December 23, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MIR ILIAIFAR, Claimant**
WCB Case No. 96-05052
SECOND ORDER ON RECONSIDERATION
Rex Q. Smith, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our May 9, 1997 Order on Reconsideration that affirmed an April 17, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which set aside the SAIF Corporation's denial of his low back injury claim. Claimant continues to challenge our determination that his injury did not occur within the course and scope of his employment, where he was injured in an automobile accident while driving to the employer's premises to deliver an "off-work" authorization slip.

On seeking reconsideration of our Order on Reconsideration, claimant again raises several "assignments of error" challenging our determination not to apply the "special errand" exception to the "going and coming" rule in this case. We conclude that, with the exception of the point addressed below, each of claimant's assignments of error have been adequately addressed in our prior orders.

Claimant challenges our conclusion that he made the trip to his employer's premises primarily for his own benefit and to secure his entitlement to temporary disability benefits. Claimant argues that because processing of claims and providing of compensation is the responsibility of the insurer or self-insured employer (see ORS 656.262(1)), and insofar as temporary disability compensation is based on communication between the employer or insurer and the attending physician (see ORS 656.262(4); OAR 436-060-0020), his personal delivery of the off work slip to the employer had nothing to do with his entitlement to temporary disability and served to benefit the employer more than claimant himself.

We conclude that even if claimant's trip to the employer's premises did not affect his entitlement to temporary disability and even assuming the employer had an interest in having injured workers personally deliver documentation of their medical status, claimant's trip does not fall within the "special errand" exception (even by analogy) because claimant was not acting in furtherance of the *employer's business* at the time of his injury. See Krushwitz v. McDonalds Restaurants, 323 Or 520 (1996) (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). Consequently, we adhere to our determination that claimant's injury did not occur in the course of his employment.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we republish our prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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June 5, 1997 Cite as 49 Van Natta 720 (1997)

In the Matter of the Compensation of
**DAN A. STURTEVANT, Claimant**
WCB Case No. 96-05158
ORDER OF ABATEMENT
Cole, Cary & Wing PC, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

The self-insured employer requests reconsideration of our May 7, 1997 Order on Review which affirmed Administrative Law Judge (ALJ) McWilliams' order that set aside the employer's denial of claimant's occupational disease claim for osteoarthritis of the lumbosacral spine and left L5-S1 foraminal stenosis.

In order to allow us sufficient time to consider the employer's motion, we withdraw our May 7, 1997 order. Claimant is granted an opportunity to submit a response to the motion. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LOIS BRIMBLECOM, Claimant**
Own Motion No. 90-0218M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Emmons, et al, Claimant Attorneys
Grocers Insurance Company, Insurance Carrier

Claimant requests reconsideration of our November 20, 1996 Own Motion Order Reviewing Carrier Closure, which affirmed the insurer's August 27, 1996 Notice of Closure. On reconsideration, we adhere to the conclusion reached in our November 20, 1996 order. We base this finding on the following reasoning.

In our November 20, 1996 order, we concluded that, in order for claimant to establish that she was not medically stationary at claim closure, she must demonstrate that there was a reasonable expectation that further or ongoing medical treatment would "materially improve" her compensable knee condition at claim closure. Lois Brimblecom, 48 Van Natta 2312 (1996).

In response to the above challenge, claimant continues to argue that "[i]t is clear in this record that Dr. Hoff feels that further medical care and treatment may be of some benefit to [claimant's] pain as it emanates from the compensable knee condition and [claimant] should be entitled to such [a psychiatric] evaluation and possible treatment to alleviate her painful situation."

However, in order to prevail in her argument that she was not medically stationary at claim closure, claimant must establish a reasonable expectation of "material" improvement for her compensable condition. In our prior order, we noted that the provision of physical therapy or pain management would not necessarily establish that claimant's compensable condition would materially improve. Maarefi v. SAIF, 69 Or App 527, 531 (1984). Here, although Dr. Hoff continued to recommend physical therapy, he also opined that claimant has not shown "any significant" improvement in her knee condition (see chart notes dated June 4, 1996 and September 10, 1996). Dr. Hoff further opined that claimant should "back off" from physical therapy because it was not providing relief of her symptoms (see chart note of June 4, 1996). Therefore, the "treatment" which was prescribed to improve claimant's knee had been ineffective in that her knee had not improved between May 14, 1996 and September 10, 1996. Furthermore, there is no supporting evidence that treatment in the form of behavior modification or pain management, even if rendered, would materially improve claimant's compensable knee condition.

Claimant contends that Dr. Hoff's opinion that she is "disabled" does not mean that she will not improve. However, the statutory definition of "medically stationary" specifically outlines the criteria by which a physician must determine a claimant's medically stationary status. See ORS 656.007(17). Dr. Hoff is very concise in his opinion 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 she can be considered permanently and totally disabled." Furthermore, in his September 10, 1996 letter, Dr. Hoff opined that further treatment may "assist" claimant; at no time since June 1996 has Dr. Hoff opined that claimant's knee will materially improve. Finally, the record establishes that claimant's knee had not improved from May 1996 through the date of claim closure. Therefore, even though his post-closure opinion suggests that there may be some benefit to further physical therapy or behavior modification, we are bound by statute to conclude that, because claimant's knee condition has not and, with reasonable expectation, will not materially improve with further treatment or the passage of time, claimant was medically stationary when the insurer closed her claim.

Thus, we find no basis to alter our decision pertaining to the propriety of the insurer's August 27, 1996 Notice of Closure. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 20, 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
**GERALD D. DUREN, Claimant**
Own Motion No. 91-0640M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Emmons, et al, Claimant Attorneys
Radler, et al, Defense Attorneys

Claimant requests review of the insurer's March 3, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from November 4, 1991 through February 7, 1996. The insurer declared claimant medically stationary as of February 7, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

## FINDINGS OF FACT

Claimant sustained a compensable injury to his right knee and low back on April 14, 1981. Claimant's aggravation rights expired on December 4, 1986.

A February 23, 1996 Opinion and Order found claimant's hypertrophy and stenosis at L4-5 compensable. That finding was affirmed by the Board on August 14, 1996.

A February 13, 1997 Own Motion Order Reviewing Carrier Closure found the insurer's June 20, 1996 Notice of Closure of claimant's claim premature, concluding that claimant was not medically stationary with respect to his compensable L4-5 condition at claim closure.

In January 1997, claimant injured his right shoulder. On March 3, 1997, the insurer again closed claimant's claim, indicating that claimant was medically stationary as of February 7, 1996. Claimant requested review of the insurer's March 5, 1997 closure of his claim.

On April 14, 1997, the insurer accepted claimant's right shoulder strain/sprain and rotator cuff tear as a compensable component of his 1981 injury claim. On April 18, 1997, the insurer submitted a new Carrier's Own Motion Recommendation form, in which it recommended that the Board deny claimant's request for temporary disability compensation on the ground that claimant was not in the work force at the time of current disability.

In a May 12, 1997 letter, the insurer asserted that claimant's medically stationary date should continue to be February 7, 1996, and requested that a deposition of Dr. Puziss be scheduled.

## CONCLUSIONS OF LAW AND OPINION

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 3, 1997 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).

The insurer contends that claimant was medically stationary on February 7, 1996, and argues that claimant's medically stationary date "should remain February 7, 1996," because claimant's right shoulder injury occurred after claimant was declared medically stationary with respect to his back condition (the condition for which the claim was reopened). In addition, the insurer objects to Dr. Puziss' contemporary reports in which he uses the term "claim closure" in conjunction with the term "medically stationary."[1]

[1] The insurer has submitted a new recommendation to deny reopening the claim, contending that claimant was not in the work force at the time of disability (injury of his right shoulder).

The insurer's argument that claimant was medically stationary on February 7, 1996 because his right shoulder injury occurred after it declared claimant medically stationary, does not take into consideration the following two criteria which must be satisfied in order to close the claim: (1) claimant must be medically stationary on the date his claim was closed; and (2) claimant must be medically stationary with respect to all compensable conditions on that date.[2]

Here, although the insurer previously closed the claim on June 20, 1995, that closure was set aside as premature because claimant established that he was not medically stationary with respect to his compensable L4-5 condition when the insurer closed the claim. Thereafter, the insurer again closed the claim on March 3, 1997, declaring claimant medically stationary from the back surgery on February 7, 1996. Therefore, claimant must establish that any of his compensable conditions was not medically stationary on March 3, 1997 (the date of claim closure), rather than on February 7, 1996, as the insurer suggests.[3]

Claimant's right shoulder injury occurred on January 19, 1997; the insurer reclosed the claim on March 3, 1997. In his January 23, 1997 report, Dr. Puziss noted that it was difficult to assess the prognosis of claimant's right shoulder. Dr. Puziss reported that claimant's condition included "severe contusion and strain right shoulder, with possible subluxation and spontaneous reduction episode," and opined that claimant was currently disabled from work. By March 11, 1997, Dr. Puziss had diagnosed "probable right rotator cuff complete tear, post contusion/strain," and requested authorization to perform "right shoulder arthroscopy, and open or arthroscopic rotator cuff repair with decompression." Therefore, the record supports that claimant was unable to work and surgery was anticipated for his compensable right shoulder condition when the insurer closed the claim. Under such circumstances, we conclude that claimant was not medically stationary with respect to his right shoulder on March 3, 1997.

Furthermore, although the insurer did not accept claimant's right shoulder condition as compensable until April 21, 1997, the acceptance by the insurer merely corroborated that the right shoulder condition is compensable; the condition existed while the claim was reopened, and the medical reports support a conclusion that the compensable condition was not medically stationary on March 3, 1997.[4]

Finally, Dr. Puziss' March 18, 1997 and May 5, 1997 opinions regarding claimant's back and knee conditions need not be addressed here, as we have already concluded that claimant was not medically stationary with respect to his compensable right shoulder condition on March 3, 1997.[5]

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[2] It is these same two points that apparently lead the insurer to conclude that claimant's "medically stationary" date cannot change, and that the date it closed the claim is irrelevant to our inquiry. The insurer objects to Dr. Puziss' opinions regarding claimant's medically stationary status on March 3, 1997 - the date of claim closure. It contends that the relevant inquiry should be whether claimant was medically stationary on February 7, 1996, when it declared him medically stationary with respect to his back condition. However, the issue under review in this claim is whether claimant was medically stationary at claim closure. See Berliner v. Weyerhaeuser Corp., 54 Or App at 624.

[3] Although claimant may or may not have been medically stationary with respect to one or more of his compensable conditions on February 7, 1996, the point is, he must be medically stationary with respect to all compensable conditions on March 3, 1997, the date his claim was closed. See Rogers v. Tri-Met, 75 Or App at 470; Dennis C. Gross, 48 Van Natta 1125 (1996).

[4] We compare the acceptance of claimant's right shoulder condition after claim closure to the acceptance of claimant's L4-5 condition after claim closure. In both cases, the condition existed or occurred while the claim was reopened, but were subsequently accepted post-closure. The Board previously found the insurer's closure premature when, subsequent to litigation regarding the compensability of claimant's L4-5 condition, claimant's compensable L4-5 condition (although not accepted at the time of claim closure) was not medically stationary at claim closure. See Gerald D. Duren, 49 Van Natta 162 (1997).

[5] The insurer contends that Dr. Puziss "has now entered the domain of the Workers' Compensation Board by offering an opinion regarding claim closure." The insurer requested all correspondence regarding this matter from claimant's attorney be made available as discovery. In addition, the insurer requests that a deposition of Dr. Puziss be scheduled "so that we may clarify the record." In this respect, it is not within the Board's authority to schedule depositions. Therefore, the insurer may schedule any deposition, supplemental medical report or interrogatory with Dr. Puziss as it may so desire. If the insurer wishes to do so, it may request reconsideration with additional or newly acquired evidence, and the Board may reconsider its order if the request is timely made. However, based on this record (notwithstanding any opinions or medical evidence regarding claimant's knee or back), we conclude that claimant's claim was prematurely closed.

Accordingly, we set aside the insurer's March 3, 1997 Notice of Closure as premature. The insurer is ordered to recommence the payment of temporary disability compensation in this claim, beginning the date the insurer previously terminated these benefits. Because claimant's claim remains reopened, his April 21, 1997 request for temporary disability compensation submitted by the insurer, becomes moot.[6] When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

[6] On this date, we have issued our Own Motion Order of Dismissal in Own Motion No. 97-0200M. Our dismissal order is issued in response to the insurer's April 21, 1997 submission of its recommendation to deny claim reopening for claimant's proposed right shoulder surgery on the ground that claimant was not in the work force at the time of current disability. Given our decision that claimant's compensable right shoulder condition was not medically stationary at the time his claim was closed, the parties' arguments regarding a subsequent request to reopen claimant's claim are rendered moot. See Esther M. Anderson, 47 Van Natta 16 (1995).

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June 4, 1997 Cite as 49 Van Natta 724 (1997)

In the Matter of the Compensation of
**ALBERT NACOSTE, JR., Claimant**
Own Motion No. 97-0211M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant, pro se, requests reconsideration of our May 5, 1997 Own Motion Order, in which we declined to reopen his 1974 industrial injury claim for the payment of temporary disability compensation because he failed to establish that his compensable condition required surgery or hospitalization now or in the near future.[1]

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

Here, claimant submits no evidence that surgery or hospitalization has been recommended. Therefore, the record continues to fail to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we continue to find that claimant's compensable condition has not worsened requiring surgery or hospitalization, and therefore, we are without authority to award temporary disability compensation as claimant requests.[2]

[1] Claimant has petitioned the Board for Own Motion relief in this matter. Claimant also requested a hearing relative to this same matter. On May 21, 1997, the SAIF Corporation requested that the hearing be dismissed, contending that the Hearings Division does not have jurisdiction to grant claimant's request for temporary disability compensation. That motion is pending before ALJ Hoguet at the Hearings Division. WCB Case No. 97-00935. Thus, we limit our consideration to claimant's request for Own Motion relief under ORS 656.278(1).

[2] In his May 9, 1997 letter, claimant contended that SAIF issued a "denial" dated April 29, 1997. In our May 21, 1997 Own Motion Order of Abatement, we noted claimant's contention, as well as our understanding that SAIF opposed reopening on the grounds that no surgery was recommended and claimant was not in the work force at the time of disability. We requested that the parties submit any further information regarding denials issued or pending litigation in this claim.

In a May 22, 1997 letter, SAIF responded that it had issued no denials in this claim, but noted that its Own Motion recommendation (which requested that claimant's request for Own Motion relief be denied) was dated April 29, 1997. Under such circumstances, we conclude that SAIF has not issued a denial, but, rather, has opposed claimant's request to reopen his claim based on the lack of hospitalization or surgery.

Accordingly, our May 5, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 5, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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June 9, 1997 Cite as 49 Van Natta 725 (1997)

In the Matter of the Compensation of
**JENIFER F. BECKETT, Claimant**
WCB Case No. 96-07067
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for a bilateral tendinitis condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant worked for SAIF's insured as a picture framer from November 1994 until June 1996. Her work involved hand and wrist intensive activities.

Claimant is also an artist, who spends considerable time on her own artwork. In addition, she is a pianist and a bicycle rider.

Claimant had no wrist, arm, or hand problems before this employment. Her left arm symptoms began in May 1995. Her right arm symptoms began a few months later. She noticed these symptoms most often when using vice clamps to frame pictures at work.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's claim for bilateral tendinitis compensable; based primarily on claimant's reporting that her work activities caused stress to her upper extremities (whereas other activities did not cause such stress) and a finding that the causation issue in this case is medically uncomplicated. We disagree.

Medical evidence is not always required to establish causation. The relevant factors for determining whether expert evidence concerning causation is required are: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly consults with a physician; (4) whether the worker promptly reports the occurrence to a superior; (5) whether the worker was previously free from disability of the kind involved; and (6) whether there was expert evidence that the alleged precipitating cause could not have caused the injury. Barnett v. SAIF, 122 Or App 279 (1993) (citing Uris v. Compensation Dept., 247 Or 420 (1967)).

In this case, claimant reported that she first noticed arm symptoms in May 1995, while she was exhibiting art at a gallery. (See Exs. 4, 13-3; Tr. 14). She first sought medical treatment a year later, in May 1996. (See Ex. 4). Thus, because claimant's symptoms did not occur "immediately" after the alleged precipitating work activities and she did not "promptly" seek medical treatment, we cannot say that this is an uncomplicated case under the "Barnett/Uris" standard. Moreover, further considering the number of potential noncompensable contributing causes, we conclude that the causation issue requires expert evidence for its resolution. (See Exs. 13-7, 18-2). See Neal S. Anderson, 49 Van Natta 1 (1997); Jose A. Pastor, 48 Van Natta 1173 (1996) (Where a thoracic and vascular surgeon considered his expertise inadequate to determine whether the injury occurred as claimed, the Board found the situation sufficiently complicated to require expert evidence of causation.); see also Kevin R. Ritchey, 48 Van Natta 1847 (1996) ("Where a treating physician finds the situation 'very unclear,' we are without the expertise to supplant her medical judgment and declare the situation uncomplicated.").

The only medical evidence arguably supporting the claim is provided by Dr. Takacs, who first saw claimant on October 11, 1996, after claimant's tendinitis had resolved with acupuncture. (Ex. 19; see also Exs. 13, 18). We do not find Dr. Takacs' opinion that "[t]he tendinitis is work related by history" persuasive, for the following reasons. (Ex. 19).

First, Dr. Takacs was not in a particularly good position to evaluate the condition because it had resolved. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298, 302 (1995) ("A treating physician's opinion, however, is less persuasive when the physician did not examine the claimant immediately following the injury.") Second, there is no indication that Dr. Takacs was aware of claimant's potentially contributory off-work activities, including art work and bicycle riding. Third, the doctor was apparently under the mistaken impression that claimant had not played piano in five years. (See Ex. 19-1; Tr. 25-26, 33-34).

Under these circumstances, we cannot say that Dr. Takacs' conclusion was based on a complete and accurate history. See Somers v. SAIF, 77 Or App 259 (1986). Consequently, we find the medical evidence insufficient in this case for claimant to establish that her work activities were the major contributing cause of her bilateral upper extremity tendinitis condition. Accordingly, the claim must fail. See ORS 656.802.

ORDER

The ALJ's order dated December 31, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee is reversed.

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In the Matter of the Compensation of
**DAVID D. INFAUSTO, Claimant**
WCB Case No. 96-00293
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our May 12, 1997 Order on Review that increased claimant's temporary disability award as granted by an Administrative Law Judge's (ALJ) order. Specifically, the insurer has brought to our attention a discrepancy between our Conclusions of Law and Opinion, concluding that claimant was entitled to temporary disability benefits from August 20, 1993 through July 21, 1995; and our Order portion, in which we awarded temporary disability from August 30, 1993 to December 31, 1995.

After reviewing the insurer's motion, our prior order, and the record, we conclude that the third sentence of the order portion should read as follows: "In our addition to the ALJ's award of temporary partial disability from January 1, 1994 to July 21, 1995, claimant is awarded temporary disability benefits from August 20, 1993 [rather than August 30, 1993] to December 31, 1993 [rather than December 31, 1995]."

Accordingly, we withdraw our prior order. On reconsideration, as corrected herein, we republish our prior 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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In the Matter of the Compensation of
**ORVEL L. CHANEY, Claimant**
Own Motion No. 95-0572M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's February 5, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from October 7, 1995 through September 22, 1996. SAIF declared claimant medically stationary as of September 23, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.[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 February 5, 1997 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). We may consider post-closure medical evidence regarding the question of whether a claimant was medically stationary at the time of closure, as long as that evidence relates to the 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).

Dr. Schwartz, claimant's treating orthopedic surgeon, recommended that claimant undergo left total knee surgery. That surgery, although approved by SAIF, was postponed several times while claimant's claim was reopened. SAIF contends that, although surgery was pending for claimant's compensable left knee injury at claim closure, claimant could have proceeded with surgery on January 20, 1997, but did not do so. Rather, SAIF contends that claimant provided "false information" regarding his health, and that the reasons he postponed surgery on several occasions were unrelated to his health and the proposed surgical procedure. SAIF further contends that claimant's physician declared him medically stationary as of September 23, 1996 and, finally, that claimant was medically stationary when his claim was closed.

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[1] On February 5, 1997, SAIF closed claimant's claim. On March 13, 1997, SAIF forwarded to the Board a recommendation to reopen claimant's 1987 claim for the payment of temporary disability compensation for his left total knee replacement. On March 17, 1997, we issued an Own Motion Order, which authorized the reopening of claimant's claim for the payment of temporary disability compensation beginning the date claimant underwent knee surgery. On April 28, 1997, SAIF forwarded a March 13, 1997 letter from claimant's treating physician, Dr. Schwartz. In its April 24, 1997 letter, SAIF indicated that "[i]t appears as though Dr. Schwartz is appealing the notice of closure on behalf of [claimant]." The Board acknowledged the request for review on April 30, 1997.

Although the request for review of SAIF's closure was received by the Board more than 60 days after SAIF's February 5, 1997 closure of the claim, we conclude that "extraordinary" circumstances exist which constitute "good cause" for claimant's failure to request review within 60 days. See OAR 438-012-0060. In reaching this conclusion, we note that Dr. Schwartz' letter was submitted to SAIF within 60 days of its Notice of Closure. Moreover, based on SAIF's April 24, 1997 letter, it is apparent that it interpreted Dr. Schwartz' letter as a request for review of the closure. Notwithstanding that interpretation, SAIF did not forward this appeal on claimant's behalf to the Board timely.

As previously noted, based on SAIF's recommendation, we issued our Own Motion Order on March 17, 1997. In light of our decision concerning claimant's request for review of SAIF's closure, it is appropriate to reconsider our March 17, 1997 order. See OAR 438-012-0065. Therefore, in an order issued on today's date, we have reconsidered our March 17, 1997 order, and addressed claimant's request to reopen his claim for the payment of temporary disability compensation for his left knee total replacement surgery.

In a February 3, 1997 "check-the-box" response to SAIF's inquiry, Dr. Schwartz agreed that claimant was medically stationary on September 23, 1996 "until he proceeds with surgery."

However, in a March 13, 1997 letter, Dr. Schwartz opined that:

> "Upon review of [claimant's] record and discussion with [claimant], it turns out that [claimant] canceled his surgery one time because of family problems. The remaining times that it was delayed were due to various medical problems which prevented him from donating blood. It is important that a person be in good health with no recent colds, flu or other illnesses when proceeding with a knee replacement, and [claimant] apparently had viral infection and also an injury to his foot causing an infection needing treatment with antibiotics. These medical conditions were the main reason for his delays in obtaining surgery. The delays were medically appropriate. [Claimant] should probably be considered to be on temporary total disability throughout that time."

Here, Dr. Schwartz has evidently withdrawn his February 3, 1997 opinion that claimant was medically stationary on September 23, 1996, and opined that claimant was temporarily and totally disabled pending his surgery.

Furthermore, claimant's surgery was still pending when SAIF closed the claim (claimant underwent left total knee surgery on March 3, 1997). We have previously held that, in those cases where a claimant's medically stationary status is contingent upon undergoing recommended surgery, the claim is not prematurely closed if the claimant refuses the surgery. See Stephen L. Gilcher, 43 Van Natta 319, 320 (1991); Karen T. Mariels, 44 Van Natta 2452, 2453 (1992). According to Dr. Schwartz, the delays in providing claimant's surgery were "medically appropriate." Therefore, we are not persuaded that claimant refused surgery. Rather, claimant's surgery was postponed for "medical problems which prevented him from donating blood." See Bill H. Davis, 47 Van Natta 219 (1995); Jerry Simmons, 47 Van Natta 2423 (1995); Richard Uhing, 48 Van Natta 465 (1996).

Finally, although Dr. Schwartz' opinion was rendered after claim closure, he is claimant's treating physician, and his opinion relates to claimant's condition at the time of claim closure. Weiland v. SAIF, 64 Or App at 810; Scheuning v. J.R. Simplot & Co., 84 Or App at 622. Furthermore, Dr. Schwartz' final opinion is unrebutted, and, therefore, persuasive.

On this record, we find that claimant's compensable left knee condition was not medically stationary on February 5, 1997, the date of claim closure.

Accordingly, we set aside SAIF's February 5, 1997 Notice of Closure as premature. SAIF is directed to recompense claimant's temporary disability beginning the date after it previously terminated such benefits. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
**MARY P. MEEKINS, Claimant**
Own Motion No. 97-0022M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On January 15, 1997, we issued our Own Motion Order which authorized the reopening of claimant's 1986 claim for the payment of temporary disability compensation. On April 17, 1997, the SAIF Corporation advised that claimant's physician had cancelled her surgery, and requested that our order "be withdrawn and/or voided until such a time in the future that [claimant's] condition requires surgery and/or hospitalization." We treated SAIF's submission as its request for reconsideration of our January 15, 1997 order.

On April 22, 1997, we issued an Own Motion Order of Abatement, in which we requested the parties' positions regarding whether claimant's compensable condition had worsened requiring surgery, and whether claimant's surgery was still recommended. We have received the parties' responses, and proceed with our review of the record.

Pursuant to OAR 438-012-0065(2), SAIF had 30 days from the mailing date of our final order in which to file a request for reconsideration, or 60 days from that mailing date if it could establish good cause for failure to file the request within 30 days. However, in extraordinary circumstances, we may, on our Own Motion, reconsider a prior order notwithstanding these filing deadlines. Id. Under the particular circumstances of this case, we conclude that an exception to the deadline is appropriate.

On December 3, 1996, Dr. Newby, claimant's treating physician, opined that claimant's current condition and need for surgery were related to her prior lumbar discectomy at L4-5 and recommended that "a repeat discectomy is warranted at this time." On January 13, 1997, SAIF recommended that the Board authorize the reopening of claimant's 1986 injury claim for the payment of temporary disability compensation. On January 15, 1997, we issued our order authorizing Own Motion relief, beginning the date of the proposed surgery.

In a January 27, 1997 chart note, Dr. Newby opined that:

> "Since [claimant] has improved, I think it would be wise at this point to cancel her surgery. She will see me in six weeks for follow-up. Certainly if her improvement is not longstanding we should consider re-exploration at her next visit."

In a May 1, 1997 letter, claimant advised that she was "in agreement with Dr. Newby's cancellation of my proposed back surgery." Claimant further noted that she was continuing palliative measures, and had "not had to miss any work at either of my jobs."

On this record, we conclude that claimant's treating physician has withdrawn his recommendation for surgery, and that claimant agrees with his decision. Therefore, claimant's current compensable condition no longer meets the criteria for reopening of her claim under ORS 656.278(1), in that her compensable condition no longer requires surgery or hospitalization, nor has any physician recommended surgery at this time. Consequently, based on the uncontroverted representations in the record, we cannot authorize the payment of temporary disability benefits at this time. See ORS 656.278(1)(a); Eldon A. Hawley, 46 Van Natta 536 (1994).

Accordingly, on reconsideration, we deny the current request for own motion relief. Should claimant's physician again recommend surgery for her compensable back injury, claimant may again request Own Motion relief. 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
**LEONA M. PRICE, Claimant**
WCB Case Nos. 96-09629 & 95-10229
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant AttorneyS
Hoffman, Hart & Wagner, Defense Attorneys

On May 9, 1997, we withdrew April 11, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which had set aside the self-insured employer's denial of claimant's claim for a consequential upper extremity fibromyalgia condition. We took this action to consider claimant's contention that we erred in evaluating the opinion of Dr. Keller, claimant's treating physician. Having received the employer's response and claimant's reply, we proceed with our reconsideration.

Claimant contends that Dr. Keller did not change her opinion, but merely refined her diagnosis over time. Claimant also argues that we illogically rejected Dr. Keller's opinion concerning the etiology of claimant's condition, even though we had accepted her fibromyalgia diagnosis. We disagree.

First, we continue to find Dr. Keller's ultimate conclusion regarding causation unpersuasive. Although Dr. Keller acknowledged numerous potential causes for claimant's problems, she offered no explanation for discounting or ruling out nonwork related causes. Under such circumstances, Dr. Keller's eventual conclusion that claimant's problems are work-related is insufficiently explained. Second, assuming that Dr. Keller did not rule out nonwork-related causes, we find no indication that Dr. Keller weighed their relative contributions in formulating her ultimate opinion. Finally, we are aware of no rule of logic or legal precedent[1] requiring us to accept a medical opinion completely or not at all.

Under these circumstances, after reviewing the record, our prior order, claimant's motion, the employer's response and claimant's reply, we continue to find Dr. Keller's opinion concerning causation unpersuasive. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 11, 1997 order in its entirety, 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] In Castle & Cook, Inc. v. Porras, 103 Or App 65, 68 n. 3 (1990), the employer argued that the Board erred in accepting a medical opinion on one aspect of a case but in rejecting it on another aspect. The court disagreed, stating:

> "Claimant correctly points out that the Board 'is free to analyze each question and medical issue separately and to fully consider all rationales, arguments, and proof on each issue before reaching a decision. The fact that the [B]oard found [a doctor's] opinions * * * persuasive on some issues does not bind the referee from considering all the evidence on [the] remaining issues.'
>
> "That would not be so if a subsequent finding could only flow from factors necessarily rejected by the initial finding, which is not the case here." (Emphasis deleted.)

In the Matter of the Compensation of
**VIRGIE WEBB, Claimant**
Own Motion No. 97-0204M
OWN MOTION ORDER
Scott McNutt, Sr., Claimant Attorney

The employer has submitted claimant's request for temporary disability compensation for her compensable L4-5 and L5-S1 disc herniations injury. The employer opposed reopening the claim on the grounds that: (1) claimant's current low back condition at L4 through S1 is not causally related to the accepted injury; and (2) it is not responsible for claimant's current condition. Claimant's aggravation rights on that claim expired on May 3, 1993. Claimant requested a hearing. (WCB Case Nos. 96-03688 and 95-09567).

By Opinion and Order dated September 6, 1996, Administrative Law Judge (ALJ) Crumme' set aside the employer's April 10, 1996 denial of compensability, assessed a penalty and an attorney fee, and set aside the employer's "aggravation" denial. The employer requested Board review of the ALJ's order.

In April 11, 1997 Order on Review, the Board: (1) found that claimant's aggravation rights had expired, and vacated that portion of the ALJ's order which set aside the employer's aggravation denial and awarded an assessed attorney fee on that issue; (2) affirmed the ALJ's findings that claimant's degenerative disc disease at L4-5 and L5-S1 was a compensable portion of her 1988 injury claim; (3) affirmed the penalty assessed by the ALJ; and (4) assessed an attorney fee for claimant's attorney's services on review. The employer has appealed the Board's decision to the Court of Appeals.

Because claimant has exhausted her "administrative remedies" pursuant to OAR 438-012-0050, we need not hold this claim in abeyance pending judicial review. See Patrick G. Mahlberg, 48 Van Natta 2405 (1996), on recon 49 Van Natta 89 (1997). Therefore, because the employer has been determined responsible for claimant's compensable condition pursuant to our prior Order on Review, and because we have jurisdiction with respect to claimant's request for temporary disability compensation, we 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 January 3, 1996, Dr. Kitchel, claimant's treating physician, performed surgery at L4-5 and L5-S1, which included excision of the remaining disc material and an anterior fusion. As previously noted, we have found the employer responsible for this claim by virtue of our prior Order on Review. Thus, we are persuaded that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1988 injury claim to provide temporary disability compensation beginning January 3, 1996, the date claimant was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the 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
**DEBORAH S. DeBILT, Claimant**
WCB Case No. 96-02148
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that declined to award claimant an insurer-paid attorney fee under ORS 656.386(1) when the SAIF Corporation's denial of a psychological condition was set aside as premature. In its respondent's brief, SAIF contests that portion of the ALJ's order that assessed an attorney fee under ORS 656.382(1) for an allegedly unreasonable denial. On review, the issue is attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, except the finding that SAIF's denial constituted an unreasonable resistance to the payment of compensation.

## CONCLUSIONS OF LAW AND OPINION

### "386(1)" Attorney Fee

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

The ALJ concluded that our decision in Robert W. Stephenson, 48 Van Natta 2287, recon 48 Van Natta 2442 (1996) (Board Chair Hall specially concurring), is controlling on this issue. In Stephenson, the carrier issued a denial of a condition for which a claim had not been filed. Because the denial was premature, we concluded that it was null and void and that claimant would receive no benefits as a result of the holding that the denial was premature and a nullity. See id. Accordingly, we found there was no authority to award an attorney fee under ORS 656.386(1).

On review, claimant attempts to distinguish Stephenson, asserting that the denial in this case was a denial of disability as well as treatment. She also asserts that an attorney fee is appropriate because SAIF denied that her current condition is related to the accepted injury claim for thoracic and lumbar strains. We disagree.

In its February 23, 1996 denial letter, SAIF asserted that claimant's current treatment and disability is due to a psychological condition that is unrelated to either the accepted injury or work exposure. (Ex. 9). The denial was not subsequently amended. Based on our review of the denial letter, we find that SAIF's denial is best interpreted as a denial of a psychological condition, not a denial of continuing responsibility for treatment and disability relating to the accepted claim. The denial was issued based on SAIF's erroneous belief that claimant had filed a claim for a psychological condition. Because no such claim had been filed, SAIF's denial was premature and a nullity, just like the carrier's denial in Stephenson. Having found no persuasive basis for distinguishing Stephenson from this case, we affirm the ALJ's order on this issue.

### "382(1)" Attorney Fee

The ALJ assessed an attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation. In particular, the ALJ found that SAIF's issuance of a premature denial was unreasonable because there was no basis for assuming that a psychological condition was encompassed in the claim. We reverse.

Notwithstanding the reasonableness of SAIF's actions in issuing a premature denial, in order to qualify for an attorney fee under ORS 656.382(1), there must be a showing that SAIF "resist[ed] the

payment of compensation." That is, there must be evidence that compensation was unpaid as a result of SAIF's premature denial. Because a premature denial is null and void upon its issuance, SAIF's denial was ineffective in denying claimant's entitlement to any compensation. In addition, there is no evidence of unpaid compensation as a result of the holding that SAIF's denial was premature. Therefore, we find no resistance to payment of compensation that would authorize 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); Patrick Richards, 49 Van Natta 218, 219 (1997).

ORDER

The ALJ's order dated December 9, 1996, as reconsidered on February 3, 1997, is reversed in part and affirmed in part. That portion of the order that assessed a $500 attorney fee under ORS 656.382(1) is reversed. The remainder of the order is affirmed.

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June 10, 1997 Cite as 49 Van Natta 733 (1997)

In the Matter of the Compensation of
**DEBORAH S. DeBILT, Claimant**
WCB Case No. 96-07984
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Claimant requests reconsideration of our May 19, 1997 order that affirmed the Administrative Law Judge's (ALJ's) order that: (1) reduced her unscheduled permanent disability for a low back condition from 7 percent (22.4 degrees), as awarded by an Order on Reconsideration, to zero; and (2) reduced her scheduled permanent disability for loss of use or function of her left foot from 5 percent (6.75 degrees), as awarded by an Order on Reconsideration, to zero. Claimant contends that Snyder v. Barrett Business Services, Inc., 147 Or App 619 (1997), compels us to reconsider our decision.

In Snyder, the claimant contended that the Board was required by former OAR 436-35-007(9)[1] to rely on the arbiters' opinion in determining permanent impairment. The court found no evaluation of impairment by the attending physician that was "different" from and could be weighed against the arbiters' evaluation. Reasoning that the only medical report that addressed the issue of the claimant's low back impairment was the medical arbiters' report, the court concluded that the Board's reliance on the rule and the attending physician's evaluation as a basis to reject the claimant's request for permanent disability was misplaced.

Here, unlike Snyder, the evaluation of claimant's impairment by claimant's treating physician was quite different from the evaluation of Dr. Hill, the medical arbiter. Claimant argues that Dr. Hill, claimant's treating physician, never addressed or evaluated the impairment issue. We disagree.

For the reasons expressed previously by the ALJ, we conclude that the preponderance of the medical evidence does not substantiate that claimant is entitled to either scheduled or unscheduled permanent disability. We rely in particular on the following report.

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[1] In Snyder, the court referred to former OAR 436-35-007(9). That rule has since been amended and renumbered to OAR 436-035-0007(13) (WCD Admin. Orders No. 96-051), which is at issue in this case. OAR 437-035-0007(13) provides:

> "Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0080 except where a preponderance of medical opinion establishes a different level of impairment pursuant to ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence."

On January 24, 1996, a Physical Capacities Evaluation (PCE) was performed by the Injured Workers Program. (Ex. 37)[2]. Claimant's somatic focus was high during the testing and she demonstrated inconsistencies in her hip range of motion and straight leg raising and she self-limited static lift strength. (Ex. 37-2). The evaluator noted that claimant's self-ratings of pain, symptoms and disability were very high and were higher than would be expected, given her ability to complete the three-hour evaluation as well as her modified work. The validity of testing was further brought into question by abnormal perceived exertion, abnormal pain diagram, abnormal pain rating scale and abnormal Waddell's signs, as well as an abnormal pain disability questionnaire. (Id.)

On January 26, 1996, Dr. Hill reviewed the January 24, 1996 Physical Capacities Evaluation and noted that there were several findings on the assessment which questioned the validity of the testing. (Ex. 38-1). Dr. Hill examined claimant, reporting that she had continued subjective complaints of pain, although all objective findings were negative, including the MRI scan, pelvic alignment and objective physical test. He found several non-anatomic findings, including pain on light skin pinch, pain on simulated tests, including light cervical axial compression and simulated rotation, non-anatomic sensory loss throughout the whole left lower extremity, significant give-away weakness with resisted ankle dorsiflexion and EHL testing. (Id.) Dr. Hill also noted significant facial grimacing during the examination. He concluded that claimant's non-anatomic findings suggested at least a partial functional component. Dr. Hill reported that, although claimant had ongoing pain, he did not feel she had any permanent disability related to the lumbar strain injury. (Id.) He concluded:

> "Closing examination is as per the assessment performed on 01/24/96 at the Injured Worker's Program. I feel the range of motion assessments are likely invalid, given the non-anatomic findings on examination. I feel the PCE is also invalid. While I feel the patient is capable of unrestricted work, I am continuing her present work restrictions, which includes no pushing, pulling, or lifting in excess of 20 pounds. For psychological reasons, I do not feel she is capable of exceeding these restrictions at this time. Psychological counseling may help her come to grips with her chronic pain situation. An independent medical evaluation (IME) could also be considered. No formal followup was arranged." (Ex. 38-2).

Dr. Wilson conducted an arbiter's examination on April 15, 1996. (Ex. 42). He reported reduced lumbar and thoracic range of motion and concluded that claimant had a limited or partial loss of ability to repetitively use the lumbar spinal area. He also found that claimant had sustained a partial loss of sensation on the sole of her left foot. (Ex. 42-2). Dr. Wilson noted that the findings "appear to be valid." (Ex. 42-4).

Where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 437-035-0007(13). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). We 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).

After reviewing the medical evidence, we agree with the ALJ that Dr. Hill provided the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. Dr. Hill adopted the January 24, 1996 evaluation performed by the Injured Workers Program as the closing examination. (Ex. 38). He concluded that claimant's range of motion assessments were invalid and the Physical Capacities Evaluation was invalid. Dr. Hill determined that claimant had no permanent disability related to the lumbar strain injury. (Id.) We agree with the ALJ that Dr. Hill had the benefit of comparing his past examinations of claimant and his findings are more persuasive than that of Dr. Wilson, who examined claimant only once. We conclude that the preponderance of medical evidence establishes a level of impairment different from that of the medical arbiter. See OAR 437-035-0007(13). Based on Dr. Hill's findings, as corroborated by those of other medical providers, claimant is not entitled to an award for either scheduled or unscheduled permanent disability.

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[2] We consider the PCE report as we find that claimant's treating doctor, Dr. Hill, adopted the report. (Ex. 38).

Accordingly, we withdraw our May 19, 1997 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our May 19, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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June 10, 1997 Cite as 49 Van Natta 735 (1997)

In the Matter of the Compensation of
**LARRY D. JOHNSON, Claimant**
WCB Case No. 93-08160
ORDER ON REVIEW
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's partial denials of his current psychological condition. On review, the issue is compensability.

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

On review[1], claimant argues that the evidence he has submitted has not been given a numerical designation, but rather has been "delegated to unidentified packets..". (Appellant's brief at pg. 5). We are unaware of any particular exhibits which claimant apparently contends have not been included in the exhibit list compiled by SAIF. Furthermore, on review, we have considered all documents admitted at hearing, which includes materials referenced and submitted by both parties, whether or not a document was included in the exhibit list and assigned a numerical designation.

Claimant next objects to the role of the Board's administrator in these proceedings. Claimant argues that the Board's current administrator was involved in prior proceedings pertaining to his case. In his affidavit, claimant essentially contends that the Board's administrator has a role in this review and that the Board will be influenced by her actions.

Contrary to claimant's belief, the administrator has no role in the Board's review of a case or the decision on the merits of any case. See ORS 656.718(3) (Board members exercise review authority over cases and sit in panels. A decision of a panel shall be by a majority of the panel). Furthermore, claimant has not pointed to any specific facts which support his contention that there has been any involvement by the administrator at any point in these proceedings.

Finally, we agree with the ALJ that the dispositive issue in this case is the scope of SAIF's original acceptance of claimant's claim in 1982. The stipulation entered into between the parties provides only that SAIF accepted claimant's "psychological occupational disease." (Ex. 18). At the time of the acceptance, claimant's treating doctor had described claimant's condition as "major depression, single episode." (Ex. 7-1). Claimant's current condition, however, has been diagnosed as bipolar disorder. Furthermore, the expert medical opinion establishes that the current bipolar condition is a different and separate diagnosis from the major depression experienced by claimant in 1981. (Ex. 51).

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[1] In his respondent's brief, claimant contends that he timely requested reconsideration of the ALJ's order and, therefore, the matter is properly before the ALJ, rather than the Board. We disagree. The ALJ's order issued December 19, 1996. Claimant's "request for reconsideration by referee or review" was signed and dated by claimant on January 17, 1997, which was within 30 days of the ALJ's order. Nevertheless, the ALJ's authority to reconsider his decision is not dependent on whether a party's motion has been mailed to the ALJ within 30 days of the order. Rather, the ALJ must abate, withdraw, or otherwise modify his order within the 30-day period. Because the request did not reach the Board until January 21, 1997, the ALJ lost jurisdiction to address claimant's request for reconsideration. In light of such circumstances, claimant's alternative request for Board review was triggered. Because that request was mailed to the Board within 30 days of the ALJ's order, we have jurisdiction to review the ALJ's decision and to consider claimant's contentions. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

Under the circumstances, we agree with the ALJ that SAIF did not accept claimant's bipolar or personality disorder in its prior stipulation. Furthermore, we conclude that, under either a material or the major contributing cause standard, the record does not establish compensability of claimant's current psychological condition. Based on this conclusion, we therefore modify that portion of the ALJ's order which found that there was no "combined condition," and set aside SAIF's denial which was premised on a combined condition. See ORS 656.262(6)(c). As with the remainder of SAIF's denials, that denial shall be upheld.

ORDER

The ALJ's order dated December 19, 1996 is affirmed in part and modified in part. That portion of the ALJ's order which "disapproved" the SAIF Corporation's denial of July 22, 1994 is modified. SAIF's July 22, 1994 denial is reinstated and upheld. The remainder of the ALJ's order is affirmed.

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June 10, 1997 Cite as 49 Van Natta 736 (1997)

In the Matter of the Compensation of
**KENNETH D. LEGORE, Claimant**
WCB Case No. TP-97001
THIRD PARTY DISTRIBUTION ORDER
Nancy F.A. Chapman, Claimant Attorney
Scheminske, Lyons & Bussman, Defense Attorneys

Claimant and the paying agency, Self-Insured Management Services (SIMS), have petitioned the Board for resolution of a third-party dispute which raises the following issues: (1) whether claimant assigned his third party cause of action to SIMS pursuant to ORS 656.591; (2) if so, whether the assignment was revoked or the cause of action "reassigned" to claimant by SIMS; and (3) whether the proceeds of the third party settlement should be distributed pursuant to the provisions of ORS 656.591(2) or the formula set forth in ORS 656.593. Claimant also requests that this matter be set for hearing to allow him to present evidence regarding the assignment and/or reassignment of the third party cause of action.

For the following reasons, we reject claimant's request for an evidentiary hearing. We further find that claimant assigned his third party cause of action to SIMS, and that the proceeds of the settlement shall be distributed pursuant to ORS 656.591(2).

FINDINGS OF FACT

Claimant, a truck driver, was compensably injured on November 27, 1993 when his truck was struck by another vehicle driven by Evelyn Martins. The paying agency (SIMS) accepted claimant's accident-related injuries and, as of November 26, 1996, has paid compensation of $27,505 as follows: $12,551.33 in medical benefits, $9,478.54 in temporary disability and $5,475.52 in permanent disability benefits.[1]

At some point in the fall of 1995, claimant, through his attorney, initiated a civil action against Ms. Martins in the Wasco County Circuit Court, seeking $100,000 in non-economic damages and $24,658 in economic damages. (Ex. 3). On February 5, 1996, claimant's counsel advised SIMS that claimant was "not interested in expending any of [his] own money to protect SIMS' interest in the lawsuit" and asked that SIMS advance certain trial costs or agree to waive its right to recovery under ORS 656.593.

One month later, on March 6, 1996, claimant's counsel advised SIMS' counsel that claimant intended to "tender the [third party] claim back to SIMS to proceed to trial." (Ex. 6). In response, SIMS' counsel stated that SIMS interpreted claimant's action (the tendering of the claim back to SIMS) as an assignment of claimant's cause of action against the third party pursuant to ORS 656.591. (Exs. 7, 8). Claimant then notified the Wasco County Circuit Court that "the handling of the claim" had been "tendered" to SIMS. (Ex. 9). On May 9, 1996, claimant's counsel moved to withdraw as attorney of record on in the third party action, on the grounds that claimant had directed her to "tender the file back to SIMS" for it to "proceed to trial on behalf of [claimant] and his personal injury claim." (Exs. 10, 11).

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[1] Claimant does not contest the current amount of SIMS' lien.

SIMS retained a new attorney to represent its interests with respect to the third party action. On June 13, 1996, SIMS' new counsel wrote to claimant's counsel asking for immediate confirmation that claimant had indeed assigned his third party cause of action to SIMS. SIMS' new counsel also explained that, pursuant to ORS 656.591, claimant's assignment of the third party claim transferred ownership of the cause of action to SIMS and vested SIMS with sole discretion concerning the further prosecution of the third party action. (Ex. 13). The next day, claimant's counsel responded by providing SIMS' new counsel with copies of her correspondence with SIMS' former counsel "wherein [the] assignment to SIMS was made." Claimant's counsel also enclosed a copy of her motion and affidavit to withdraw as counsel in the third party action. (Ex. 14).

In response to claimant's counsel's June 14, 1996 correspondence, SIMS' new counsel wrote to claimant's attorney requesting clarification that claimant and his attorney understood that if the third party case was assigned to SIMS, claimant's rights with respect to the third party claim would be terminated and that SIMS had no obligation to proceed "on behalf of" claimant in the third party action. This letter further advised that if claimant's counsel did not respond within seven days, her silence would be interpreted "as an admission that the third party claim has been assigned to SIMS without qualification." (Ex. 15-2). Four days later, on June 18, 1996, claimant's counsel questioned SIMS' counsel's interpretation of the law on assignment of third party claims under ORS 656.591 and 656.593, but acknowledged that "[t]he claim was assigned to SIMS sometime ago."[2] (Ex. 16).

SIMS' counsel proceeded to pursue the third party action against Ms. Martins. On October 7, 1996, SIMS' counsel wrote to claimant's counsel advising that he had received a settlement offer from Ms. Martins' insurer that could be accepted if claimant would sign a release.[3] SIMS' counsel also noted that the settlement proceeds would be distributed pursuant to ORS 656.591. (Ex. 17). Claimant's counsel did not respond to this letter, prompting SIMS' counsel to send another letter on October 25, 1996.

In his October 25, 1996 letter to claimant's counsel, SIMS' counsel stated that although claimant had assigned the third party claim, his efforts to settle the third party action "necessitated the request" that claimant's counsel and claimant sign a formal assignment document. SIMS' counsel further indicated that "[s]ince you have not responded to that request * * * I can only assume that your intent is to revoke your earlier assignment of the [third party] cause of action." SIMS' counsel continued: "That being the case, this letter will place you on notice, on behalf of my clients, that my clients [SIMS] will not pursue the case and my clients expect you to protect the lien accordingly." (Ex. 18). In addition, SIMS' counsel expressed his "suspicion" that claimant's attorney and claimant would be willing to allow settlement of the third party action, provided the parties petition the Board to resolve the dispute concerning distribution of the settlement proceeds. SIMS' counsel further stated that "if that is the case," such arrangements could be made. Id.

SIMS' counsel continued his efforts to secure a settlement of the third party action through negotiations with counsel for the third party defendant. On November 25, 1996, SIMS' counsel wrote to claimant's attorney confirming an oral agreement the parties had reached a few days prior. This letter indicated, among other things, that the third party action would be settled upon payment by Ms. Martins' insurer of $10,000, that the check would be issued to claimant, his counsel and SIMS jointly, that claimant, his counsel and SIMS would sign a release and that the proceeds of the settlement would be distributed in conformance with a final third party distribution order. (Ex. 19).

On December 9, 1996, Ms. Martins' counsel requested that claimant's counsel sign a "Stipulated Judgment of Dismissal With Prejudice" in the third party action. (Ex. 21). Claimant's counsel advised Ms. Martin's attorney that SIMS' counsel was "the attorney of record in the civil case" and forwarded

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[2] In July 1996, claimant petitioned the Board for intervention into any proposed compromise of the third party action. We dismissed the petition without prejudice because no settlement had been reached at the time.

[3] On October 17, 1996, claimant again petitioned the Board "for intervention" into the third party action because he disagreed with the Assignment of Cause of Action form provided to him by the paying agency. We dismissed the petition as premature, concluding that we were without authority to address the assignment issue in the absence of any proposed third party settlement or a final judgment in the third party action. See Kenneth D. Legore, 48 Van Natta 2432 (1996).

the Stipulated Judgment to SIMS' counsel for signature. (Ex. 22). By letter dated January 22, 1997, SIMS' counsel advised claimant's counsel that he had signed the Stipulated Judgment and returned it to Ms. Martin's attorney for presentation to the Circuit Court. SIMS' counsel further stated that claimant had assigned his third party cause of action to SIMS and, although the action had proceeded in claimant's name, SIMS' counsel was not representing claimant in the action. (Ex. 23). The record does not include any response to this letter by claimant's counsel. On January 31, 1997, the Wasco County Circuit Court entered the Stipulated Judgment of Dismissal in the third party action.

## CONCLUSIONS OF LAW AND OPINION

### Motion To Strike Reply Brief

As a preliminary matter, SIMS has moved to strike claimant's reply on the grounds it was not timely filed. Pursuant to the briefing schedule set forth in the Board's March 18, 1997 letter, claimant's reply was to be filed within 14 days from the mailing date of SIMS' cross-petition. SIMS' cross-petition was mailed on April 14, 1997, making claimant's reply due on April 28, 1997.

Claimant did not request an extension and did not mail his reply until May 5, 1997, 21 days after the mailing date of SIMS' cross-petition. Because claimant's reply was untimely, we grant SIMS' motion. See Tammy Locke, 48 Van Natta 250 (1996) (rejecting untimely reply brief).

### Request for Hearing

Claimant requests that this matter be set for hearing so that testimony may be presented regarding the terms and circumstances of claimant's assignment of the cause of action to SIMS. We reject claimant's request.

Board decisions under the third party law must be made on a record sufficient to sustain judicial review. Blackman v. SAIF, 60 Or App 446, 448 (1982). Here, the parties agreed to present the dispute pertaining to the assignment of the third party claim and the distribution of the settlement proceeds to the Board. The parties have had a full opportunity to present their positions, as well as offer documentary evidence. Both claimant and SIMS have submitted substantial documentation, including pleadings from the third party action, correspondence among the parties' counsel and correspondence between the paying agent and the third party's insurer, in support of their respective positions concerning the validity of claimant's assignment to SIMS. While referring a "third-party" dispute to a fact-finding hearing is not unprecedented, see Nova Y. Knutzen, 40 Van Natta 1825 (1988), we conclude that the record has been sufficiently developed so that we can decide the issues presented for resolution. See Kim J. Hayes, 48 Van Natta 1635 (1996).

### Distribution of the Settlement Proceeds

If a worker suffers a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The paying agency may require the worker to exercise the right of election provided in ORS 656.578 by serving a written demand by registered or certified mail or by personal service upon such worker. ORS 656.583(1). Where the worker elects not to pursue the third party action and assigns the cause of action to the paying agency, any proceeds recovered by the third party are distributed pursuant to ORS 656.591(2). Under this section, the worker is entitled to any sum recovered by the paying agency is excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical-related service, together with the present worth of future monthly payments of compensation.

On the other hand, when the worker elects to bring the third party action, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). Pursuant to that provision, costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1). Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

As noted at the outset, claimant asserts that the settlement proceeds should be distributed pursuant to ORS 656.593 because he did not make a valid assignment of his cause of action under ORS 656.591 or, to the extent he did, that assignment was revoked or the cause of action was reassigned back to him. SIMS, on the other hand, argues that claimant expressly assigned his cause of action to SIMS and that no revocation or reassignment of the cause of action occurred. SIMS further asserts that because claimant assigned his cause of action to SIMS, and SIMS negotiated the third party settlement, the proceeds of the settlement should be distributed pursuant to ORS 656.591(2).

We have jurisdiction to decide whether an election by a worker to assign his rights to pursue a third party action was improperly obtained where, as here, the relief sought for such conduct is an order distributing the proceeds of the third party action under ORS 656.593 (as if claimant had elected to prosecute the action himself) rather than under ORS 656.591. See EBI Companies v. Cooper, 100 Or App 246 (1990); compare Donald E. Yedloutschnig, 43 Van Natta 615 (Board lacks jurisdiction where the claimant does not dispute the distribution of the proceeds).

Claimant argues that, to the extent he assigned SIMS his cause of action for purposes of ORS 656.591, he did so "under coercion" because SIMS and the third party's insurer were involved in "a civil conspiracy." We find no evidence of any fraud or coercion in claimant's assignment of the cause of action to SIMS.[4] Rather, the record establishes that on numerous occasions, claimant (though his attorney) expressed his intention to assign his third party cause of action to the paying agency and to have the paying agency incur the costs of proceeding with the civil litigation.

As set forth above, claimant's counsel expressly advised SIMS' counsel on March 6, 1996, that her client had elected to "tender the claim back to SIMS to proceed to trial" so that SIMS would incur the costs associated with litigating the action. (Ex. 6-1). SIMS' counsel responded that SIMS was interpreting the "tendering" as an assignment of the cause of action under ORS 656.591 (Ex. 9), and claimant's counsel did not express any objection to SIMS' understanding. Claimant's counsel represented to the Wasco County court that the claim had been tendered to SIMS and withdrew as attorney of record for the plaintiff. (Ex. 9, 10. 11). Furthermore, in response to SIMS' counsel's subsequent inquiries and requests for confirmation, claimant's counsel acknowledged on more than one occasion that the claim had been "assigned" to SIMS. (Exs. 14, 16). In light of this evidence, we conclude that claimant knowingly chose not to pursue the third party claim and to assign his cause of action to SIMS.[5]

Claimant also argues that the third party cause of action was subsequently "re-assigned" to him by virtue of SIMS' counsel's October 25, 1996 letter.[6] We disagree. First, we do not consider SIMS' counsel's assumptions, gathered from claimant's (and his counsel's) silence, to be a legitimate basis on which to establish a "reassignment" of the claim, assuming SIMS even had the statutory authority to do so. Second, even if SIMS' counsel's letter could be interpreted as an attempt to re-assign the claim, the parties' conduct subsequent to October 25, 1996 indicates that SIMS retained the cause of action. SIMS (and not claimant) proceeded to negotiate the settlement with the third party defendant and executed the stipulated dismissal of the civil action. (See Exs. B-2, 19, 23). Indeed, even after the settlement had been negotiated, claimant's counsel acknowledged that SIMS' counsel was the attorney of record in the civil case and did not object to SIMS' counsel's representation that the cause of action had been assigned to SIMS. (Exs. 22, 23).

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[4] Claimant argues that the paying agency's refusal to provide discovery of surveillance films made it untenable for his counsel to effectively represent him, but provides no evidence on this issue and offers no explanation as to why or how this evidence would be relevant to the prosecution of his third party claim in civil court. Under these circumstances, we are unpersuaded by claimant's unsubstantiated allegations of conspiracy and coercion.

[5] Claimant's position that he only tendered representation of the claim but not the cause of action itself does not square with his acknowledgment (through counsel) that the "claim" had been "assigned" to SIMS (see Exs. 14, 16) or his failure to contest SIMS' counsel's letters characterizing the arrangement as an assignment of the cause of action. (Exs. 13, 15).

[6] As set forth above, after claimant failed to respond to SIMS' counsel's request that claimant execute a formal and explicit assignment of the cause of action, SIMS' counsel wrote to claimant's counsel that if claimant intended to revoke his assignment of the cause of action, claimant should be on notice that SIMS would not pursue the case further and claimant would be expected to protect SIMS' lien accordingly. (Ex. 18).

Consequently, we conclude that after initiating the third party action (by filing the complaint in the Wasco County Circuit Court), claimant validly assigned his third party cause of action to SIMS to proceed against the third party. We distinguish the circumstances in this case from those in Thomas McBroom, 40 Van Natta 495 (1988), where we found the claimant had not assigned the third party cause of action to the paying agency and was therefore entitled to a 1/3 share of the settlement proceeds under ORS 656.593(1)(b). There, we were unable to conclude that the claimant's conduct equated with the "intentional and affirmative act" occasioned by electing not to proceed against the third party. Here, on the other hand, claimant (through his counsel) repeatedly acknowledged his intention to assign the third party claim to SIMS and to have SIMS incur the costs of prosecuting the third party action. Further, unlike the claimant in McBroom, claimant and his counsel were well advised that SIMS was not proceeding on claimant's behalf, and that the assignment terminated claimant's rights with respect to the third party action.[7]

Having concluded that claimant assigned his third party action to SIMS, we find that SIMS is authorized to distribute the proceeds of the third party recovery pursuant to ORS 656.591(2). SIMS' current uncontested lien of $27,505 attaches to the entire $10,000 settlement. See Dennis J. Harvey, 40 Van Natta 1940 (1988), aff'd Harvey v. Lou Surcamp Logging, 100 Or App 227 (1990) (the claimant may not rescind a prior "de-facto" assignment of his cause of action; pursuant to ORS 656.591(2), the paying agency's lien attaches to any sum recovered by the paying agency).

Accordingly, SIMS' counsel is directed to forward the $10,000 settlement check to SIMS as partial reimbursement for its third party lien.

IT IS SO ORDERED.

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[7] In McBroom, the paying agency's correspondence led the claimant to believe that it was proceeding on the claimant's behalf. 40 Van Natta at 499. In this case, however, we are persuaded that neither SIMS' counsel's correspondence nor claimant's counsel's conduct in response to that correspondence indicate that claimant believed that SIMS was pursuing the claim on claimant's behalf. Rather, the record establishes that SIMS was proceeding in the third party action on its own behalf.

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In the Matter of the Compensation
**BRADFORD SEXTON, Deceased, Claimant**
WCB Case No. C700145
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
William H. Wimsatt, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On May 28, 1997, 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 February 25, 1997, we disapproved the parties' previous CDA. We found that agreement unreasonable as a matter of law because it released the surviving spouse's substantial monthly benefit in exchange for a consideration of one dollar. Bradford Sexton, Deceased, 49 Van Natta 183 (1997). The parties have submitted a revised CDA.

Page 4 of the revised CDA provides, in part: "The parties (claimant and insurer) have separately reached an agreement through which insurer's lien is released. The value of the third party lien, which is released by the insurer in an agreement separate from this Claim Disposition Agreement, when reduced to present value, is $212, 242.01. Insurer's release of its lien is contingent upon Board approval of this Claim Disposition Agreement."

The CDA provides that the insurer's release of its $212,242.01 third party lien from the third party settlement "well in excess of one million dollars" is contingent upon approval of the CDA.[1] Because the release of the $212,242.01 third party lien is contingent upon approval of the CDA, we interpret the CDA as providing that, in addition to $1, the consideration for the CDA is the insurer's agreement to waive its otherwise recoverable $212,242.01 third party lien. Moreover, the CDA provides sufficient information regarding the third party settlement and the insurer's lien that we are able ascertain the value of the consideration flowing to claimant under the agreement. See Michael Salber, 48 Van Natta 757 (1996); Kenneth Hoag, 43 Van Natta 991 (1991).

As interpreted herein, the parties' CDA 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.

IT IS SO ORDERED.

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[1] It is not uncommon for the Board to receive CDAs which involve carrier approvals of claimants' third party settlements. When such circumstances arise, it is equally commonplace for all or a portion of the consideration for the CDA to be the carrier's full or partial waiver of its third party lien. Here, considering the parties' reference to a "contingent" waiver of the insurer's third party lien, we have interpreted the parties' CDA in a manner consistent with these more common CDAs.

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In the Matter of the Compensation of
**BEVERLY J. KELLOW, Claimant**
WCB Case No. 93-09427
ORDER ON REMAND
Peter O. Hansen, Claimant Attorney
Ronald Atwood & Associates, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Kellow v. Tillamook Co. Creamery, 143 Or App 311 (1996). The court has reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order upholding the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Reasoning that the amended version of ORS 656.005(7)(a)(B) might be applicable, the court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant began working for the employer in September 1992. Claimant's job duties involved the repetitive use of her hands and arms. In October 1992, she began to experience symptoms of numbness and pain in her right hand and wrist, and shortly thereafter, began having symptoms in her left hand and wrist. In January 1993, claimant changed job duties. When her symptoms recurred, claimant sought medical treatment. On February 12, 1993, Dr. Thompson diagnosed carpal tunnel syndrome. The insurer denied claimant's claim on June 16, 1993.

The ALJ concluded that claimant's underlying disease process had not been worsened by her work activities. Accordingly, the ALJ upheld the insurer's denial. On review, we adopted and affirmed the order of the ALJ. The court has remanded to us to consider whether amended ORS 656.005(7)(a)(B)[1] is applicable.

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[1] 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."

Subsequent to the issuance of our prior order, the occupational disease statute, ORS 656.802, was amended by the 1995 Legislature. 1995 Or Laws Chapter 332, sec. 56. Those amendments apply retroactively to this case. See 1995 Or Laws, Chapter 332, sec. 66(1); Volk v. America West Airlines, 135 Or App 565 (1995). Amended ORS 656.802(2)(b) provides:

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

"Preexisting disease" is defined as:

> "[A]ny injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease...." Amended ORS 656.005(24).

Accordingly, under the statutes, we must first decide whether claimant has a preexisting condition.[2] Here, claimant concedes that even Dr. Long has found that she has a preexisting median neuropathy condition. (Appellant's Brief on Remand, pg. 5). Furthermore, we find that the record, including Dr. Long's opinion, establishes that the median neuropathy condition has "combined" with the carpal tunnel symptoms. (Exs. 5-5; 13A).

Accordingly, we must analyze the expert medical opinions to determine whether the compensable injury is the major contributing cause of claimant's disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B). Four physicians have provided opinions with respect to the issue of causation. Claimant's treating doctor, Dr. Thompson, reported that, because of the "timing in relationship," or the "temporal relationship," he believed that claimant's work with the employer was primarily responsible for claimant's carpal tunnel syndrome. (Ex. 13).

Dr. Long, who performed a records review for claimant's counsel, agreed that claimant had median compression prior to beginning work for the employer. Dr. Long further concluded that claimant's work not only provoked symptoms of median nerve compression, "but almost certainly contributed to pathologic worsening of the median lesions." (Ex. 13A).

Dr. Radecki examined claimant on behalf of the insurer and found that claimant had bilateral median nerve slowing in the carpal tunnel and mild carpal tunnel syndrome. Dr. Radecki found no evidence that claimant's work activity "altered or accelerated the underlying neuropathic process." (Ex. 12-3).

Finally, Dr. Nathan also examined claimant and administered nerve conduction studies. (Ex. 5-3). Dr. Nathan reported that claimant had a chronic nerve slowing process that predated her employment. Dr. Nathan's current diagnosis was that of carpal tunnel syndrome, and he found that claimant developed numbness and pain in both hands after working a month for the employer. Dr. Nathan found no evidence that claimant's work activity altered or accelerated the underlying neuropathic process. Nevertheless, Dr. Nathan recommended that claimant undergo bilateral carpal tunnel releases. (Ex. 5-5).

In a later report, Dr. Nathan reiterated that claimant's preexisting bilateral median nerve neuropathy had not been materially affected by her work for the employer. Dr. Nathan reasoned that the chronicity of the neuropathies, as demonstrated by the tests, ruled out claimant's period of employment as a major cause of her problem. Dr. Nathan further concluded that claimant's work did not constitute the major contributing cause of her carpal tunnel process or symptoms. (Ex. 14).

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[2] We note that the insurer has requested that we disregard claimant's brief on remand, due to claimant's "failure to address the appropriate issue on remand." Response Brief, Pg. 2. Specifically, the insurer contends that claimant has not briefed the issue before us on remand, but rather, has reargued the case "de novo." We do not agree that claimant is prevented from making such an argument on remand, as the court has reversed our prior order and remanded to us for reconsideration. See e.g. Shawn P. Harold, 49 Van Natta 254 (1997). Accordingly, we have considered claimant's brief on remand.

After reviewing the various medical reports, we agree with the ALJ that Drs. Nathan and Radecki have provided the most thorough and well-reasoned opinion regarding the issue of causation. See Somers v. SAIF, 77 Or App 259 (1986).[3] We note that we generally defer to the opinion of a claimant's treating physician, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810 (1983).

In this case, we have found persuasive reasons which lead us to reject the opinion of claimant's treating doctor, Dr. Thompson. Specifically, we agree with the ALJ's reasoning that Dr. Thompson's report is not persuasive as it is primarily based on a temporal relationship between claimant's symptoms and her work. See Gormley v. SAIF, 52 Or App 1055 (1981). Additionally, Dr. Thompson first concurred with Dr. Nathan's conclusion that claimant was suffering from a chronic process, which predated her work with the employer. However, Dr. Thompson subsequently changed his opinion and concluded that work was the major contributing cause of claimant's condition. (Exs. 5, 9, 13). Without an explanation for his changed opinion, we do not find Dr. Thompson's opinion to be persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Finally, we also agree with the ALJ's reasoning that Dr. Long's opinion is not persuasive, as he has provided no reasoning or evidence to support his conclusion that claimant's underlying condition has worsened.

Accordingly, based on the opinions of Drs. Nathan and Radecki, we conclude that claimant has failed to establish that work conditions were the major contributing cause of a pathological worsening of the preexisting disease under the amended statute ... Furthermore, likewise under the amended version of the statute, we are unable to find that work conditions were the major contributing cause of the combined condition (i.e., the median neuropathy and carpal tunnel syndrome) itself. See ORS 656.802(2)(b); ORS 656.005(7)(a)(B); Dan D. Cone, 47 Van Natta 2220 (1995).

Consequently, we conclude that claimant has failed to prove compensability of her bilateral carpal tunnel syndrome condition. Therefore, on remand, as supplemented herein, we republish our September 8, 1994 order.

IT IS SO ORDERED.

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[3] Claimant argues that Drs. Nathan and Radecki are not persuasive as they have not considered or evaluated contributions from other sources. However, both doctors considered claimant's work and off-work activities, in addition to factors personal to claimant. (Exs. 5, 12, 14). Under the circumstances, we disagree that their opinions are not persuasive for a failure to consider all relevant possible causal factors.

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In the Matter of the Compensation of
**MICHAEL T. ALIOTH, Claimant**
Own Motion No. 95-0128M
OWN MOTION ORDER OF ABATEMENT
C. David Hall, Claimant Attorney
VavRosky, et al, Defense Attorneys

Claimant requests reconsideration of our May 30, 1997 Own Motion Order Reviewing Carrier Closure, in which we affirmed the self-insured employer's March 20, 1997 Notice of Closure of his claim because claimant failed to meet his burden of proving that he was not medically stationary on the date his claim was closed.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The 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.

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In the Matter of the Compensation of
**BRUCE J. BURGESS, Claimant**
WCB Case No. 96-03182
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that awarded claimant 8 percent (25.6 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration awarded no awarded no permanent disability. On review, the issues are extent and, alternatively, offset.[1] We reverse.

## FINDINGS OF FACT

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

Claimant has a 10 year history of back problems. He was diagnosed with a slight herniation of L4-5 in 1993. On November 23, 1994, while working as a fireman, claimant injured his low back when he fell down an embankment. X-rays were negative for compression fractures or structural abnormalities.

SAIF accepted a low back strain and mild contusion to the left shoulder. Claimant was found medically stationary on May 16, 1995, by Dr. Donahoo, who examined him at SAIF's request. As part of the examination, Dr. Donahoo measured claimant's lumbar range of motion using dual inclinometers. He noted that claimant demonstrated 50 degrees maximum flexion, 10 degrees maximum extension, 92 degrees of maximum straight leg raising bilaterally with complaints of back pain, 34 degrees of maximum right lateral flexion angle and 22 degrees maximum left lateral flexion angle. Dr. Donahoo found the Waddell's test positive with rotation and negative with compression, no sensory deficit, no evidence of nerve root deficit and 5/5 muscle testing. Dr. Donahoo concluded that claimant's subjective complaints outweighed the objective findings and that there were some inconsistencies in his examination. Dr. Donahoo further opined that claimant had no permanent impairment resulting from his low back strain and shoulder contusion.

On June 16, 1995, claimant's treating physician, Dr. Adams, concurred with Dr. Donahoo's report. On June 28, 1995, claimant returned to Dr. Adams for a follow up visit, at which time Dr. Adams noted that claimant still showed pain behavior characteristics and that his Waddell's rotation test was significantly positive.

The claim was closed by a June 30, 1995 Notice of Closure, which awarded no permanent disability. Claimant requested reconsideration, but was not examined by a medical arbiter. A March 22, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects.

## CONCLUSIONS OF LAW AND OPINION

Based on Dr. Donahoo's May 16, 1995 findings, the ALJ found that claimant was entitled to an impairment value of 8 percent under former OAR 436-35-360 (WCD Admin. Order 6-1992) for his loss of lumbar range of motion. On review, SAIF contests the ALJ's award of unscheduled permanent disability, given Dr. Donahoo's determination that there were inconsistencies in claimant's examination and his conclusion that claimant had no objective permanent impairment resulting from his accepted low back strain. We agree with SAIF.

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[1] In the event we affirm the ALJ's award of unscheduled permanent disability, SAIF seeks to offset its $788.23 overpayment of temporary disability benefits against the permanent disability award. Because we reverse the ALJ's order, we do not address the offset request.

Claimant has the burden of proving the extent of permanent disability resulting from his compensable injury. ORS 656.266. Although claimant did not attend a closing examination by his attending physician, Dr. Adams concurred with Dr. Donahoo's May 16, 1995 report. Therefore, Dr. Donahoo's report may be used to determine claimant's impairment. See former OAR 436-35-007(8); Tektronix, Inc. v. Watson, 132 Or App 483 (1995).

In this case, the only evidence indicative of permanent impairment is Dr. Donahoo's findings of reduced lumbar range of motion, but Dr. Donahoo did not identify these findings as valid nor did he specifically relate the loss of motion to claimant's accepted low back strain.[2] On the contrary, as noted above, Dr. Donahoo reported that claimant had no objective permanent impairment resulting from his accepted low back strain and shoulder contusion. In addition, Dr. Donahoo characterized claimant's findings as "primarily subjective" and inconsistent, considering his gait outside the examination setting. Dr. Adams concurred with this assessment, and independently determined that claimant did not have any real objective findings. On this record, we conclude that claimant has not proven permanent disability resulting from his compensable injury by a preponderance of the evidence. We therefore reverse the ALJ's order and reinstate the Order on Reconsideration.

ORDER

The ALJ's order dated August 27, 1996 is reversed. The March 22, 1996 Order on Reconsideration is reinstated and affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

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[2] Dr. Donahoo also addressed claimant's preexisting slight herniation of the L4-5 disc.

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In the Matter of the Compensation of
**PAMALA K. CANNONE, Claimant**
WCB Case No. 96-08039
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome and bilateral upper extremity nerve entrapment disorder. 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 bilateral upper extremity conditions, reasoning that the medical opinions of Dr. Lundsgaard, an attending physician, and Dr. Ames, a physician who treated claimant's hypothyroidism, did not establish a compensable occupational disease claim under ORS 656.802(2)(b). On review, claimant contends that the record does not establish the presence of a preexisting bilateral upper extremity condition, but that, even if the pathological worsening requirement of ORS 656.802(2)(b) is applied, the medical opinions of Drs. Lundsgaard and Ames satisfy her burden of proof. For the following reasons, we disagree.

To establish a compensable occupational disease, claimant must prove that her employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If an occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), claimant must prove that her employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b); Robert T. Ries, 48 Van Natta 86 (1996).

In this case, regardless of whether claimant must prove a pathological worsening of an underlying condition, we do not find the medical evidence on which claimant relies persuasive. Dr. Lundsgaard initially opined that he was "uncertain" whether a preexisting condition was playing a significant role in claimant's medical condition. (Ex. 10). SAIF subsequently had an examining physician, Dr. Jewell, evaluate claimant's bilateral upper extremity complaints. Dr. Jewell diagnosed a multiple bilateral entrapment neuropathy disorder of the upper extremities. (Ex. 13-3). Dr. Jewell concluded that claimant's work exposure was not the major contributing cause of electrical abnormalities within the median nerve and that claimant's work activities had not contributed to the development or worsening of the upper extremity condition. (Ex. 13-4).

Claimant characterizes Dr. Jewell's report as "peculiarly confused" and "totally flawed." However, Dr. Lundsgaard, the physician on whose opinion claimant primarily relies, concurred with the "diagnosis(es), findings and opinion and discussion" contained in that report. (Ex. 15). Although Dr. Lundsgaard subsequently opined in response to an inquiry from claimant's counsel that claimant's work was "consistent with aggravation of her underlying condition causing carpal tunnels" and that "overuse" at work was "the major contributing cause to her pain," Dr. Lundsgaard provided no explanation of his previous concurrence with Dr. Jewell's opinion that claimant's work exposure had not contributed to her upper extremity conditions. (Ex. 17). Since Dr. Lundsgaard did not explain the inconsistencies in his apparent change of opinion regarding causation of claimant's upper extremity conditions, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987).

Moreover, Dr. Ames agreed in a "check-the-box" report that claimant's work combined with an underlying thyroid condition to cause her need for treatment and that claimant's work was the major contributing cause of the combined condition and need for treatment. (Ex. 18). However, no explanation was provided for Dr. Ames' opinion. Because Dr. Ames' report is conclusory, we agree with the ALJ that it, too, was entitled to little probative weight 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).

In conclusion, we agree with the ALJ that claimant failed to sustain her burden of proof, regardless of which occupational disease statute is applied. We, accordingly, affirm.

ORDER

The ALJ's order dated December 18, 1996 is affirmed.

In the Matter of the Compensation of
**KATHERINE A. COBB, Claimant**
WCB Case No. 96-09305
ORDER ON REVIEW
Van Valkenburgh, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for a sciatica condition. On review, the issue is compensability.

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

The ALJ concluded that claimant proved a compensable occupational disease claim for sciatica. In contesting this conclusion, the insurer first asserts that we should find claimant not credible. Specifically, the insurer contends that the ALJ did not base his credibility finding on demeanor and that the record is sufficiently inconsistent to show that claimant's testimony is not reliable.

Because the ALJ's order found that claimant "credibly testified" concerning the onset of her symptoms, the ALJ found claimant credible based at least in part on her demeanor. Although not statutorily required, the Board generally defers to the ALJ's credibility determination. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Here, we agree with the ALJ's reasoning for finding insufficient testimony of an off-work injury. Consequently, we find no basis for not deferring to the ALJ's credibility finding.

The insurer also contends that the medical evidence does not carry claimant's burden of proof because it is based on a different history than claimant's testimony. We disagree. Only claimant's treating osteopath, Dr. Alaimo, provided an opinion. His report stated that claimant "experienced the onset of lower back pain" after she carried some heavy cases of liquor bottles. (Ex. 25). The report further found that claimant's "work activities" were the major contributing cause of her sciatica condition and that his opinion was based on the history provided to Dr. Alaimo by claimant and a review of her medical records. (Id.) The record shows that claimant told Dr. Alaimo in May 1996 that she had been experiencing burning pain into the left leg for the previous two months and the pain had progressively worsened. (Exs. B, 2).

Based on the history reflected in Dr. Alaimo's records, and his reference to it in his report, we disagree with the insurer that Dr. Alaimo based his opinion on a history that claimant sustained an injury following an incident of carrying the cases of liquor. Rather, we understand Dr. Alaimo's opinion as being based on a history that claimant's leg symptoms began in March 1996, and progressively worsened, with low back pain beginning after carrying the cases of liquor. Such history is consistent with claimant's testimony. (Tr. 40, 56-57).

Thus, we find that Dr. Alaimo's opinion is based on an accurate history. Furthermore, it is uncontradicted. Consequently, we find it sufficient to prove compensability. See ORS 656.802(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 is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

## ORDER

The ALJ's order dated January 15, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
**RANDALL S. FARRELL, Claimant**
WCB Case No. 96-02030
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and summarize as follows. We do not adopt the ALJ's findings of ultimate fact.

Claimant, who is an insulin-dependent diabetic, and his wife own an old house which they have been maintaining and remodeling for eight years. (Tr. 12, 20). Claimant performed most of the demolition and hammering. (Tr. 20). Claimant had no hand symptoms prior to the time he began working for the self-insured employer as a press operator in a lumber mill in December 1993. (Tr. 7). Claimant performed less work on his house after he began working at the employer. (Tr. 23).

Claimant's work at the employer entailed breaking off, pulling and pushing with both hands four-by-eight foot wooden panels 30 to 40 times during a period of two to five and one-half minutes continuously in an eight-hour shift. (Tr. 8). After about a year, claimant noticed tingling and numbness in his hands and pain up into the forearms. (Tr. 7). Hammering while working on his house caused claimant's hands to become numb. (Tr. 13).

On June 16, 1995, claimant sought treatment from Dr. Keller for his hand symptoms, which were worse on the left, and his diabetes. (Ex. 1). Dr. Keller diagnosed CTS and placed claimant's left hand in a splint. (Id.) Dr. Keller found claimant's blood sugars were poorly controlled. In order to treat his diabetic condition, Dr. Keller supervised changes in claimant's insulin intake and referred him to a registered dietitian. (Exs. 4, 5).

After claimant had been using the splint for several months without significant abatement of his hand and arm symptoms, Dr. Keller referred him for nerve conduction studies, which revealed mild to moderately severe CTS on the right and mild CTS on the left. (Exs. 6, 8, 10). On October 5, 1995, claimant filed a claim for bilateral CTS. (Ex. 13).

On October 16, 1995, Dr. Whitney, orthopedist, evaluated claimant's CTS and recommended surgery. (Ex. 16).

On November 22, 1995, Dr. Button, hand surgeon, examined claimant and performed a records review regarding his CTS condition for the employer. (Ex. 18).

On February 13, 1996, the employer denied claimant's CTS claim on the basis that the CTS did not exist, and, if it did, it did not arise from the course and scope of employment. (Ex. 20).

## CONCLUSIONS OF LAW AND OPINION

The ALJ effectively determined that claimant failed to prove, by a preponderance of the evidence, that he had CTS. On the basis that Dr. Keller's and Dr. Whitney's reports were not persuasive, the ALJ upheld the self-insured employer's denial of claimant's occupational disease claim for CTS. Claimant contends that he is not required to prove a specific diagnosis in order to establish compensability of an occupational disease, but that he need only prove that his condition was caused in major part by occupational exposure.

We agree with claimant that he need not prove a specific diagnosis in order to establish a compensable occupational disease. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). Here, however, based on electrodiagnostic studies performed by Dr. Bernstein, three doctors diagnosed claimant's hand and arm condition as bilateral CTS: Dr. Keller, claimant's attending physician; Dr. Button, hand surgeon, who examined claimant for the employer; and Dr. Whitney, orthopedist. (Exs. 2, 10, 16, 18). There is no contrary medical opinion.[1] Nevertheless, we agree with the ALJ's ultimate conclusion that claimant has not established a compensable occupational disease claim based on the following rationale.

Claimant, who is an insulin-dependent diabetic, performed intensive work with his hands and arms as a press operator at the employer. Claimant and his wife own an old house which they have been maintaining and remodeling for eight years. Claimant performed most of the demolition and hammering, which caused his hands to feel numb.

In order to establish compensability of his bilateral CTS condition, claimant must prove, by a preponderance of the evidence, that his work activities were the major contributing cause of his disease. ORS 656.266; 656.802(1), (2). Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 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 bilateral CTS condition by claimant's hammering, demolition and renovation of his home, as well as his work activities and diabetic condition.

Here, after evaluating the relative contributions of claimant's work activities and diabetes to his CTS, each of the doctors concluded that work activities were the major contributing cause of claimant's bilateral CTS. However, there is no evidence that the doctors who treated and examined claimant were adequately apprised of claimant's home improvement activities, which Dr. Whitney acknowledged had characteristics that had "equal potential" of being a major cause, depending on the specifics of the work. (Exs. 18; 23-26, -27, -29; 24-24, -25).

Although it is possible that the doctors' opinions would have remained the same had they been aware of the actual extent of claimant's work on his house, the doctors were unable to properly evaluate the relative contribution of each potential cause of claimant's CTS. Consequently, in the absence of medical evidence based on an accurate understanding of claimant's history, Mandell v. SAIF, 41 Or App 253 (1979), we cannot conclude that claimant's bilateral CTS condition is compensable.

## ORDER

The ALJ's order dated December 17, 1996, is affirmed.

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[1] We note that an ALJ is not permitted to substitute his or her own opinion for the medical evidence in the record. E.g., Robert B. Cummings, 45 Van Natta 11 (1993). Accordingly, we do not find the ALJ's lay opinion a basis for finding that claimant's CTS condition is not compensable.

In the Matter of the Compensation of
**CARL L. GRUENBERG, Claimant**
WCB Case No. 95-12463
ORDER ON REVIEW
Welch, Bruun, 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) Hazelett's order that dismissed claimant's hearing request concerning the self-insured employers alleged "de facto" denial of several left knee conditions. In addition, claimant moves to suspend our review pending the issuance of a court decision. On review, the issues are claimant's procedural motion and the propriety of the ALJ's dismissal order.

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

Claimant has an accepted claim for a left knee contusion. (Ex. 6). On November 13, 1995, he filed a request for hearing, alleging a "de facto" denial of several left knee conditions. On August 1, 1996, claimant filed another request for hearing, making the same allegations regarding a "de facto" denial of left knee conditions. At hearing and on review, claimant argues that the first request for hearing satisfied the requirements of ORS 656.262(6)(d),[1] whereas the second request for hearing served solely as a request for hearing. Relying on our decisions in Shannon E. Jenkins, 48 Van Natta 1482 (1996), and Diane S. Hill, 48 Van Natta 2351 (1996), the ALJ rejected claimant's argument and dismissed his hearing request as premature.

On review, claimant notes that Shannon E. Jenkins, and Diane S. Hill are presently pending review before the Court of Appeals. He requests that his case be stayed pending a final judgment in both cases. The employer objects to claimant's request. In the absence of the parties' agreement to do otherwise, we decline to hold a matter in abeyance indefinitely pending resolution of the pending court appeal in other cases. See, e.g., Weston C. Foucher, 47 Van Natta 1518 (1995). Accordingly we deny claimant's request to stay our review. See also William M. Beardsley, 48 Van Natta 2210 (1996); Alonso S. Alvarado, 43 Van Natta 1303 (1991).

We turn to the merits of claimant's appeal. As the ALJ noted, we have disavowed our decision in Guillermo Rivera, 47 Van Natta 1734 (1995) (holding 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)). 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. Id. at 1484, 1486.

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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."

Here, claimant argues that his initial hearing request satisfied the requirements of ORS 656.262(6)(d) and his subsequent hearing request served to request a hearing. We disagree. For the reasons explained in Jenkins, as summarized above, a request for hearing alleging a "de facto" denial does not satisfy ORS 656.262(6)(d). It follows that none of a series of requests for hearing alleging a "de facto" denial will satisfy ORS 656.262(6)(d). To hold otherwise would thwart the legislative intent of ORS 656.262(6)(d), as explained in Jenkins.

In addition, we agree with the ALJ that claimant's requests for hearing also failed to satisfy the requirements of ORS 656.262(7)(a), which provides, in pertinent part, that after claim acceptance, a new medical condition claim must "clearly request formal written acceptance of the condition." In Diane S. Hill, 48 Van Natta at 2352-53, we held that a hearing request concerning an unaccepted condition was premature where a "new medical condition" claim had not been filed with the carrier prior to the filing of the hearing request and the carrier had challenged the propriety of the compensability proceeding. In light of the considerable administrative time and expense incurred in acknowledging and scheduling a hearing, we noted that our holding avoided needless expenditures of resources where the matter could be resolved simply through improved communication.[2] Marlene L. Stacy-Bryant, 49 Van Natta 164 (1997).

Here, claimant does not point to any "clear request" for formal written acceptance of the left knee conditions, and we find none in the record. Furthermore, claimant's requests for hearing do not meet this requirement. Diane S. Hill, 48 Van Natta at 2352-53.

Therefore, as the ALJ found, claimant failed to meet the requirements of ORS 656.262(6)(d) and 656.262(7)(a). Accordingly, we affirm the ALJ's dismissal of claimant's request for hearing.

## ORDER

The ALJ's order dated January 13, 1997 is affirmed.

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[2] We note that this same reasoning applies regarding claimant's argument that the requirements of ORS 656.262(6)(d) can be satisfied with multiple requests for hearing alleging a "de facto" denial. When a request for hearing is filed with the Board, the request is acknowledged to all parties, a hearing date and locations are scheduled, and the matter is assigned to an Administrative Law Judge. Under claimant's interpretation, no needless expenditure could be avoided through improved communication because, no matter how claimant attempts to classify it, an initial hearing request represents a request for hearing, with all of the associated administrative costs.

In the Matter of the Compensation of
**ISMAEL P. HERNANDEZ, Claimant**
WCB Case No. 96-08892
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) reduced claimant's unscheduled permanent disability award for a low back condition from 32 percent (102.4 degrees), as awarded by an Order on Reconsideration, to 9 percent (28.8 degrees); and (2) awarded no scheduled permanent disability, whereas the Order on Reconsideration awarded 5 percent (6.75 degrees) for loss of use or function of the right leg. On review, the issues are extent of unscheduled and scheduled permanent disability.

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

Claimant has an accepted claim for a low back strain and disk herniation. Claimant underwent surgery for the herniation. A Notice of Closure awarded temporary disability and 9 percent unscheduled permanent disability. Relying on a medical arbiter report, the Order on Reconsideration increased the unscheduled permanent disability award to 32 percent and also awarded 5 percent scheduled permanent disability.

Finding other medical reports more persuasive than that of the medical arbiter, the ALJ found that claimant was entitled only to 9 percent unscheduled permanent disability. Claimant challenges the ALJ's order, asserting that the medical arbiter should be found most persuasive.

After claimant's treating occupational health physician, Dr. Barnhouse, declared claimant medically stationary, examining physicians Dr. Donald Peterson and Dr. Reimer performed a closing examination. The panel found that claimant "exhibited gross overreaction with range of motion testing and exaggerated pain response with compression of the subcutaneous tissues." (Ex. 15-4). The panel also found that range of motion measurements were not valid because there was a discrepancy of more than 10 degrees between straight leg raising and sacral flexion-extension. (Id.) Dr. Barnhouse concurred with the report. (Ex. 16).

Dr. Christine Peterson performed the medical arbiter examination. In discussing whether findings were invalid, Dr. Peterson acknowledged that claimant exhibited "evidence of symptom magnification." (Ex. 26-7). Dr. Peterson also found, however, that claimant "has real limitations on the basis of post-surgical status" and she believed that the "limitations and range of motion are attributable to residuals of his surgery." (Id. at 7-8). According to Dr. Peterson, claimant's "objective findings ... have significance and do not appear to be affected by the symptom magnification." (Id. at 8).

On reconsideration, impairment is determined by the medical arbiter, "except where a preponderance of medical opinion establishes a different level of impairment." OAR 436-035-0007(13). On review, we do not automatically defer to a medical arbiter's opinion in evaluating a worker's permanent impairment but rely on the most thorough, complete, and well- reasoned evaluation of the claimant's injury-related impairment. E.g., Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Here, we agree with the ALJ that the Peterson/Reimer panel and Dr. Barnhouse provided more compelling evidence of claimant's impairment than the medical arbiter. First, as the treating physician, Dr. Barnhouse had more contact with claimant. Furthermore, the Peterson/Reimer panel explained why the range of motion findings were not valid, pointing to the discrepancy between the straight leg raising and sacral flexion/extension. Dr. Peterson, on the other hand, did not explain why she believed that claimant's symptom magnification had not affected the findings of impairment.

Consequently, we agree with the ALJ that claimant did not prove impairment beyond the value for surgery awarded by the Notice of Closure.

ORDER

The ALJ's order dated December 31, 1996 is affirmed.

In the Matter of the Compensation of
**JIM R. REED, Claimant**
WCB Case No. 96-06663
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) found that claimant was not entitled to temporary disability for the period from November 1, 1995 through March 12, 1996; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to pay such benefits. On review, the issues are entitlement to temporary disability and penalties. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Entitlement to Temporary Disability

On November 1, 1995, claimant made an aggravation claim, which was accepted by the insurer on March 28, 1996. On April 22, 1996, Dr. Gray, one of claimant's treating physicians, authorized time loss, beginning on November 1, 1995. The aggravation claim has not been closed. The insurer did not pay temporary disability for the period from November 1, 1995 through March 12, 1996.

Relying on ORS 656.262(4)(a) and (f), the ALJ found that the insurer was not required to pay temporary disability for that time period because the authorization retroactively applied only 14 days before its issuance. As he did at hearing, claimant argues that ORS 656.262(4)(c) required the insurer to obtain verification of claimant's temporary disability status. According to claimant, had the insurer fulfilled this duty, it would have received verification of time loss beginning on November 1, 1995.

ORS 656.262(4)(c) provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claim injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control."

In interpreting a statute, our task is to discern what the legislature intended when it enacted the statute. ORS 174.020. We begin by examining the text and context of ORS 656.262(4)(c). PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). Only if those sources do not reveal legislative intent do we resort to legislative history and other extrinsic aids. Id. at 611-12.

In asserting that the insurer was obligated to obtain authorization of time loss, claimant in particular relies on the statute's language that a carrier is not required to pay temporary disability when it "has requested from the worker's attending physician verification of the worker's inability to work * * * and the physicians cannot verify the inability to work[.]" We find no indication in the language imposing a duty on the carrier to request verification of time loss. Rather, we agree with the ALJ that the statute is most reasonably construed as providing the consequences if the carrier chooses to request verification and fails to receive it.

This textual construction is supported by the context of the statute. ORS 656.262(4)(a) provides that temporary disability must be paid no later than the 14th day after notice or knowledge of the claim,

"if the attending physician authorizes the payment of temporary disability compensation." Subsection (f) states that temporary disability is not due and payable under 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." Finally, subsection (g) allows the carrier to suspend payment of temporary disability under certain circumstances "until temporary disability is reauthorized by an attending physician."

Although not prohibiting a carrier from seeking verification of time loss, none of the provisions support claimant's position that the carrier is required to do so. Thus, we conclude that the insurer did not contravene any statute by failing to obtain verification of temporary disability.

Claimant also relies on OAR 436-060-0020(6) (WCD Order No. 96-070). That rule provides:

> "The insurer or self-insured employer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the worker's disability or claim. Authorization from the attending physician may be oral or written. The insurer, or the Department at the time of claim closure or reconsideration, may infer authorization from such medical records as surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician pursuant to ORS 656.262(4)(f)."

Although the order containing the rule did not become effective until November 27, 1996, the application of the preceding provision is "fully retroactive." OAR 436-060-0003(2).

Unlike the relevant statutes, the rule can be interpreted to require the carrier to obtain from the attending physician any authorization of time loss. Under such an interpretation, however, the rule would not be consistent with the statute and, consequently, could not be upheld. See Springfield Education Assn. v. Springfield School Dist. No. 19, 290 Or 217, 228 (1980).

Furthermore, the rule does not mandate the payment of "retroactive" temporary disability if a carrier neglects to seek verification of time loss authorization. In any case, such an interpretation of the rule would conflict with ORS 656.262(4)(f), which prohibits "retroactive" authorization beyond 14 days.

Finally, we disagree with claimant that, if the rule requires verfication, it necessarily results in finding that claimant is entitled to temporary disability for the disputed period. In making this argument, claimant relies on Dr. Gray's April 22, 1996 time loss authorization from November 1, 1995. Prior to March 13, 1996 (when the insurer began paying temporary disability), the record contains no indication that claimant was less disabled than at claim closure. For instance, on the notice for the aggravation claim, Dr. Gray checked neither "yes" nor "no" as to whether time loss was authorized. (Ex. 75). Based on the absence of evidence showing disability, we will not assume that Dr. Gray's authorization of time loss in April 1996 necessarily means that he would have provided the same authorization in November 1995.

In sum, because the authorization in this case did not issue until April 22, 1996, claimant is not entitled to temporary disability for the period from November 1, 1995 to March 12, 1996. ORS 656.262(4)(a), (f). Furthermore, even assuming that OAR 436-060-0020(6) imposes a burden on the insurer to have obtained from the attending physician authorization for temporary disability, based on the preceding discussion, we conclude that any failure to satisfy the rule does not result in an entitlement to temporary disability benefits.

Penalties

In the absence of any amounts then due, claimant is not entitled to a penalty for the insurer's failure to pay temporary disability for the period from the November 1, 1995 to March 12, 1996. ORS 656.262(11)(a). Furthermore, we find that the insurer was not unreasonable in failing to provide such benefits. Reasonableness is judged according to whether the carrier lacks a legitimate doubt as to its

liability for the claim. Brown v. Argonaut Insurance Co., 93 Or App 588, 591 (1988). Here, because the statutes make entitlement to temporary disability contingent on the attending physician's authorization and any authorization cannot retroactively apply more than 14 days before its issuance, the insurer was reasonable in determining that Dr. Gray's April 22, 1996 authorization did not entitle claimant to temporary disability for the disputed period. Moreover, because OAR 436-060-0020(6) did not exist until after the ALJ's order issued, the rule did not affect the insurer's legitimate doubt of its liability. Consequently, we find no basis for awarding a penalty.

ORDER

The ALJ's order dated December 9, 1996 is affirmed.

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June 12, 1997 Cite as 49 Van Natta 755 (1997)

In the Matter of the Compensation of
**ROBERT P. RODER, Claimant**
WCB Case No. 96-03038
ORDER ON REVIEW
Thomas J. Flaherty, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that: (1) admitted Exhibit 48; (2) upheld the SAIF Corporation's denial of claimant's left shoulder condition; and (3) found that a left shoulder strain claim was not prematurely closed. On review, the issues are evidence, compensability and premature claim closure. We affirm.

FINDINGS OF FACT

In January 1993, claimant injured his left shoulder in a nonwork-related motor vehicle accident. (Ex. 12-1). On November 12, 1993, claimant underwent surgery for the left shoulder. (Ex. 13). Claimant returned to work about two weeks after the surgery. (Ex. 20).

On December 9, 1993, claimant filed a Form 801 stating that, on December 7, 1993, he tripped and fell at work, injuring his left shoulder, arm and hip. (Ex. 18). SAIF accepted the claim for left shoulder strain. (Exs. 24, 27). On March 15, 1995, a Determination Order issued closing the claim. (Ex. 38). On June 26, 1995, an Order on Reconsideration issued, awarding permanent disability and otherwise affirming the Determination Order. (Ex. 43).

Claimant requested a hearing from the Order on Reconsideration, in part alleging premature claim closure. On May 6, 1996, ALJ Johnstone affirmed the Order on Reconsideration. (Ex. 47A). On February 2, 1997, the Board adopted and affirmed ALJ Johnstone's order.[1]

Meanwhile, on March 11, 1996, claimant filed a Form 801 for a "new medical condition" arising from the December 7, 1993 injury for a rotator cuff tear and frozen left shoulder. (Ex. 46). SAIF denied the condition. (Ex. 47). Claimant requested a hearing, challenging the denial and asserting that, if compensability was proved, he also established premature claim closure. The ALJ upheld the denial, finding that the medical evidence failed to prove the existence of a left shoulder rotator cuff tear or that the compensable December 1993 injury was the major contributing cause of a frozen left shoulder condition.

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[1] We take administrative notice of the February 2, 1997 Order on Review. E.g., Rodney J. Thurman, 44 Van Natta 1572 (1992) (Board may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned").

## CONCLUSIONS OF LAW AND OPINION

Evidence

Exhibit 48 is a report from Dr. Strukel, orthopedic surgeon, who conducted a file review at SAIF's request. The report is dated June 10, 1996 and was provided to claimant's attorney shortly before the June 20, 1996 hearing. Claimant objected to admission of the document based on OAR 438-007-0018[2] because it was not provided within 28 days before the hearing. The ALJ overruled claimant's objection because SAIF provided the document within seven days of the hearing. The ALJ's ruling is correct. E.g., Phyllis J. Wheeler, 44 Van Natta 970, 971 (1992) (submission of documents to the opposing party that satisfy OAR 438-007-0015(4)[3] may not be excluded at hearing).

Compensability

There are numerous opinions concerning the cause of claimant's current left shoulder condition. Examining physicians Dr. Marble, orthopedic surgeon, and Dr. Smith, neurosurgeon, found that the December 1993 injury produced an irritation of the rotator cuff but, by the time of their April 1994 examination, the major contributing cause of claimant's symptoms was the preexisting condition for which he underwent surgery in November 1993. (Ex. 31A-7, 31A-8). There is evidence that Dr. Thomas, who treated claimant before and after the December 1993 event, concurred with the report. (Ex. 34).

Dr. Brenneke, orthopedic surgeon who also treated claimant, also found that claimant's shoulder condition was "more related to a previous injury" and that the December 1993 incident was not "the key factor." (Ex. 34).

Dr. Martens, medical arbiter, found that 51 percent of claimant's limited range of motion in his shoulder was due to the December 1993 injury and 49 percent was due to the preexisting condition. (Ex. 40-4).

Dr. Strukel found that the major contributing cause of claimant's current shoulder condition was the January 1993 accident and subsequent surgery. (Ex. 48-7).

Dr. Piepgrass, claimant's current treating physician, first indicated that he concurred with that portion of the Marble/Smith report stating that the cause for claimant's current shoulder treatment was not the December 1993 injury. (Ex. 34B). Dr. Piepgrass then concurred with a "check-the-box" report stating that claimant's current shoulder condition was "causally related" to the December 1993 injury. (Ex. 49-1).

Based on the medical evidence showing that claimant's preexisting left shoulder condition contributed to his current shoulder condition, claimant must show that the compensable injury is the major contributing cause of his need for medical treatment for his combined left shoulder condition. See ORS 656.005(7)(a)(B). We agree with the ALJ that the medical evidence is not sufficient to carry claimant's burden of proof. Dr. Piepgrass' ultimate opinion indicated only that claimant's shoulder condition was "causally related" to the December 1993 injury, which does not equate to providing that the compensable injury is the major contributing cause. Furthermore, Dr. Piepgrass did not provide a consistent opinion, since he previously agreed that the December 1993 incident did not cause the current need for treatment.

Claimant also relies on Dr. Martens' opinion that the majority of claimant's impairment was due to the December 1993 injury. We first note that Dr. Martens' apportionment of impairment does not necessarily translate into an opinion for the cause of the condition. Moreover, even if Dr. Martens' report supported the claim, it is overcome by Dr. Thomas and Dr. Brenneke who, as treating physicians, provided more persuasive opinions than Dr. Martens, who saw claimant only one time.

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[2] OAR 438-007-0018(1) requires the carrier to provide to claimant "copies of all documents that are relevant and material to the matters in dispute in the hearing, together with an index" not later than 28 days before the hearing.

[3] OAR 438-007-0015 provides for the exchange and disclosure of documents. Subsection (4) provides: "Documents acquired after the initial exchanges shall be provided to the other parties within seven days after the disclosing party's receipt of the documents."

Consequently, we conclude that claimant failed to prove compensability. ORS 656.005(7)(a)(B).

Premature Claim Closure

Finally, claimant contends that, because his left shoulder requires treatment, he is not medically stationary and his claim was prematurely closed. SAIF contends that the proper time for claimant to make such an argument was during the prior proceeding when he requested reconsideration of the Determination Order and that it is not appropriate for us to now consider such an issue. See ORS 656.268(5)(b), 656.268(6)(f), 656.268(8). Inasmuch as we have upheld the denial of claimant's left shoulder condition, it follows that the claim was not prematurely closed. Therefore, even assuming that we could consider the propriety of the prior claim closure, we would reject claimant's contention that the claim was prematurely closed.

ORDER

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

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June 12, 1997 Cite as 49 Van Natta 757 (1997)

In the Matter of the Compensation of
**SHARON K. RORABAUGH, Claimant**
WCB Case No. 95-12447
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that affirmed an Order on Reconsideration awarding no scheduled permanent disability for a right arm condition. On review, the issue is extent of scheduled permanent disability.

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

For the reasons stated by the ALJ, we agree that claimant proved no entitlement to scheduled permanent disability. Claimant also asserts that the ALJ erred in allowing her only to testify as an offer of proof. Although acknowledging prior Board cases holding that ORS 656.283(7), which prohibits the admission at hearing of evidence that was not submitted on reconsideration, does not violate constitutional protections, claimant argues that this case is "distinguishable" because claimant "had absolutely no way of knowing what the arbiter had to say prior to the issuance of the Order on Reconsideration" and that "the hearing was the first opportunity claimant had [the] opportunity" to respond to the arbiter's report.

As we have previously noted, claimant could have asked the Director to abate, withdraw and/or amend the order to correct any errors in the reconsideration order itself at any time after the Department issued the Order on Reconsideration until she requested a hearing. E.g., Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996). Thus, although claimant could not predict the substance of the arbiter's report, she had an opportunity to respond to the arbiter's report before requesting a hearing. In sum, we find no merit to claimant's argument.

ORDER

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

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In the Matter of the Compensation of
**GEORGE A. VENABLE, Claimant**
WCB Case No. 96-02202
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that set aside its denial of claimant's consequential condition claim for depression. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant compensably injured his left knee on May 3, 1993. He was initially seen by Dr. Mortimer-Lamb, and then changed to Dr. Wiltse. In August 1993, Dr. Wiltse recommended a surgical consultation, and claimant was examined by Dr. Watrous. (Ex. A-1) Dr. Watrous ultimately performed a medial meniscectomy and anterior cruciate ligament reconstruction on claimant's left knee in October 1993. (Exs. A, B, 2, 4A-1). Claimant continued to treat with Dr. Watrous through October 1994.

Claimant's left knee injury claim was closed by a June 1995 Determination Order. Claimant was awarded 17 percent unscheduled permanent disability and 56 percent scheduled permanent disability for the loss of use of his left leg.

In the meantime, as early as September 1993, Dr. Wiltse has prescribed Zoloft to claimant. Claimant has taken the Zoloft, an anti-depressant, on a daily basis since that time. (See Exs. A-3, C-3, 2D-2).

In March 1995, claimant was examined by Drs. Gancher and Staver at the insurer's request for symptoms related to his accepted injury. Among other things, Drs. Gancher and Staver found no substantial evidence to indicate that claimant had a psychological problem in addition to his knee injury. (Ex. 2D-6). In April 1995, Dr. Wiltse concurred with the report of Drs. Staver and Gancher in its entirety.

In January 1996, Dr. Wiltse reported that he prescribed the Zoloft to treat claimant's depression, which developed as a result of the compensable injury and subsequent disability. On February 27, 1996, the insurer denied the compensability of claimant's depression.

On May 15, 1996, claimant was examined by Dr. Fried, a psychiatrist, at the insurer's request. Dr. Fried opined that although claimant showed worry, anxiety and depressed mood regarding his injury, he did not have any diagnosable psychiatric condition related to the compensable injury.

## CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant sustained his burden of proving that his depression condition was caused in major part by the compensable injury of May 3, 1993. We find to the contrary.

Under ORS 656.005(7)(a)(A), claimant has the burden of establishing that his compensable injury, including injury-related sequelae, is the major contributing cause of his alleged depression.[1] Where, as here, the medical evidence as to the nature and cause of claimant's psychological condition is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986).

In this case, Dr. Wiltse was the only doctor to diagnose depression and to relate that depression to claimant's compensable injury. Neither Dr. Watrous, who was claimant's surgeon and attending physician between August 1993 and October 1994 nor the insurer-arranged medical experts who

[1] As noted in the insurer's appellant's brief, the issues in this case are whether claimant suffers from depression and whether that depression is compensable as a consequence of his accepted injury. The insurer does not dispute claimant's continued use of Zoloft for pain management purposes.

examined claimant in 1994 and 1995,[2] identified any psychological condition or diagnosed depression in connection with claimant's knee injury. (See Exs. A, C, 2D). Furthermore, Dr. Fried, who examined claimant in May 1996, specifically found no psychiatric condition causally related to claimant's compensable injury. Dr. Fried determined that although the administration of Zoloft may be appropriate to help manage claimant's chronic pain and to modulate his anger, claimant's compensable injury was not the major contributing cause of any consequential psychological condition. (Ex. 6A).

On this record, we are not persuaded by Dr. Wiltse's opinion because it is conclusory and lacking in explanation and analysis. As noted above, in April 1995, Dr. Wiltse concurred with Drs. Gancher and Staver that claimant had no psychological problem related to his compensable injury. (Exs. 2D-6, 6). This concurrence is at odds with Dr. Wiltse's subsequent opinion that claimant has suffered from injury-related depression since at least September 1993. (Ex. 8-1). Because Dr. Wiltse did not explain his apparent change of opinion regarding claimant's psychological condition, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987).

In addition, we note that Dr. Wiltse's diagnosis is not supported by the contemporaneous medical reports. The only evidence indicating that claimant suffered from depression is Dr. Wiltse's July 10, 1996 report, in which he explained that when he prescribed the Zoloft in September 1993, claimant exhibited a depressed mood, fatigue, low self-esteem and feelings of hopelessness. There are, however, no records documenting claimant's psychological treatment or progress between 1993 and 1996. After considering the record as a whole, we conclude that claimant has not proven by a preponderance of the evidence that he has experienced a major depressive episode caused in major part by his compensable injury. We therefore reverse the ALJ's order on the issue of compensability.

ORDER

The ALJ's order dated August 30, 1996 is reversed. The insurer's denial of depression is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] At the insurer's request, claimant was examined by Drs. Staver and Brooks on February 18, 1994 and by Drs. Gancher and Staver on March 11, 1995.

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June 12, 1997 Cite as 49 Van Natta 759 (1997)

In the Matter of the Compensation
**SUSANNE E. STARK, Claimant**
WCB Case No. 96-05760
ORDER REMANDING
Goldberg & Mechanic, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Claimant has requested Board review of Administrative Law Judge (ALJ) Herman's order that: (1) upheld the self-insured employer's denial of claimant's injury/occupational disease claim for a lumbar, thoracic and cervical condition; and (2) declined to assess penalties and attorney fees. The hearing was electronically recorded.

Following claimant's request for review, a transcript of the proceeding was requested. See ORS 656.295(3). However, the second of two tapes used in recording the hearing was blank. Thereafter, the Board's staff counsel notified the parties and asked the parties to explore the possibility of reaching an agreement regarding the events/testimony that had transpired during the unrecorded phase of the hearing.

In response to the Board's staff counsel's notification, the employer's counsel set forth a summary of testimony from the two witnesses who spoke during the unrecorded phase of the hearing. In reply, claimant's counsel stated that she was "not in a position to disagree or agree with [the employer's counsel's] characterization of the testimony of those two witnesses."

In light of such circumstances, we find that a complete hearing transcript is unobtainable. Moreover, the parties have been unable to reach a stipulation regarding all relevant facts developed by the testimony provided during the unrecorded phase of the hearing.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction or other necessary action. See ORS 656.295(5). Inasmuch as a complete transcript of the hearing has been rendered unobtainable and the parties have been unable to reach an accommodation concerning the "unrecorded" testimony, we conclude that the present case has been incompletely and insufficiently developed. Consequently, remand is warranted. See Nicolai D. Mathiesen, 47 Van Natta 2298 (1995).

Accordingly, the ALJ's October 22, 1996 order, as reconsidered December 11, 1996, is vacated and this matter is remanded to ALJ Herman for the introduction of evidence from the witnesses who testified during the "unrecorded" phase of the prior hearing. This evidence may be presented and admitted in whatever manner the ALJ deems achieves substantial justice. Following the admission of this previously omitted evidence, ALJ Herman shall issue a final, appealable, Order on Remand addressing the effect, if any, this additional evidence has had upon her prior order. Any dissatisfied party may then request Board review of the ALJ's Order on Remand.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**TATYANA ZIMA, Claimant**
WCB Case No. 96-04385
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that awarded 3 percent (9.6 degrees) unscheduled permanent disability for claimant's thoracic condition, whereas an Order on Reconsideration had awarded 17 percent (54.4 degrees) for thoracic and cervical conditions. On review, the issue is extent of unscheduled permanent disability.

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

We do not find that the Director lacked subject matter jurisdiction to decide whether claimant's cervical impairment is injury-related. However, we note (as did the ALJ) that the accepted condition is a "thoracic strain" and claimant did not file a claim for a new cervical condition. See ORS 656.262(7)(a). Under these circumstances, we agree with the ALJ that an issue regarding the compensability of a cervical condition is not ripe. The statutory scheme set out in ORS 656.262(7) limits compensability litigation in the "extent" rating process. See Robin W. Spivey, 48 Van Natta 2363, 2366 (1996). Our conclusion in Spivey, (that ORS 656.262(7)(b) does not apply unless the accepted condition is a "combined" condition) "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." Id. at n.6 (emphasis in original); see also Brian D. Shipley, 48 Van Natta 994, 996 (1996) (Where the claimant did not comply with ORS 656.262(7)(a), we declined to address the compensability of a non-accepted condition); Charles S. Grove, 48 Van Natta 829, 830 n.2 (Compensability of a non-accepted condition was not properly before the ALJ, where no formal claim for that condition had been made). See also ORS 656.262(6)(b) (the notice of acceptance shall "[s]pecify what conditions are compensible") and ORS 656.268(16) (conditions that are direct medical sequelae to the original "accepted injury" shall be rated). Accordingly, we agree that the Department's permanent disability award for a cervical condition must be reversed.

ORDER

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

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In the Matter of the Compensation of
**DEBBIE A. KAHN, Claimant**
Own Motion No. 97-0114M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys
Industrial Indemnity, Insurance Carrier

Claimant requests reconsideration of our March 20, 1997 Own Motion Order in which we declined to reopen her 1977 claim for the payment of temporary disability compensation because she failed to establish she was in the work force at the time of her current disability. On April 17, 1997, we abated our prior order to allow the insurer sufficient time to respond to claimant's motion. Having received the insurer's response, we issue the following order in place of our prior 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 November 5, 1996, Dr. Golden, claimant's treating physician, recommended that claimant undergo an anterior diskectomy with interbody fusion at L4-5 and L5-S1. Thus, we continue to 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).

The insurer contends that claimant was not in the work force at the time of disability. Claimant contends that she qualifies for temporary disability compensation because, although willing to work, it was futile for her to work or to seek work because of the compensable injury at the time of disability. Claimant has the burden of proof on this issue, and must provide persuasive evidence that she was willing but unable to work because of her compensable injury during the relevant time period.

Claimant contends that she ceased working in June of 1994 because of her compensable injury. The insurer does not contend that claimant has been unable to work since 1994. Rather, it contends that it was not futile for claimant to work or to seek work because of her compensable back condition since June 1994.

We recite a brief history of this claim. The insurer initially accepted claimant's 1977 "L4, L5-S1 fusion" injury. In December 1979, claimant underwent a lumbar laminectomy at the L4-5 level with spinal fusion. Claimant underwent carpal tunnel surgery in August 1993. In September 1993, claimant underwent a cervical discectomy.

In June 1994, claimant left her job as a log truck driver. In a September 27, 1994 medical report, Dr. Weller, consulting physician, noted that claimant was referred by Dr. Marjanovic for evaluation of low back, neck, arm and leg pain, and headaches. Dr. Weller reported that claimant complained of constant low back pain with occasional intermittent stabbing pain, travelling down the back of her legs to her knees. Claimant also described constant pain behind her left shoulder blade, numbness in the lower arms and forearms, travelling into her hands.

In a November 1, 1994 report, Dr. Dickerman, examining claimant at the insurer's request, stated that "[claimant] indicates that her main problems are in the low back." Furthermore, Dr. Dickerman noted that in Dr. Baker's March 1, 1994 through June 22, 1994 records, claimant complained of neck, back and bilateral arm pain. Dr. Dickerman further stated that:

> "The records reveal that [claimant] was referred to Dr. Rees Freeman, his first consultation and evaluation of July 14, 1994 with subsequent notes have been available. The main complaint on that occasion was of an insidious onset with steady progression of low back pain, pain progressing down into [claimant's] lower extremities, described as back, buttock, posterior thighs, posterior calves on the right, lateral anterior aspect of the calf on the right."

Dr. Dickerman also noted that, in July 1994, Dr. Freeman recommended surgical intervention for claimant's low back. No surgery was recommended at that time for any other condition.

In an April 13, 1995 medical report, Dr. Kuller, consulting orthopedic surgeon, also noted that claimant was examined by Dr. Freeman in 1994 for recurrent left low back and leg pain. Dr. Kuller further noted that an MRI and CAT scan were performed at Dr. Freeman's request, and that Dr. Freeman diagnosed lumbar stenosis at that time. Dr. Kuller reported that claimant was currently being treated for severe left shoulder pain, neck and carpal tunnel symptoms, as well as her current low back pain. Dr. Kuller opined that claimant's low back pain at that time was secondary to fibromyalgia.

In a March 8, 1996 report, Dr. Golden diagnosed stenosis of the spinal canal at L3-4, with L5 and S1 hypalgesia in the right lower extremity. A myelogram, CT scan and four-level lumbar discography were performed to determine whether claimant's low back condition required surgery. In April 1996, Dr. Karasek opined that claimant's need for treatment was due either to the stenosis at L3-4 or discogenic pain within the fusion itself. On May 1, 1996, the insurer denied the compensability of claimant's current low back condition; that denial was set aside by Opinion and Order dated September 10, 1996. The insurer subsequently accepted claimant's current "back & L leg pain" condition.

On November 5, 1996, Dr. Golden recommended anterior diskectomy with interbody fusion at L4-5 and L5-S1. On January 7, 1997, the managed care organization (MCO) disapproved the proposed surgery. Dr. Golden appealed the MCO's decision. On January 16, 1997, the MCO again declined to certify the proposed surgical procedure.

However, Dr. Miller provided a second opinion that Dr. Golden's surgical recommendation was appropriate. In his February 25, 1997 report, Dr. Miller opined that claimant "has developed a progressive internal disk disruption underneath her fusion at both of her previous fusion levels." Dr. Miller further opined that claimant "is clearly disabled by her pain." Finally, Dr. Miller opined that claimant was an excellent candidate for the surgery, and that he would "expect an interbody fusion at L4-5 and L5-S1 to completely relieve all her pain." On March 3, 1997, the insurer informed Dr. Golden that the surgery was approved. On March 17, 1997, claimant underwent the surgery recommended by Dr. Golden.

The record establishes that claimant has been disabled in major part by low back pain since early 1994, although she complained of other conditions as well during that time. However, the record also establishes that, although surgery had been recommended for claimant's low back condition since 1994, no surgical intervention was required for any other condition since that time.

Dr. Golden provides the final persuasive opinion in this matter. In an April 11, 1997 letter, Dr. Golden opined that:

> "I started treating [claimant] on February 26, 1996 and certainly from that date on, she has been incapable of performing work, due to her work-related injury. However, she was not able to work according to other records since June 1994. I believe this is also due to her work-related injury. However, I do not have full documentation of all the findings from June 1994 to February 1996. In this regard, you may have to consult with Dr. Marjanovic for more comprehensive documentation. Nevertheless, it is my opinion that [claimant] was incapable of performing her regular duty from June, 1994."

Dr. Golden further opined that claimant's low back condition had progressively worsened since February 1996, and that "[t]here was never any period of time under my management that [claimant] could have returned to work."

On this record, we conclude that claimant has established that, although other complaints have occurred between the time she left work in June 1994 and March 1997, her compensable low back condition was the only condition for which surgery was consistently recommended. Dr. Golden opined that claimant was unable to work because of her compensable injury since June 1994. Therefore, although other complaints may have initially contributed to claimant's inability to work, we conclude that claimant's compensable low back condition provided the major contribution to her inability to work or to seek work at the time of current disability. See Dawkins v. Pacific Motor Trucking, 308 Or at 254. Compare, Bill L. Martin, 48 Van Natta 448 (1996) (although unable to work, in part, because of a compensable injury, the claimant was disabled, in major part, by nondisabling injuries).

The insurer contends that claimant's application for social security benefits "call[s] into question her expectation of returning to work." We treat the insurer's contention as an assertion that claimant was not willing to work or to seek work at the time of disability. However, we have previously found that the receipt of social security benefits is not determinative in establishing whether a claimant qualifies for temporary disability compensation. See Robert E. Carper, 48 Van Natta 1160 (1996); Kenneth C. Felton, 48 Van Natta 725 (1996). Furthermore, claimant submitted an April 12, 1997 affidavit, in which she stated that:

> "I successfully worked form 1981 to June, 1994. On June 23, 1994, I stopped working due to the worsening of my workers' compensation injury which has now resulted in an anterior diskectomy and interbody fusion.
>
> "I have been more than willing to work from June, 1994 to present but with the worsening of my low back condition I experienced increasingly disabling pain. Due to the severity of the pain my physicians removed me from work. In addition, as my low back condition worsened and the pain became progressively worse, I did not seek employment because no employer would have hired me in that condition. As such, seeking work would have been futile."

We are persuaded by claimant's affidavit that she was willing to work. See Janice Connell, 47 Van Natta 292 (1995).

On this record, we find that claimant has established that she was in the work force at the time of her current disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning March 17, 1997, the date she was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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June 13, 1997 Cite as 49 Van Natta 763 (1997)

In the Matter of the Compensation of
**JACK B. HOOPER, Claimant**
WCB Case No. 96-03400
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Moscato, Skopil, et al, Defense Attorneys

The self-insured employer requests reconsideration of our May 23, 1997 Order on Review. In that order, we adopted and affirmed, with supplementation, Administrative Law Judge (ALJ) Neal's order that dismissed the employer's hearing request from an Order on Reconsideration that granted claimant permanent total disability benefits.

In our supplementation, inter alia, we rejected the employer's argument that the Department was without subject matter jurisdiction to issue the Order on Reconsideration. Specifically, citing SAIF v. Roles, 111 Or App 597 (1992), we noted that subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry and exists when a statute authorizes that body to do something about the dispute. We found that, in this case, the Department clearly had the authority under ORS 656.268 and 656.704 to address the issue in dispute. Therefore, we found that, contrary to the employer's argument, the reconsideration order was not void ab initio and could not be collaterally attacked due to lack of subject matter jurisdiction.

Seeking reconsideration, the employer renews its argument that the Department did not have subject matter jurisdiction to issue the Order on Reconsideration and, therefore, the order may be collaterally attacked. Claimant opposes the employer's motion. Finally, the employer has replied to claimant's challenge to its motion.

We withdraw our May 23, 1997 order. After consideration of the parties' positions, we adhere to the reasoning and conclusions expressed in our initial Order on Review.

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

Accordingly, as supplemented herein, we republish our May 23, 1997 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GREGORY C. NOBLE, Claimant**
WCB Case No. 96-01824
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the insurer's denial of claimant's right knee injury claim; and (2) declined to assess a penalty for an 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 with the following correction and exception. Claimant slipped on a piece of bark while working for the insured on October 28, 1995. We do not adopt the second finding of ultimate fact.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

Claimant first injured his right knee while in the Navy in 1967 when he was involved in a motorcycle accident. Treatment for that injury consisted of crutches and light duty for a couple of days. In 1975, claimant underwent right knee surgery after spraining his right knee. This surgery included an open medial meniscectomy and a medial collateral ligament repair with staple placement. The surgery eliminated the sensation of buckling which claimant had been experiencing since the motorcycle accident.

In 1987, claimant underwent several arthroscopies, including one performed on June 10, 1987 that involved staple removal and debridement. At that time, claimant was noted to have degenerative joint disease (DJD) in the right knee. On September 12, 1988, claimant underwent an arthroscopy to remove a loose body from the suprapatellar region of the right knee. During this surgery, claimant was again noted to have DJD.

On October 28, 1995, claimant sustained an injury to the right medial collateral ligament (MCL) when he slipped on a piece of bark while working for the insured. On November 10, 1995, claimant began treating with Dr. Lange, orthopedist, due to increased right knee pain. Dr. Lange took x-rays of the right knee which showed severe DJD in all three compartments but worse along the medial compartment, which appeared to be bone on bone on the notch view. (Ex. 1-2). At that time, Dr. Lange diagnosed "severe DJD, right knee" and "acute sprain, right MCL." Id. On November 30, 1995, after claimant did not experience lasting improvement with conservative treatment, which included an injection to the right knee, Dr. Lange suggested a total knee arthroplasty (TKA). (Ex. 3). On January 4, 1996, after conservative treatment continued to provide no relief, claimant agreed to the TKA.

On January 12, 1996, claimant was examined by Dr. Donahoo, orthopedist, and Dr. Melson, neurologist, on behalf of the insurer. (Ex. 4). Drs. Donahoo and Melson opined that claimant's preexisting right knee DJD combined with the October 28, 1995 injury, which history they found compatible with strain or sprain of the right MCL. (Ex. 4-6). They opined that the preexisting DJD was the major contributing cause of the residual in claimant's knee. (Ex. 4-7). On January 30, 1996, Dr. Strukel, orthopedist, performed a record review on behalf of the insurer. (Ex. 5). Dr. Strukel opined that the need for the TKA was due entirely to claimant's preexisting DJD. (Ex. 5-4).

On February 2, 1996, the insurer issued a denial of claimant's claim for a right knee injury. (Ex. 7). Claimant requested a hearing on this denial.

The ALJ found that claimant suffered from severe DJD, which had been previously treated surgically on several occasions. In addition, there was no dispute that the preexisting condition combined with the October 1995 injury to produce the symptoms which necessitated medical treatment and resulted in disability at the onset of the claim. Given this, the ALJ found that ORS 656.005(7)(a)(B)[1] was applicable. The ALJ further found that claimant failed to meet his burden of proof under ORS 656.005(7)(a)(B). While we agree that claimant's claim is governed by ORS 656.005(7)(a)(B), we find that he has established a compensable claim under that statute.

Given the court's recent decision in SAIF v. Nehl, 148 Or App 101 (1997), which issued after the ALJ's order, we find it necessary to review the court's interpretation of ORS 656.005(7)(a)(B) in order to decide the proper application of that statute to the facts of this case.

In Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995), the court applied former ORS 656.005(7)(a)(B)[2] to an initial injury claim. There, the claimant had preexisting coronary artery disease and suffered a heart attack after being exposed to smoke at work. The physicians evaluating the cause of the claimant's heart attack either found that the smoke incident caused or precipitated the heart attack. The court held that former ORS 656.005(7)(a)(B) applied and required an assessment of the "major contributing cause." In explaining what that standard entailed, the court rejected the claimant's position that a work event that is the immediate cause of a disease or injury is always also the major cause. Instead, citing past court cases that applied the "major contributing cause" standard, the court held that "determining the 'major contributing cause' involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause." Dietz, 130 Or App at 401 (emphasis in original, citations omitted). Furthermore, the court concluded that, "although work activities that precipitate a claimant's injury or disease may be the major contributing cause, that is not necessarily always true. Under [former] ORS 656.005(7)(a)(B), the relative contribution of each cause, including the precipitating cause, must be evaluated under the particular circumstances." Id. at 401-02.

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[1] ORS 656.005 provides, in part:

"(7)(a) A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; * * *

"* * * * *

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

[2] Former ORS 656.005(7)(a)(B) provided:

"If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

In Robinson v. SAIF, 147 Or App 157, 162 (1997), the court again relied on its analysis in Dietz in applying ORS 656.005(7)(a)(B) to an injury claim. In Robinson, the claimant had a preexisting bilateral hernia condition. After a lifting incident at work, the claimant's "combined condition" was a symptomatic left inguinal hernia. The Robinson court rejected the claimant's argument that the Board erred because it disregarded the language in ORS 656.005(7)(a)(B) that provides that an injury that combines with a preexisting condition is compensable if it is the major contributing cause for the claimant's need for treatment of the "combined" condition. The court found that, while the Board had correctly stated the law, it focused on the major cause of the combined condition itself, rather than addressing the major contributing cause of either "the disability of the combined condition" or "the need for treatment of the combined condition." Id. However, the court noted that the claimant did not explain why the major contributing cause of the need for treatment in that case should be different from the major cause of the hernia itself. The court stated that, "[a]lthough there may be cases where that difference exists, we do not see that that is the case here. Although the Board could have chosen its words with the statute closer in mind, it did not apply the wrong test." Id.

In addition, the court found that the "Board also did not err in finding that [the] claimant failed to establish that his work activity was the major contributing cause of his need for treatment." Id. In support of this finding, the court cited Dietz and restated that determination of the major contributing cause involves evaluation of the relative contribution of different causes and determining the primary cause. In addition, the court emphasized that "the 1995 amendments to ORS 656.005(7)(a)(B) make it clear that it is the primary cause of the disability or need for treatment of the combined condition that must be determined." Id. (emphasis in original).

Finally, in SAIF v. Nehl, 148 Or App at 103, the court most recently applied ORS 656.005(7)(a)(B). There, as a result of a noncompensable low back injury, the claimant underwent multiple surgeries, including a surgical fusion from L3 to the sacrum with the installation of Steffe plates, which were secured to the spine with screws. Several years later, the claimant experienced a change in his back pain while working. Subsequently, the claimant was found to have loss of bone around the screws in the L3 vertebrae and underwent another surgery on his low back. He filed a claim for a low back injury, which the carrier denied.

After a hearing, the ALJ set aside the carrier's denial, finding that the claimant's otherwise compensable injury was the major contributing cause of the need for treatment of his combined low back condition under ORS 656.005(7)(a)(B). The Board adopted and affirmed the ALJ's order. The carrier appealed.

In rendering its decision, the Nehl court quoted from the ALJ's order, finding that "the 'combined condition' was the claimant's post surgical low back with loosened hardware" and "the surgical treatment being claimed (the surgical repair of the failed fusion instrumentation) is directed at a very specific and limited part of [the] claimant's 'combined condition.'" Id. at 105. The court also quoted the legal standard the ALJ used in applying ORS 656.005(7)(a)(B): "The focus of the fact finder in determining the applicability of ORS 656.005(7)(a)(B) is on the entire combined condition. It requires a determination of the relative contributions to the need for treatment of the combined condition or to the disability arising from the combined condition." Id. at 105.

The court rejected the carrier's argument that the claimant must show that his entire combined condition, not just his specific need for treatment, was caused in major part by his work injury. The court stated that:

> "[ORS 656.005(7)(a)(B)] provides that the on-the-job injury must be the major contributing cause of the need for treatment, not the major contributing cause of the combined condition. Accord Robinson v. SAIF, 147 Or App 157, 162 * * * (1997) ('The Board also did not err in finding that claimant failed to establish that his work injury was the major contributing cause of his need for treatment')." id.

The court found that the Board had used the correct test and concluded that, "regardless of the extent of claimant's underlying condition, if the immediate cause of claimant's need for treatment is an on-the-job accident, the treatment is compensable." Id. at 106.

In isolation, this final statement from the Nehl court could be read as overturning the major contributing cause standard discussed in Dietz and its progeny, i.e., the requirement that determination of major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause. For the following reasons, we do not interpret the court's final statement in Nehl in such a manner.

In the first place, as quoted by the court, by adopting and affirming the ALJ's order, the Board's order restated the general Dietz analysis. Furthermore, the Nehl court found that the Board used the correct test. In addition, the Nehl court found that its decision in Robinson was in accord with its current decision, focusing on that part of the Robinson decision that relied on the Dietz analysis in determining that the Board did not err in finding that the claimant had failed to establish that his work injury was the major contributing cause of his need for treatment. Nehl, 148 Or App at 106; Robinson, 147 Or App at 162.

Moreover, the Nehl court's decision focused on whether ORS 656.005(7)(a)(B) required a determination of the major contributing cause of the entire combined condition or the major contributing cause of the need for treatment. This is in contrast to Dietz, which focused on analyzing what constituted major contributing cause, without any discussion of "combined condition" versus "need for treatment."

Further, the Nehl court did not discuss changing the standard used to determine the major contributing cause. In fact, the court did not explicitly discuss Dietz or the "major contributing cause" standard at all. We conclude that, if the court had intended to make such a substantial change in the law, it would have explicitly done so.

The court in Robinson acknowledged that the Board's focus on the major contributing cause of the claimant's combined condition itself was inexact. The Robinson court also noted that, although there might be cases where there would be a difference between the major contributing cause of the need for treatment and the major contributing cause of the combined condition, it did not find such a difference in that case. However, the court apparently found such a difference in Nehl and focused on the major contributing cause of the need for treatment there.

Finally, as noted in the Robinson decision, ORS 656.005(7)(a)(B) provides that it is the major contributing cause of the disability of the combined condition or of the need for treatment of the combined condition that must be determined. 147 Or App at 162. The court is without authority to omit statutory language. ORS 174.010. Therefore, we decline to interpret the Nehl holding in a manner that would, in effect, omit statutory language regarding the major contributing cause of the disability or the need for treatment of the combined condition. ORS 656.005(7)(a)(B).

Therefore, considering all of these factors, we find that Nehl did not overturn the Dietz analysis regarding determination of the major contributing cause. Instead, we find that Nehl held that a claimant is not required to prove a work injury is the major contributing cause of the entire combined condition; rather, he or she must prove that the work injury is the major contributing cause of the need for treatment of the combined condition. In reaching that compensability determination, the standard for proving major contributing cause, as articulated by Dietz and its progeny, remains unchanged.

Here, Drs. Lange, Donahoo, and Melson opined that the October 1995 work injury to claimant's right MCL combined with claimant's preexisting DJD to cause the subsequent disability and need for treatment. (Exs. 4-6, 8). Dr. Strukel does not render an opinion regarding whether the conditions combined.

The issue is whether claimant has established that the MCL injury is the major contributing cause of the disability or need for treatment of the combined condition pursuant to ORS 656.005(7)(a)(B). Determination of major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment (the TKA) of the combined condition (the right MCL injury and the preexisting DJD) and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App at 401. Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993).

Drs. Donahoo and Melson opined that more than 90 percent of the changes described in the x-rays and clinically presented on the date of their January 12, 1996 examination predated the October 28, 1995 work injury. (Exs. 4-7). They found that these changes could not have occurred in the interim between October 28, 1995 and November 19, 1995, the date Dr. Lange first examined claimant. Id. They concluded that "the pre-existing condition is the majority (greater than 51 percent) of [claimant's] residual in the knee." Id.

Dr. Strukel also opined that the radiologic features of claimant's DJD did not occur within 10 to 15 days of injury. (Ex. 5-4). He found that claimant's problem was long-standing, requiring multiple surgeries which led to severe DJD in all compartments of the right knee. He noted that the treatment for a MCL strain or sprain would consist of two to three weeks of protected weight bearing with quadriceps rehabilitation and protection against further injury. Therefore, Dr. Strukel concluded that claimant's continuing need for treatment and the need for a TKA was entirely due to the DJD. Id.

Dr. Lange acknowledged that claimant had significant preexisting degenerative arthritis in his right knee prior to the work injury. However, Dr. Lange noted that claimant did not have any significant pre-injury instability in his right knee. (Ex. 8-1). He opined that the October 28, 1995 injury resulted in a Grade II tear of the MCL, which converted a knee that was previously mechanically stable to one with significant instability. (Ex. 8-2). He noted that, while claimant had some activity-related pain in his right knee before the work injury, those symptoms did not limit claimant's ability to work or perform activities of daily living. However, after the October 1995 work injury, the newly acquired right knee instability caused increased pain to where claimant could no longer walk more than 2-3 minutes and could not put his own shoes on or off. Id. Finally, Dr. Lange found claimant's preexisting knee condition responsible for 20-30 percent of his current knee condition, and the October 28, 1995 work injury responsible for 70-80 percent. Id.

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). There is no persuasive reason in this case not to defer to claimant's treating physician, Dr. Lange, whose opinion is well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259 (1986). Furthermore, Dr. Lange evaluated the relative contribution of the different causes of the injury and found that the work injury represented 70 to 80 percent of the cause. Thus, Dr. Lange's opinion establishes that the major contributing cause of claimant's need for treatment is the work injury. ORS 656.005(7)(a)(B); Dietz, 130 Or App at 401.

In addition, we also find persuasive reasons to discount the countervailing medical opinions. Drs. Donahoo and Melson focused on the major contributing cause of claimant's entire combined condition, rather than the cause of claimant's current need for treatment for his combined condition. Finally, unlike Dr. Lange, who had an opportunity to examine and treat claimant several times, Dr. Strukel performed only a record review.

In conclusion, based on Dr. Lange's persuasive opinion, we find that claimant has established a compensable right knee injury claim. Accordingly, we set aside the insurer's denial.

Penalties

The ALJ declined to assess a penalty based on the insurer's allegedly unreasonable denial, finding that the insurer had legitimate doubt concerning its liability for the claim based on the opinions of Drs. Donahoo, Melson, and Strukel. We adopt the ALJ's reasoning and conclusions on this issue. While we have found these opinions unpersuasive, they still provided the insurer with legitimate doubt concerning its liability.

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 $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 22, 1996 is reversed in part and affirmed in part. That portion that upheld the insurer's denial of claimant's right knee injury claim is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded a fee of $3,500, payable by the insurer.

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

I agree that claimant is not entitled to a penalty based on the insurer's allegedly unreasonable denial. Furthermore, I agree with the majority's interpretation of SAIF v. Nehl, 148 Or App 101 (1997), and its conclusion that Nehl did not change the major contributing cause standard in ORS 656.005(7)(a)(B), as explained in Dietz v. Ramuda, 130 Or App at 401. However, I disagree that the opinion of Dr. Lange meets that standard. Therefore, I respectfully dissent regarding the compensability issue.

Applying ORS 656.005(7)(a)(B) to the facts of this case, I would adopt the ALJ's reasoning and conclusions that claimant has failed to establish a compensable claim. In this regard, only Dr. Lange supports claimant's claim. Furthermore, although Dr. Lange is claimant's current treating physician, the record indicates that Dr. Lange only saw claimant three times. Therefore, Dr. Lange has no long treatment history with claimant, the primary reason for deferring to the opinion of a treating physician. See Weiland, 64 Or App at 814 (absent persuasive reasons to do otherwise, Board will generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time). Furthermore, there are very persuasive reasons not to defer to Dr. Lange's opinion.

Dr. Lange saw claimant twice in November 1995, and once on January 4, 1996. (Exs. 1, 3). At each of the November 1995 visits, Dr. Lange diagnosed severe DJD, right knee and acute MCL sprain, right knee. (Exs. 1-1, 3-1). In his November 30, 1995 chart note, Dr. Lange discussed claimant's treatment options, stating:

> "Those options include living with his pain as it currently exists, having knee arthroscopy done which might decrease some of his intra-articular symptoms but would, of course, not treat his medial collateral ligament sprain, or having a right TKA performed which would eliminate his interarticular symptoms. One would need to wait for another month or two before one proceeded with that operation in order to give the MCL enough time to heal before the operation is done. [Claimant] understands that he will need to have a total knee replacement arthroplasty done at some point. He wishes to delay the operation as long as possible. He is hopeful that it is his MCL sprain and that he will be able to return to his pre-injury level of function which was to have soreness in the knee at the end of an active day; but, otherwise, to be able to get around fairly well." (Ex. 3-1).

Dr. Lange provided no diagnosis in the January 4, 1996 chart note, although he noted that claimant needed a right TKA and claimant agreed to proceed with it. (Ex. 3-3). The record contains no indication that Dr. Lange saw claimant after the January 4, 1996 visit.

On January 31, 1996, Dr. Lange reviewed the report from Drs. Donahoo and Melson and stated that, although they had an accurate history and physical findings, he reached a different conclusion based on that information. Dr. Lange stated that, while claimant has preexisting degenerative changes and previous surgery on his injured knee, he was able to perform very vigorous occupations without significant difficulty since 1987. However, as a result of the October 1995 injury, claimant was no longer able to work. Dr. Lange stated that the October 1995 injury dramatically worsened claimant's knee. He apportioned the preexisting knee condition as 20-30 percent of the current knee condition and the October 28, 1995 injury as 70-80 percent responsible for claimant's current difficulty. He emphasized that claimant was able to work before the work injury and was unable to work after that injury.

On April 11, 1996, Dr. Lange concurred with a statement from the insurer's attorney that it was Dr. Lange's opinion that claimant's disability and need for treatment after October 28, 1995 was caused by the combination of both an acute sprain and the preexisting knee condition, with the work incident primarily responsible for claimant's current right knee condition. (Ex. 8).

The next day, April 12, 1996, Dr. Lange submitted an opinion to claimant's attorney in which he opined that the October 28, 1995 injury "resulted in a Grade II tear of [claimant's] medical collateral ligament. This injury converted a knee which was previously mechanically stable to one with significant instability." (Ex. 8A-2). Dr. Lange stated that before the injury claimant had activity-related soreness but those symptoms did not limit his ability to work or perform activities of daily living, whereas, after the October 28, 1995 injury, claimant's newly acquired right knee instability caused or was associated with a dramatic increase in knee pain to where claimant cannot walk more than 2-3 minutes and cannot put his own shoes on or off. Dr. Lange repeated that the October 28, 1995 injury was 70-80 percent responsible for claimant's current difficulty. Id.

Like the ALJ, I do not find Dr. Lange's opinion persuasive. First, Dr. Lange repeatedly diagnosed a MCL sprain and did not see claimant after his January 4, 1996 examination. However, in his April 12, 1996 causation opinion, without explanation, Dr. Lange changes his diagnosis to MCL tear. This represents an unexplained change of opinion, which is not persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Second, Dr. Lange focuses on the increased symptoms that followed the October 1995 incident in rendering his opinion and, in effect, used a "precipitating event" analysis to conclude that the MCL injury is the major contributing cause of claimant's current right knee condition. While I acknowledge Dr. Lange assigned 70-80 percent of the cause of claimant's current right knee condition to the October 1995 injury, the "precipitating event" analysis Dr. Lange used to reach that assignment is not persuasive. Dietz, 130 Or App at 401-02; Robinson, 147 Or App at 162.

Finally, and most importantly, the above-quoted portion of Dr. Lange's November 30, 1995 chart note makes it clear that the major contributing cause of the need for treatment (the TKA) of the combined condition is not the work injury. In this regard, in recommending the TKA surgery, which Dr. Lange opined would relieve claimant's "interarticular symptoms," Dr. Lange stated that such surgery must wait a month or two for the MCL to heal.[1] (Ex. 3-1). If the MCL injury must be allowed to heal before proceeding with the TKA surgery, the MCL injury cannot be the major contributing cause of the need for the TKA surgery.

Therefore, for all of these reasons, Dr. Lange's opinion is unpersuasive. No other opinion supports compensability of the right knee injury claim. Consequently, claimant has not proved that the otherwise compensable MCL injury is the major contributing cause of the need for treatment of the combined condition. Nehl, 148 Or App at 106.

Accordingly, I find that claimant has failed to prove a compensable injury claim under ORS 656.005(7)(a)(B) and would uphold the insurer's denial.

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[1] I note that this opinion regarding the time for the MCL sprain to heal comports with that of Dr. Donahoo, examining orthopedist, who opined it was reasonable for a MCL strain to take up to six weeks to heal. (Ex. 9).

In the Matter of the Compensation of
**MICHAEL BEDSAUL, Claimant**
Own Motion No. 88-0264M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Emmons, et al, Claimant Attorneys
Liberty Northwest, Insurance Carrier

Claimant requests review of the insurer's March 21, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from April 13, 1988 through March 4, 1997. The insurer declared claimant medically stationary as of February 20, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

In an April 30, 1997 letter, we requested the insurer submit copies of materials considered in closing the claim. We received the insurer's response on April 30, 1997. Claimant has submitted no further reply. Therefore, we will proceed with our review.

## FINDINGS OF FACT

On September 17, 1978, claimant injured his low back. Claimant's aggravation rights on that claim expired on July 20, 1986. Claimant's claim was last reopened by the Board on May 18, 1988.

Claimant underwent five low back surgical procedures between 1980 and 1989. Claimant has not worked since 1987. In 1995, claimant underwent a spinal implant to relieve pain. The implant was unsuccessful. Claimant developed pancreatitis, difficulty with his liver, pneumonitis and sepsis as a result of heavy drinking when his methadone intake was reduced.

In 1996, Dr. Guidry, claimant's treating neurosurgeon, suggested spinal fusion and foraminotomies with decompression. Neither Dr. Guidry's recommendation nor medical records to support his opinion are in the record.

A February 20, 1997 Independent Medical Examination (IME) indicated that claimant was medically stationary, that claimant is not a good surgical candidate, and that surgery was not indicated as beneficial or appropriate to improve claimant's condition. On March 21, 1997, the insurer closed claimant's claim.

In an April 8, 1997 letter, Dr. Cole, claimant's treating physician, opined that claimant's electrical stimulator was not effective, and that further neurosurgery was indicated by Dr. Guidry. Dr. Cole opined that claimant was not medically stationary.

In an April 8, 1997 letter to Dr. Guidry, claimant's attorney requested that Dr. Guidry respond to the February 20, 1997 IME. Specifically, Dr. Guidry was asked to respond to four questions / responses indicated by the IME physicians. Dr. Cole responded in Dr. Guidry's stead, opining that claimant was not medically stationary, that claimant's current problems were not due to alcoholism or pancreatitis, and that further surgery was indicated.

## 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 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 21, 1997 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 closing claimant's claim, the insurer relied on a February 20, 1997 Independent Medical Examination report submitted by Dr. Mayhall, orthopedic surgeon, and Dr. Kirschner, neurologist. In response to the insurer's respective inquiries, the IME physicians opined that:

1. Claimant was diagnosed with lumbosacral sprain;

2. Claimant's alcoholism, pancreatitis and liver disease, though unrelated to his 1978 injury, may be playing a role in his present condition;

3. None of claimant's back surgeries provided claimant with any significant benefit; the spinal cord stimulation was ineffective; claimant is not a surgical candidate; objectively, there appears to be no change in claimant's condition; subjectively, claimant complains of more pain; claimant's condition is affected by issues of secondary gain;

4. Claimant was medically stationary on an objective basis;

5. Claimant was medically stationary on February 20, 1997; and

6. Claimant's subjective complaints do not correspond with objective findings; non-physiologic and economic factors are present in claimant's situation.

Claimant submitted two letters from Dr. Cole, his attending physician. In his April 8, 1997 letter, Dr. Cole opined that:

> "The notion that [claimant] is medically stationary is pure and absolute baloney. I have had [claimant] seen by several neurosurgeons. He has an implanted electrical stimulator which is not effective and he needs further neurosurgery as indicated by Dr. George Guidry. The insurance company has been denying this and in fact for the last many years I have thought of several procedures which have generally been denied by the insurance company."

On April 8, 1997, claimant's attorney forwarded a questionnaire regarding the IME physicians' opinions and claimant's medically stationary status to Dr. Guidry. In an April 15, 1997 response, Dr. Cole opined that:

> "[Claimant] asked me to respond since I know him better than Dr. Guidry does. In your statement number one that it was felt that [claimant's] problems are due to alcoholism, etc. That is, I must say, absolute pure 100% baloney. As a matter of fact [claimant] drank to excess because of his pain and because the medical board in Wyoming does not permit us to prescribe enough analgesic medication. They evidently believe that we are contributing to "addiction" and the possible "selling of drugs on the street". Number two I would for the most part pass to Dr. Guidry but I have been following [claimant] for many years and I feel that further surgery is indicated. Number three, I don't know what their thinking was. As to number four, I do not think that his condition is stable. I think it will continue to worsen."

The record establishes that several other surgical procedures were recommended by Dr. Cole over the years, none of which were approved as appropriate or necessary. Claimant has submitted no medical reports other than the statements and opinions of Dr. Cole. Although surgery appears to be "suggested" by Dr. Guidry, no report is submitted from that physician to indicate why he recommends yet another surgery. Because of the lack of medical documentation in the record, we are not persuaded that Dr. Cole's reports rely on any objective measures. Rather, Dr. Cole appears to provide a subjective opinion that it is "pure baloney" that claimant was medically stationary when the insurer closed his claim.

There is no evidence in the record that claimant's condition has improved since his last surgery, nor that it improved with the spinal stimulator implant. Thus, claimant has not established any improvement in his compensable condition, nor do his physicians opine that, even with the "suggested" surgery, claimant will improve. See Gerald D. Duren, 49 Van Natta 162 (1997). Furthermore, we are

not persuaded by Dr. Cole's opinion that, although claimant "drank to excess," and that his drinking caused pancreatitis (which required two hospital stays in 1996), claimant's condition at closure was unaffected by other noncompensable conditions. Dr. Cole opined that claimant's condition "will continue to worsen." The record does not establish that claimant's compensable low back condition has worsened, although it appears that other, noncompensable conditions have worsened. Rather, claimant's low back condition does not appear to have changed since his 1989 surgery. Thus, we do not find Dr. Cole's opinion persuasive because the record does not establish that claimant's compensable condition has improved (nor that it has worsened) with medical treatment or the passage of time. See ORS 656.005(17); Weiland v. SAIF, 64 Or App at 810; Patrick E. Kelly, 48 Van Natta 1642 (1996).

The IME physicians provided a thorough examination, record review, and well-reasoned and well-supported opinions regarding claimant's condition at claim closure. The IME physicians opined that, objectively, and based on the entire record, it was not reasonable to assume that any more surgery would be of any benefit in improving claimant's low back condition. These physicians noted that claimant's claim has been reopened for about nine years, and that "[claimant's low back] situation is very similar, if not the same, over the past approximately 10 years and perhaps before that." The IME physicians also noted other non-physiologic and economic factors which might effect claimant's condition at claim closure. Those factors included: alcoholism with recurrent pancreatitis; pneumonitis; sepsis; hypertension; chronic pain syndrome with inconsistent physical exam findings and pain behavior; supraventricular tachycardia; hypercholesterolemia, cholecystitis; and claimant's economic status being dependent on maintaining "disability."

Claimant must establish that his compensable injury was not medically stationary at claim closure. Claimant's condition has not materially improved since 1989. ORS 656.005(17). There is no medical documentation to support that another surgery would materially improve claimant's condition. Based on this record, we are not persuaded that claimant has met that burden of proof. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's March 21, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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June 17, 1997 Cite as 49 Van Natta 773 (1997)

In the Matter of the Compensation of
**REBECCA C. COLE, Claimant**
WCB Case No. 94-03392
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Schultz' order that upheld the insurer's denials of claimant's current low back, fibromyalgia, myofascial pain syndrome, somatic dysfunction, neck, somatoform pain disorder, mid-back and right shoulder conditions.[1] In its brief, the insurer contends that claimant is barred from litigating the scope of its acceptance. On review, the issues are scope of acceptance, claim/issue preclusion and compensability.

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

Claimant, a jewelry concessionaire, alleged that she sustained a compensable injury on November 28, 1987, when a customer fell into her display stand, requiring her to catch her jewelry and to prevent her display stand from falling. Dr. Helman provided claimant's initial treatment and diagnosed a soft tissue low back strain. (Exs. 28, 29).

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[1] The ALJ's order stated that exhibits 1-44, 32A, and 65A were admitted into evidence. However, there appears to have been a typographical error, since the transcript indicates that exhibits 1 through "144" were admitted. (Tr. 1). The ALJ's order is corrected accordingly.

On March 21, 1988, the insurer denied that claimant had sustained a compensable injury. (32A). However, a prior ALJ determined that claimant had suffered a compensable injury as alleged and set aside the insurer's denial. (Ex. 41). The prior ALJ did not specifically identify the compensable condition, nor did the insurer. Claimant received considerable medical treatment and evaluation over the ensuing years for complaints concerning numerous parts of her body.

Eventually, on January 27, 1994 and October 25, 1994, the insurer denied claimant's "current condition," as well as neck, shoulder and somatoform pain disorder conditions. (Exs. 130, 140). Claimant requested a hearing, contesting the denials.

At the hearing, the issues concerned the scope of the insurer's acceptance and the compensability of a number of conditions: low back strain, fibromyalgia, myofascial pain syndrome, somatic dysfunction, a cervical condition, somatoform pain disorder, a mid-back condition, and a right shoulder condition. The insurer argued that it had only accepted a low back strain, while claimant contended that the insurer's acceptance encompassed all the above conditions. Moreover, the insurer asserted that issue/claim preclusion prevented claimant from expanding the scope of its acceptance. This argument was based on claimant's failure to raise the issue of the compensability of the disputed conditions during a hearing in May 1990 concerning extent of disability.

The ALJ found that the insurer's claim/issue preclusion argument was persuasive. However, the ALJ determined that, even if no preclusive effect attached to the "extent of disability" litigation in May 1990, the medical evidence overwhelmingly established that the claimed conditions were not related to the compensable 1987 injury. Thus, the ALJ upheld the insurer's denials.

On review, claimant contends that the insurer's denials were improper "back-up" denials because the scope of the insurer's acceptance encompassed all the denied conditions. The employer responds that its acceptance was of a low back strain only and that claimant's current condition (including all the denied conditions) is not compensable.[2] We agree with the insurer.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). "Merely paying or providing compensation shall not be considered as an acceptance of a claim or an admission of liability...." ORS 656.262(10).

Here, the insurer did not specifically accept a condition as a result of the prior ALJ's 1988 order. Inasmuch as there was no specific acceptance, we look to the contemporaneous medical evidence to determine what condition the insurer accepted. See Cecilia A. Wahl, 44 Van Natta 2505 (1992) (When an acceptance does not identify a specific condition, contemporaneous medical records are examined to determine the condition accepted).

From our de novo review of the contemporaneous medical records, we are persuaded that the insurer accepted only a low back strain. As previously noted, Dr. Helman diagnosed a soft tissue strain on November 30, 1987, affecting claimant's low back. (Ex. 29). On his form 827, Dr. Helman also noted the diagnosis of "back strain." (Ex. 29). On May 25, 1988, another physician, Dr. Luria, diagnosed a low back strain/sprain. (Ex. 38; see also Ex. 40).

Accordingly, we conclude that, since the insurer's acceptance was limited to a low back strain, it was free to subsequently deny the disputed conditions. It follows from this finding that the insurer's denials in 1994 were not prohibited "back-up" denials. Finally, we agree that, for the reasons the ALJ cited, claimant's "current" low back condition, as well as the other denied conditions, are not compensably related to the accepted 1987 injury. Therefore, we affirm the ALJ's decision to uphold the insurer's denials.

## ORDER

The ALJ's order dated January 3, 1997 is affirmed.

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[2] The insurer also reiterates its claim/issue preclusion argument, but, in light of our resolution of the case, we need not address the merits of the insurer's argument.

In the Matter of the Compensation of
**DONNA C. KUZELKA, Claimant**
WCB Case No. 96-03262
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). In its respondent's brief, the insurer moves to strike portions of claimant's appellant's brief. On review, the issues are the insurer's motion to strike and compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Motion to strike

The insurer moves to strike that portion of claimant's brief which refers to the insurer's allegedly "unlimited resources," contending that there are no facts in the record concerning the insurer's resources. (Appellant's Br. p.2). We need not resolve this motion because we consider the parties' arguments only insofar as they are supported by the record. See Gilbert T. Hale, 43 Van Natta 2329, 2330 (1991) (Board is capable of ignoring unsupported assertions of fact). In any event, the aforementioned reference to "unlimited resources" has no effect on our compensability decision.

### Compensability

We begin with a brief summary of the relevant facts.

Claimant has worked for the employer for 17 years as a computer assistant administrator. She spends about six hours a day typing at a keyboard.

In 1990, the employer moved and claimant began working with new computer equipment. The new equipment required claimant to type with her wrists at about a 45 degree angle. The previous equipment had not required wrist angulation.

In August 1994, claimant first sought medical treatment for right hand numbness. By late 1995, claimant's wrist symptoms were bilateral and severe. Her doctors diagnosed bilateral carpal tunnel syndrome (CTS) and recommended surgery.

The insurer denied claimant's occupational disease claim. Claimant requested a hearing. The ALJ found that claimant failed to carry her burden of proving that work activities were the major contributing cause of her bilateral CTS condition, based on the medical evidence. See ORS 656.802(2). We disagree.

Considering the number of potential causes identified for claimant's condition, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. See Barnett v. SAIF, 122 Or App 279 (1993). We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983); Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

The evidence regarding the etiology of claimant's CTS is provided by Drs. Baum, Fisher, treating surgeon and treating physician, and examining physicians Smith, Aversano, Radecki, and Rosenbaum.

The parties agree that Dr. Fisher's opinion supports the claim.[1] (Exs. 3, 19B). The insurer contends that Dr. Baum does not persuasively support the claim because his opinion changed without explanation and he was ultimately unable to say that work activities caused claimant's CTS. We disagree.

Dr. Baum's initial impression was that claimant's work exposure was the major contributing cause of her CTS. (Ex. 14). Later, he stated that conclusion was not "clear"; it was "really impossible to say what percentage contribution is made" by the various causes; and "I am unable to determine with any precision the percentage which would be related to each of these areas." (Exs. 16A-1, 19). Dr. Baum concluded, more specifically: "Thus it is impossible to indicate with certainly [sic] the percentage contribution by this patient's work activity, by her obesity, by the aging process or by any other etiological factor." (Ex. 16A-2).

We first note that medical probability, not certainty, is the required standard of proof. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298 (1995). With this in mind, we find that Dr. Baum's opinion is consistent over time and well reasoned. In reaching this conclusion, we particularly note Dr. Baum's explanation regarding the mechanism of CTS, in the context of ongoing repetitive hand intensive activities and the aging process. (Exs. 16A, 19C). Further considering Dr. Baum's reason for effectively ruling out obesity as a significant contributor in claimant's case,[2] and the applicability of Dr. Baum's reasoning to claimant's individual circumstances, we find Dr. Baum's opinion to be well reasoned and based on an accurate history.

We find the contrary opinions unpersuasive, for the following reasons.

First, the opinions implicating nonwork-related causes other than obesity (i.e., age, gender, and/or narrow carpal tunnels) are essentially general, rather than specific to claimant.[3] (See Exs. 18, 19A, 20-5-6). See Sherman v. Western Employer's Insurance, 87 Or App 602 (1987); see also Elizabeth Beairsto, 47 Van Natta 750, 751 (1995) (Where physician discounted 21-year work exposure in favor of CTS statistical "risk factors," his opinion was insufficiently explained). Second, although several examining physicians acknowledged that claimant's work activities contributed to her CTS to some extent, they did not evaluate the ergonomic differences between claimant's work environment before and after the employer moved in 1990. In light of the evidence indicating that wrist angulation increases the likelihood of keyboard work trauma[4] and the consistency between this evidence and claimant's particular history,[5] we find the treating physicians' opinions more well reasoned and consistent with claimant's work and medical history than those of the examining physicians. Under these circumstances, we find the treating physicians' opinions to be persuasive. See Weiland, 64 Or App at 814. Accordingly, because we further find that the persuasive opinions Drs. Baum and Fisher together establish that claimant's repetitive, hand intensive work activities for the employer were the major contributing cause of her CTS, we conclude that the claim is compensable.

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[1] Dr. Fisher has treated claimant since June 1994. She first treated claimant for hand problems August 1994. (Tr. 16-17). In June 1996, Dr. Fisher opined: "It is my opinion that [claimant's] carpal tunnel syndrome is directly related to her work activity. It is not just the major cause of her disability but may be the only cause of her condition and disability." (Ex. 19-2B).

[2] Dr. Baum explained that, if obesity caused claimant's CTS, one would expect her to have developed the condition much sooner, because she has been obese all of her adult life. (Exs. 9, 16A-2). Dr. Baum's opinion in this regard is uncontradicted.

[3] Drs. Smith and Aversano, for example, apparently assume that claimant has narrow carpal tunnels, without evidence to that effect. (See Exs. 12-2, 12-4, 16).

[4] See Tr. 32, 34-36.

[5] This consistency is further elucidated by Dr. Baum's explanation regarding the interaction between repetitive wrist trauma, aging, and time.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The ALJ's order dated July 23, 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 is awarded a $3,500 attorney fee, payable by the insurer.

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In the Matter of the Compensation of
**FRANCISCO J. DeLACERDA, Claimant**
WCB Case Nos. 96-06987 & 96-01594
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Company (Liberty) requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its "de facto" denial of claimant's "aggravation"[1] claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility.

We adopt and affirm the ALJ's order.

Although not argued on Board review, the ALJ's order addressed the compensability of claimant's condition. Under such circumstances, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our de novo review of the ALJ's order. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 252-53 (1992), mod 119 Or App 447 (1993); Paul R. Huddleston, 48 Van Natta 4 (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 $400, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 19, 1996 is affirmed. For services on review, claimant's attorney is awarded $400, pursuant to ORS 656.382(2), payable by Liberty Northwest Insurance Company.

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[1] As the ALJ noted, because Liberty and claimant had previously entered into a Claim Disposition Agreement (CDA) regarding Liberty's accepted lumbar strain condition, claimant's future benefits regarding that injury are limited to medical services.

In the Matter of the Compensation of
**ELEANOR McCRACKEN, Claimant**
WCB Case No. 96-08716
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that awarded an assessed attorney fee of $500. On review, the issue is attorney fees. We affirm.

## FINDINGS OF FACT

Claimant filed a claim for a back injury occurring on August 10, 1996. (Ex. 1). On that same date, claimant sought treatment at a hospital emergency room and was diagnosed with a lumbar strain. (Exs. 2, 3, 4). Claimant also was released from work from August 10 through August 15, 1996. (Ex. 5).

On August 14, 1996, claimant sought follow-up care with Dr. Ramirez, who continued claimant's work release through August 21, 1996. (Exs. 6, 7). Claimant subsequently received three physical therapy treatments. (Ex. 8). Claimant saw Dr. Ramirez again on August 21, when she was released to light duty, and August 28, when claimant was released to regular work for August 29, 1996. (Exs. 9, 11). Claimant received no other treatment for her back injury.

On August 26, 1996, the self-insured employer denied the claim. (Ex. 10). The denial stated that "we will be resolving your claim via disputed claim settlement." (Id.) The settlement, however, did not occur and, on September 17, 1996, claimant retained her attorney. On September 23, 1996, claimant's attorney filed a request for hearing, challenging the denial.

On November 12, 1996, the employer accepted a claim for lumbar strain. (Ex. 12). On November 25, 1996, the employer issued a Notice of Closure awarding claimant temporary total disability for the period of August 13, 1996 through August 20, 1996 and temporary partial disability for the period of August 21, 1996 through August 28, 1996. (Ex. 14). Claimant was not awarded permanent disability.

## CONCLUSIONS OF LAW AND OPINION

At hearing, claimant's attorney asserted that he was entitled to an assessed fee of $2,000 for his services in obtaining the rescission of the denial. The ALJ disagreed, finding that, under the factors set forth in OAR 438-015-0010(4), counsel's efforts were "minimal" and that a fee of $500 was reasonable.

On review, claimant's attorney continues to assert that he should be awarded $2,000. Although conceding that the time devoted to the case is "minimal," claimant's counsel asserts that "the benefits secured were not minimal, the interests at stake were high, the risk that the attorney may go uncompensated was high and claimant's attorney obtained an excellent result."

ORS 656.386(1) provides that, "[i]n such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed." Under OAR 438-015-0010(4), in any case where an ALJ or the Board is required to determine a reasonable attorney fee, the following factors are considered:

"(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."

Applying the first factor to this case, as stated above, claimant's attorney asserts that he devoted "approximately" 5.5 hours to the case, which, as he concedes, is minimal. It is unclear how much of this time may have been spent to secure the attorney fee itself. The complexity of the issue is apparently below average since it concerns a relatively uncomplicated issue of whether claimant sustained a compensable injury at work requiring very little medical opinion evidence. To date, the value of the interest also is not significant because medical services and temporary disability benefits were relatively limited; there was no permanent disability.

Claimant's attorney did not submit a statement of services[1] or otherwise explain what services he provided to claimant, other than filing a request for hearing. The nature of the proceeding also is relatively uncomplicated since it concerned a prehearing rescission; there is no evidence that claimant's attorney generated any documents in preparation for the hearing and no hearing was held concerning the denial.

Claimant did receive a benefit from her attorney's services since the acceptance enabled her to receive medical services, temporary disability and potential future benefits. There was a risk that counsel's services would go uncompensated. There was no assertion of frivolous issues.

After considering these factors, we agree with the ALJ that $500 is a reasonable fee for counsel's services in obtaining a prehearing rescission of the denial. In reaching this conclusion, we particularly rely on our findings that the time devoted to the case was minimal, the value of the interest was not significant, and the complexity of the issue and nature of the proceeding were not complicated. Compare James R. Lazenby, 48 Van Natta 1058 (1996) ($2,500 was reasonable attorney fee for prehearing rescission where counsel devoted 30 hours to case and filed several requests for hearing); Eloy Cuellar, 48 Van Natta 814 (1996) ($2,300 was reasonable attorney fee for prehearing rescission when counsel devoted 15.5 hours, which included generating medical report showing causation, and secured medical benefits that included surgery).

ORDER

The ALJ's order dated January 22, 1997 is affirmed.

[1] Although there is no statement of services, in a letter to the ALJ, claimant's attorney indicated that he spent approximately 5.5 hours on the case and customarily charges $150 per hour.

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June 17, 1997 Cite as 49 Van Natta 779 (1997)

In the Matter of the Compensation of
**CAROLYN P. LARSON, Claimant**
WCB Case No. 96-00658
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

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

We adopt and affirm the ALJ's order except for the last paragraph under "Conclusions of Law and Opinion" and also provide the following supplementation.

Claimant challenges the ALJ's order concluding that claimant did not prove compensability of her low back injury claim. In particular, claimant asserts that she carried her burden of proof under ORS 656.005(7)(a)(B) with the opinion of her treating osteopath, Dr. Takacs.

For the reasons cited by the ALJ, we agree that Dr. Takacs did not provide the most persuasive opinion. Additionally, we note that her opinion contained little reasoning to support her conclusion. Consequently, whether or not Dr. Takacs' opinion would satisfy ORS 656.005(7)(a)(B), as construed in SAIF v. Nehl, 148 Or App 101 (1997), we find insufficient medical evidence to carry claimant's burden of proof.

ORDER

The ALJ's order dated December 31, 1996 is affirmed.

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June 17, 1997 Cite as 49 Van Natta 780 (1997)

In the Matter of the Compensation of
**CARL MORROW, Claimant**
WCB Case No. 96-08086
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Steven J. Maher, Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) found that claimant had not established good cause for his untimely filed hearing request regarding the insurer's denial of claimant's neck and right shoulder injury claim; and (2) dismissed claimant's request for hearing. On review, the issue is propriety of the ALJ's dismissal order and, potentially, compensability.

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

In support of his contention that he has established good cause for his untimely appeal of the denial, claimant cites Alice M. Derrick, 42 Van Natta 2743 (1990). There, after the claimant telephoned the claims examiner concerning the denial letter, the claimant had the impression the examiner would arrange for a hearing. In addition, ten days after the phone conversation with the claims examiner, the claimant learned that the insurer had agreed to pay mileage expenses and some medical bills and had scheduled an IME (insurer-arranged medical examination) after the 60-day appeal period from the denial. We held that any "well-intentioned reassurances" from the insurer's claims examiner, plus the subsequent actions on the part of the insurer, reasonably misled the claimant to mistakenly believe that the denial was withdrawn or that her right to a hearing was protected. We found that this constituted "good cause" under ORS 656.319. In reaching this decision, we relied on the claimant's version of events because the claims examiner could not remember relevant portions of the telephone conversation with claimant.

Here, the employer had paid some of claimant's initial medical expenses ostensibly under ORS 656.262(5), which allows an employer to pay medical bills in amounts under $500 but does not constitute a waiver of the insurer's duty to determine entitlement to benefits. Subsequently, claimant's claim was denied by the employer's insurer. After receiving the denial, claimant telephoned the employer's safety director. Claimant indicates that the safety director told him to resubmit the medical bill to the insurer. Claimant was not told that the claim would be accepted or that the insurer's denial was rescinded. In addition, unlike in Derrick, no medical examinations were scheduled and no claim related expenses were paid after the appeal period from the denial expired. Under such circumstances, we find this case distinguishable from Derrick.

Here, it is undisputed that claimant received the denial and knew his claim had been denied by the insurer. Claimant testified he thought he "didn't have any * * * grounds" and that he knew that the claim was "denied." (Tr. 15-16). Claimant did not testify that the employer's safety director (Smail) told him the claim would be accepted or that other bills would be paid. According to claimant's testimony,

Smail only told claimant to resubmit the medical bill to the insurer. (Tr. 14). Claimant did testify that after talking to Smail, he thought the bill was "going to be taken care of" either through the insurer or through the employer. (Tr. 16). However, neither Smail nor a representative of the employer ever told claimant the claim would be accepted or the denial rescinded. In addition, despite the fact that claimant received correspondence (i.e., the denial) directly from the insurer, claimant did not attempt to contact the insurer to discuss the meaning of the denial.

There is no evidence that claimant was misled or told that his claim would be accepted, or told to disregard the denial. Thus, given that claimant knew the claim had been denied and was never told that the denial would be rescinded or that the bill would be paid, we agree with the ALJ that claimant has not established good cause for failing to timely appeal the denial. See Michael D. Stanley, 49 Van Natta 345 (1997) (where the claimant was not informed that the claim would be accepted, the claimant's reliance on the carrier's statements did not constitute good cause for an untimely filing).

ORDER

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

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In the Matter of the Compensation of
**JAVIER MUNOZ, Claimant**
WCB Case Nos. 96-00838 & 95-08092
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Barrett Business Services, a self-insured employer, requests review of Administrative Law Judge (ALJ) Herman's order that: (1) dismissed claimant's hearing request regarding Barrett's processing of his accepted injury claim; (2) dismissed claimant's hearing request concerning a denial of his injury claim issued by the SAIF Corporation; and (3) approved a Disputed Claim Settlement (DCS) between claimant and Rain Master. In its reply brief, Barrett moves to strike claimant's respondent's brief as untimely filed. On review, the issues are the procedural motion, jurisdiction, and Barrett's challenge to the DCS. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to strike

In its reply brief, Barrett moved to strike claimant's respondent's brief as untimely filed. However, subsequent to submitting its reply brief, Barrett has written to acknowledge that claimant was granted an extension. Consequently, Barrett has withdrawn its objection to the brief. Accordingly, on review, we have considered claimant's respondent's brief.

Jurisdiction

The ALJ concluded that there was no jurisdiction over Barrett's request for a decision regarding compensability and an issue of apportioning claim costs. We agree.

As noted by the ALJ, claimant withdrew his requests for hearing, which the ALJ subsequently dismissed. Furthermore, Barrett had not cross-requested a hearing. Under such circumstances, we agree with the ALJ that the Hearings Division lacked jurisdiction to consider Barrett's contentions. See, e.g., Jimmie Parkerson, 35 Van Natta 1247 (1983) (Cross-request for review was dismissed as untimely.

The Board noted that the primary purpose for filing a cross-request for review was to maintain control over the Board's jurisdiction. The Board concluded that a respondent who failed to cross-request Board review and who raised an issue in its respondent's brief was at the mercy of the appellant who could withdraw the request for review. If the respondent had not cross-requested review, the Board held that there would be nothing to retain jurisdiction over, and the respondent would lose the opportunity to have the issue raised in its brief reviewed.)

Barrett also requests that the DCS approved by the ALJ be found invalid as it was a plan by Rain Master and another party to "circumvent the law" regarding payment of claimant's temporary disability benefits. As we have above affirmed the ALJ's finding of a lack of jurisdiction, we are unable to address Barrett's argument pertaining to the DCS. However, we note that if the jurisdictional barrier did not exist, Barrett would nevertheless be required to establish that it had standing to challenge the DCS. See, e.g., Jack Spinks, 43 Van Natta 1181 (1991) (Where compensability of the claimant's claim had not been conceded through the issuance of a "307" order, the claimant was entitled to settle his claims with potentially responsible carriers without the participation or approval of other potentially responsible carriers); Kenneth D. Johnson, 42 Van Natta 997 (1990).

Attorney fees

As noted above, claimant has submitted a respondent's brief on review. Claimant's counsel has also submitted a statement of services, seeking an assessed attorney fee for services on review. For the following reasons, we do not find that an attorney fee is available for claimant's counsel's services on review.

ORS 656.382(2) provides that, if a request for review is initiated by an employer or insurer and the Board finds that "the compensation awarded to claimant should not be disallowed or reduced," an attorney fee may be awarded for services on review. In the present case, however, the ALJ made no decision on the merits that compensation to claimant should not be disallowed or reduced. See Strazi v. SAIF, 109 Or App 105, 108 (1991). Furthermore, although the ALJ approved a DCS between claimant and Rain Master, we have previously held that DCS proceeds are not "compensation." Mary M. Mitchell, 47 Van Natta 300 (1995); Howard v. Liberty Northwest Ins., 94 Or App 283 (1988). Accordingly, we are unable to find a basis for an attorney fee award under the circumstances of this case.

ORDER

The ALJ's order dated November 21, 1996 is affirmed.

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June 17, 1997 Cite as 49 Van Natta 782 (1997)

In the Matter of the Compensation of
**MARK A. WOLF, Claimant**
WCB Case No. 96-04246
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

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

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

On review, SAIF contends that, in discussing the burden of proof issue, the ALJ erred in relying on a civil case, Hansen v. Oregon-Wash. R. & N. Co., 97 Or 190 (1920). However, the ALJ also explained that claimant had the burden of proof, pursuant to ORS 656.266. Therefore, regardless of whether the Hansen case applies, we conclude that the ALJ correctly assigned the burden of proof in this case to claimant. Furthermore, based on the ALJ's credibility finding, and the remainder of the record, we agree with the ALJ that claimant has met his burden of proof in establishing both legal and medical causation.

Claimant's attorney is entitled to an assessed fee for defending against SAIF's 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 assessed attorney fee for claimant's counsel's services on review is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 3, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**JODY CROMPTON, Claimant**
Own Motion No. 95-0287M
OWN MOTION ORDER
Carney, et al, Claimant Attorneys
Garrett, et al, Defense Attorneys

Claimant requests that the Board enforce its June 12, 1996 Own Motion Order which authorized the reopening of claimant's 1989 injury claim for the payment of temporary disability benefits (TTD). In addition, claimant requests that the Board assess penalties and attorney fees for the self-insured employer's allegedly unreasonable conduct and unreasonable resistance to the payment of compensation.

FINDINGS OF FACT

In April 1990, the employer accepted claimant's nondisabling right carpal tunnel syndrome, with a date of injury of September 30, 1989. Claimant's aggravation rights on that claim expired on September 30, 1994. On April 13, 1995, claimant underwent a right carpal tunnel release. On August 24, 1995, the employer provided an amended notice accepting bilateral carpal tunnel syndrome as part of claimant's 1989 injury claim.

On June 12, 1996, the Board vacated that portion of an Administrative Law Judge's (ALJ's) Opinion and Order that upheld the employer's August 23, 1995 aggravation denial, finding that, because claimant's 1989 claim was in the Board's Own Motion jurisdiction, the Hearings Division did not have jurisdiction over any "aggravation" relating to that claim. Jody Crompton, 48 Van Natta 1181 (1996). The Board affirmed the remainder of the ALJ's order, including the ALJ's decision setting aside the employer's denial of medical services relating to the 1989 claim. In an Own Motion Order issued on the same date, the Board authorized the reopening of claimant's 1989 Own Motion claim for the payment of temporary disability compensation, beginning April 13, 1995, the date claimant underwent right carpal tunnel release surgery. Jody Crompton, 48 Van Natta 1183 (1996).

The employer has appealed the Board's June 26, 1996 Order on Review to the Court of Appeals. The Board's June 26, 1996 Own Motion Order was not appealed.

Subsequently, claimant requested a hearing with the Hearings Division to seek enforcement of our Own Motion Order. At hearing, the parties stipulated to the following facts: (1) claimant was off work for her right carpal tunnel surgery beginning April 13, 1995 and returned to her regular job on May 25, 1995; (2) claimant used her sick leave benefits during the period from April 13, 1995 through May 25, 1995 and received the equivalent of full wages for that period; and (3) the employer did not appeal the Own Motion Order issued on June 12, 1996 and it did not pay claimant any time loss benefits for the April 13, 1995 through May 25, 1995 period. On March 26, 1997, ALJ Nichols dismissed claimant's request for hearing for lack of jurisdiction.

On April 8, 1997, claimant requested that the Board enforce its June 12, 1996 Own Motion Order, and assess penalties and attorney fees for the employer's allegedly unreasonable failure to pay temporary disability compensation as ordered by our June 12, 1996 order.

On April 10, 1997, the Board requested the parties' positions with respect to claimant's motions. The employer asserts that it is willing to pay temporary disability benefits if claimant "repays" her sick leave benefits. The employer contends that it "should not be required to pay a second time for the same period of time." Citing the employer's allegedly unreasonable conduct, claimant responded that the employer's attempt to avoid paying temporary disability compensation and / or requirement that claimant repay sick leave benefits would "run afoul of [claimant's] collective bargaining agreement" and, further, would allow the employer to "set a dangerous precedent" in its refusal to comply with the Board's directive.

## CONCLUSIONS OF LAW AND OPINION

### Entitlement to Temporary Disability Compensation

The Board has 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 Lee R. Parker, 48 Van Natta 2473 (1996); Larry P. Karr, 48 Van Natta 2183; Thomas L. Abel, 45 Van Natta 1768 (1993); David L. Waasdorp, 38 Van Natta 81 (1996).

Pursuant to ORS 656.278, our June 12, 1996 order authorized temporary disability compensation for claimant's April 13, 1995 surgery. Thereafter, the employer was required to pay temporary disability benefits until one of the following events occurred: (1) the claim was closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement was submitted to the Board pursuant to ORS 656.236(1), unless the claim disposition agreement provided for the continued payment of temporary disability benefits; or (3) termination of such benefits was authorized by the terms of ORS 656.268(3)(a-c). See Jeffrey T. Knudson, 48 Van Natta 1708 (1996).

The employer did not pay temporary disability compensation in this claim. Claimant utilized her "sick" leave for the period of April 13, 1995 through May 25, 1995. Although the Board has jurisdiction over temporary disability compensation in this claim, it does not have jurisdiction over other benefits, including those provided through collective bargaining agreements between employers and employees. Therefore, we need not consider any argument regarding repayment of sick leave benefits, as those arguments are not pertinent to the issue before us, that being claimant's entitlement to temporary disability benefits under ORS 656.278. See Garry W. Rogers, 43 Van Natta 1233 (1991).

Our June 12, 1996 order found that claimant is entitled to temporary disability benefits beginning April 13, 1995. The employer has not paid temporary disability compensation in this claim as directed by our June 12, 1996 order. Our June 12, 1996 Own Motion Order became final on July 12, 1996. The employer had not yet paid TTD by the date of claimant's April 8, 1997 enforcement request. Under such circumstances, we conclude that the employer failed to timely comply with our order reopening this claim. See Larry P. Karr, 48 Van Natta at 2183.

Accordingly, we enforce our June 12, 1996 order that directs the employer to pay temporary disability compensation beginning the date claimant underwent right carpal tunnel release surgery. Further, pursuant to our June 12, 1996 order, we direct the employer to pay claimant's attorney an approved fee, in the amount of 25 percent of the increased temporary disability compensation awarded by our June 12, 1996 order, not to exceed $1,050. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

### Penalty/Attorney Fee

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." The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991); Castle & Cook Inc. v. Porras, 103 Or App 65 (1990). If so, the refusal to pay is not unreasonable.

The employer did not timely request reconsideration of our order, nor did it pay compensation pursuant to our order. We conclude that there could have been no legitimate doubt that one of these two actions must have been taken by the employer in order for it to withhold TTD expressly awarded by our prior order. The employer contends that "[p]aying the claimant once for her wages for sick leave and then paying her a second time for time loss for the workers' compensation claim for the same period of time would result in a double recovery." However, we find that the employer's explanation for its failure to pay compensation is unpersuasive in that: (1) claimant's decision to utilize her sick leave is not relative to the employer's decision not to pay temporary disability compensation as expressly directed by our order; and (2) the employer does not cite, nor have we found, any authority which would allow it to disregard an unappealed Own Motion order. In fact, such a position is contrary to prior Board precedent. See Garry W. Rogers, 43 Van Natta at 1233. Therefore, we find unreasonable the employer's conduct in refusing to pay temporary disability compensation as explicitly ordered by the Board.

Accordingly, under ORS 656.262(11)(a), we assess a 25 percent penalty of the amounts "then due" claimant beginning the date she 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 her attorney.[1] ORS 656.262(11).

IT IS SO ORDERED.

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[1] Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. We do not find that we have the authority to award an assessed fee for claimant's attorney's efforts in securing enforcement and penalties in this case. See ORS 656.386(1); Forney v. Western States Plywood, 297 Or 628 (1984). Therefore, we are unable to grant claimant's request for an assessed fee in this matter. However, because claimant has prevailed in the enforcement and penalty issues, we award half of the assessed penalty to claimant's attorney in lieu of an assessed attorney fee. Furthermore, our June 12, 1996 order, which, by this order we enforce, allowed an approved (out-of-compensation) fee to claimant's attorney.

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June 18, 1997 Cite as 49 Van Natta 785 (1997)

In the Matter of the Compensation of
**DAVID L. GRENBEMER, Claimant**
Own Motion No. 94-0544M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Ronald Pomeroy (Saif), Defense Attorney

On April 1, 1997, we referred claimant's request for reconsideration of our January 31, 1996 Own Motion Order Reviewing Carrier Closure to the Hearings Division for a Fact Finding Hearing.

In doing so, we found the record insufficiently developed for us to determine a dollar amount due, if any, for claimant's temporary partial disability for the period from October 24, 1994 to April 13, 1995, and the dollar amount of any offset due the SAIF Corporation.

The parties have now submitted a "Stipulation and Order," which resolves the dispute pending before the Board. Pursuant to that agreement, SAIF agrees to waive its $1,308 overpayment claim. Furthermore, the agreement resolves all issues raised or raisable between the parties. Finally, the stipulation provides that this matter is dismissed with prejudice.

We have approved the parties' stipulation, thereby fully and finally resolving this Own Motion dispute. Accordingly, on reconsideration of our prior orders, this matter is dismissed. 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
**DEBRA D. ROBINSON, Claimant**
Own Motion No. 96-0521M
OWN MOTION ORDER
Jeff Carter, Claimant Attorney
Bostwick, et al, Defense Attorneys

Claimant requests that the Board authorize the payment of temporary disability compensation for her compensable low back strain injury, commencing September 24, 1996, the date she underwent surgery. In addition, claimant requests an assessed attorney fee under ORS 656.386 for her attorney's services in litigating this claim. Finally, claimant requests a penalty be assessed under ORS 656.262(11) for the insurer's allegedly unreasonable "continuation of the denial or failing to pay medical forward."

## FINDINGS OF FACT

Claimant sustained an industrial injury to her low back on May 17, 1988. Claimant's aggravation rights on that claim expired on November 28, 1994. On September 24, 1996, Dr. Stevens, claimant's treating physician, performed left L5-S1 interlaminar exploration with recurrent disc removal, and segmental fusion with instrumentation at L5-S1.

The insurer initially submitted claimant's request for temporary disability compensation for her compensable low back strain, L5-S1 ruptured disc injury. The insurer opposed reopening the claim on the grounds that: (1) claimant's current condition did not require surgery or inpatient hospitalization; (2) it was not responsible for claimant's current condition; and (3) surgery or hospitalization was not reasonable and necessary for the accepted condition. The insurer did not issue a denial pursuant to ORS 656.262(6) or ORS 656.308(2), however, it did note that it "will be submitting request for Director review next week." On November 13, 1996, the insurer requested Director's review of the requested medical treatment. (Medical Review Case No. 11516).

On November 18, 1996, the Board issued its Order Postponing Action on Own Motion Request pending resolution of the medical services dispute. We noted in our order that, pursuant to ORS 656.327, "this medical services issue is within the Director's jurisdiction."

On April 8, 1997, the Director issued an Administrative Order, which found that claimant's left L5-S1 interlaminar exploration with recurrent disc removal, and segmental fusion with instrumentation at L5-S1 surgery was appropriate. That order was not appealed, and became a final order of the Director on May 8, 1997.

On April 21, 1997, claimant requested that the Board proceed with its "review of the matter," and authorize the payment of temporary disability compensation. Claimant further requested an assessed attorney fee pursuant to ORS 656.386. On May 5, 1997, claimant requested that the Board assess a penalty for the insurer's unreasonable delay in making medical payments and in paying compensation.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability Compensation

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

Here, the dispute regarding claimant's proposed surgery has been resolved. ORS 656.327. Therefore, as we have jurisdiction in this matter under ORS 656.278(1), we conclude that claimant's compensable condition worsened requiring surgery. Because it has been determined that the insurer is responsible for claimant's September 24, 1996 surgery, we are authorized to reopen claimant's 1988 injury claim for the payment of temporary disability compensation, commencing the date claimant underwent that surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Attorney Fee

Claimant requests an attorney fee be assessed pursuant to ORS 656.386. Claimant asserts that this is a "denied" claim as defined by ORS 656.386. Claimant further contends that:

> "[Claimant's claim] is a claim for compensation (medical services and time loss) which the insurer refused to pay on the expressed ground that the condition was not compensably related to the accepted condition. If this Board determines as a result of the medical examiner's report, that the surgery is causally connected to the accepted claim, she will be entitled to not only payment of her medical bills, but also time loss. If such an order is issued from the Board, it will qualify as a situation where claimant prevails "in a review by the Workers' Compensation Board", In such a case, the Board is entitled to assess a reasonable attorney fee."

Here, claimant's aggravation rights have expired. Once aggravation rights on a claim have expired, the Board, in its Own Motion authority under ORS 656.278, does not have jurisdiction to decide compensability, responsibility or reasonableness and necessity of medical treatment. Rather, we have jurisdiction only to authorize temporary disability compensation under certain circumstances pursuant to ORS 656.278. We have previously found no statutory authority, including that under ORS 656.386, which would allow the Board to award an assessed fee for a claimant's attorney's services in obtaining Own Motion relief (temporary disability compensation). See ORS 656.278; ORS 656.382(2); OAR 438-015-0010; 438-015-0080; Forney v. Western States Plywood, 297 Or 628 (1984); Donald E. Woodman, 44 Van Natta 2429 (1992), on recon 45 Van Natta 4 (1993). Consistent with these points and authorities, we are unable to assess an attorney fee in this claim.

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

Penalty

Claimant requests a penalty for the insurer's allegedly unreasonable delay in the payment of compensation. When a claim is under the Board's Own Motion jurisdiction, no temporary disability compensation is due claimant until the Board issues an order reopening the claim.[1] Thereafter, "the insurer shall make the first payment of temporary disability compensation within 14 days from the date of an order of the Board reopening the claim." See OAR 438-012-0035(3); John R. Woods, 48 Van Natta 1016 (1996). We do not find that the insurer unreasonably withheld temporary disability in this matter because it was not required to pay time loss until our order issued providing the authorization for the insurer to do so.

Citing William K. Bowler, 48 Van Natta 1445 (1996), claimant apparently contends that the insurer was aware (or should have been aware) at the time of hearing that claimant's surgery was appropriate. Claimant asserts that the "continuation of the denial or failing to pay medical forward was unreasonable and there should be an [sic] penalty imposed because of such unreasonable delay." While we empathize with claimant's frustration over the administrative processing involved in this claim, we do not find that the insurer unreasonably delayed the payment of temporary disability compensation, as none was due prior to issuance of our order. Therefore, no penalty is due.

Accordingly, we authorize the reopening of claimant's 1988 injury claim for the payment of temporary disability compensation beginning September 24, 1996, the date of claimant's surgery, until claimant is medically stationary. OAR 438-012-0055. Claimant's attorney is awarded an approved attorney fee pursuant to OAR 438-015-0080. Claimant's requests for an assessed attorney fee under ORS 656.386(1) and penalties are denied.

IT IS SO ORDERED.

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[1] The Board has previously assessed a penalty pursuant to ORS 656.262 (11) where a carrier failed to pay, or untimely paid compensation due in a reopened Own Motion claim. See John R. Woods, 48 Van Natta at 1016; Jeffrey T. Knudson, 48 Van Natta 1708 (1996); Larry P. Karr, 48 Van Natta 2183 (1996). However, until this date, we have not authorized the reopening of claimant's claim for the payment of temporary disability compensation.

In the Matter of the Compensation of
**LOIS J. SCHOCH, Claimant**
WCB Case No. 92-09982
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Supreme Court. Schoch v. Leupold & Stevens, 325 Or 112 (1997). The court has reversed the Court of Appeals' decision, Schoch v. Leupold & Stevens, 137 Or App 633 (1995), which affirmed our order which awarded a $3,000 attorney fee under ORS 656.386(1) for claimant's counsel's services related to prevailing over a Director's order regarding a surgery dispute. Lois J. Schoch, 47 Van Natta 71 (1995). Finding that our order did not contain a sufficient explanation to permit an appellate court to review our exercise of discretion in setting a reasonable attorney fee, the Court has remanded for reconsideration of claimant's attorney fee award.

## FINDINGS OF FACT

We republish the "Findings of Fact" set out in our January 23, 1995 Order on Review. Lois J. Schoch, 47 Van Natta at 71.

## CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

The issue at the initial hearing was whether the Director's order regarding the appropriateness of claimant's low back surgery was supported by substantial evidence. Administrative Law Judge (ALJ) Holtan initially affirmed a Director's order which had found that the proposed surgery was not appropriate under the "substantial evidence" standard of review. (WCB Case No. 92-09982). On review, we found that the Hearings Division, rather than the Director, had jurisdiction to resolve the dispute about proposed surgery. Lois J. Schoch, 45 Van Natta 2291 (1993), on recon 46 Van Natta 157 (1994). We remanded the matter to ALJ Holtan for reconsideration.

Meanwhile, the insurer denied claimant's second request for authorization for the same surgery. Claimant again sought a hearing. (WCB Case No. 93-09584).

After a hearing concerning WCB Case No. 93-09584, ALJ Podnar found the surgery reasonable and necessary and awarded a $10,500 attorney fee. We subsequently modified that order, awarding a $5,750 fee under ORS 656.386(1) and a $2,000 assessed fee under ORS 656.382(1). Lois J. Schoch, 46 Van Natta 1816 (1994).

On remand in this case, the insurer advised ALJ Holtan that it was no longer contesting claimant's request for surgery. The insurer requested dismissal of the case on the ground that the issue was moot. Claimant opposed the insurer's motion, seeking an attorney fee for finally prevailing on the disputed surgery. ALJ Holtan issued an order on remand which found the case moot and denied claimant's request for an attorney fee.

Claimant requested Board review, seeking an attorney fee award regarding the disputed surgery and for successfully defending against the insurer's appeal of an Order on Reconsideration. On review, we found that the case was not moot because the entire controversy was not resolved. Lois J. Schoch, 47 Van Natta 71 (1995). We found that claimant was not entitled to an attorney fee based on the insurer's withdrawal of its cross-appeal of the September 17, 1992 Order on Reconsideration. Concerning the surgery dispute, we awarded a $3,000 attorney fee for claimant's counsel's services at hearing, on Board review, and on remand.

Thereafter, claimant asked us to reconsider our fee award and increase the fee to $19,897.50. On reconsideration, we adhered to our initial order.

Claimant requested judicial review. The Court of Appeals affirmed without opinion. Schoch, 137 Or App at 633. Claimant petitioned for Supreme Court review.

The Supreme Court reversed the Court of Appeals' decision. Citing Drew v. PSRB, 322 Or 491, 500 (1996), and Williams v. SAIF, 310 Or 320, 329 (1990), the Court concluded that it is crucial that an agency's order reveal a rationale for an attorney fee award. Specifically, the Court reasoned that, at a minimum, where the basis for an agency's discretionary choice is not obvious, an agency must provide sufficient explanation to allow a reviewing court to examine the agency's action in relation to the range of discretion granted by the legislature.

Although there might have been several bases for our attorney fee award, the Supreme Court concluded it could not make such assumptions, particularly considering the significant and unexplained disparity between the requested fee and the Board's award. Determining that our order did not contain a sufficient explanation to permit an appellate court to review our exercise of discretion in setting a reasonable attorney fee, the Court remanded for reconsideration.

The issue before us is the amount of a reasonable attorney fee for claimant's counsel's services regarding the surgery dispute at hearing, on Board review, and on remand from the Board. See ORS 656.386(1); ORS 656.388(1). Any services subsequent to the insurer's "pre-remand hearing" concession on the surgery issue are not considered in determining a reasonable award. See Amador Mendez, 44 Van Natta 736 (1992).

We consider the amount of claimant's counsel's attorney fee 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 issues in dispute concerned original/appellate jurisdiction regarding the propriety of claimant's disputed low back surgery. (The insurer withdrew its cross-appeal from the September 17, 1992 Order on Reconsideration before the hearing.) Exhibits 1 through 9, submitted by the Department, were admitted at the November 4, 1992 hearing. Exhibits C-1 through C-34 were submitted by claimant's attorney, but not admitted, because the ALJ found that the record was properly limited to the evidence previously before the Director. (Rec. at 11). Dr. Berkeley was deposed on claimant's behalf. The deposition lasted about an hour, with a transcript consisting of approximately 50 pages. The hearing lasted three and one-half hours and the transcript consists of 65 pages. Claimant testified on her own behalf. No other witnesses testified.

Claimant's counsel initially submitted approximately 12 pages of appellate briefs to the Board, devoted to the jurisdiction/surgery issue. After we held that the ALJ had original jurisdiction over the disputed surgery, claimant's counsel requested reconsideration, submitting a 3 1/2 page description of events which ensued since ALJ Holtan's order. Claimant's counsel also presented additional medical reports, claim processing documents, and subsequent ALJ's orders (including one which set aside claimant's claim for low back surgery).

Following our reconsideration order remanding the case to ALJ Holtan, claimant's counsel submitted a written response to the insurer's motion to dismiss the hearing request. (Rec. at 85-6). Following the ALJ's dismissal order, claimant's counsel requested review of the ALJ's order, submitting approximately 25 pages of argument on review, mostly devoted to the attorney fee issue.

After issuance of our January 23, 1995 Order on Review (which had awarded $3,000 for claimant's attorney's services in evoking the insurer's eventual concession concerning the disputed surgery), claimant's counsel submitted a statement of services requesting a $19,897.50 attorney fee, based in part on an hourly fee of $175, and including a summary of services for the period from April 23, 1992 through January 24, 1995, totaling 75.8 hours. (Rec. at 155-163). Before the Supreme Court, claimant's counsel subsequently argued entitlement to an $8,312.50 attorney fee for 47.5 hours of services expended on this case up to the insurer's February 2, 1994 "pre-remand hearing" concession regarding claimant's entitlement to surgery.

As compared to typical medical services cases which come before us, the issues here were of average complexity. The hearing was also of average length. On the other hand, in light of the "original/appellate jurisdiction" and "de novo/substantial review" aspects of this case, we consider the issues to have been of above average procedural complexity. Moreover, the nature of the proceedings was also beyond the normal case in that claimant's counsel performed services at the hearings level, on Board review, and before the Board on remand.

Considering the complicated procedural aspects of the claim, there was a decided risk that claimant's counsel's efforts might have gone uncompensated.[1] For the same reason, expenditure of substantial time was required to secure claimant's benefits.[2] The parties' respective counsels also presented their positions in a thorough, well-reasoned and skillful manner.

Finally, we take into consideration that claimant previously prevailed against a denial of the same surgery in a collateral proceeding for which her counsel has already been awarded a $5,750 attorney fee. See Lois J. Schoch, 46 Van Natta 1816 (1994). In addition, claimant's counsel is not entitled to an attorney fee for services devoted to the insurer's withdrawal of its appeal from the Order on Reconsideration. Finally, no attorney fee is awardable for claimant's counsel's services at any level concerning the attorney fee issue. See Mendez, 44 Van Natta 736.

After considering the aforementioned factors, we continue to conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services regarding the insurer's "pre-remand hearing" concession concerning claimant's surgery. In particular, we have considered the time devoted to the issue (as represented by the record, claimant's appellate briefs, and her counsel's statements of services), the procedural complexity of the issue, the nature of the proceedings (hearing, Board review and remand), the value of the interest involved, and the risk that claimant's counsel might go uncompensated.[3]

Accordingly, on reconsideration, our January 23, 1995 order is republished as supplemented herein.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we reiterate that we do not use a contingency factor in a strict mathematical sense. See Lois J. Schoch, 49 Van Natta 170, 173, N1 (1997). Instead, in conjunction with the other relevant factors discussed above, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding has been considered in our ultimate determination of a reasonable attorney fee.

[2] In determining an appropriate attorney fee in this case, we consider claimant's counsel's time devoted to the surgery/jurisdiction issue at hearing, on review, and on remand until the insurer's February 2, 1994 concession regarding claimant's entitlement to the surgery in question. We do not consider the time devoted at any level of the proceedings to any attorney fee issue or the insurer's withdrawal of its cross-appeal from the 1992 Order on Reconsideration.

[3] In reaching this conclusion, we wish to emphasize that we are not questioning claimant's counsel's representations regarding the amount of time expended in pursuit of the insurer's eventual concession regarding claimant's surgery claim. Rather, for the reasons expressed above, particularly claimant's successful efforts in another proceeding regarding the same surgery, services which resulted in a $5,750 attorney fee award), we find $3,000 to constitute a reasonable attorney fee award in this proceeding.

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In the Matter of the Compensation of
**CLAUDE W. CURRAN, Claimant**
WCB Case Nos. 96-05003, 94-14329 & 96-04943
ORDER ON REVIEW
Bennett, Hartman, et al, Claimant Attorneys
H. Thomas Anderson (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 denials of his claims for fibromyalgia, chronic fatigue syndrome, Lyme disease and porphyria. On review, the issue is compensability.

We adopt and affirm the order of the ALJ[1], with the following supplementation.

On review, claimant disagrees with the ALJ's conclusion that Dr. Gillette was not convinced of a diagnosis of Lyme disease. Claimant argues that Dr. Gillette testified that claimant probably suffered from Lyme disease.

After reviewing the testimony, we conclude that Dr. Gillette's opinion is not persuasive. Dr. Gillette first stated that he "had no support for the diagnosis of Lyme disease," and agreed that there had "not been any conclusive studies indicating that [claimant] does have Lyme disease." (Ex. 61-14, 15). Therefore, without further explanation, we are not persuaded by Dr. Gillette's later statement that it was "reasonably medically probable" that claimant did have Lyme disease.

Claimant also contends that the ALJ erred by concluding that Dr. Gillette's findings regarding a fibromyalgia syndrome were not "diagnostic" and were not supported by objective findings. We conclude that, even if we accept claimant's argument regarding the diagnostic or objective findings, we nevertheless agree with the remaining reasons the ALJ provided for finding that Dr. Gillette's opinion regarding fibromyalgia was not persuasive. Similarly, we adopt the ALJ's conclusions regarding a porphyria condition.

Finally, claimant argues that the ALJ erred by relying on the opinion of Dr. Ochoa in finding that claimant's symptoms were psychiatric, rather than physical. Claimant contends that Dr. Ochoa is not a psychiatrist and his opinion regarding a psychological condition should be given little weight.

In discussing why Dr. Ochoa's file review "made sense," the ALJ noted that the record contained comments from two prior treating doctors who expressed similar concerns about a psychological, rather than a physical, basis for claimant's symptoms. As the ALJ pointed out, one of those doctors, Dr. Fried, was both claimant's treating doctor and a psychiatrist. Under the circumstances, we do not agree that the ALJ erred by according weight to Dr. Ochoa's opinion.

Accordingly, we agree with the ALJ that claimant has failed to establish compensability. The ALJ's order is, therefore, affirmed.

ORDER

The ALJ's order dated January 27, 1997 is affirmed.

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[1] We note that the ALJ found that the case primarily involved "legal causation." Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. See Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981). Here, for the reasons discussed in the ALJ's order and our Order on Review, we conclude that claimant has failed to provide persuasive medical evidence to support compensability. Accordingly, while we agree with the ALJ that "legal" causation has not been proven, we also conclude that claimant has failed to prove "medical causation" by a preponderance of the evidence.

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In the Matter of the Compensation of
**MARTHA L. LADD, Claimant**
WCB Case No. 96-04890
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denials of her current left shoulder condition. On review, the issue is compensability.

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

The ALJ upheld the insurer's current condition denials, concluding that the medical evidence did not establish that claimant's compensable April 1993 left shoulder injury, accepted as nondisabling left shoulder tendinitis, was the major contributing cause of her current condition, disability and need for treatment. We agree with the ALJ's reasoning that claimant's current left shoulder condition is not compensable.

Claimant, however, contends that the insurer's April and July 1996 denials of her current left shoulder condition should be set aside because they are invalid "back-up" denials. Moreover, noting that the insurer had accepted an aggravation claim in August 1995, claimant asserts that the doctrine of claim preclusion bars the insurer's subsequent denials because her left shoulder condition did not change so as to create a new set of operative facts that could not have been litigated at the time of the acceptance. See Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560 (1989).

As the insurer observes, claimant identified the issue at hearing as the compensability of her current left shoulder condition. (Tr. 5). Because claimant did not raise the "back-up" denial and claim preclusion issues at hearing, we decline to address them on review. See Kenneth L. Devi, 48 Van Natta 2349 (1996), on recon 49 Van Natta 108 (1997) (declining to consider claim preclusion issue not raised at hearing or until closing argument, at the earliest); Janice A. Talevich, 48 Van Natta 2318, 2319 (1996) (declining to consider "back-up" denial issue raised for first time on review).

ORDER

The ALJ's order dated December 18, 1996 is affirmed.

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June 19, 1997 Cite as 49 Van Natta 792 (1997)

In the Matter of the Compensation of
**HOWARD R. MATHER, Claimant**
WCB Case Nos. 95-05369, 95-04997, 95-03494, 95-04996, 95-04354,
95-04353, 95-04352, 95-03495 & 95-02631
ORDER ON REVIEW
Max Rae, Claimant Attorney
Richard C. Pearce, Defense Attorney
Zimmerman, Rice, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney
Garrett, Hemann, et al, Defense Attorneys
Wallace & Klor, Defense Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation, on behalf of Umpqua River Navigation Co., requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its responsibility denial of claimant's C6-7 disc herniation claim; (2) upheld Argonaut Insurance Company's disclaimer of responsibility, on behalf of S.M. Motor Company, for the same condition; and (3) directed SAIF to reimburse Argonaut for all benefits attributable to claimant's C6-7 disc condition after January 6, 1995. Claimant cross-requests review of that portion of the ALJ's order that awarded a $5,000 attorney fee. On review, the issues are responsibility and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ findings of fact with the following changes. In the fifth paragraph on page 8, we change the last sentence to read: "In relation to the April 22, 1994 thoracic spine MRI, Dr. Berkeley reported: 'There is no canal stenosis and no discogenic lesions or any other pathological changes causing neural element compression.' (Ex. 131)."

We change the last two paragraphs of the findings of fact to read: "Drs. Dickerman and Berkeley were subsequently deposed. (Exs. 173A, 176)."

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

On December 18, 1984, claimant injured his neck while working for Argonaut's insured, S.M. Motor Company. Argonaut accepted a cervical and upper dorsal strain. (Exs. 2, 3). Claimant subsequently filed an aggravation claim regarding the 1984 neck injury. (Exs. 29, 63). Dr. Tanabe performed a C5-6 anterior cervical diskectomy and fusion on April 26, 1991. (Ex. 35). Claimant eventually received 30 percent unscheduled permanent partial disability for the neck condition. (Exs. 83, 87, 93). He continued to have some neck and shoulder symptoms.

After the 1984 injury, claimant worked for several other employers.[1] In mid-August 1994, claimant began working for SAIF's insured, Umpqua River Navigation (Umpqua). Claimant's work involved steel fabrication, welding, fitting and some mechanics. (Tr. I-24). During the first few weeks, claimant worked around the shop and did not have any unusual problems with his neck or shoulders. (Tr. I-24-25). In October or November 1994, claimant began working on a barge, which involved a lot of overhead work. (Tr. I-25). The work was more intense and caused a lot of stress to his neck. (Id.) Claimant had an incident where he was working under the barge and jammed his neck on a timber. (Tr. 27). After that incident, he began experiencing severe stiffening of the neck and severe pain in the right shoulder and down into the arm. (Id.)

A January 17, 1995 cervical MRI showed a herniated disc at C6-7 that compromised the right root sleeve. (Ex. 114). Dr. Berkeley performed surgery on May 18, 1995, reporting that a ruptured and prolapsed intervertebral disc at C6-7 was causing cord and right radicular compression. (Ex. 152A-1).

At hearing, Argonaut took the position that responsibility should pass to claimant's subsequent employment at Umpqua, but it conceded that if claimant had not sustained a new injury or new occupational disease, responsibility remained with Argonaut.

The ALJ found that claimant had sustained a traumatic injury in January 1995 while working at Umpqua. Finding no evidence that claimant's accepted C5-6 condition combined with his current C6-7 condition, the ALJ applied a material causation standard. The ALJ relied on Dr. Berkeley's opinion to conclude that claimant sustained a "new injury" at Umpqua, for which SAIF was responsible.

SAIF argues that the ALJ erred by applying the material contributing cause standard. SAIF asserts that claimant has a preexisting neck condition and his work activities combined with the preexisting condition to cause his disability and need for treatment. SAIF contends that the medical evidence establishes that claimant's work activities with Umpqua were not the major contributing cause of his C6-7 condition. On review, Argonaut reiterates that it does not contest compensability or responsibility for claimant's C6-7 condition.[2]

Claimant argues that he sustained a new injury or new occupational disease during his employment with Umpqua.[3] He contends that, whatever standard of proof applies, he has satisfied it. Claimant relies on Dr. Berkeley's opinion to prove a new compensable claim under any potentially applicable legal standard.

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)). We first address SAIF's argument that the ALJ erred by applying the material contributing cause standard.

Claimant argues that his preexisting neck problems cannot be considered in deciding this case because no actual causal contribution has been shown. We disagree.

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[1] Claimant originally filed claims against other employers, but he voluntarily withdrew his requests for hearing against all employers except S. M. Motor Company and Umpqua River Navigation.

[2] In light of Argonaut's concession of compensability and responsibility for claimant's C6-7 herniated disk condition, we need not address whether the C6-7 condition is causally related to the condition Argonaut previously accepted. See ORS 656.308(1).

[3] On review, claimant continues to rely on his written closing arguments at hearing.

Dr. Berkeley testified that claimant's C6-7 disk had herniated approximately a year before he first saw him in March 1995. (Ex. 176-7). Dr. Berkeley reached that conclusion because that was the time when claimant related an increase in intensity of his symptoms. (Id.) Based on Dr. Berkeley's testimony, we conclude that claimant's C6-7 herniated disk preexisted his employment with Umpqua. Therefore, the C6-7 herniated disk constitutes a "preexisting condition." See ORS 656.005(24).

In determining whether ORS 656.005(7)(a)(B) or ORS 656.802(2)(b) applies, we must determine whether claimant's preexisting C6-7 herniated disk "combined" with either an injury or his work activities to cause disability or a need for medical treatment.

Dr. Berkeley, claimant's treating physician, reported that claimant's C5-6 fusion was solid and played no role in his present symptoms. (Ex. 175). However, as discussed above, Dr. Berkeley testified that claimant's C6-7 disk had herniated before he began working at Umpqua. (Ex. 176-7). Dr. Berkeley reported that claimant's symptoms changed after August 1994 and the changes implied there had been a worsening of the condition or a new condition was arising. (Ex. 176-17). Dr. Berkeley felt that the welding or overhead activity changed the pathology of the C6-7 disk. (Ex. 176-22). He also testified that claimant's work on the barge and hitting his head against the beam were more than 50 percent responsible for claimant's ruptured disk at C6-7 and the need for surgical treatment. (Ex. 176-25).

Based on Dr. Berkeley's testimony, we conclude that claimant's January 1995 work incident and/or his work activities at Umpqua "combined" with his preexisting C6-7 condition to cause a disability or need for medical treatment.[4] We conclude 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 apply ORS 656.005(7)(a)(B) since claimant's preexisting C6-7 herniated disk combined with the January 1995 work incident, 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 at Umpqua were the major contributing cause of a pathological worsening of his preexisting C6-7 herniated disk. ORS 656.802(2)(b).

Claimant relies on Dr. Berkeley's opinion to prove a new compensable claim under any potentially applicable legal standard. 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, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons to do otherwise.

Dr. Berkeley first examined claimant on March 20, 1995. He reported that claimant's symptoms had gradually increased in intensity and had become particularly worse in the last 12 months with his activities at work. (Ex. 131). He noted that claimant was forced to change jobs from that of an auto mechanic because he had difficulty in using his arms overhead. He recommended an anterior cervical discectomy and interbody fusion at C6-7.

On August 7, 1995, Dr. Berkeley reported that claimant had mild symptoms before he started work with Umpqua, but his symptoms became much more severe after he started working at Umpqua. (Ex. 172). Dr. Berkeley described claimant's recent symptoms and concluded that claimant's welding work at Umpqua was "a" major contributing cause of his disability and need for surgical treatment. (Id.)

On December 18, 1995, Dr. Berkeley reported that, if claimant had jammed his neck while working at Umpqua, that would increase the probability that his work at Umpqua was the major contributing cause and the need for surgery. (Ex. 175). Dr. Berkeley explained that, based on his surgical findings, claimant's condition did "not appear to be just a simple degenerative condition, but rather a traumatic condition, suggesting an incident of neck trauma and further aggravation by repeated activities such as welding, wearing a helmet, holding one's head in a flexed position, and using one's arms repeatedly." (Id.)

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[4] Dr. Dickerson's opinion also supports the conclusion, on different grounds, that claimant had a "combined condition" and the major contributing cause standard applies to this claim.

Medical opinions based on an inaccurate or incomplete history are entitled to little weight. Miller v. Granite Construction Co., 28 Or App 473 (1977). At a deposition, Dr. Berkeley testified that he had not reviewed any of claimant's medical records before 1994. (Ex. 176-15). Because Dr. Berkeley did not have a complete and accurate history of claimant's prior treatment for his neck condition, his opinion on causation is not persuasive.

In addition, Dr. Berkeley did not have an accurate history of claimant's April 1994 cervical MRI scan. When Dr. Berkeley first examined claimant in March 1995, he had reviewed claimant's April 1994 MRI. He reported that the April 22, 1994 MRI scan "reveals normal cord signal. There is no canal stenosis and no discogenic lesions or any other pathological changes causing neural element compression." (Ex. 131-3). In fact, the April 22, 1994 MRI indicated that there was posterior disc bulging or herniation, apparently at C6-7. (Ex. 91). When Dr. Berkeley was asked about the MRI report at deposition, he replied: "I do not seem to have noticed that he had a protruding disk at C6-7." (Ex. 176-9).

Dr. Berkeley's deposition testimony is inconsistent with regard to when claimant's neck symptoms increased. On the one hand, Dr. Berkeley testified that claimant's neck symptoms increased in intensity approximately a year before he first saw him in March 1995, which would have been approximately March 1994. (Ex. 176-7). Later in the deposition, however, Dr. Berkeley agreed that claimant's symptoms changed after August 1994 and those changes implied there had been a worsening of the condition or a new condition was arising. (Ex. 176-17). It is unclear from Dr. Berkeley's reports and testimony exactly when claimant's neck symptoms increased, or if they increased during two different time periods. In any event, since Dr. Berkeley had not reviewed claimant's medical records before 1994, he did not actually compare claimant's previously reported symptoms to his current symptoms.

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, 401 (1994), rev dismissed 321 Or 416 (1995). The precipitating cause is not necessarily the major contributing cause of those symptoms. Id.

Dr. Berkeley testified that claimant's work activities were important in that they seemed to have been "a main, serious factor, and the main precipitating cause" of his changing jobs and seeking treatment. (Ex. 176-13). Dr. Berkeley said that he considered the precipitating factor in causing claimant to seek medical treatment and the major contributing cause to be the same thing. (Id.) Dr. Berkeley's testimony indicated that he viewed the major contributing cause to be whatever caused claimant seek treatment. Although the precipitating cause may occasionally constitute the major contributing, Dr. Berkeley's opinion is not persuasive because he did not sufficiently weigh the relative contributions from the preexisting neck condition and the work injury or work activities to claimant's current cervical condition. See Dietz, 130 Or App at 401.

There are no other medical opinions that support claimant's argument that he sustained a new injury or new occupational disease during his employment with Umpqua. Dr. Dickerson found no evidence that claimant's current complaints were related to his work at Umpqua. (Ex. 148-23). Dr. Keizer reported that claimant's current C6-7 condition was "related primarily to his underlying condition of the cervical spine, which was initiated by his earlier injury of the cervical spine which required the initial C5/6 fusion." (Ex. 127).

In sum, we conclude that claimant has failed to establish that he sustained a new injury or new occupational disease during his employment with Umpqua. Therefore, SAIF is not responsible for claimant's C6-7 cervical condition. Since Argonaut does not contest compensability or responsibility for claimant's C6-7 condition, we conclude that it is responsible for the C6-7 cervical condition.

Additional Arguments

On review, claimant continues to assert his alternative arguments set forth in his closing arguments. Claimant argues that consideration of noncausal predispositions or susceptibilities violates the Americans with Disabilities Act (ADA). He also contends that ORS 656.802(2)(e) is invalid in that it "deems" preexisting conditions to be causes. Claimant's arguments are based on the premise that we have analyzed the claim based on a preexisting condition with no actual causal contribution. As we have discussed above, Dr. Berkeley testified that claimant's C6-7 herniated disc preexisted his employment with Umpqua. Dr. Berkeley's testimony indicated that claimant's preexisting C6-7 disc condition is causally related, in some part, to his current C6-7 herniated disc condition. Therefore, we need not address claimant's argument concerning "noncausal" preexisting conditions. In any event, we

have prevously held that the Board is not the proper forum for an ADA challenge. See Rex Brink, 48 Van Natta 916 (1996), aff'd mem Brink v. Falcon Cable TV, 146 Or App 777 (1997).

Claimant argues that the major contributing cause standard cannot be applied to deprive him of his common law and Employer Liability Law remedies. Claimant contends that if ORS 656.005(7)(a)(B) and ORS 656.802(2) are applied as written and his workers' compensation claim against Umpqua fails because he did not establish major contributing cause, a fundamental difficulty would exist regarding his access to remedies for his other rights. Claimant cites Article I, Section 10, of the Oregon Constitution and ORS 656.018 in support of his argument. We do not consider this issue because claimant has not demonstrated that he has been injured by operation of ORS 656.018. See Jim M. Greene, 47 Van Natta 2245 (1995). 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 us. 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 at 916 (same).

Attorney Fees

The ALJ found that extraordinary circumstances applied to this case and, therefore, the $1,000 limit in ORS 656.308(2)(d) did not apply. The ALJ awarded claimant's counsel a fee of $5,000. Claimant cross-requests review, seeking additional attorney fees for prevailing at hearing.

ORS 656.308(2)(d) provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

In light of our conclusion that claimant failed to establish that he sustained a new injury or new occupational disease during his employment with Umpqua, claimant has not "finally prevail[ed]" against SAIF's responsibility denial. Moreover, since Argonaut did not contest compensability or responsibility for claimant's C6-7 condition at hearing or on review, claimant did not "finally prevail" against a responsibility denial from Argonaut. Inasmuch as claimant has not finally prevailed against a responsibility denial pursuant to ORS 656.308(2)(d), he is not entitled to an attorney fee. Therefore, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated December 18, 1996 is reversed. The SAIF Corporation's responsibility denial of claimant's C6-7 disc herniation claim is reinstated and upheld. Argonaut Insurance Company's disclaimer of responsibility is set aside and the claim is remanded to Argonaut for processing according to law. The portion of the ALJ's order that ordered SAIF to reimburse Argonaut for all benefits attributable to claimant's C6-7 disc condition after January 6, 1995 is reversed. The ALJ's attorney fee award is also reversed.

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In the Matter of the Compensation of
**SHARON F. McFERON, Claimant**
WCB Case No. 96-06600
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order which affirmed the Order on Reconsideration on Remand that awarded 9 percent (28.8 degrees) unscheduled permanent disability for the right shoulder condition and 17 percent (32.64 degrees) scheduled permanent disability for the loss of use or function of the right arm. On review, the issue is extent of permanent disability, scheduled and unscheduled.

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

Claimant has an accepted claim for right hip and right shoulder conditions resulting from operation of a power jack at work. She received conservative treatment and her conditions became medically stationary in October 1994. Her claim was closed by Notice of Closure on December 27, 1994 with no permanent disability award. (Ex. 11). Claimant requested reconsideration and a medical arbiter examination. She also specifically requested promulgation of a rule to address permanent disability that is not addressed under the existing standards. (Ex. 12).

The medical arbiter, Dr. Gritzka, examined claimant on July 5, 1995. He found that, while her right hip pain had largely resolved, she continued to have pain in the right shoulder and the right lateral arm to the elbow. (Ex. 13-2). Isometric manual muscle testing revealed diffuse regional weakness in the entire right upper extremity, which was attributed to disuse. (Ex. 13-3). Dr. Gritzka found weakness of right grip strength and ranges of motion of the fingers, thumb, elbow and shoulder, and lost ranges of right shoulder motion. (Ex. 13-4). He also found a limitation on the ability to repetitively use the right shoulder. (Ex. 13-5). He did not indicate that any impairment findings were invalid, and opined that the "right shoulder impairment is due to the accepted compensable injury." (Id.)

The Department declined to promulgate a temporary rule, reasoning that the arbiter's finding of muscle strength loss was not related to the accepted right shoulder condition. (Ex. 14). By Order on Reconsideration dated August 1, 1995, as amended August 9, 1995, the Department awarded 5 percent unscheduled permanent disability for the limitation of repetitive use of the right shoulder. (Exs. 15, 16). Claimant requested a hearing.

At hearing, claimant requested that the matter be remanded to the Director for the promulgation of a temporary rule addressing loss of muscle strength due to disuse. By Opinion and Order dated February 12, 1996, a prior ALJ remanded the claim to the Director for the adoption of a temporary rule rating claimant's disability due to lost strength in her right shoulder and right upper extremity from disuse. (Ex. 18). The prior ALJ found that claimant sustained permanent loss of muscle strength in the right shoulder and right arm due to disuse, which was related to the compensable condition. (Ex. 18-3). The prior ALJ also found that the standards did not adequately address claimant's lost strength because the arbiter did not relate the lost strength to nerve injury, muscle loss or disruption of the musculotendinous unit.[1] (Ex. 18-4).

On remand, the Department promulgated a temporary rule which made the then-current "loss of strength" standards applicable to claimant's claim. See OAR 436-035-0110(8), 436-035-0350(3), (5) (WCD Admin. Order 96-051). (Ex. 20-3). Applying those standards to the claim, the Department issued an Order on Reconsideration on Remand dated July 8, 1996, which awarded 9 percent unscheduled permanent disability for losses of strength and motion in the right shoulder and 17 percent scheduled permanent disability for loss of strength in the right arm. (Ex. 21). The employer requested a hearing, which is the subject of the current proceeding.

At hearing, the employer requested reinstatement of the August 1, 1995 Order on Reconsideration, arguing that there was insufficient evidence to prove that the medical arbiter's findings of lost strength in the right shoulder and right arm constituted a permanent impairment which is related to the compensable condition. The ALJ noted that the employer raised these same arguments before the prior ALJ. Reasoning that the prior ALJ's order was a final, appealable order which the employer did not appeal to the Board, the ALJ concluded that the employer is now precluded by res judicata from relitigating issues decided in that prior proceeding. Finding no error in the Department's application of the temporary rule to this claim, the ALJ affirmed the Order on Reconsideration on Remand.

On review, the employer contends that the ALJ erred in concluding that it is barred by the prior ALJ's order from contesting the finding that claimant sustained permanent loss of strength in the right shoulder and right arm due to the compensable condition. We do not need to address the employer's contention because we conclude that, even if we considered the merits of the permanent disability issue, we would conclude that the claim was correctly remanded to the Director for the promulgation of a temporary rule and that the temporary rule adopted by the Department was correctly applied to the claim.

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[1] Under the standards that were applicable to the rating of claimant's disability, loss of muscle strength could be rated only if the loss was due to a nerve injury, muscle loss, or disruption of a musculotendinous unit. Former OAR 436-35-110(8), 436-35-350(3), (5) (WCD Admin. Order 6-1992).

On the merits of the permanent disability issue, the employer argues that the prior ALJ misinterpreted the medical arbiter's report. We disagree. Like the prior ALJ, we find that the arbiter's report proves by a preponderance of the evidence that claimant sustained permanent losses of strength in the right shoulder and right arm due to the compensable condition.

The medical arbiter, Dr. Gritzka, found losses of strength in both the right shoulder and right arm. He did not indicate that those findings were invalid, nor did he attribute them to causes other than the compensable injury. Rather, he specifically opined that the "right shoulder impairment is due to the accepted compensable injury." (Ex. 13-5). Based on that statement, we find that claimant's right shoulder impairment is due to the compensable injury. We reject the employer's assertion that the "right shoulder impairment" was restricted to the limitation on repetitive use of the right shoulder. Based on the arbiter's finding of strength loss in the right shoulder, we conclude that "right shoulder impairment" is most reasonably interpreted as including the lost strength, as well as the lost ranges of motion and limitation on repetitive use of the shoulder.

With regard to the losses of strength in the right arm, the arbiter did not explicitly relate those findings to the compensable condition. We find, however, that the lost strength findings in the right arm were consistent with the compensable right shoulder condition. Therefore, because the arbiter did not relate those right arm findings to any cause other than the compensable shoulder condition, we find that they are related to the compensable condition. See SAIF v. Danboise, 147 Or App 550, 553 (1997) (If the medical arbiter's impairment findings are consistent with the compensable injury and the record shows no other cause for the impairment, impairment is "due to" the compensable injury.)

In this regard, we disagree with the employer's interpretation of the arbiter's statement that the lost strength in the right arm "was not on the basis of an injury to a musculotendinous unit or on the basis of a nerve injury." (Ex. 13-4). The arbiter was not saying that the lost strength in the arm is unrelated to the compensable condition. Rather, the arbiter was saying that claimant's strength loss did not meet the requirement, under the then-applicable standards, to prove that the strength loss was due to a nerve injury or disruption of a musculotendinous unit. At the same time, however, the arbiter did not question the validity of the strength loss findings.

Based on this record, therefore, we agree with the current ALJ's conclusion that the Department correctly applied the temporary rule that was adopted on remand. For these reasons, we affirm the ALJ's order.[2]

Claimant's attorney is entitled to an assessed 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 attorney fee for services on review is $1,000, to be paid by the self-insured employer. We have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated November 21, 1996 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

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[2] In its Reply Brief, the employer also requests that this case be remanded to the ALJ for a full hearing on the merits. Based on our review of the record, we find that the parties fully litigated the extent of claimant's permanent disability, subject to the limitation on "post-reconsideration" evidence. In addition, the employer has not indicated what, if any, evidence he wished to offer on remand. Inasmuch as the record appears to be fully developed, we find no compelling reason to remand this case to the ALJ. See ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

**Chair Hall specially concurring.**

I write separately to underscore my own factual determination, based primarily on my interpretation of the medical arbiter's report, that the arm impairment is "due to" the compensable injury, within the meaning of ORS 656.214(2).

In the Matter of the Compensation of
**BESSIE B. MITTS, Claimant**
WCB Case No. 96-07805
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that affirmed an Order on Reconsideration that awarded 9 percent (12.15 degrees) scheduled permanent disability for loss of use or function of the right foot. In its respondent's brief, the self-insured employer contends that claimant's award should be reduced. On review, the issue is scheduled permanent disability.

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

The Order on Reconsideration awarded claimant 9 percent scheduled permanent disability for the right foot and awarded no scheduled permanent disability for the left foot. Based on the medical arbiter's report, claimant seeks to have her scheduled award for the right foot increased to 13 percent and also seeks an award for the left foot of 6 percent. The employer asserts that claimant's 9 percent scheduled permanent disability award for the right foot should be reduced to a 25 percent scheduled permanent disability award for the right toe.

Claimant argues that the appellate reviewer erred by comparing claimant's right ankle joint range of motion to her left ankle joint in rating claimant's disability. Claimant argues that her left ankle was also injured in the accident. OAR 436-035-0007(22) provides that: "The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease." (Emphasis added).

Dr. Hunt, the medical arbiter, reported that "[a]nkle motions were normal and symmetrical with 15 degrees of dorsiflexion." Claimant asserts that if the right and left ankles are rated under the standards instead of compared with one another, claimant is entitled to a 2 percent award for each ankle under OAR 436-035-0190.

The medical evidence reveals that claimant's right foot crush injury was much more severe than the injury to the left foot. There is insufficient evidence in the record to find that claimant's left ankle joint was injured as a result of the compensable injury. Thus, based on this record, we are unable to conclude that claimant's contralateral left ankle joint had a history of injury. Under such circumstances, comparison of the joints was appropriate under OAR 436-035-0007(22).

The employer argues that the Order on Reconsideration award of 5 percent impairment for loss of plantar sensation is not warranted. The employer asserts that claimant's sensory findings are unreliable because the arbiter suspected "psychosocial motivational factors affecting physical." Although the medical arbiter suspected "psychosocial motivational factors," he did not indicate that his finding of loss of plantar sensation was unreliable or attributable to anything other than the compensable injury. Under such circumstances, the Order on Reconsideration award for loss of plantar sensation in the right foot was appropriate.

Finally, claimant seeks an award for reduced range of motion in the left great toe. The medical arbiter indicated that "[claimant] has no obvious impairment of either by motor strength or ranges of motion of her hips, knees, ankles or other toes same the right foot great toe * * *." Under such circumstances, claimant has not established an entitlement to an award for lost range of motion in the left great toe.

Because the employer sought a reduction in claimant's permanent disability award and we have not reduced or disallowed claimant's compensation, claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2); Kordon v. Mercer Industries, 308 Or 290 (1989); Christopher E. Lindon, 47 Van Natta 1104 (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 regarding the right foot issue is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 3, 1997 is affirmed. For services on review, claimant's attorney is awarded $500, payable by the employer.

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In the Matter of the Compensation of
**KELLY A. NIELSON, Deceased, Claimant**
WCB Case No. 94-12584
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's claim for a consequential acute myelogenous leukemia (AML) condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Finding of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant carried his burden of proving that his AML condition was a compensable consequence of his compensable work injury, based on the opinion of Dr. Weinstein. We disagree.

Claimant suffered a severe head injury at work in 1992. He developed a seizure disorder as a result, for which he took Tegretol (carbamazepine), an anti-convulsant. In June 1994, a bone marrow biopsy revealed AML, in a setting of myelodysplastic syndrome (bone marrow injury).

To establish entitlement to compensation for his arguably consequential AML condition, claimant must prove that his compensable injury was its major contributing cause. 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)). Specifically, in this case, claimant must show that his Tegretol treatment was the major contributing cause of his AML condition. A finding of "major" causation requires that the injury contributes 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 309-310 (1983).

Here, the primary medical evidence supporting the claim is provided by Dr. Weinstein, treating oncologist.[1] Dr. Weinstein opined that claimant's AML was a compensable consequence of the Tegretol treatment for the compensable injury. In reaching this conclusion, Dr. Weinstein noted that Tegretol is a known cause of aplastic anemia, a condition which causes damage to the stem cells (early blood cell precursors of bone marrow). Because stem cells become leukemia cells when a person develops leukemia and the appearance of claimant's peripheral blood is consistent with bone marrow injury, Dr. Weinstein reasoned that, in claimant's case, the Tegretol caused damage to stem cells, which then evolved into leukemia via myelopysplastic syndrome, rather than via aplastic anemia. (Exs. 23-1, 32-8).

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[1] Drs. Mawk and Hansen agree with Dr. Weinstein or defer to him. (See Exs. 19-2-4, 24-1). However, because these doctors offer little or no reasoning, we do not find their conclusions persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Drs. Maas, Henner, and Granatir challenge Dr. Weinstein's reasoning on the following bases. All three doctors noted that there is no recorded case of Tegretol-related AML. Although there are well-documented cases of drug therapy-related aplastic anemia, they involved drugs other than Tegretol and aplastic anemia is much less common than AML. Moreover, all such cases involved a 30 to 60 month delay between ingestion of the cytotoxic chemical and development of the anemia. Claimant's AML, in contrast, was diagnosed only a year and a half, or 18 months, after he started taking Tegretol. In addition, nearly 90 percent of therapy-related aplastic anemia cases evidenced chromosomal abnormalities present in fewer than 15 percent of idiopathic AML cases.[2] (Exs. 21, 31).

Considering the differences between claimant's condition and the known therapy-related anemia cases, we find that the persuasiveness of Dr. Weinstein's theory of causation depends largely on the strength of his premise: Because Tegretol has been known to cause aplastic anemia, it logically follows that it probably also caused claimant's AML. However, the persuasive medical opinions establish that aplastic anemia is not the same as acute myelogenous leukemia and Tegretol is not the same drug as those associated with aplastic anemia. Moreover, Dr. Weinstein failed to explain the notably short latency period in claimant's case. Under these circumstances, we cannot say that Dr. Weinstein's reasoning and conclusions are persuasive. Because the record therefore only supports the possibility of a causal relationship between claimant's Tegretol treatment and his AML condition, we conclude that the claim must fail. See Gormley v. SAIF, 52 Or App 1055 (1981).

ORDER

The ALJ's order dated September 23, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] Cytogenetic analysis of claimant's bone marrow was not performed until standard induction therapy resulted in remission of the AML. Consequently, this information is unavailable. (See Exs. 31-2).

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In the Matter of the Compensation of
**KIP D. OSWALD, Claimant**
WCB Case No. 96-05831
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock, Haynes, and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Marshall's order that set aside its denial of claimant's claim for a left ankle injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant, a deputy sheriff, was involved in an altercation with a suspect in January 1996 in which gunshots were exchanged. The suspect was wounded by claimant. Following this incident, claimant experienced insomnia, memory lapse, concentration problems and physical difficulties. Claimant was treated for these symptoms by Dr. Jones, who recommended that claimant exercise to relieve his stress. Claimant filed a workers' compensation claim for the stress condition resulting from the shooting incident. The claim was first denied, but was eventually accepted by stipulated agreement.

Prior to January 1996, claimant occasionally did physical exercise during his off work hours. Sometime prior to April 28, 1996, claimant had a conversation with his supervisor, in which the supervisor mentioned a gym and a lunch-time basketball game as ways for claimant to exercise. On April 28, 1996, a detective invited claimant to play in a lunch-time basketball game. Claimant agreed to participate in the game believing it would help relieve his stress. During the course of the game, claimant was kicked in the back of his left lower leg by another player.

Claimant sought medical treatment for the left leg from Dr. Keizer, who diagnosed a torn Achilles tendon of the left ankle. Claimant underwent surgery to repair the left Achilles tendon. Claimant filed a workers' compensation claim for the tendon injury which was denied by the employer on the basis that it was unrelated to claimant's accepted stress claim and did not arise in the course and scope of claimant's employment.

The ALJ found that claimant's Achilles tendon injury did not occur within the course and scope of his employment. Claimant does not challenge this portion of the ALJ's order. The ALJ, however, further found that claimant's participation in the basketball game on April 28, 1996 was reasonable and necessary medical treatment for his compensable mental stress claim. The ALJ reasoned that Dr. Jones had recommended exercise to relieve claimant's work-related stress and had indicated that basketball was a reasonable exercise for that purpose. Finding that the basketball game was a reasonable and necessary medical treatment for the stress condition and that it directly caused claimant's left ankle injury, the ALJ set aside the insurer's denial.

On review, the insurer argues that the basketball game did not amount to reasonable and necessary medical treatment for claimant's stress condition. Based on the following reasoning, we agree.

Where a worker sustains a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). Barrett Business Services v. Hames, 130 Or App 190 (1994). In Hames, the claimant sustained an injury to his right ulnar nerve during physical therapy designed to treat his compensable shoulder dislocation injury, and the court found that the ulnar nerve injury was a direct consequence of appropriate treatment for the shoulder injury and, thus, compensable.

In Bradley B. Rogers, 48 Van Natta 1849 (1996), which issued subsequent to the date of the ALJ's order, we distinguished Hames. In Rogers, the claimant had a compensable back injury for which his physician recommended exercises to maintain flexibility and avoid recurrent pain after the claimant became medically stationary. While doing his unsupervised exercise program, the claimant hyperextended his neck and sustained a neck injury.

We found the causal relationship between the claimant's compensable low back injury and the cervical injury too tenuous and indirect to render the cervical injury a compensable consequence of the back injury under ORS 656.005(7)(a)(A). Because the claimant was doing his exercises after claim closure as a preventative measure without any direct medical supervision, we found that the home exercise program did not constitute "medical treatment" for the compensable injury for purposes of the Hames analysis.

By contrast, in Martin I. Fowler, 47 Van Natta 614 (1995), the claimant's physician had prescribed physical therapy for the claimant's compensable right hip injury. While performing weightlifting, which was directed and overseen by the physical therapist, the claimant injured his neck. Although the claimant's physician had not specifically prescribed weightlifting prior to the claimant's injury, he later characterized such therapy as an "integral part" of the claimant's recovery from the original injury.

We found that the weightlifting activity in Fowler was reasonable and necessary treatment for the claimant's compensable right hip injury. We further found that this treatment directly resulted in the claimant's cervical condition. Thus, we found that the claimant had established compensability of the neck condition as a consequence of the compensable hip injury.

Here, claimant's psychologist, Dr. Jones, indicated that physical activity was "potentially beneficial" to anyone experiencing significant stress, and he recommended that claimant participate in some sort of physical activity. Dr. Jones made no specific recommendations regarding the type of physical activity. Claimant's participation in the basketball game was not supervised by a medical professional. Subsequent to claimant's injury, Dr. Jones indicated that basketball was a reasonable stress-relieving exercise.[1]

After reviewing the cases discussed above, we conclude that claimant's choice to engage in the basketball game at lunch-time did not amount to "medical treatment" for the compensable stress condition. In this regard, claimant testified that he had engaged in physical activities other than basketball to reduce his stress. Furthermore, like the exercise program in Rogers, the basketball game was not directed or overseen by a medical professional. Rather, claimant engaged in this activity on his own initiative. Bradley R. Rogers, supra; Martin J. Fowler, supra. At most, Dr. Jones stated that physical activity was "potentially beneficial" to anyone experiencing stress and recommended that claimant engage in some type of physical activity. We do not find that such general recommendations for unsupervised activities constitute "medical treatment" for purposes of Hames.[2]

Accordingly, based on this record, we are unable to find that claimant's left ankle injury is a compensable consequence of his accepted stress claim.

## ORDER

The ALJ's order dated September 17, 1996 is reversed. The insurer's denial is reinstated and upheld. The ALJ's award of an assessed attorney fee is also reversed.

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[1] We tend to discount Dr. Jones' after-the-fact opinion that the basketball activity was a reasonable activity for relieving claimant's stress. Had Dr. Jones suggested or discussed basketball as a potential stress-relieving activity with claimant prior to the injury, we would find his opinion more persuasive. Here, however, Dr. Jones did not suggest or discuss any specific stress-relieving activities with claimant prior to the injury. Under such circumstances, we do not find that claimant's self-prescribed activity constituted reasonable and necessary medical treatment for the compensable injury.

[2] We find this case to be distinguishable from Martin J. Fowler, supra, for two reasons. First, claimant's activity was not directed or overseen by a medical professional as was the weightlifting activity in Fowler. Second, in Fowler, the weightlifting activity was an "integral" part of claimant's recovery rather than merely "potentially beneficial" in alleviating claimant's stress. See also Elizabeth A. Bergin, 49 Van Natta 650 (1997) (Injury while performing home-exercise stretch program for accepted injury was compensable because program was prescribed by attending physician for curative purposes).

**Board Chair Hall dissenting.**

Under Barrett Business Services v. Hames, 130 Or App 190 (1994), claimant's left ankle injury is itself compensable if it is the "direct result of reasonable and necessary treatment for the compensable injury." I believe that the facts of this case fit within the holding of Hames.

Claimant was injured while following his psychologist's instructions to engage in physical exercise to treat his compensable mental stress claim. Dr. Jones, claimant's psychologist, specifically recommended physical exercise to relieve claimant's mental stress. Moreover, Dr. Jones has also opined that playing basketball was a reasonable exercise for relieving claimant's stress.

As I stated in my dissenting opinion in Bradley B. Rogers, 48 Van Natta 1849 (1996), it is immaterial, for purposes of the analysis of Hames, whether the treatment was under the "direct supervision" of claimant's physician or another medical professional. I also believe that the majority further departs from the Hames analysis by making a distinction between treatment that is "integral" to a claimant's recovery and treatment that is "potentially beneficial." No such distinction is contained in ORS 656.005(7)(a)(A) or Hames. Rather, the requirement is that the further injury result directly from "reasonable and necessary" treatment.

Here, as the ALJ found, the record establishes that claimant's basketball activity was reasonable and necessary treatment for claimant's compensable mental stress condition. Because claimant was injured as a direct result of performing a "reasonable and necessary" treatment activity, as recommended by his physician, I would find claimant's ankle injury compensable under ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
**KENNETH N. ROBISON, Claimant**
WCB Case No. 95-10810
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's left wrist condition (ulnar bruising, disruption of the fibrous union, and frayed extensor tendon). On review, the issue is compensability.

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

On review, the employer argues that the ALJ erred in relying on the opinion of claimant's treating physician, Dr. Adams. The employer contends that Dr. Adams' opinion is speculative and not supported by any observations made at the time of claimant's surgery. However, although Dr. Adams testified that, at the time of surgery he could not tell whether claimant's bone condition was old or new, Dr. Adams did observe that claimant's extensor tendon appeared frayed, rather than smooth. Dr. Adams attributed the fraying to a recent injury, as he explained that irregular edges would not be that rough after a long period of time. (Ex. 7-10). Accordingly, we do not agree with the employer that Dr. Adams' findings were purely speculative.

The employer also contends that Dr. Adams' opinion is not persuasive because it is inconsistent with his prior opinion. The employer notes that Dr. Adams previously agreed with a letter from the employer's attorney which related claimant's current problems to the preexisting injury, rather than the recent work incident. (Ex. 4-1). However, Dr. Adams later agreed with a letter from claimant's counsel which noted that Dr. Adams' concurrence had been issued prior to claimant undergoing surgery. Dr. Adams subsequently agreed that, based on claimant's prior history of being asymptomatic despite performing significant work activity over a period of years, the fact of his acute work injury, and the observations made at the time of surgery, his opinion was that claimant's work was the major contributing cause of the combined condition. (Ex. 6-2). Dr. Adams adhered to his opinion at the time of his deposition. (Ex. 7).

Consequently, we find that Dr. Adams has explained why his opinion changed. Furthermore, we conclude that Dr. Adams' opinion is persuasive and legally sufficient, as it considers and weighs the various possible contributors to the combined condition, as required by the court in Dietz v. Ramuda, 130 Or App 397 (1994). Therefore, we agree with the ALJ that claimant has established compensability of the combined condition.

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

## ORDER

The ALJ's order dated November 7, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
**SUSAN VEGA, Claimant**
WCB Case No. 96-04560
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the self-insured employer's denial of claimant's low back condition. On review, the issue is compensability. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

On January 20, 1996, claimant experienced the onset of low back pain while working. Claimant has a preexisting low back condition as a result of a March 1994 nonwork-related motor vehicle accident. The ALJ concluded that the medical evidence was insufficient to carry claimant's burden of proof under ORS 656.005(7)(a)(B). Although agreeing with the application of ORS 656.005(7)(a)(B), claimant contends that the opinion of her treating physician, Dr. Stringham, proved compensability.

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."

Determining the compensability of a "combined condition" requires a comparison of the relative contribution to the worker's need for treatment of the preexisting condition and the compensable injury. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). The focus of the inquiry is on the primary cause of the claimant's need for treatment. Id. Work activities that precipitate a claimant's need for treatment of the combined condition may be, but are not necessarily, the major contributing cause. Id. See also SAIF v. Nehl, 148 Or App 101 (1997) (a specific need for treatment for "a very specific and limited part of the claimant's 'combined condition'" was compensable because the on-the-job injury caused, in major part, the claimant's immediate need for treatment, even though the claimant's entire condition may not have been caused in major part by the on-the-job injury).

The record contains several medical opinions concerning causation. Dr. Pribnow treated claimant on two occasions, beginning on May 30, 1996. (Exs. 55, 57). Dr. Pribnow concurred with a letter drafted by the employer's attorney stating that claimant had a preexisting low back condition and, "while the January 20, 1996 [work] incident * * * may have precipitated her returning for medical care in connection with her low back, the major contributing cause of her need for medical treatment and the duration of the treatment through the present is due to her pre-existing low back condition and not due to the January 20, 1996 incident." (Ex. 59).

Dr. Olson, neurosurgeon, treated claimant's low back following the March 1994 motor vehicle accident; claimant did not see Dr. Olson after the January 1996 work incident. (Ex. 21). Dr. Olson concurred with a letter drafted by the employer's attorney essentially providing the same opinion as the letter to which Dr. Pribnow concurred. (Ex. 60).

The last opinion is from Dr. Stringham, who began treating claimant on January 24, 1996. In response to whether claimant's work activities were the major contributing cause of her condition, Dr. Stringham stated the following:

"* * * I would view this as a combined condition. The work activity was the major contributing cause for [claimant's] development of symptoms of the low back strain on 1/20/96. * * * [S]he has [sic] temporary aggravation of her back condition, which appears to have returned to baseline. I would view her initial MVA as the major contributing cause of her chronic back condition. I would view the 1/20/96 work activity as the major contributing cause of her temporary aggravation, which has lasted for several months. The last record I have on [claimant's] status was 7/3/96, Occupational Medicine Clinic in Kaiser. At that time, [claimant] was working at the level of lifting of 20 lb., whereas her final release from Dr. Olsen in April 1995 was based on a November 1994 PCE, indicating she shouldn't lift above 15 lb. Therefore, at this point, she is better than baseline reported at time of being declared medically stationary from MVA. I think this supports my premise that the work injury caused a temporary worsening of her condition from which she recovered.

"* * * I agree with Dr. Pridnow [sic] that the MVA is the major contributing cause of [claimant's] overall long-term low back condition. However, I have made an additional category. I do feel the work injury caused a temporary worsening of [claimant's] chronic low back condition. This worsening required appropriate acute treatment. [Claimant] recovered from the worsening. She has returned to baseline. The work injury was the major contributing cause for the temporary worsening. The MVA is the major contributing cause for the chronic back condition." (Ex. 61-2, 61-3).

We agree with claimant that Dr. Stringham provided the most persuasive opinion. Unlike the other physicians, Dr. Stringham saw claimant shortly after the work incident and had the most contact with claimant. Dr. Stringham's report also was better-reasoned than the conclusory concurrence letters from Dr. Pribnow and Dr. Olson. Thus, we defer to Dr. Stringham's opinion. See Somers v. SAIF, 77 Or App 259 (1986).

According to Dr. Stringham, claimant had a "combined condition" for a discrete period and the major contributing cause for such condition during that time was the work injury. We find that such an analysis shows that Dr. Stringham considered the relative contribution of the work injury and preexisting condition. Dietz, 130 Or App at 401. Based on this opinion, we also conclude that claimant proved that the need for treatment during the time of her "combined condition" is compensable. ORS 656.005(7)(a)(B). In other words, claimant proved compensability for claimant's disability and need for medical treatment during the discrete period of time she had the "combined condition" (from January 20, 1996 to July 3, 1996). Nehl, 148 Or App at 106. Once the strain resolved, claimant's condition was no longer compensable since the "combined condition" resolved, leaving only the preexisting condition. Id.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing over the employer's denial of claimant's "combined condition." ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review 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 December 27, 1996 is reversed in part and affirmed in part. The self-insured employer's denial of claimant's "combined condition" is set aside insofar as it pertains to claimant's disability and need for medical treatment before July 3, 1996 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 employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
**THERESA L. HOLLAND, Claimant**
WCB Case No. 95-08279
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
John Pitcher, Defense Attorney

Reviewed by Board Members Moller, Bock and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Black's order which set aside its denial of claimant's low back injury claim. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the employer's denial of her left knee injury claim; (2) upheld the employer's denial of her right ankle injury claim; and (3) awarded an assessed attorney fee of $1,800 pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Left Knee and Right Ankle Conditions

We adopt and affirm the ALJ's reasoning and conclusions regarding the compensability of these conditions.

### Low Back Condition

Claimant, a paper machine operator, sustained a compensable right knee injury when she slipped and fell on November 14, 1993, as she moved from one work area to another. The initial diagnosis was right knee contusion and sprain. (Ex. 2).

Dr. Walton began treating claimant in August 1994. On September 28, 1994, Dr. Walton noted that claimant had her back "pop" that Monday and opined that this was "probably secondary to favoring her knee." (Ex. 4-5). By mid-October 1994, Dr. Walton reported that claimant's back problems were resolving. (Ex. 4-6).

On June 29, 1995, the employer denied that claimant's low back condition was a compensable component of the right knee injury claim. (Ex. 16). Claimant appealed the denial.

Examining physicians, Drs. Laycoe and Wilson, evaluated claimant's low back condition on September 13, 1995. (Ex. 17). They recorded a history that claimant had bent over a sink and heard a pop in her low back. (Ex. 17-3). Concluding that claimant's low back pain was purely coincidental with her knee injury, Drs. Laycoe and Wilson opined that bending over the sink would have produced back pain regardless of the status of claimant's knee condition. (Ex. 17-7).

At the hearing, claimant testified that her back problem first occurred at home while leaning over a sink and that her back symptoms resolved in a few weeks. (Trs. 14, 15).

The ALJ set aside the employer's denial, relying on Dr. Walton's opinion that claimant's low back condition was due to an altered gait from her compensable knee injury. On review, the employer contests the ALJ's decision to set aside its denial because the opinions of Drs. Laycoe and Wilson are more persuasive than Dr. Walton's. For the following reasons, we agree with the employer's contentions.

Inasmuch as claimant alleges that her low back condition is a consequence of her compensable right knee injury, she must prove that her compensable injury is the major contributing cause of her allegedly consequential low back condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Considering the timing and nature of the onset of claimant's low

back symptoms, we find that the causation issue 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 not to rely on the medical opinion of Dr. Walton, claimant's attending physician.

Claimant's acute onset of low back pain occurred while leaning over a sink at home. (Exs. 4-5; Tr. 8). Those symptoms resolved in a few weeks. (Ex. 4-6; Tr. 15). Although Dr. Walton opined that claimant's low back problems were "probably secondary to favoring her knee," which may have resulted in an altered gait, he testified at his deposition that claimant's history of a sudden onset of low back symptoms while bending over in her kitchen was different from his understanding. (Ex. 4-5; 20-15). After obtaining an accurate history of the onset of claimant's low back pain, Dr. Walton agreed that claimant's low back pain could have been postural in nature. Id. In addition, Dr. Walton testified that his altered-gait hypothesis was based on the assumption that there was no intervening cause or intervening activity that precipitated claimant's back pain. (Ex. 20-13, 14). Considering that claimant's low back pain did arise after an intervening activity (bending over a sink), the basis for Dr. Walton's theory is undermined by claimant's history. Moreover, Dr. Walton's reasoning ... that it is very common to see people who have low back symptoms secondary to gait problems ... is so unspecific as to claimant that it lacks persuasiveness.

In light of this testimony, we conclude that Dr. Walton's causation opinion is not consistent with claimant's history. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (medical opinion based on an inaccurate or incomplete history is not persuasive). Given the circumstances of the onset of claimant's low back pain, and the relatively rapid resolution of those symptoms, we are not persuaded that Dr. Walton's opinion establishes that claimant's compensable right knee injury was the major contributing cause of her low back condition.

Instead, we find the medical opinion of Drs. Laycoe and Wilson to be more persuasive. Specifically, we find their opinion that the onset of claimant's low back pain was coincidental with claimant's knee injury to be more consistent with the history of a sudden onset of low back pain while claimant was leaning over a sink at home and with the history of a resolution of the condition a few weeks later. See Somers v. SAIF, 77 Or App 259, 262 (1986).

Accordingly, we conclude that claimant's low back condition is not compensable. Therefore, we reverse those portions of the ALJ's order that set aside the employer's denial of claimant's low back condition and awarded an attorney fee.

## ORDER

The ALJ's order dated August 24, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which set aside the employer's denial of claimant's low back condition is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

**Board Member Biehl dissenting.**

I agree with the majority that claimant's left knee and right ankle injury claims are not compensable. However, I disagree with their conclusion regarding the compensability of claimant's low back condition. Thus, I must respectfully dissent.

The majority finds persuasive reasons not to rely on the medical opinion of Dr. Walton, the attending physician. Their primary objection seems to be that Dr. Walton's opinion is not consistent with claimant's history of the onset of her low back complaints. I believe the majority's concerns are unfounded.

First, the majority overlooks Dr. Walton's testimony that it is common for people who have low back symptoms secondary to altered gait to experience those problems intermittently, including times when they are merely standing. (Ex. 17-14). Therefore, even though claimant's low back symptoms first occurred while standing over her kitchen sink and appeared to resolve within a few weeks, this is not necessarily inconsistent with altered-gait causation.

Second, the majority ignores Dr. Walton's testimony at the close of his deposition. Even after learning the circumstances of the onset of claimant's low back pain, Dr. Walton confirmed that his causation opinion remained the same: that claimant's low back condition was the result of an altered gait due to the compensable right knee injury. (Ex. 17-17). I am puzzled by the majority's concerns regarding the consistency of Dr. Walton's opinion, when he was clearly advised in the deposition of all circumstances surrounding the onset of claimant's low back condition. Armed with that knowledge, Dr. Walton still related claimant's low back condition to the compensable injury.

In conclusion, Dr. Walton's opinion was based on a complete and accurate history and it was tested under rigorous cross-examination. I would, therefore, defer to Dr. Walton's opinion regarding the etiology of claimant's low back condition. Somers v. SAIF, 77 Or App 259 (1986). For this reason, I would conclude that claimant sustained her burden of proving that her low back condition was compensable.

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In the Matter of the Compensation of
**ERNEST C. VROMAN, Claimant**
WCB Case No. 95-09487
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Vroman v. Jerry Harris Logging, 146 Or App 776 (1997). The court has reversed our prior order, Ernest C. Vroman, 48 Van Natta 795 (1996), which: (1) found that the SAIF Corporation properly recalculated the rate of claimant's temporary total disability (TTD) benefits; and (2) allowed an offset for overpayment of TTD benefits. Citing Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), the court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on August 9, 1990. He did not return to work thereafter. SAIF accepted claimant's claim for the work injury. The employer reported that claimant worked eight hours five days a week and was paid $13 per hour. SAIF computed claimant's weekly wage as $520 (40 hours x $13 per hour). For the period from August 10, 1990 to February 10, 1995, SAIF paid claimant $89,682.79 in temporary disability compensation, based upon a TTD rate computed from a "weekly wage" of $520.

On about February 15, 1995, SAIF recomputed claimant's weekly wage based upon his average weekly earnings with the employer during the 26 weeks prior to his date of injury. On that basis, SAIF considered claimant to have been overpaid $52,946.45. For the period since February 9, 1995, SAIF paid claimant temporary disability compensation based on a TTD rate computed on a "weekly wage" of $213.

Claimant requested a hearing, contending that the TTD rate was correct before SAIF's recalculation and requesting penalties and/or attorney fees for SAIF's allegedly unreasonable denial of, or resistance to payment of, compensation. SAIF requested authorization to offset the allegedly overpaid temporary disability benefits that were paid prior to its recalculation of claimant's TTD rate.

The ALJ concluded that SAIF had properly recalculated claimant's TTD rate. In reaching this conclusion, the ALJ relied on prior Board cases that held that determination of whether an "extended gap" existed under the applicable version of former OAR 436-60-020 depended on whether the gap had caused a change in the work relationship between the employer and the employee. The ALJ determined that there had been no change in the work relationship between the employer and claimant. Therefore, the ALJ found that the gaps in claimant's employment were not "extended gaps."

Accordingly, the ALJ found that claimant's weekly wage was properly determined by averaging his earnings over the 26 weeks prior to his injury, the method SAIF had used in recalculating claimant's TTD rate. The ALJ also found that neither a penalty nor an attorney fee was warranted. Finally, the ALJ approved SAIF's request for an offset of its overpayment of TTD.

On review, we adopted and affirmed the ALJ's order, with supplementation regarding the ALJ's "extended gap" analysis. This supplementation included a discussion of Earin J. Hadley, 48 Van Natta 216 (1996), a case in which we had adhered to our long-standing interpretation of former OAR 436-60-025(5)(a)[1] 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 the employee. Claimant appealed.

Citing Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), the court reversed our order and remanded for reconsideration. We proceed with our reconsideration.

Temporary Disability Rate

Temporary disability is calculated based on the wage of the worker at the time of injury. ORS 656.210(2)(b)(A). 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 is authorized to prescribe by rule methods for establishing the worker's weekly wage. ORS 656.210(2)(c). Claimant was compensably injured on August 9, 1990. Therefore, the applicable rule is former OAR 436-60-020(10), WCD Admin. Order 8-1990 (temp.), effective July 1, 1990, which provides, in relevant part:

> "The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section. The insurer shall resolve situations not covered by ORS 656.210 or this section by contacting the employer and worker to determine a reasonable wage.
>
> "(a) 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. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at the time of hire as confirmed by the employer and the worker."

In Hadley, 144 Or App at 161-62, the court determined that our interpretation of "extended gaps" under a subsequent version of this rule impermissibly added a requirement that there be a change in the employment relationship before an extended gap could be found. However, on reconsideration in this case, we do not find it necessary to determine whether "extended gaps" existed here because, for the following reasons, we find that claimant was employed less than four weeks at the time of his injury. Thus, claimant's disability rate is calculated based on the intent at the time of hire as confirmed by the employer and the worker. Former OAR 436-60-020(10)(a).

Claimant first worked for this employer, Jerry Harris Logging (Harris), as a chaser in 1985. Claimant worked for another employer for several years and returned to work for Harris as a chaser in late 1989. In 1989 and 1990, the employer did contract logging almost exclusively. The employer had to shut down its operation each time it relocated to a new logging site. Those shut downs typically lasted a few days. During those shut downs most of the crew, including claimant, was laid off. The employer was unable to work at certain times because the falling and bucking operation or the building of roads had not been completed. At times, the weather prevented work, and operations were occasionally shut down due to equipment failure. Because of these circumstances, claimant was off work at various times during his employment with Harris from December 1989 until about the third week of June 1990. During these times off work, claimant collected unemployment insurance benefits. (Tr. 13).

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[1] Former OAR 436-60-025(5)(a) is a subsequent version of the applicable Department rule regarding calculation of TTD rate, which contains substantially the same language as the rule applicable in the present case, former OAR 436-60-020(10)(a).

However, in late June 1990, claimant began working for another employer, Harvest Logging Company (Harvest), rather than continue to file for unemployment insurance benefits. (Tr. 8). At that time, the work at Harvest was more steady than at Harris, although Harvest paid less per hour than Harris. (Tr. 6, 7). While working for Harvest, claimant did not consider himself to be employed by Harris. (Tr. 8). Claimant kept in touch with the employer at Harris and was aware that Harris had bought a piece of timber to log and was continually looking for more contract jobs. (Tr. 6, 7, 14). The prospect of steady work at Harris influenced claimant's decision to leave Harvest. (Tr. 7). Claimant would have stayed at Harvest if there had not been more steady work available at Harris. (Tr. 8, 14-15). On July 23, 1990, claimant returned to work for Harris. On August 9, 1990, he was compensably injured.

The employer did not feel that workers were obligated to him if they found other work during periods that his operation was down. (Tr. 27). Although he appreciated it if workers came back to work for him, he did not expect them to do so. Id.

Claimant's and the employer's testimony establish that claimant left the employ of Harris in June 1990 and was rehired by Harris on July 23, 1990. Thus, claimant was employed less than four weeks at the time he was injured on August 9, 1990. Therefore, claimant's TTD rate is calculated based on the intent at the time of hire as confirmed by the employer and the worker. Former OAR 436-60-020(10); Thomas J. Kollen, 49 Van Natta 554 (1997). We make that determination by reviewing the information provided by the employer on the "801" form and the parties' testimony at hearing. See Qualified Contractors v. Smith, 126 Or App 131 (1994); Ralph L. Keller, 48 Van Natta 146 (1996).

Here, the "801" form completed by the owner of the company stated that claimant worked 8 hours per day, five days per week, at $13 per hour. (Ex. 1). Claimant understood that work at Harris would be "pretty steady" when he returned to work there. (Tr. 16). He understood that he would be working 40 hours per week. (Tr. 17).

The owner tried to work his crew four nine hour days and an eight hour day, or about 44 hours per week. (Tr. 21). However, there was no guarantee of a certain number of hours per week and he paid his workers based on the actual number of hours worked. (Tr. 21, 24-25). Various situations could arise to cause the employer's operation to shut down temporarily, including weather, equipment breakdowns, delay in getting roads to the timber approved, delay in getting the timber felled and bucked, and trouble getting contracts. (Tr. 21-23). At the time claimant was injured, the crew was working on a private timber tract the employer had purchased to make work more steady and make more money. (Tr. 27). This work lasted about a month, then the employer returned to bigger contract jobs with the lumber mills. (Tr. 28-29).

Based on the "801" form filled out by the employer and the parties' testimony at hearing, we conclude that the parties' intent at the time of claimant's rehire on July 23, 1990 was for claimant to work five days per week, 8 hours per day, at $13 per hour. Thus, SAIF's initial calculation of claimant's temporary disability rate based on a weekly wage of $520 per week (40 hours per week x $13 per hour) was correct.

Penalties

The ALJ declined to assess a penalty and/or attorney fee for SAIF's claims processing. We also find that a penalty is not justified.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time it denies benefits. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

In this case, we find that SAIF had a legitimate doubt regarding the proper calculation of claimant's TTD rate. Prior Board case law had determined that "extended gaps," as that term was used in the Department's rule regarding calculation of TTD rate, required that there be a change in the employment relationship before an "extended gap" could be found. Jerry J. Raines, 47 Van Natta 6

(1995); Steven B. Caldwell, 44 Van Natta 2566 (1992). In addition, claimant's employment with Harris over the past several months before returning to work there in June 1990 included several periods when he was not working while the operations were shut down for various reasons. While we have determined that claimant's return to work in June 1990 represented a rehire and, thus, the "extended gap" analysis does not apply, we do not find the issue to have been so clear that SAIF acted unreasonably in recalculating claimant's TTD rate based on an "extended gap" analysis and applying prior Board case law in making that recalculation. See Marie E. Kendall, 46 Van Natta 2520 (1994), on recon 47 Van Natta 335 (1995) (carrier's conduct held reasonable where case law at the time supported propriety of that conduct). Under these circumstances, a penalty is not warranted.

Offset

We have found that SAIF's initial calculation of claimant's TTD rate based on a weekly wage of $520 was correct. Therefore, it follows that SAIF made no overpayment during the period from August 10, 1990 to February 10, 1995, when it paid claimant's TTD based on a weekly wage of $520. Accordingly, we reverse that portion of the ALJ's order that authorized SAIF to offset the alleged overpaid of TTD made during that period.

Attorney Fees

We have found that claimant is entitled to have his TTD rate calculated based on a weekly wage of $520. Inasmuch as our finding will 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.

Finally, we find that claimant's attorney is not entitled to an assessed fee for prevailing on the offset issue. In Strazi v. SAIF, 109 Or App 105, 108 (1991), the court reasoned that an offset is a correction of an overpayment which neither reduces nor disallows any portion of a claimant's compensation award; therefore, a request for an offset is not a threat to the award of compensation. Consequently, the court found that a claimant was not entitled to an attorney fee award under ORS 656.382(2) for successfully defending against a carrier's offset request. Id. Under the reasoning in Strazi, claimant is not entitled to an attorney fee award under ORS 656.382(2) for prevailing on the offset issue. Compare Bowman v. Esam, Inc., 145 Or App 46 (1996)(where a notice of closure erroneously awarded TTD at a higher rate and that notice of closure had become final, the carrier's subsequent request for an offset represented a challenge to the correctness of the award of compensation; therefore, the claimant was entitled to attorney fees under ORS 656.382(2) for prevailing on the carrier's challenge to the award of compensation). In addition, an offset does not represent a "denied claim" under ORS 656.386(1). Therefore, claimant is not entitled to an attorney fee pursuant to either ORS 656.382(2) or ORS 656. 386(1) for his counsel's services regarding the offset issue.

Accordingly, on reconsideration, the ALJ's order dated December 5, 1995 is reversed in part and affirmed in part. The SAIF Corporation is directed to calculate claimant's temporary disability based on a weekly wage of $520 and to pay claimant these benefits based on this recalculation. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
**PAMELA R. COVEY, Claimant**
WCB Case No. 96-08634
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) awarded temporary disability from December 2, 1995 through January 16, 1996; (2) affirmed an Order on Reconsideration's award of temporary disability from January 17, 1996 through May 8, 1996; and (3) awarded an assessed fee under ORS 656.382(2). On review, the issues are temporary disability and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable left knee and left ankle injury on May 1, 1995. An Order on Reconsideration was issued on September 13, 1996, awarding claimant temporary disability from May 1, 1995 through May 29, 1995; October 20, 1995 through December 1, 1995; and January 17, 1996 through May 8, 1996. Claimant requested a hearing, seeking an award of temporary disability from December 2, 1995 through January 16, 1996. SAIF cross-requested a hearing, contesting the award of temporary disability beginning October 20, 1995 and ending December 1, 1995 and the award of temporary disability from January 17, 1996 through May 8, 1996.

The ALJ found that claimant was entitled to temporary disability from December 2, 1995 through January 16, 1996, based on retroactive authorizations of temporary disability from her attending physicians, Drs. Meyers and Freudenberg. However, the ALJ determined that claimant was not entitled to temporary disability from October 20, 1995 through December 1, 1995, finding no valid contemporaneous or retroactive authorizations of temporary disability for this period. Thus, the ALJ eliminated the award of temporary disability for that period from the Order on Reconsideration. Finally, the ALJ affirmed the reconsideration order's award of temporary disability from January 17, 1996 through May 8, 1996 and awarded claimant an assessed fee pursuant to ORS 656.382(2) because SAIF was only partially successful in reducing claimant's overall award of temporary disability compensation in the reconsideration order.

On review, SAIF contends that claimant was not entitled to temporary disability from December 2, 1995 through March 13, 1996, asserting that the retroactive authorizations of temporary disability from Drs. Meyers and Freudenberg were ineffective for this time period under ORS 656.262(4)(f). However, SAIF concedes that we have ruled contrary to its position in Kenneth P. Bundy, 48 Van Natta 2501, 2503 (1996). Finding no reason to reconsider our holding in Bundy, we affirm the ALJ's determination that claimant was entitled to temporary disability during this period.

The primary issue on review concerns the ALJ's award of an assessed fee pursuant to ORS 656.382(2). Citing Gerald A. Zeller, 48 Van Natta 501, on recon 48 Van Natta 735 (1996), SAIF argues that the ALJ incorrectly awarded a fee pursuant to that statute because claimant's overall award of compensation in the reconsideration order was reduced by its cross-request for hearing when the ALJ eliminated the award of temporary disability from October 20, 1995 through December 1, 1995. For the following reasons, we agree with SAIF's contention.

In Zeller, the ALJ concluded that the claimant was entitled to temporary disability compensation from April 13, 1995 through May 18, 1995. We held, however, that the claimant's entitlement to temporary disability benefits began on May 4, 1995. Thus, we modified the ALJ's award of temporary disability. The claimant asserted that he was entitled to an assessed attorney fee under ORS 656.382(2) because his temporary disability benefits, while diminished, were not eliminated on review. We disagreed.

We reasoned that ORS 656.382(2) authorizes a fee when the claimant's right to compensation is at risk of disallowance or reduction and the reviewing authority finds that the compensation should not be disallowed or reduced. We found that the claimant's temporary disability compensation as granted by the ALJ's order should be reduced. The fact that a portion of the ALJ's temporary disability award had been undisturbed did not alter our conclusion that the ALJ's entire temporary disability award had been reduced. Therefore, we concluded that the claimant was not entitled to an assessed attorney fee under ORS 656.382(2).

In this case, a portion of the Order on Reconsideration's award of temporary disability was not disturbed (January 17, 1996 through May 8, 1996). However, claimant's overall award of temporary disability compensation in the reconsideration order was reduced as a result of SAIF's cross-appeal when the ALJ eliminated the reconsideration order's temporary disability award from October 20, 1995 to December 1, 1995. As in Zeller, we conclude that claimant was not entitled to an assessed fee pursuant to ORS 656.382(2) for defending a portion of the reconsideration order's temporary disability award.

In reaching this conclusion, we distinguish Roseburg Forest Products v. Boqua, 147 Or App 197 (1997). In Boqua, the court affirmed our order in Rodney V. Boqua, 48 Van Natta 357 (1995), which had awarded the claimant a carrier-paid attorney fee under ORS 656.382(2) for successfully defending at hearing one of several permanent disability (PPD) awards granted by an Order on Reconsideration. Noting that the claimant's PPD awards for two other conditions had been reduced, the carrier contended in Boqua that the claimant was not entitled to an attorney fee under ORS 656.382(2) for defending a PPD award for another condition because his "overall" compensation had been reduced.

The court disagreed. Citing Shoulders v. SAIF, 300 Or 606 (1986), the court reasoned that, when a carrier requests review of a compensation award regarding multiple conditions and the reviewing body affirms the compensability of some, but not all, conditions, yielding a reduction in the claimant's overall compensation, the claimant is entitled to attorney fees for services incurred with respect to those conditions for which compensation was not reduced. Inasmuch as the claimant had successfully defeated the carrier's attempt at the hearing to reduce his compensation award for one of the contested conditions, the court held that he was entitled to an attorney fee reasonably incurred in that effort. The court specifically noted that, when the carrier sought review of the disability awards before the ALJ, it treated and challenged each condition separately.

In this case, there was only one temporary disability award, although it was broken down into separate time periods for temporary partial and temporary total disability. Unlike Boqua, where compensation was awarded for separate conditions, there were no separate temporary disability awards for the accepted left knee and left ankle conditions. Our review of the medical records indicates that claimant's temporary disability during the disputed periods was due to the left knee condition. (Exs. 12, 12aA, 14, 16). Because this case does not involve separate temporary disability awards for separate conditions, we find that Boqua is not controlling. Therefore, we reverse the ALJ's decision to award an attorney fee pursuant to ORS 656.382(2).

Despite our reversal of the ALJ's attorney fee award pursuant to ORS 656.382(2), we have affirmed the ALJ's determination that claimant is entitled to an award of temporary disability from December 2, 1995 to March 13, 1996. Therefore, claimant's compensation as awarded by the ALJ's order has not been disallowed or reduced on review. Thus, claimant's attorney is entitled to an assessed fee for services on review regarding the temporary 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 temporary disability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the temporary disability 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 27, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded an assessed fee pursuant to ORS 656.382(2) is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is entitled to an assessed fee of $1,000, payable by SAIF.

In the Matter of the Compensation of
**DAVID F. LEMUS, Claimant**
WCB Case No. 96-02392
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the insurer's "back-up" denial of claimant's low back injury claim. On review, the issues are the propriety of the "back-up" denial and, if proper, compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the last sentence and with the following supplementation.

On January 24, 1996, the insurer's claim representative, Debbie Wade, sent a letter to claimant's treating physician, Dr. Neuberg, requesting information concerning claimant's condition. (Ex. 50-60). The letter also asked whether Dr. Neuberg was aware that claimant "had at least two prior claims in 1988 and 1990" and stated that the insurer was "in the process of obtaining the records[.]" (Id. at 61).

On February 13, 1996, the insurer accepted the claim for nondisabling lumbar strain. (Ex. 46). On March 1, 1996, the insurer, through Debbie Wade, informed claimant that, following the acceptance, it had "received a significant volume of information which demonstrates that the history you provided to your examining and treating physicians misrepresented your true medical history[.]" (Ex. 47-1). The letter further stated that, "[h]aving now received accurate information regarding your health history, we have come to the conclusion that your alleged injury * * * is not compensable." (Id.) The insurer therefore revoked its acceptance and denied the claim.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant misrepresented his medical history to his two treating physicians and that such misrepresentation could have influenced the insurer's decision to accept. Consequently, the ALJ concluded that the insurer properly issued its "back-up" denial under ORS 656.262(6)(a). The ALJ further concluded that claimant failed to prove compensability and, thus, upheld the "back-up" denial. Claimant challenges the ALJ's order, first asserting that the "back-up" denial is procedurally invalid.

ORS 656.262(6)(a) in relevant part provides:

> "The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim."

Under this provision, the insurer first must prove fraud, misrepresentation or other illegal activity by claimant. See Bauman v. SAIF, 295 Or 788 (1983). The insurer then must show that such fraud, misrepresentation or other illegal activity "could have reasonably affected" its decision to accept the claim. See Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987).

We agree with the ALJ that claimant misrepresented his previous low back injuries when seeking treatment for this claim. Claimant has an accepted 1988 low back condition claim with the SAIF Corporation for which he eventually was awarded permanent disability. (Ex. 11). In 1990, claimant filed another claim with SAIF concerning his low back, left leg and right ankle. (Ex. 27). Claimant and SAIF eventually settled that compensability dispute. (Ex. 34).

On December 2, 1996, claimant went to the hospital emergency room; the chartnote states that claimant was complaining of low back and left hip pain "since he was injured lifting a Christmas tree on 11/29/95." (Ex. 35). The chartnote also states "[n]o prior history of back problems." (Id.) On December 4, 1996, claimant saw Dr. Neuberg; the chartnote from that visit states that claimant "denies any previous back problems" and he "did have a previous Workers' Compensation claim in 1988 while tree planting." (Ex. 37). The accompanying form 827 indicates that the "same body part" was not previously injured. (Ex. 36). A March 11, 1996 chartnote (subsequent to the issuance of the "back-up" denial) provides that claimant "did have a previous injury in 1988 but denies he has had any back problems since then." (Ex. 48).

This evidence shows that claimant was untruthful concerning his prior low back treatment and resulting 1988 and 1990 claims. By telling the emergency room physician and Dr. Neuberg that he had no previous back problems, we find that he misrepresented his medical history. The record also shows, however, that the insurer was aware of the 1988 and 1990 claims because it provided such information to Dr. Neuberg in a letter dated January 24, 1996. The letter also states that the 1988 claim was with SAIF for "lumbo/sacral strain," that claimant treated with Dr. Poulson, and that the claim was denied. (Ex. 50-61). The letter further indicates that the 1990 claim "appears to be for overexertion resulting in multiple parts sprain/strain." (Id.)

The insurer argues that the information in the letter is wrong because it states that the 1988 claim was denied and does not refer to a low back injury with regard to the 1990 claim. The insurer asserts that, therefore, "it was misinformed about claimant's prior claims and injuries" before it issued its acceptance.

It is apparent from the record that, at the time of the January 24 letter to Dr. Neuberg, the insurer did not have every available document concerning claimant's prior medical history.[1] The information also possibly is at least partly incorrect because there is no evidence that SAIF denied the 1988 claim.[2] What the letter does show, however, is that the insurer knew that claimant had at least one previous injury to his low back and had received treatment for it. The letter also shows that claimant had been involved in claims in 1988 and 1990. Thus, the insurer knew before it issued its acceptance that claimant was not truthful when he told his treating physicians that he had not previously injured his low back and that he omitted to inform them of the 1990 claim. Because the insurer was aware of this misrepresentation and nevertheless issued its acceptance of a lumbar strain, we conclude that the insurer failed to show that claimant's misrepresentation "could have affected" its decision to accept. See Charles A. Tureaud, 47 Van Natta 306 (1995). (In light of carrier's knowledge of the claimant's prior injury to same body part, the carrier's failure to further investigate the claim prior to acceptance was not sufficient to support a "back-up" denial based on fraud, misrepresentation, or other illegal activity). Therefore, we conclude that the insurer did not properly issue its revocation of acceptance and denial of the claim on the basis of fraud, misrepresentation or other illegal activity. ORS 656.262(6)(a).

The insurer also contends that its "back-up" denial properly was issued based on "later obtained evidence." ORS 656.262(6)(a) provides:

> "If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance, and issue a formal notice of claim denial, if such revocation and denial is issued no later than two years after the date of the initial acceptance."

According to the insurer, the "later obtained evidence" is claimant's prior history of low back treatment.

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[1] Most of the reports dated before November 1995 are "date stamped" as having been received by the insurer on February 21, 1996, after it issued its acceptance.

[2] SAIF denied a 1989 aggravation claim. (Ex. 17).

As discussed above, the insurer did not have claimant's entire available medical record and obtained the majority of such evidence after it issued its acceptance. The January 24, 1996 letter to Dr. Neuberg, however, shows that the insurer knew the basic facts of claimant's 1988 and 1990 claims and that claimant previously had been treated for a low back injury although it did not realize the extent of the prior injuries. This information may have indicated that the claim was not compensable because claimant was untruthful concerning his prior medical history. Thus, because the insurer had evidence at the time of acceptance that the claim was not compensable, we also conclude that its revocation of acceptance and issuance of the denial were not proper. ORS 656.262(6)(a); Darwin G. Widmar, 46 Van Natta 1018 (1994), aff'd mem Alexsis Risk Management v. Liberty Northwest Insurance Corporation, 134 Or App 414 (1995).

Having found that the "back-up" denial is not proper under the statute, we set aside the revocation of the insurer's acceptance and subsequent denial of the lumbar strain.

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 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 August 29, 1996 is reversed. The insurer's revocation of acceptance and denial of the claim are set aside. The claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the insurer.

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June 23, 1997 Cite as 49 Van Natta 817 (1997)

In the Matter of the Compensation of
**DAVID D. INFAUSTO, Claimant**
WCB Case No. 96-00293
SECOND ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

On June 6, 1997, we issued an Order on Reconsideration in which we corrected that portion of our May 12, 1997 Order on Review that increased claimant's temporary disability award as granted by an Administrative Law Judge's (ALJ) order. In its first request for reconsideration, the insurer brought to our attention a discrepancy between our Conclusions of Law and Opinion, in which we concluded that claimant was entitled to temporary disability benefits from August 20, 1993 through July 21, 1995, and our Order portion, in which we awarded temporary disability from August 30, 1993 to December 31, 1995. After reviewing the insurer's motion, our prior order, and the record, we modified the order portion of the Order on Review to read as follows: "In addition to the ALJ's award of temporary partial disability from January 1, 1994 to July 21, 1995, claimant is awarded temporary disability benefits from August 20, 1993 [rather than August 30, 1993] to December 31, 1993 [rather than December 31, 1995]."

The insurer moves for abatement and reconsideration of our June 6, 1997 Order on Reconsideration, asserting that the order should award benefits from August 20, 1993 to July 21, 1995. In response to the insurer's motion, we offer the following comments.

In reconsidering our May 7, 1997 Order on Review, we took into account the following. The evidence established that claimant was partially disabled as of August 20, 1993 and that he was not released to regular work until July 21, 1995. The ALJ had already awarded temporary disability from January 1, 1994 to July 21, 1995. We did not disturb this award. In addition to this award, we awarded temporary disability benefits from August 20, 1993 through December 31, 1993. Consequently, the total award for temporary disability (as granted by the ALJ's order and our order) spanned the period from August 20, 1993 to July 21, 1995.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our June 6, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DONNA L. MEYERS, Claimant**
WCB Case No. 96-03750
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) awarded a $2,500 attorney fee for claimant's counsel's services for finally prevailing over the employer's denial of claimant's claim for a consequential headache condition; and (2) found that claimant's request for hearing regarding an alleged "de facto" denial of a dorsal strain condition was not frivolous. On review, the issues are attorney fees and sanctions.

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

ORS 656.390(1) gives the ALJ and the Board authority to impose an appropriate sanction against an attorney who files a frivolous request for hearing or review (or a request filed in bad faith or for the purpose of harassment). "'Frivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see also Westfall v. Rust International, 314 Or 553 (1992) (defining "frivolous" under former ORS 656.390); Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996); Sheri A. Wheeler, 48 Van Natta 1780 (1996).

Here, the employer seeks sanctions, contending that claimant had no reasonable prospect of prevailing on his request for hearing regarding an alleged "de facto" denial of a dorsal strain condition, because he did not comply with the prerequisites of ORS 656.262(6)(d) before filing the hearing request. The employer argues that Guillermo Rivera, 47 Van Natta 996, on recon 47 Van Natta 1723, 1724 (1995), did not support or legitimize claimant's hearing request in this case, because Rivera focused on the first of two hearing requests (and found that the first request constituted a "communication in writing" which satisfied ORS 656.262(6)(d)), whereas the present case involves only one hearing request. We find the distinction insignificant for purposes of evaluating the employer's sanctions request, noting that Rivera was followed (until disavowed[1]) in cases involving single hearing requests. See Debra S. Harrison, 48 Van Natta 420 (1996); Elizabeth A. O'Brien 47 Van Natta 2152, 2154 (1995). Accordingly, because we agree with the ALJ that claimant's request for hearing was not initiated without a reasonable prospect of prevailing (and not filed in bad faith or for the purpose of harassment), based on the law in effect at the time of the request (including Rivera), we agree with the ALJ's decision to deny the employer's motion for sanctions. See Wheeler, 48 Van Natta at 1780.

The employer also argues that the ALJ's attorney fee award was excessive because it was not commensurate with the amount of time claimant's counsel devoted to the headache condition denial.

In determining an appropriate attorney fee on de novo review, we consider all the factors set forth in OAR 438-015-0010(4). After considering the parties' arguments and the factors required by the rule (and applying them to this case), we find that a reasonable fee for claimant's attorney's services at hearing regarding the denial of the headache condition is $2,500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the benefit secured for claimant, and the skill of the attorneys. Accordingly, we affirm the ALJ's attorney fee award.

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[1] Shannon E. Jenkins, 48 Van Natta 1482 (1996), disavowed the relevant reasoning and conclusion in Rivera. Accordingly, since July 9, 1996, when Jenkins issued, a request for hearing does not satisfy the "communication in writing" prerequisite in ORS 656.262(6)(d) because the communication must precede the request.

Claimant is not entitled to an attorney fee for services at hearing or on review regarding the sanctions issue, because sanctions are not compensation. See ORS 656.005(8); ORS 656.382(2).[2] See also Nero v. City of Tualatin, 142 Or App 383 (1996). Finally, 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 October 1, 1996 is affirmed.

[2] There are three predicates to attorney fees under this statute: first, that the insurer filed a request or cross-appeal for a hearing to obtain a disallowance or reduction in the claimant's award of compensation; second, that the claimant's attorney performed legal services in defending the compensation award; and third, that the ALJ found on the merits that the claimant's award of compensation should not be disallowed or reduced. See Strazi v. SAIF, 109 Or App 105, 107-08 (1991).

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In the Matter of the Compensation of
**CHRISTOPHER J. CROZIER, Claimant**
WCB Case No. 96-02306
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of claimant's occupational disease claim for a left thumb condition; and (2) assessed a penalty for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

"Claimant had chopped firewood for his personal residence over a four-year period, chopping 2 to 3 times per week, and never more than one-half hour at a time."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's reasoning and conclusion regarding compensability with the following change and supplementation. In the first full paragraph on page 3, we change the fourth sentence to read: "Claimant testified that he never chopped wood more than one-half hour on the 2 or 3 days during the week during which he engaged in this activity."

Claimant has worked as a storekeeper for 12 years. Claimant has a left thumb condition, which was diagnosed as post-traumatic resting instability and early arthritis of the left thumb MP joint. (Ex. 4). In order to prove compensability of his occupational disease claim under ORS 656.802(2), claimant must establish that his employment conditions were the major contributing cause of the left thumb condition.

We agree with the ALJ that claimant's work activities were the major contributing cause of the left thumb condition. Claimant's work included loading items on the cart, moving the items on both the cart and the shelves, pushing and pulling the cart, writing and using the computer. The record supports a finding that all of these activities, which claimant performed with his only functioning hand, contributed to the left thumb condition.

Further, claimant demonstrated to Dr. Butters how he used his hand so Dr. Butters had a basis to evaluate the work activity. Significantly, Dr. Butters opined that pushing and pulling the carts **once an hour** over a 12-year period would be sufficient to cause claimant's left thumb condition. (Ex. 10-9). The record reflects that claimant had worked as a storekeeper for 12 years doing the same activities, while he only engaged in chopping wood for four years. Although Dr. Butters noted that chopping wood could contribute to the problem, we note that claimant had begun using pre-cut wood in 1995, the year preceding the date of hearing. Therefore, we believe that Dr. Butters' comments regarding the contribution from chopping wood were based on inaccurate data. We discount Dr. Butters' comments regarding that contribution accordingly. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980).

Penalties

The ALJ found that the insurer issued its denial in the absence of any medical evidence that suggested the claim was not compensable. Concluding that the denial was unreasonable, the ALJ assessed penalties.

The insurer argues that the ALJ erred by assessing a penalty. The insurer contends that the ALJ failed to consider other information available at the time the denial was issued.

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 16, 1996, the insurer issued a denial, asserting that an investigation failed to establish that claimant's osteoarthritis condition was related to his work activity. (Ex. 2). At the time the insurer issued the denial, it was aware that claimant had complained to a coworker that chopping firewood bothered his hand. (Tr. 16). Under these circumstances, we conclude that the insurer had a legitimate doubt as to whether claimant's osteoarthritis condition was compensable. Therefore, claimant is not entitled to a penalty for an unreasonable denial.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,400, 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 concerning the penalty issue. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated August 27, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty for the insurer's unreasonable denial is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,400, payable by the insurer.

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

Although I agree that claimant is not entitled to a penalty, I disagree with that portion of the majority's opinion that affirms the ALJ's conclusion that claimant's left thumb condition is compensable. The insurer correctly asserts that the critical question in determining compensability is how much time claimant spent pushing the delivery cart at work. The ALJ's conclusion on that issue is not supported by the record. Moreover, the ALJ erred by concluding that Dr. Butters' opinion supports compensability.

Claimant has worked as a storekeeper for 12 years. His job duties included taking supply orders from the nursing units, locating supplies, loading them on a cart and delivering them to the proper floor. Claimant has a left thumb condition, which was diagnosed as post-traumatic resting instability and early arthritis of the left thumb MP joint. (Ex. 4).

The ALJ concluded that claimant made deliveries of the supplies by pushing/pulling the supply carts only on the weekends and he filled the orders daily, placing the items on the cart, which were then delivered by another person. The ALJ reasoned that claimant was pushing and pulling the cart as he took and filled the orders. The insurer correctly asserts that there is no evidence to establish that claimant pushed and pulled the cart as he took and filled the orders.

Claimant testified that his left hand symptoms began in the fall of 1994. (Tr. 11). He said that the activities that caused pain in his hand were writing, operating the computer and pushing and pulling carts at work, as well as chopping wood. (Tr. 20-22). When claimant was asked who moves the cart at work, he replied:

"A. Occasionally I do.

"Q. Okay. When you say occasionally, is there a particular pattern to when you move the cart?

"A. I do all the deliveries on Saturday and Sundays and I work every weekend and during the week, somebody else does most of them.

"Q. Okay. So three days a week, somebody else is doing most of the deliveries for you; is that right?

"A. Yes." (Tr. 6).

I agree with the insurer that there is no evidence to support the ALJ's and the majority's conclusion that claimant pushed and pulled the cart as he took and filled the orders. Claimant testified that his duties were to "Locate the supplies in the warehouse, pull them off the shelf, load them up on the cart." (Tr. 5). Claimant did not testify that he moved the cart as he filled the orders.

Moreover, the ALJ's and the majority's reliance on Dr. Butters' opinion is misplaced. Dr. Butters' opinion is not persuasive because it is inconsistent and confusing.

Dr. Butters examined claimant on February 1, 1996, reporting that claimant was "a store keeper and pushes carts around." (Ex. 4). Dr. Butters diagnosed post-traumatic resting instability and early arthritis of the left thumb MP joint. (Id.) Dr. Butters concluded that claimant's work activities were the major contributing cause of his disability and need for treatment. (Ex. 9).

In a post-hearing deposition, Dr. Butters said that the thumb joint can be injured by an acute injury or from a chronic, repetitive force on the joint that can stretch the ligament. (Ex. 10-6). He explained that the chronic force "can come from repetitive pushing something with the hand where the thumb is resting against the object to be pushed, stretching out the ligament on the radial side of the thumb joint." (Ex. 10-7). An example was "doorman's thumb," which comes from the doorman pushing the door open constantly and stretching out the ligament. (Id.)

Dr. Butters said that claimant had described his job as pushing carts and lockers working as a storekeeper, and when claimant showed him how he used his hand in his job, it appeared to give the type of stress that would cause this problem. (Ex. 10-8, -9). Dr. Butters testified that pushing the cart would have to be a repetitious activity, not something claimant did once in awhile. (Ex. 10-9). He thought that once an hour over a 12-year time period would probably be sufficient. (Id.)

Dr. Butters also said that chopping wood could be a force that could cause the thumb problem. (Ex. 10-7). When Dr. Butters was told that claimant had been chopping firewood for four years for about a half hour at a time, he thought that "could" be a significant contributing cause of claimant's thumb problem. (Ex. 10-12, 13).

Dr. Butters testified that pushing the cart or large contents on the cart could cause claimant's condition. (Ex. 10-18). He explained that pushing a box of reasonable size on the cart and changing its location with his thumb would put stress on the thumb ligament. (Id.) Claimant told Dr. Butters that he loaded boxes on the cart and then repositioned them by pushing them with his thumb. (Ex. 10-19).

When Dr. Butters was asked whether pushing the cart contributed to claimant's thumb problem more than chopping wood for a half an hour two to three times a week, he replied:

> "I guess it boils down to how much he actually pushed the cart. If he told me that's a significant part of his job over 12 years, I guess I would still say that's the main cause. If he in fact only did push a cart once a day or occasionally, then that would certainly be less meaningful." (Ex. 10-15).

Dr. Butters said "[i]f it's shown that [claimant] really didn't push the cart and he actually did chop wood as much as you say, then that would probably change my opinion." (Ex. 10-16). If claimant was only pushing the cart a couple of times per day, Dr. Butters said he "would probably back off on saying that it was the major cause of his problem." (Id.)

At hearing, claimant testified that he did all the deliveries on Saturdays and Sundays, and during the rest of the week, "somebody else does most of them." (Tr. 6). In the deposition, when Dr. Butters was asked to assume that claimant only made deliveries with the cart on Saturdays and Sundays, he said that would change his opinion about the major contributing cause of claimant's condition. (Ex. 10-19). Dr. Butters said that claimant had indicated that he was pushing the cart and boxes on a regular basis. (Id.)

Claimant's attorney asked Dr. Butters to assume that, in addition to taking orders and pushing the carts, claimant also had to fill the cart with the orders, which included small items as well as equipment weighing 50 pounds or more. (Ex. 10-17). Assuming that claimant engaged in pushing and pulling-type activities at work with much greater frequency than the chopping activities off work, Dr. Butters agreed that it was "likely" that work was the major cause of claimant's thumb condition. (Id.) Dr. Butters agreed that the "issue" was where claimant did the bulk of his repetitive pushing-type activities that stretched the thumb out. (Ex. 10-20). If claimant did the bulk of his thumb-pushing activities at work, Dr. Butters agreed "that's likely going to be the major cause." (Id.)

I am not persuaded by Dr. Butters' opinion because it is inconsistent. Dr. Butters testified that the issue of causation "boils down to how much [claimant] actually pushed the cart." (Ex. 10-15). Claimant testified that he "occasionally" moved the cart and he did all the deliveries on Saturdays and Sundays. (Tr. 6). Somebody else did most of the deliveries the rest of the week. (Id.) If claimant only pushed the cart a couple of times per day, Dr. Butters said he "would probably back off on saying that it was the major cause of his problem." (Ex. 10-16). Assuming that claimant only made deliveries with the cart on Saturdays and Sundays, Dr. Butters said that would change his opinion about the major contributing cause of the condition. (Ex. 10-19). Thus, based on claimant's testimony, Dr. Butters indicated he would change his opinion that claimant's work activities were the major contributing cause of the left thumb condition.

On the other hand, when questioned by claimant's attorney, Dr. Butters said that if claimant did the majority of his repetitive pushing type activities that stretched the thumb out at work, it was "likely" that work was the major cause of claimant's thumb condition. (Ex. 10-17, -20). Dr. Butters' agreement that it was "likely" that work was the major cause of claimant's thumb condition (Ex. 10-17, -20) suggests only the possibility, rather than probability of a causal connection. See Gormley v. SAIF, 52 Or App 1055 (1981).

In summary, the ALJ erred by concluding that claimant was pushing and pulling the cart as he took and filled the orders. Moreover, Dr. Butters' opinion is not persuasive because it is inconsistent and confusing. Since there are no other medical opinions that establish compensability, I would conclude that claimant has failed to prove that his work activities were the major contributing cause of his left thumb condition.[1] For these reasons, I dissent from the majority's compensability decision.

[1] Claimant argues that, if we find the claim to be non-compensable because of the congenital defect in his right hand, the Workers' Compensation Act is superseded by the Americans with Disabilities Act (ADA). Although I would not find the claim compensable, I would do so because Dr. Butters' opinion is not sufficient to establish compensability. Since my decision is not based on the congenital defect in his right hand, it is not necessary to address claimant's arguments based on the ADA.

In the Matter of the Compensation of
**ANNA R. HEATON, Claimant**
WCB Case No. 96-03646
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the SAIF Corporation's denial of her right knee and ankle injury claim. On review, the issue is whether claimant's injury arose out of the course and scope of her employment.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 23, 1996 is affirmed.

**Board Member Biehl dissenting.**

For the following reasons, I find that claimant established that her right knee and ankle injury arose out of the course and scope of her employment. Because the majority finds otherwise and inappropriately injects an element of fault, I respectfully dissent.

In March 1996, claimant was hired as a telemarketer for an opera association. In this capacity, she worked in an office with four other employees who performed the same work. Claimant called potential customers on the phone to sell season opera tickets. She was paid an hourly salary plus a commission on sales above a certain base level. Claimant worked for several days before making her first sale, which proved to be a large one. As a result of making this sale, claimant became excited, jumped up out of her chair and attempted to click her heels together. When she came down, she twisted her right ankle and knee and fell to the floor.

To establish the compensability of an injury, claimant must prove that the injury: (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Norpac Foods, Inc., v. Gilmore, 318 Or App 363, 366 (1994). In assessing the compensability of an injury, neither element is dispositive. Id. Therefore, all of the circumstances must be considered to determine whether claimant has shown a sufficient work connection. Id.

I first consider the issue of whether claimant's injury occurred in the course of her employment. Claimant was being paid a salary at the time of her injury, which occurred during work hours and on the employer's premises. Therefore, I conclude, as did the ALJ, that claimant's injury occurred in the course of her employment.

In addition, claimant's injury must also "arise out of" her employment. In determining whether a causal connection existed between the injury and the employment, I consider whether the conditions of claimant's employment put her in a position to be injured. Henderson v. S. D. Deacon Corp., 127 Or App 333, 338-39 (1994). Based on the following, I conclude that claimant's injury "arose out of" her employment.

The majority relies on Donna M. Wilson, 47 Van Natta 2160 (1995), aff'd mem 142 Or App 205 (1996), to find that the current claim did not "arise out of" claimant's employment. However, I find Wilson distinguishable on its facts. In Wilson, the claimant, happy because of a long upcoming weekend and because she had received permission to leave work early, did a skip step around a corner on the way to her office; in the process, she tore her Achilles tendon. Other than the injury occurring on the employer's premises, the Board concluded that there was no risk connected with the claimant's employment. In reaching this conclusion, the Board relied on the fact that there was no condition associated with the claimant's work to cause the injury, other than the fact that the claimant was "happy" because she could leave work early. The Board found the causal connection insufficient to establish that the injury "arose out of" the claimant's employment.

Here, unlike Wilson, claimant's injury was directly attributable to the performance of her work activities. Specifically, claimant became excited when she made a big sale, which was the prime objective of her duties as a telemarketer. Granted, this activity was mutually beneficial in that it increased the employer's sales and, if claimant made a certain number of sales, her salary would increase based on commissions. However, the major goal of claimant's employment was to make sales. When claimant successfully performed this goal, she became excited, jumped up from her chair and attempted to click her heels. Furthermore, there is no evidence that the employer had any policy or prohibition against such actions. I find that these facts create sufficient causal connection to find that claimant's injury "arose out of" her employment.

Accordingly, I would find that claimant's injury resulted from an act which was an ordinary risk of, or incidental to, her employment and, therefore, "arose out of" her employment. Thus, claimant has established that the injury was sufficiently related to her employment to be compensable. In addition, barring exceptions for horseplay or being under the influence of intoxicants, to find against claimant is to place fault in the Oregon Workers' Compensation system, which is supposed to be a "no-fault" system. See Andrews v. Tektronix, Inc., 323 Or 154 (1996) (the Oregon Workers' Compensation system is a "no-fault" system). Therefore, I would reverse the ALJ's decision and set aside SAIF's denial.

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In the Matter of the Compensation of
**LINDY J. MAGILL, Claimant**
WCB Case No. 95-06170
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock, and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denials of claimant's injury claim for a right wrist condition/ulnar impaction syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated November 1, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

**Board Member Haynes dissenting.**

In adopting and affirming the ALJ's order, the majority concludes that claimant has established by a preponderance of the evidence that her work activity was the major contributing cause of her combined condition, diagnosed as ulnar impaction syndrome of the right wrist. I dissent, because I am unpersuaded by the medical opinion supporting the compensability of claimant's condition.

At all times pertinent to this claim, claimant worked as a maintenance worker for the Oregon Department of Transportation. On January 19, 1995, she was shoveling hot, pre-mixed blacktop into potholes in a road when she developed an aching pain in her right wrist. The work activity required the repetitive use of both hands and arms to lift and twist the shovel, which weighed 25 to 30 pounds when full of blacktop.

Claimant sought emergency treatment for her painful right wrist and was initially diagnosed with overuse syndrome versus tendinitis. By late February 1995, claimant's treating doctor, Dr. Bills, suspected claimant had Kienbock's disease in her right wrist because an MRI showed an abnormal signal intensity in the ulnar aspect of the lunate bone. Dr. Bills referred claimant to Dr. Watkins for a second opinion. A July 1995 MRI of the right wrist showed an elongated ulna into the lunate. In August 1995, Dr. Watkins diagnosed claimant's condition as an inflammatory process secondary to ulnar impaction syndrome. Dr. Watkins recommended ulnar shortening surgery with internal fixation.

Claimant underwent surgery on September 22, 1995. Thereafter, her right wrist pain improved.

The majority has determined that claimant's work activity was the major contributing cause of her right wrist ulnar impaction syndrome, presumably based on the opinion of Dr. Seyfer, who examined claimant at SAIF's request. I am unpersuaded by Dr. Seyfer's conclusory opinion, especially in light of the contrary and well-explained opinions of claimant's treating physicians, Drs. Bills and Watkins.

It is undisputed that claimant has an anatomical abnormality in that the ulna bone of her right forearm is slightly longer than the radius bone at the wrist. The medical evidence persuasively establishes that this anatomical abnormality predisposed or contributed to claimant's disability and need for treatment. (Exs. 49, 50, 52, 53, 54). Therefore, claimant has the burden to show that her work activity was the major contributing cause of her disability or need for treatment under ORS 656.005(7)(a)(B).

Dr. Watkins initially opined in a "check the box" letter that claimant's condition was caused in major part by her work activity on January 19, 1995. (Ex. 47). Dr. Seyfer concurred with this assessment. (Ex. 49). Dr. Watkins then changed his opinion on causation when he was provided with the legal definition of major contributing cause, i.e., an activity or exposure, or combination of activities or exposures, that contributes more to the onset or worsening than all other conditions, explanations, or exposures combined.[1] (Ex. 50-2). In his deposition, Dr. Watkins explained that he believed it was not possible to determine within a medical probability which factor was the greatest contributor to claimant's condition, her anatomy or her work activity.[2] (Ex. 53-6). Dr. Bills similarly concluded that he could not identify which factor was the most important cause of claimant's combined condition. (Ex. 55-34, 55-41).

The ALJ concluded that claimant's treating doctors had "no opinion" as to the cause of claimant's combined condition because they would not identify the major cause. Unlike the ALJ and the majority, I do not consider Dr. Watkins and Bills to have "no opinion" on this issue. Rather, I would find that the thorough and well-explained opinions of Drs. Watkins and Bills weigh against a finding of compensability, because neither doctor was willing to designate claimant's work activity as the as the primary cause of her condition.

Although Dr. Seyfer's opinion tends to support the compensability of claimant's condition, I do not find it persuasive because it lacks explanation and analysis. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). Indeed, in reporting that claimant's work was the major cause (because the onset of her symptoms correlated with her shoveling activities), Dr. Seyfer relies primarily on the temporal correlation between claimant's work activity and the development of symptoms. I believe this reasoning is insufficient to establish causation, especially since Dr. Seyfer does not address the relative contribution of claimant's preexisting abnormality. See Dietz v. Ramuda, 130 Or App 397, rev den 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined); see also Pamela A. Burt, 46 Van Natta 415 (1994) (temporal relationship will not, by itself, satisfy claimant's burden of proof).

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[1] See, e.g., McGarrah v. SAIF, 296 Or 145 (1983). While an unexplained change of opinion renders a physician's opinion unpersuasive, see Kelso v. City of Salem, 87 Or App 630 (1987), the record in this case documents the reason for Dr. Watkins' change of opinion. (See Exs. 50, 53-6).

[2] Dr. Watkins explained that as a result of her anatomical abnormality, claimant's ulna impinged on the bones of the right wrist, giving rise to symptoms when she engaged in the strenuous wrist motion of shoveling . (Ex. 53-4, 53-5). Dr. Watkins reported that both the anatomical abnormality and the work activity contributed to claimant's condition, but was unwilling to speculate as to the relative contribution of these two factors. (Ex. 53-6).

Consequently, I would find that Dr. Seyfer's opinion does not carry claimant's burden. See ORS 656.266. Because there is no other medical opinion which supports the compensability of claimant's condition under the major contributing cause standard, I would find that there has been a failure of proof and reinstate SAIF's denial.

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In the Matter of the Compensation of
**SHIRLEY A. MEAUX, Claimant**
WCB Case No. 96-05422
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock, Biehl, and Moller.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its "de facto" denial of claimant's right wrist tendinitis; (2) assessed a penalty for the insurer's allegedly unreasonable failure to timely disclose pertinent documents to claimant's attorney; (3) assessed a penalty for the insurer's allegedly unreasonable failure to accept or deny the tendinitis condition; and (4) awarded attorney fees pursuant to ORS 656.386(1). On review, the issues are compensability, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation. On page 3, we change the last sentence of the fifth paragraph to refer to Exhibit 11A, rather than Exhibit 11.

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. Claimant is not entitled to an attorney fee for services on review regarding the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 30, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

**Board Member Moller dissenting.**

In adopting and affirming the ALJ's order, the majority holds that claimant has established the compensability of her right wrist tendinitis condition. Although I do not agree with the insurer's argument that there was no "de facto" denial of the tendinitis condition, I agree with the insurer that claimant has not established medical causation. Therefore, I respectfully dissent.

Claimant relies on Dr. McDonald's opinion to establish compensability. Assuming arguendo that claimant has established a need for medical treatment related to the alleged tendinitis, Dr. McDonald's conclusory opinion is not persuasive.

On February 15, 1996, Dr. McDonald diagnosed right wrist tendinitis. (Ex. 1). He did not explain that diagnosis. Moreover, Dr. McDonald did not provide any explanation of the diagnosis in his March 11, 1996 response to the insurer's questions. (Ex. 3). In both documents, Dr. McDonald simply stated that claimant was acutely tender throughout the volar wrist area, which is where her cyst was located. (Exs. 1, 3).

Dr. McDonald referred claimant to Dr. Long for an orthopedic consultation. Dr. Long did not diagnose tendinitis. Rather, he diagnosed a ganglion cyst and "suspect[ed] carpal tunnel syndrome." (Ex. 4). He noted that claimant reported "a syndrome of hypesthesia about the classic median nerve distribution[.]" (Id.) However, subsequent nerve conduction studies ruled out carpal tunnel syndrome. (Ex. 5). On reexamination, Dr. Long noted that claimant's hand symptoms were "now" described in the radial nerve distribution. (Id.) Notably, claimant's cyst was located over the "palmar radial aspect" of her wrist and was "adherent to the underlying radial artery." (Ex. 6-2). After again describing claimant's symptoms, Dr. Long discussed only her cyst. (Ex. 5).

Dr. Button examined claimant on behalf of the insurer. He rejected the tendinitis diagnosis. Dr. Button explained claimant's symptoms as follows:

> "This is a very typical, commonplace ganglion of the right wrist. With the analogy of it being somewhat like a balloon with a stem or neck originating from the wrist capsule, fluid gradually accumulates in the mass, causing its enlargement. It is usually adherent to the radial artery and, with range of motion, may irritate other surrounding structures, such as the flexor tendon, minor sensory peripheral nerve branches, etc. Therefore, the symptoms of vague aching, discomfort, burning sensation, etc. are quite typical for this condition, simply a space-occupying mass that, by compression, is irritating surrounding structures." (Ex. 6-3).

In his physical examination, Dr. Button noted no shoulder or elbow complaints, normal flexor and extensor musculotendonous systems throughout the forearm region and the wrist, and no indication of deQuervain's tendonitis, etc. (Ex. 6-2).

Dr. Button's report was forwarded to Dr. McDonald for his comments. (Ex. 7). Because Dr. McDonald was ill, Dr. Browning reviewed the occupational health file and Button's report, and indicated her concurrence with the report. (Ex. 7).

Claimant was examined by Dr. McDonald on May 21, 1996. (Ex. 9). After reviewing Dr. Button's report and noting Dr. Browning's concurrence, Dr. McDonald stated: "I do feel that she still carries a component of tendinitis, which should be covered by the work injury." (Id.) Again, Dr. McDonald offered no explanation. To the contrary, in discussing claimant's symptoms, he merely stated: "Her ganglion cysts have continued to worsen, she is much more tender, and they have enlarged." (Id.) Although Dr. McDonald continued to refer to claimant's ganglion "cysts," in fact claimant had only a single biolobular cyst. (Ex. 6-2).

Subsequently, on August 8, 1996, Dr. McDonald indicated his concurrence with Dr. Button's report. (Ex. 10). Two weeks later, Dr. Long indicated his concurrence with Dr. Button's report. (Ex. 11).

Finally, on August 26, 1996, Dr. McDonald again referred to a tendinitis condition caused in major part by her repetitive work exposure. (Ex. 13). He provided no explanation for the continuing tendinitis condition, except noting the absence of any "prior history of wrist symptoms such as this." (Id.)

Unlike the ALJ and the majority, I cannot find Dr. McDonald's unexplained opinion persuasive. Dr. Button offers a well-reasoned explanation for claimant's symptoms, to which Dr. McDonald did not respond. To the contrary, Dr. McDonald indicated that he concurred with Dr. Button's report, although his other reports indicated that he did not, in fact, concur. Dr. McDonald referred claimant to a specialist, Dr. Long, who concurred with Dr. Button, another specialist. In addition, Dr. Browning, after reviewing the medical record, also concurred with Dr. Button.

The ALJ misreads Dr. Button's report. The ALJ states that Dr. Button offered a "conclusory statement as to whether said [tendinitis] condition, which he thinks claimant does not have, is work-related. (Ex. 6-3)." (Opinion and Order at 5). However, it is apparent from reading Dr. Button's report that he is referring to the cyst being unrelated to work, not any tendinitis condition.

For the foregoing reasons, I dissent from the majority's conclusion that claimant's tendinitis condition is compensable.

In the Matter of the Compensation of
**MELISSA L. MERRICK, Claimant**
WCB Case No. 96-01207
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Bock, Biehl and Moller.

The insurer requests review of Administrative Law Judge (ALJ) McWilliam's order that set aside its denial of claimant's C5-6 disc 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 $1,000, 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 August 7, 1996 is affirmed. For services on review, claimant's attorney's is awarded $1,000, payable by the insurer.

**Board Member Moller dissenting.**

In adopting and affirming the ALJ's order, the majority upholds the ALJ's determination that Dr. Gallo's opinion is sufficient to establish the compensability of claimant's C5-6 herniation. I dissent, because I believe Dr. Gallo's opinion is based on an incomplete and inaccurate history and is therefore unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinions based on incomplete or inaccurate information are not afforded persuasive force).

The undisputed medical evidence establishes that claimant has preexisting degenerative disc disease of the cervical spine. At issue is whether claimant's work activities in July 1995 (specifically, computer data processing and lifting and carrying boxes of printer paper) combined with her preexisting condition and whether those activities were the major contributing cause of her C5-6 disc herniation and need for treatment of that condition.

As set forth in her consultation report, Dr. Gallo initially understood that claimant had a motor vehicle accident in 1989 and treated for complaints of headaches for about nine months following the accident. Dr. Gallo further believed that claimant did not have any spine or arm pain from this accident.[1] (Ex. 40-1). In fact, however, claimant did have complaints of spinal pain, particularly in her neck and low back, after her 1989 collision. When claimant began treating with chiropractor Labinder in August 1990, she listed "neck pain" as one of her primary symptoms. (Ex. 24-3, 24-4). Thus, although Dr. Gallo concluded that claimant's work activities led to her cervical disc herniation, Dr. Gallo's opinion was based on incomplete and/or inaccurate information.

The ALJ acknowledged Dr. Gallo's inaccurate history, but concluded that the problem had been cured by the history later provided to Dr. Gallo by claimant's counsel. I disagree, because I believe the abridged history provided by claimant's counsel was also incomplete. Dr. Gallo was advised that claimant had "a history of neck and low back strains without any symptoms of weakness or pain in her upper extremities" but was not told that claimant complained of spinal pain and, to a lesser extent, right arm and shoulder pain following her 1989 automobile accident or that she received chiropractic treatments on her neck, upper and lower back for almost two years after the accident. (See Exs. 24-28, 60B). In addition, it is not clear to me that Dr. Gallo even relied on this revised history in concluding that claimant's disc herniation was related to her work activities, because she responded that she was given a different history, i.e., that claimant had treated for headaches but not neck pain after her 1989 accident. (Ex. 57-2).

[1] Even in her October 24, 1995 surgical report, Dr. Gallo noted that claimant had "no problem at all with the neck until July [of 1995]."

Finally, even assuming that Dr. Gallo had a complete and accurate history of claimant's symptoms following her 1989 motor vehicle accident, I am not persuaded that Dr. Gallo's opinion is legally sufficient to satisfy the "major contributing cause" standard. Dr. Gallo reported that claimant's work activities, "when combined with her preexisting condition, were the cause in major part . . . ." However, this statement does not consider whether the work activity was the major cause *as compared to* the contribution of her preexisiting degenerative disease of the cervical spine. Because the determination of major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause, see, e.g., Dietz v. Ramuda, 130 Or App 397 (1994), I would find that Dr. Gallo's brief opinion does not satisfy claimant's burden of proof on causation.

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In the Matter of the Compensation of
**ELIZABETH H. NUTTER, Claimant**
WCB Case Nos. 96-01326 & 95-13473
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for right shoulder (impingement syndrome) and elbow (epicondylitis) conditions; and (2) upheld Self-Insured Management Services' (SIMS) denial of responsibility for the same conditions. SIMS cross-requests review of that portion of the order that awarded attorney fees for claimant's attorney's efforts in obtaining a rescission of its compensability denial prior to hearing. On review, the issues are responsibility and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

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

In September 1994, claimant began working as a secondary school sign language interpreter for the employer, insured by Liberty. In March 1995, claimant first sought treatment for right shoulder and elbow symptoms, which were later diagnosed as right shoulder impingement syndrome and right elbow epicondylitis. Claimant quit signing during the school's summer vacation. On July 1, 1995, the employer's insurance coverage changed from Liberty to SIMS. Claimant returned to work from September 5 to September 29, 1995, when she quit for reasons unrelated to her conditions. At hearing, the parties disputed responsibility only. The ALJ assigned responsibility to Liberty.

On review, the parties do not dispute that this case is governed by the last injurious exposure rule (LIER), nor do they dispute the ALJ's assignment of initial responsibility to Liberty. Therefore, to shift responsibility to a later carrier, Liberty must show that the later employment at SIMS actually contributed to a worsening of claimant's right shoulder and elbow conditions. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992). Moreover, to show an actual worsening, Liberty must prove that claimant experienced more than a mere increase in symptoms. Timm v. Maley, 125 Or App 396 (1993).

Liberty contends that Dr. Townsend's testimony establishes an actual worsening, as he explained that claimant's September 1995 work activity caused increased inflammation in the shoulder joint, and, in turn, the increased inflammation caused increased symptoms. Liberty also contends that Dr. Townsend noted that one could not separate claimant's symptoms from her impingement condition.

Liberty misconstrues Dr. Townsend's testimony. Dr. Townsend specifically testified that, although claimant's inflammation-related symptoms increased, there was no medical evidence of a pathological worsening of claimant's underlying right shoulder condition. (Ex. 20-10, -12, -13, -16). Consequently, Liberty has failed to prove, by medical evidence, that claimant's employment conditions while SIMS was on the risk contributed to a pathological worsening of claimant's underlying shoulder and elbow conditions. Accordingly, responsibility remains with Liberty.

Attorney Fees

The ALJ awarded claimant's attorney a fee of $1,500, to be paid by SIMS, for the attorney's efforts in obtaining SIMS' rescission of its compensability denial prior to hearing. SIMS asserts that the ALJ erred in awarding this attorney fee because claimant did not "finally prevail" over its denial. SIMS further asserts that the entire attorney fee award should be paid by Liberty. We disagree with both of SIMS' assertions.

Here, both Liberty and SIMS denied compensability of claimant's claim. On August 1, 1996, prior to hearing, both carriers conceded compensability. ORS 656.386(1)[1] allows an attorney fee if an attorney is instrumental in obtaining rescission of a denial prior to hearing. Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994) (claimant entitled to carrier-paid fee under ORS 656.386(1) when carrier rescinded compensability portion of denial before hearing regarding responsibility for claim); see Dale A. Karstetter, 46 Van Natta 147 (1994) (same). Moreover, we have previously decided that there is no requirement that claimant "prevail" where there has been a "rescission" of a denial prior to a decision by an ALJ.[2] E.g., Vickie M. Emerson, 48 Van Natta 821 (1996). Thus, the crucial inquiry under ORS 656.386(1) is whether there was a "denied claim" and whether there was a "rescission." If so, then claimant's counsel is entitled to an assessed attorney fee under ORS 656.386(1), to be paid by SIMS, provided that counsel was instrumental in obtaining the rescission.

Here, we find that SIMS' denial raised an issue of compensability. SIMS denied claimant's claim relying on the fact that it was not the insurer on the risk on August 3, 1995, the date claimant first sought treatment from Dr. Townsend, but its denial contained notice of hearing provisions and did not indicate that a "307" order had been requested. Most importantly, in its response to claimant's hearing request, SIMS specifically contended that claimant did not sustain a work-related injury or occupational disease. Under such circumstances, we conclude that SIMS denied claimant's claim on the express ground that claimant's shoulder and elbow conditions were not compensable or otherwise did not give

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[1] ORS 656.386(1) provides in part: "In [all] cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed."

[2] SIMS cites Rita R. Lovelace, 47 Van Natta 167 (1995) in support of its argument that claimant must "finally prevail." Lovelace is inapposite here. In Lovelace, both employers continued to deny compensability and responsibility at hearing. The ALJ set aside both compensability denials and found one of the employers responsible. Reasoning that the nonresponsible employer's compensability denial placed claimant's entitlement to compensation at risk, the ALJ found it responsible for paying the assessed attorney fee award. On review, the nonresponsible employer argued that, inasmuch as the responsible employer also denied compensability of claimant's claim, the responsible employer was solely liable for paying the ALJ's assessed attorney fee award. We applied that portion of ORS 656.386(1) that provides: "In [all] cases involving denied claims where the claimant prevails finally in a hearing . . ., a reasonable attorney fee shall be allowed." We found that, because the nonresponsible employer's denial was reversed on compensability but upheld on responsibility at hearing, the claimant did not "finally prevail" over that employer. Accordingly, we concluded that the entire attorney fee award should be paid by the responsible employer.

Here, in contrast, SIMS' compensability denial was rescinded prior to hearing, which is governed by a different provision of ORS 656.386(1). Under ORS 656.386(1), an attorney is entitled to a fee if he or she is instrumental in obtaining rescission of a denial prior to hearing. Unlike the provision governing in Lovelace, the applicable provision in this case does not specify that claimant must "finally prevail in a hearing."

rise to entitlement to compensation.[3] Moreover, considering claimant's counsel's efforts in submitting a hearing request and preparing a case concerning SIMS' compensability denial, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of SIMS' denial prior to hearing. Therefore, we affirm the ALJ's award of an insurer-paid attorney fee under ORS 656.386(1), payable by SIMS.

ORDER

The ALJ's order dated December 3, 1996, is affirmed.

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[3] In reaching this conclusion, we distinguish Michael J. Galbraith, 48 Van Natta 351 (1996). There, we concluded that a carrier's response to the claimant's hearing request, which stated that "The claimant is entitled to no relief," was not sufficient "on its own" to manifest a "denied claim" under ORS 656.386(1). In contrast to Galbraith, SIMS in this case specifically denied that claimant had sustained a work-related injury or disease in its response to claimant's hearing request. Thus, we find that its response more definitively signaled an intention to deny compensability than did the carrier's response to the claimant's hearing request in Galbraith. See Emily M. Bowman, 48 Van Natta 1199 (1996), aff'd Kimberly Quality Care v. Bowman, 148 Or App 292 (1997). Moreover, unlike Galbraith, SIMS' response to claimant's hearing request in this case is not the sole factor indicating that compensability was denied. Considering that SIMS did not request a ".307" order and did not clearly concede compensability, we find that its denial (in conjunction with its response to claimant's hearing request) satisfied the requirements of a "denied claim" pursuant to ORS 656.386(1).

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June 24, 1997 Cite as 49 Van Natta 831 (1997)

In the Matter of the Compensation of
**RONDA G. PREWITT, Claimant**
WCB Case No. 96-06501
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for her accepted right carpal tunnel syndrome condition; (2) did not award interim compensation; and (3) declined to award penalties/attorney fees for the employer's discovery violation. On review, the issues are aggravation, interim compensation, penalties, and attorney fees. We reverse.

FINDINGS OF FACT

In December 1993, claimant compensably injured her right wrist, when she struck it against a shelf cross bar support while taking down an in-store display. Dr. Reeves diagnosed a contusion/sprain condition.

In April 1994, Dr. Reeves recommended an orthopedic assessment. By August 1994, Dr. Macha suspected carpal tunnel syndrome (CTS) and ordered nerve conduction studies. These tests showed significant prolongation of the distal sensory latency consistent with a clinical diagnosis of right CTS. Subsequent nerve conduction studies showed dysfunction or pathology involving the ulnar nerve at the elbow.

In September 1994, the employer accepted a right CTS condition. Claimant underwent right carpal tunnel surgery in November 1994.

A June 28, 1995 Notice of Closure awarded 5 percent scheduled permanent disability for loss of use or function of the right forearm. Claimant requested reconsideration, and was seen by Dr. Olson for a medical arbiter's examination. Dr. Olson diagnosed CTS residuals, along with a secondary neuritis condition, an ulnar neuropathy, myositis, and a possible collagen systemic disturbance.

An October 2, 1995 Order on Reconsideration increased claimant's scheduled permanent disability award to 17 percent of the forearm, based on range of motion losses and a chronic condition limiting repetitive use. The Order on Reconsideration was not appealed.

On March 18, 1996, Dr. Reeves completed a Department aggravation claim form and authorized time loss due to claimant's inability to use her right arm. (Ex. 18). Claimant's counsel forwarded this form, along with Dr. Reeves' prescription for a TENS unit, to the employer on March 20, 1996. (Ex. 18A). On April 2, 1996, claimant's counsel sent another aggravation claim form to the employer. (Ex. 19A). On April 5, 1996, the employer acknowledged receipt of the aggravation claim, and requested that Dr. Reeves provide chart notes documenting a worsening of claimant's condition. (Ex. 21A).

In the meantime, claimant was referred to Dr. Miller, who suspected claimant's problems were related to a neuroma of the distal branch of the radial nerve in the region of claimant's right wrist. Further electrodiagnostic tests was ordered to rule out other possible causes of her symptoms. (Ex. 22)

On May 20, 1996, claimant's counsel forwarded to the employer a copy of Dr. Reeves May 19, 1996 report. In that report, Dr. Reeves described Dr. Miller's findings. Although claimant's right arm complaints were most likely generated by a peripheral neuroma in the distal branch of the radial nerve in the wrist area, Dr. Reeves reported that further testing regarding claimant's C6-7 disc was needed to determine if there was any evidence of an occult radiculopathy more than the C6-7 disc would suggest by physical examination. Until it was determined whether claimant's neck or neuroma was the source of her pain, Dr. Reeves concluded that it was difficult to provide a prognosis. Nonetheless, because of claimant's inability to use her right arm due to the radiculopathy, Dr. Reeves advised that claimant continued to be disabled since April 4, 1996 and would continue to be disabled until a clearer picture of her diagnosis and possible treatment options were known. (Ex. 23A, 23B).

In May 1996, further nerve conduction studies were performed. These tests noted an abnormality of the right radial nerve in the region of the wrist. (Ex. 23C). On June 4, 1996, Dr. Miller reported to Dr. Reeves that these studies were consistent with a peripheral radial nerve neuropathy due to a traumatic injury to the distal branch of the radial nerve, and that this nerve condition was primarily responsible for her ongoing symptoms. (Ex. 24). Concluding that surgery would not ultimately prove beneficial, Dr. Miller recommended that claimant's symptoms should be followed.

On June 12, 1996, Dr. Reeves reported to the employer that claimant had a probable abnormality of the right radial nerve "in the region of her previous trauma." Dr. Reeves further stated that claimant had evidence of ulnar neuropathy, which was likely "secondary to the neuroma formation, secondary to her traumatic injury." Raising a question that a potential source of the ulnar neuropathy may be cervical radiculopathy, Dr. Reeves noting that an EMG study would be performed. Considering claimant's positive nerve conduction study, Dr. Reeves concluded that she had "indeed had a worsening of her previous injury." (Ex. 25). The employer received Dr. Reeve's June 12, 1996 report on August 1, 1996.

On July 9, 1996, claimant requested a hearing. As issues, she raised aggravation, temporary disability, penalties, and attorney fees. On July 29, 1996, the employer filed its response, denying claimant's assertions that she had sustained an aggravation and that she was entitled to penalties and attorney fees.

Rather than appearing at the scheduled October 7, 1996 hearing, the parties agreed to present their respective positions based on the documentary evidence and written closing arguments. In response to claimant's assertion that her neuroma/neuropathy conditions constituted a compensable aggravation claim, the employer contended that claimant was alleging the compensability of unaccepted conditions. To do so, the employer argued that she must first comply with the filing requirements for a new medical condition claim under ORS 656.262(7)(a).

The ALJ found that the record did not establish that claimant's accepted carpal tunnel syndrome condition had worsened. Furthermore, determining that there had not been a prima facie claim for aggravation until August 1, 1996, the ALJ did not award interim compensation. Turning to claimant's neuroma and radial/ulnar neuropathy conditions, the ALJ concluded that a question arose regarding whether Dr. Reeve's reports constituted a "new medical condition" claim for those conditions. However, because that issue had not been presented, the ALJ declined to rule on it. Finally, in light of his previous decisions, the ALJ did not assess penalties or attorney fees because no compensation was due and there had not been an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

On review, claimant first asserts that the employer's failure to contest the Order on Reconsideration permanent disability award precludes it from now challenging the compensability of her current neuroma/neuropathy conditions. Inasmuch as this "preclusion" argument was not presented at hearing, we decline to address it on review. See Kenneth L. Devi, 48 Van Natta 2349 (1996), on recon 49 Van Natta 108 (1997).

Claimant further contends that her neuroma/neuropathy condition represents a worsening of her accepted carpal tunnel syndrome. In this regard, she invites us to take "administrative notice of the fact that carpal tunnel syndrome is a medical condition involving a constellation of symptoms relative to the wrist, hand, and arm." We decline claimant's invitation.

Our authority to take administrative notice is limited to facts that are "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Ladonna Eagleton, 49 Van Natta 75 (1997). Claimant neither refers us to such a source nor are we aware of an indisputable oracle which would resolve the medical question posed by claimant's request.

Claimant next asserts that she perfected an aggravation claim. We agree. However, in doing so, we do not share her assessment that Dr. Reeves' "Director-form" aggravation claim, May 19, 1996 report, and claimant's counsel's letters constituted an aggravation claim. These documents certainly represent Dr. Reeves' opinion that claimant was unable to work. Nevertheless, none of these documents provided objective findings supporting a worsening of claimant's compensable condition. Moreover, in his May 19, 1996 report, Dr. Reeves' stated that, although claimant's problem was most likely generated by a peripheral neuroma, it was difficult to give a prognosis until further studies determined whether claimant's C6-7 disc radiculopathy or the neuroma were the source of claimant's pain. Such comments do not satisfy the requirements for an aggravation claim under ORS 656.273(3).

The statutory prerequisites were not satisfied until Dr. Reeves' June 12, 1996 report. Based on claimant's positive nerve conduction study, Dr. Reeves concluded that claimant "has indeed had a worsening of her previous injury." Because the record establishes that the employer received this report on August 1, 1996, we find that claimant's aggravation claim was perfected as of this date.[1]

The employer had 90 days from its August 1, 1996 receipt of the "perfected" aggravation claim within which to conduct its investigation to determine whether the claim would be accepted or denied. See ORS 656.273(6); 656.262(6). That statutory period had not expired when the case was presented to the ALJ on the written record on October 7, 1996. It is permissible to proceed to the merits of a claim if a carrier does not raise a procedural challenge to the claim. See EBI Companies v. Thomas, 66 Or App 105 (1983); Syphers v. K-M Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981); Diane S. Hill, 48 Van Natta 2351 (1996).

Here, however, by contesting claimant's aggravation claim based on an alleged noncompliance with the "new medical condition" claim requirements, the employer has effectively raised a procedural challenge.[2] Because the 90-day period to respond to the perfected aggravation claim had not expired by

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[1] The employer does not question the validity of claimant's aggravation claim based on the fact that Dr. Reeves' reports were not submitted along with the "Director's-form" aggravation claim; i.e., that such a filing does not satisfy the "accompanied by" requirement of ORS 656.273(3). In light of such circumstances, we do not address that issue.

[2] We recognize that the employer submitted a response to claimant's hearing request in which it denied that claimant had sustained an aggravation. Without further subsequent clarification or elaboration, such a response would likely represent a defense to the claim based solely on its merits. However, considering the employer's written submission to the ALJ, it is apparent that it was challenging the aggravation claim on a procedural basis. This conclusion is further supported by the fact that the employer's July 29, 1996 response preceded the August 1, 1996 "perfection" of claimant's aggravation claim. Thus, the employer's written submission to the ALJ represents its first response to the "perfected" aggravation claim. Because that response challenged the claim's procedural validity, it would be premature to proceed to the merits.

the "hearing," we hold that it was premature to consider the merits of claimant's aggravation claim.[3]

Notwithstanding our decision regarding the aggravation issue, it is not premature to consider claimant's request for interim compensation. As previously discussed, claimant's aggravation claim was perfected on August 1, 1996, when the employer received Dr. Reeves' June 12, 1996 report. On receipt of that report, the employer's claim processing obligations under ORS 656.273(6) were triggered. In other words, because that report provided medical verification of an inability to work resulting from a prima facie compensable worsening under ORS 656.273(1), the employer was required to begin the payment of interim compensation within 14 days from its August 1, 1996 receipt of that report. See ORS 656.273(6); Melba D. Moore, 49 Van Natta 631 (1997); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993). Because no such benefits have been paid, claimant is entitled to this temporary disability beginning August 1, 1996 and continuing until these benefits can properly be terminated under the law.

Based on its July 29, 1996 response to claimant's hearing request, the employer contends that it was under no obligation to begin the payment of interim compensation. We disagree. As we have previously reasoned, we do not consider the employer's response (which preceded the August 1, 1996 "perfection" of claimant's aggravation claim) to constitute a denial of the claim. To do otherwise, would be inconsistent with our prior conclusion that the employer was effectively contending that it was premature to consider the merits of claimant's aggravation claim.

Although we have found that the employer is obligated to pay interim compensation benefits, we do not consider its failure to have begun paying such benefits to have been unreasonable. In light of the confusing procedural circumstances detailed above (particularly its July 29, 1996 response to claimant's hearing request, in which it denied that claimant had sustained an aggravation), we conclude that the employer had a legitimate doubt regarding its liability to provide interim compensation on its August 1, 1996 receipt of claimant's "perfected" aggravation claim. Consequently, we conclude that penalties for the employer's conduct are not warranted.

Finally, because we have found that claimant was entitled to compensation, we assess the employer a penalty for its admitted discovery violation. The penalty shall equal 25 percent of the compensation payable, as a result of this order, from August 1, 1996 through October 7, 1996 (the date of the "hearing"). This penalty shall be equally shared by claimant and her counsel.

## ORDER

The ALJ's order dated November 20, 1996 is reversed. Insofar as claimant's hearing request pertains to an aggravation claim, it is dismissed as premature. Claimant is awarded interim compensation, payable from August 1, 1996 until such benefits can be terminated under the law. Claimant's attorney is awarded 25 percent of the additional compensation created by this order, not to exceed $3,800, to be paid directly to claimant's counsel. For its discovery violation, the employer is assessed a penalty equal to 25 percent of the compensation, as granted by this order, payable between August 1, 1996 through October 7, 1996. This penalty shall be equally shared by claimant and her counsel.

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[3] Our decision should not be interpreted as a conclusion that the requirements for filing a "new medical condition" claim must also be satisfied when pursuing an aggravation claim. Instead, as explained above, we are merely adhering to the well-established principle that it would be premature to address the aggravation claim. Notwithstanding today's decision, we note that, if and when such a question is ripe for adjudication, the litigants will need to consider the effect, if any, the traditional analytical framework for compensability of an aggravation claim has on the issue. See Wheeler v. Liberty Northwest Insurance Corporation, 148 Or App 301 (1997); Gloria Olson, 47 Van Natta 2348 (1995).

Likewise, we need not resolve the question of whether Dr. Reeves' reports (either separately or in conjunction with claimant's counsel's letters) constituted a "new medical condition" claim. However, should such a question subsequently arise, the litigants will need to address whether claimant has "clearly request[ed] formal written acceptance of any new medical condition." See ORS 656.262(7)(a); Diane S. Hill, 48 Van Natta 2351 (1996).

In the Matter of the Compensation of
**GLENN E. WHITLOCK, Claimant**
WCB Case No. 93-13776
ORDER ON REMAND
Bennett, Hartman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

This case is before the Board on remand from the Court of Appeals. Whitlock v. Klamath County School District, 142 Or App 137 (1996). The court has reversed our order, Glenn E. Whitlock, 47 Van Natta 179 (1995), which reversed the Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's claim for a psychological condition. In our order, we held that claimant had failed to prove a compensable psychological claim under ORS 656.802, because the stressors that caused his psychological condition were conditions which are generally inherent in every working situation. The court reversed and remanded for reconsideration, concluding that our order did not articulate the rationale connection between the facts and our legal conclusion that the work stressors cited by claimant were all conditions which are generally inherent in every working situation. Having received and considered the parties' supplemental briefs, we now proceed with our reconsideration.

## FINDINGS OF FACT

We recite the following facts from the court's opinion:

"Claimant taught music to elementary school children in the Klamath School District from 1981 until 1993. At the end of the 1992-93 school year, in the wake of Ballot Measure 5, the employer District eliminated all elementary school music positions. Consequently, claimant exercised his "bumping" rights under a collective bargaining agreement and secured a secondary school social studies teaching position. Although claimant had a secondary social studies certification, he had never actually taught that subject.

"For the 1993-94 school year, the [employer] assigned claimant either six or seven class periods a day, in four subject areas: 7th grade social studies, 10th grade global history, 12th grade economics, and 12th grade federal government. Claimant, like all teachers in the District, was allotted one 49-minute preparation period a day.

"Claimant felt overwhelmed and stressed by his new duties. He worked 12 to 14 hours a day, including spending four to six hours a night preparing for the next day's classes. Nevertheless, he received 'considerable' criticism from his students and some criticism from the school administration.[1] Claimant became very despondent and, at the urging of family and friends, sought treatment from his physician, who referred him for psychiatric treatment. The psychiatrist diagnosed 'a single episode of nonpsychotic major depression due to stress at work.'

"In October 1993, claimant filed a claim for workers' compensation. [The employer] denied coverage." 142 Or App at 139-40 (Footnotes omitted).

## CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding that claimant's stress came about because he was put in a position for which he had neither training nor experience. Reasoning that this situation occurred as a result of the collective bargaining agreement, and finding that the agreement is not generally inherent in every working situation, the ALJ concluded that claimant carried his burden of proving a compensable mental disorder claim under ORS 656.802(3).

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[1] The parties stipulated that claimant's interaction with school administrators "falls into the category of reasonable disciplinary, corrective, or job-performance activities," and are not the basis of his claim. (Tr. 6).

On Board review, we reversed. Focusing on the portion of ORS 656.802(3)(b) that provides that "[t]he employment conditions producing the mental disorder [must be] conditions other than conditions generally inherent in every working situation," we concluded that the stressors cited by claimant were all conditions which are generally inherent in every working situation. We reasoned that claimant's change of teaching position was caused by financial constraints due to budget cuts and by an employment contract which provided for "bumping" rights; we concluded that both conditions are inherent in every working situation. We also rejected claimant's contention that he lacked training to teach social studies, because he had received certification to teach that subject.

On judicial review, the court reversed our decision. Noting that claimant's claim rested entirely on the premise that his mental disorder was caused by stress he experienced after he assumed the social studies position, the court stated that our consideration of conditions that antedated claimant's assumption of the position was immaterial. In addition, the court stated that we neglected to consider whether claimant's preparation for the social studies position was a condition "generally inherent in every working situation." The court remanded for our consideration of that question.

The conditions producing a mental disorder may not be "conditions generally inherent in every working situation." ORS 656.802(3)(b). Conditions "generally inherent in every working situation" are conditions that are common to all employments. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). The Board develops the legal standard of what conditions are common to all employments on a case-by-case basis. SAIF v. Campbell, 113 Or App 93 (1992).

Here, the employer argues that the extra time claimant spent preparing for his new social studies position is a condition common to all employments involving the commencement of new job duties. It explains that, notwithstanding adequate training, the assumption of new job duties inevitably entails a transition period during which unusual time demands can be foreseen. In those circumstances, the employer argues, working extra hours is a natural part of gaining experience and proficiency with any new job.

We agree that the assumption of a new job ordinarily will result in extra work hours gaining experience and proficiency. Under certain circumstances, the extra work preparation time may be deemed excessive and, hence, not a condition common to all employments. Under the circumstances in this case, however, we find that claimant's extra preparation time was not excessive. Claimant was adequately trained for the teaching position because he had over 10 years of actual teaching experience and possessed a secondary social studies teaching certificate. Although his teaching experience was in music education at the elementary school level, we are persuaded that the teaching skills he gained at the elementary level were largely transferable to the secondary level. In addition, claimant's teaching certificate established that he had the minimum level of proficiency required to teach secondary social studies.[2]

Claimant's assumption of the new teaching position brought with it the expectation that he would devote extra preparation time to gain proficiency in the teaching position. This was particularly true given the fact that claimant had no practical teaching experience at the secondary level and his teaching experience was limited to music education. Both the subject matter and the older students were more demanding than what claimant had previously experienced as an elementary music teacher. Under circumstances such as these, where a worker assumes a new position in the same occupation (e.g., teaching) and has met the minimum level of proficiency required to perform the tasks of the new position, we conclude that it is a condition common to all employments for the worker to devote extra time and efforts gaining proficiency in the position.

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[2] Based on claimant's substantial teaching experience and secondary social studies teaching certificate, we adhere to our earlier finding that claimant's asserted lack of training for the secondary teaching position was not a condition that existed in a "real and objective sense." See ORS 656.802(3)(a). Furthermore, claimant's past teaching experience and current certification distinguish this case from Joy Burke, 43 Van Natta 1237 (1991), a case cited by claimant, where we held that a claimant who had no prior training for a new supervisory position had established a compensable mental disorder claim. Unlike Burke, where the claimant had no supervisory training, here, claimant had at least gained certification in secondary social studies and therefore had a sufficient degree of training to assume his new position.

The number of hours that claimant spent preparing for his social studies classes (i.e., 12 to 14 hours including four to six hours at home) was significant, particularly when compared to his preparation time as an elementary music teacher. Yet, when properly viewed in the context of commencing a new position, an event that commonly occurs in all employments, those number of hours do not appear to be unusual. Claimant was not directed by the employer to work or prepare for long hours. At the same time, though, he had begun the first term of his new teaching position and should reasonably have expected to devote extra hours during the first term gaining experience and proficiency; it was during this transition period that claimant first sought treatment for depression.

We find that claimant's extra hours of preparation was a condition "generally inherent in every working situation" and, therefore, may not be considered a condition producing his mental disorder.[3] See ORS 656.802(3)(b). Because claimant's mental disorder claim is based, in essential part, on the extra work preparation time, we conclude that claimant has not established the "generally inherent condition" element in ORS 656.802(3)(b).[4] Accordingly, there is a failure of proof and the employer's denial must be upheld.

Accordingly, on reconsideration, the ALJ's order dated March 28, 1994 is reversed. The employer's denial is reinstated and upheld. The ALJ's assessed fee award is also reversed.

IT IS SO ORDERED.

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[3] Claimant argues that the Board held in a 1992 case called Louise M. Heesacker, WCB Case No. 91-05174, that a teacher whose new position significantly increased her work load, including her class preparation time, experienced stresses not "generally inherent in every working situation." However, claimant provides no case citation and we find no order for that case reported in Van Natta's. Because the Board's order in Heesacker is unreported, we conclude that it has no precedential value. Moreover, we cannot tell from claimant's representation of the facts in Heesacker whether the claimant in that case had a certificate for the new teaching position.

[4] Because we conclude that claimant has not established one of the four essential statutory elements of a mental disorder claim under ORS 656.802(3), his claim is not compensable, and we do not need to address the other disputed elements of the claim.

**Board Member Biehl dissenting.**

The majority concludes in this case that working 12 to 14 hours a day, including four to six hours of preparation at night, is a condition common to all employments. I must respectfully disagree.

While I acknowledge that the assumption of a new job ordinarily will result in extra work hours gaining proficiency, I do not agree that claimant's expenditure of 12 to 14 hours a day can be reasonably deemed a condition common to all employments. Surely, in comparison to most jobs, claimant's work hours were overwhelming. Moreover, claimant needed to expend those hours to meet a satisfactory level of performance in his new job. This is not a case where a worker was working extra hours to exceed a satisfactory level of work performance; by all accounts, claimant was struggling to achieve a satisfactory level of performance.

Based on my review of the record, I find that claimant's struggle was due to his lack of practical experience teaching secondary social studies. The majority makes much of claimant's 11 years of experience teaching music to elementary school students, and his certification to teach secondary social studies. However, neither the elementary teaching experience nor the certification adequately prepared claimant to teach four different (social studies) subjects every day and to manage secondary school classrooms.[1] See Joy Burke, 43 Van Natta 1237 (1991) (lack of training for new supervisory position was not a condition generally inherent in every working situation). This fact is evident from the criticism he received from both students and the school administration, despite his long hours of preparation.

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[1] As claimant argues on remand, his situation was analogous to an attorney who has graduated from law school and passed the bar exam. Although the attorney is licensed to practice all aspects of law, he would not necessarily be trained to be a Supreme Court Justice, or to practice corporate tax law or try a capital murder case. Similarly, claimant's certification did not provide him practical training to teach secondary social studies.

Moreover, contrary to the employer's argument on remand, claimant does not have the burden to describe what training could or should have been provided. The fact remains that claimant had no training and no prior experience for the teaching position he assumed pursuant to the collective bargaining agreement. I believe the lack of training was a significant contributing factor in claimant's need for overwhelming preparation time.

I conclude that claimant's lack of training and overwhelming preparation time were not conditions that are common to all employments. In this regard, I reject the conclusions by Drs. Turco, Davies and Sasser that the stressors experienced by claimant are generally inherent in every working situation. As the court stated in SAIF v. Campbell, the "generally inherent" standard is a legal standard which is developed by the Board; it is not a medical or psychological conclusion which the doctors are qualified to make. 113 Or App 93, 96. I also reject the employer's suggestion that claimant has the burden to prove that the conditions of his teaching position were "unique." Claimant's burden is to prove that his work conditions were not common to all employments. As I have stated, the assumption of a new job with no prior training or experience and with overwhelming preparation time demands are not conditions that are common to all employments.

Having concluded that claimant's inadequate training and extra preparation time were not conditions generally inherent in every working situation, I would further conclude that claimant has carried his burden of proving by clear and convincing evidence that those conditions were the major contributing cause of his psychological condition. See ORS 656.802(2)(a), (3)(d). Causation opinions were offered by Dr. Nagy, treating psychiatrist; Dr. Turco, examining psychiatrist; Dr. Sasser, examining psychiatrist; and Dr. Davies, examining psychologist. All of the doctors attributed claimant's condition to job-related stress. The employer argues, however, that the doctors' opinions are insufficient to carry claimant's burden of proof because they considered stress due to claimant's interaction with school administration, a condition which must be excluded from consideration pursuant to ORS 656.802(3)(b). I disagree.

Dr. Nagy opined that job stress was the major contributing cause of claimant's condition. (Ex. 21). He did not attribute the job stress to claimant's interaction with the school administration. (Id.) Dr. Davies opined that the major contributing cause of claimant's depression was his employment problems; he explained:

> "[I]t appears that [claimant] was overwhelmed by his employment responsibilities. He perceives himself as a music teacher, not a Social Studies teacher, and he did not feel comfortable in the job and he did not like it. He felt the need to put in long hours, was inefficient, and apparently developed a transient depression." (Ex. 20-8).

Thus, Dr. Davies relates claimant's condition to his discomfort with the social studies position and his inefficient use of lengthy preparation time; he did not attribute the condition to claimant's interaction with the school administration. (Id.)

Dr. Sasser wrote: "I do not believe that [claimant's] problem was caused by his work as much as it was his own inabilities to perform in the social studies teacher position." (Ex. 23-4). Dr. Sasser noted that claimant "may have felt under-the-gun by his principal"; however, contrary to the employer's assertion, the doctor did not attribute claimant's job stress to his interaction with the principal. (Id.) Rather, Dr. Sasser simply felt that claimant was not prepared to teach social studies. (Id.)

Dr. Turco was the only doctor to attribute claimant's condition, in part, to his interaction with the school administration. He opined that "[t]he major contributing cause of [claimant's] depression and decision to seek treatment was the 'pressure' he was experiencing in the context of teaching social studies and the observations he was placed under [by the school administration]." (Ex. 19-6). Because the "observations" by the school administration may not be considered as a work-related stressor under ORS 656.802(3)(b), Dr. Turco's opinion alone would not support claimant's claim.

However, Dr. Turco did not render an opinion as to whether claimant's difficulty in teaching social studies would have been a sufficient stressor alone to constitute the major contributing cause of his condition. Therefore, Dr. Turco's opinion does not contradict the opinions of the remaining doctors that claimant's inability to teach social studies was the major contributing cause of his condition. Furthermore, based on my review of the record, I am persuaded that claimant's inability to teach social studies, as well as his inefficient use of lengthy preparation time, was directly attributable to his lack of prior experience or training for that position.

I conclude, therefore, that the claimant has carried his burden of proving by clear and convincing evidence that his lack of training and overwhelming preparation time were the major contributing cause of his psychological condition. It is undisputed that claimant has established the remaining elements of a mental disorder claim. Therefore, I would find the claim compensable and set aside the employer's denial. For these reasons, I dissent.

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In the Matter of the Compensation of
**HARRY T. McCREA, JR., Claimant**
WCB Case Nos. 93-05231 & 93-02507
ORDER ON REMAND
Cole, Cary & Wing, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney
John M. Pitcher, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. McCrea v. Arriola Bros., Inc., 145 Or App 598 (1997). The court reversed our prior order, Harry T. McCrea, Jr., 48 Van Natta 157 (1996), that affirmed the Administrative Law Judge's (ALJ's) order that upheld Weyerhaeuser Company's denial of claimant's current low back condition. Citing Hiatt v. Halton Company, 143 Or App 579 (1996), and Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996) (Messmer II), the court concluded that we incorrectly interpreted ORS 656.262(10) in determining that Weyerhaeuser's denial was permissible. Consequently, the court has remanded for reconsideration.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on April 27, 1982 while employed by Weyerhaeuser. The accepted back strain was superimposed on Grade I spondylolysis (L5-S1 level) and spondylolisthesis (L4-5 level). The claim was first closed on October 9, 1984 with temporary, but no permanent, disability.

In 1987, a prior ALJ ordered the claim reopened for an aggravation. The claim was last closed April 18, 1988 without an award of permanent disability. In May 1989, another ALJ awarded claimant 10 percent unscheduled permanent disability for his low back condition. Claimant worked for Weyerhaeuser until August 1991 when he began working for SAIF's insured. In August 1992, claimant sought treatment for increased low back pain and stiffness. Weyerhaeuser denied compensability of claimant's current low back condition, while SAIF denied compensability of an occupational disease claim involving the same low back condition.

Addressing the merits, the ALJ found that claimant had not established compensability of his current condition against SAIF or Weyerhaeuser. On this basis, the ALJ upheld the compensability and responsibility denials of Weyerhaeuser and SAIF as to claimant's 1992-1993 low back condition.

On review, we affirmed the ALJ's order. In doing so, we held that, although a prior ALJ's permanent disability award in claimant's 1982 low back injury claim with Weyerhaeuser was arguably based, in part, on a symptomatic worsening of claimant's preexisting spondylolisthesis condition, ORS 656.262(10) permitted Weyerhaeuser to deny compensability of the preexisting condition.

Citing Hiatt v. Halton Company, 143 Or App 579 (1996), Messmer II, 140 Or App at 548, the court has reversed our order on the basis that we incorrectly interpreted ORS 656.262(10). Consequently, the court has remanded for reconsideration.

In Messmer II, the court determined that amended ORS 656.262(10) did not effectively overrule its prior decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (Messmer I).[1] In

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[1] Both Messmer I and Messmer II decisions were issued after the date of the ALJ's order.

Messmer I, the court had held that an employer's failure to appeal a Determination Order that awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease, precluded the employer from contending later that the condition was not part of the compensable claim. The court reasoned that the result was not that the degenerative condition had been accepted, it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. 130 Or App at 258.

Here, in a May 1989 Opinion and Order, a prior ALJ awarded 10 percent unscheduled permanent disability for claimant's low back injury. In reaching his decision, the prior ALJ reasoned that: "Taken as a whole, the evidence preponderates that claimant's underlying asymptomatic condition was made symptomatic by the compensable injury and that claimant has suffered impairment therefrom." (Ex. 9-4). Based on the prior ALJ's order, including the following portion of the ALJ's reasoning, we are persuaded that the 1989 permanent disability award was based, in part, on claimant's underlying preexisting spondylolisthesis condition:

> "Claimant testified that he experiences pain after 15-20 minutes of sitting on the seat of the yarder and that he continues to work as a yarder operator as his best means of providing for his family. Claimant testified that the pain is enhanced when the yarder is not on level ground. Such complaints are consistent with spondylolisthesis which by all accounts was asymptomatic prior to the injury. The evidence is clear that a person with spondylolisthesis should avoid undue back stress. Dr. Howell acknowledges that claimant's activity as a yarder operator is inconsistent for one suffering from back pain and that due to the spondylolisthesis, claimant is relegated to medium work with restrictions on repetitive activities of the lumbar spine with restrictions of 25 pounds frequently and 50 pounds occasionally * * *. Claimant has spent his relevant work in the heavy occupations which are now foreclosed due to his industrial injury. This foreclosure represents a loss of earning capacity." (Ex. 9, pages 4-5).

Weyerhaeuser contends that the prior ALJ's permanent disability award was based on disabling symptoms caused by the preexisting spondylolisthesis, rather than the underlying pathology of the spondylolisthesis condition. On this basis, Weyerhaeuser argues that the present case is distinguishable from Messmer and it is not precluded from denying the spondylolisthesis condition. We disagree for the following reasons.

Citing Barrett v. D & H Drywall, 86 Or App 605 (1987), Weyerhaeuser argues that a permanent disability award based on symptoms of a degenerative condition does not establish the compensability of the underlying degenerative pathology. We do not disagree with Weyerhaeuser's interpretation of Barrett. However, we do not consider Barrett to be inconsistent with the Messmer holdings.

Under Messmer I and II, failure to challenge a permanent disability award for a preexisting condition does not amount to a finding that the condition is compensable. Rather, it results in the carrier being precluded by claim preclusion from denying the condition. For purposes of applying the Messmer holding, we likewise see no distinction where the award was based on symptoms of the underlying condition versus an award based on the pathology of an underlying condition. Here, permanent disability was awarded for the disabling effects of the preexisting spondylolisthesis. Regardless of whether the disability was caused by the symptoms or pathology of the preexisting condition, the permanent disability award was based on the preexisting spondylolisthesis condition. Under Messmer I and II, Weyerhaeuser's failure to challenge that award has resulted in Weyerhaeuser being barred by claim preclusion from denying that the spondylolisthesis was part of the compensable claim. Messmer I, 130 Or App at 258; see also Joyce L. Reedy, 49 Van Natta 643 (1997).

We also reject Weyerhaeuser's argument that it did not have a reasonable opportunity to litigate the issue of permanent disability for the spondylolisthesis condition. Because the prior ALJ's permanent disability award was expressly based on symptoms from the spondylolisthesis condition, Weyerhaeuser had an opportunity to challenge that award if it disagreed with the ALJ's decision. Inasmuch as it chose not to contest that award, it is now precluded from challenging its responsibility for claimant's spondylolisthesis condition.

Weyerhaeuser next argues that claimant's condition has worsened since the 1989 ALJ's order and it is, therefore, precluded at most from denying the condition as it existed at the time of the prior ALJ's May 1989 litigation order. We disagree.

To begin, as we have previously discussed, Weyerhaeuser is barred by claim preclusion from denying the spondylolisthesis condition. Joyce L. Reedy, 49 Van Natta at 646.

In any event, after reviewing the medical evidence, we are not persuaded claimant's condition has changed. Based on the medical evidence, claimant's condition is the same condition he had in 1989, spondylolisthesis. Drs. Kitchel, Whitney, Rosenbaum and Donahoo all agree that claimant has spondylolisthesis of L5 on the sacrum. Although claimant's symptoms of spondylolisthesis have worsened, there is no evidence that claimant has developed any new condition.[2] Under such circumstances, we are not persuaded that claimant's condition has changed to such a degree that there is a new set of operative facts that could not previously have been litigated. Thus, even if the spondylolisthesis condition has worsened, it is not a noncompensable condition which may be denied.

Finally, Weyerhaeuser argues that claimant also has preexisting spondylosis and degenerative conditions[3] which have also contributed to claimant's current low back condition. Weyerhaeuser argues that since permanent disability was not awarded for these conditions, it is not precluded from denying them. We agree that if permanent disability has not been awarded for these conditions, Weyerhaeuser is not precluded from denying these conditions. However, we note that the persuasive medical evidence supports the conclusion that claimant's current condition is caused in major part by the spondylolisthesis condition which Weyerhaeuser is precluded from denying. (Exs. 17; 19; 25-10). In reaching this conclusion, we rely on the opinion of claimant's attending physician, Dr. Whitney, which is supported by the opinion of Dr. Kitchel. See Weiland v. SAIF, 64 Or App 810, 814 (1983) (Board generally defers to the treating physician's opinion absent persuasive reasons not to do so).

No party contends that claimant's current condition is compensable as to SAIF's insured or that claimant's employment at SAIF's insured was the major contributing cause of claimant's current condition. Under such circumstances, and in the absence of any persuasive evidence that claimant's current condition was caused or worsened by claimant's employment at SAIF's insured,[4] we conclude that responsibility for the spondylolisthesis remains with Weyerhaeuser.

In cases in which a claimant finally prevails after remand from the Court, we must award a reasonable attorney fee for services before every prior forum. ORS 656.388(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, on Board review, before the court and on remand before the Board is $7,250, payable by Weyerhaeuser. 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.

Accordingly, on reconsideration, the ALJ's order dated July 29, 1994 is reversed in part and affirmed in part. Weyerhaeuser's denial is set aside and the claim remanded to Weyerhaeuser for processing according to law. For services at the hearing, Board and court levels, claimant's attorney is awarded $7,250, payable by Weyerhaeuser. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

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[2] We note that Dr. Whitney, who has treated claimant since 1979, has indicated that claimant had symptoms of radiculopathy prior to 1989, although the symptoms were intermittent. (Ex. 26-9). Thus, we conclude that the right-sided radiculopathy is not a new condition which was not present in 1989. The preponderance of the medical evidence also supports the conclusion that the radiculopathy is a result of the spondylolisthesis. (Exs. 16; 17).

[3] We note that there is medical evidence which attributes the degenerative changes to the spondylolisthesis. (Ex. 25-10).

[4] The only medical opinions which attribute claimant's need for treatment to his work activities for SAIF's insured are Drs. Donahoo and Whitney. Dr. Donahoo's opinion is unpersuasive since it is based on his incorrect belief that claimant did not have any right-sided radiculopathy symptoms prior to his employment with SAIF's insured. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinion based on incomplete and inaccurate history is unpersuasive). Like the ALJ, we do not find that Dr. Whitney's opinion establishes a sufficient causal relationship between claimant's 1992-1993 low back condition. In this regard, Dr. Whitney's opinion does not support a conclusion that claimant's work activities for SAIF's insured were the major contributing cause of the combined condition and pathological worsening of the disease as required by ORS 656.802(2)(b). Under such circumstances, responsibility for claimant's current low back condition does not shift from Weyerhaeuser to SAIF since claimant did not sustain a new compensable injury or disease involving the same condition. ORS 656.308(1).

In the Matter of the Compensation of
**DENNIS P. ADAMS, Claimant**
WCB Case No. 96-01892
ORDER ON REVIEW
Lavis, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the self-insured employer's denial of claimant's current bilateral arm condition; and (2) upheld the employer's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and aggravation. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction and supplementation. On June 2, 1993, claimant underwent electrodiagnostic tests performed by Dr. Radecki, M.D., on referral from his then-treating physician, Dr. Swanson. (Ex. 15). We change the ultimate finding of fact to read: "The compensable disease is the major contributing cause of claimant's current condition."

In 1995, claimant sustained a noncompensable tear of his right shoulder rotator cuff, a condition for which he underwent surgery in 1996. That right shoulder injury is not related to the accepted bilateral arm overuse syndrome.

On February 16, 1996, the employer: (1) denied claimant's current condition was related to the accepted bilateral arm overuse syndrome claim; and (2) denied claimant had sustained a worsening of his accepted bilateral arm overuse syndrome. (Ex. 50).

## CONCLUSIONS OF LAW AND OPINION

From December 1992 through February 1993, claimant had intermittent aches in both upper extremities, while performing physical labor for his employer. In April 1993, claimant sought medical treatment and was taken off work. In July 1993, the employer accepted claimant's bilateral myofascial overuse syndrome. (Exs. 21, 24).

Claimant's claim was eventually closed by a July 21, 1994 Determination Order that found claimant's condition medically stationary on October 27, 1993 and awarded no permanent disability. This Determination Order was subsequently affirmed by a March 8, 1995 Order on Reconsideration, which was, in turn, affirmed by a July 10, 1995 Opinion and Order.

On January 20, 1996, Dr. Long, who had begun treating claimant in August 1994, filed an aggravation claim. On February 16, 1996, the employer denied both that claimant's current condition was related to the accepted claim and that there had been a worsening of the accepted claim. (Ex. 50). Claimant requested a hearing.

Finding that claimant's current condition was unrelated to his accepted bilateral arm overuse syndrome, the ALJ upheld the employer's denial. We disagree.

ORS 656.273(1) requires proof of two elements in order to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Peter J. LaFreniere, 48 Van Natta 988 (1996); Gloria T. Olson, 47 Van Natta 2348 (1995). If the allegedly worsened condition is not already a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

Because of the length of time between claimant's work activities and his current claim, as well as the varying diagnoses for his current condition, we consider the causation issue to be a complex medical question. Resolution of the issue, therefore, requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Where, as here, there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986).

As previously noted, claimant began treating with Dr. Long shortly after the July 1994 Determination Order. In October 1994, Dr. Long performed nerve conduction tests, which showed ulnar compression neuropathy at the elbows, which Dr. Long noted were "not clearly of clinical significance." (Ex. 34-2). In December 1994, following claimant's compliance with a prescribed stretching program, Dr. Long concluded that there must be a significant neurologic element to claimant's continuing symptoms. (Ex. 38-2).

In May 1995, based on a record review, Dr. Swanson (claimant's earlier attending physician, who had last examined claimant in the latter part of 1993), found no improvement in claimant's condition since October 27, 1993, the date he considered claimant medically stationary. In addition, relying on June 1993 tests, Dr. Swanson opined that claimant did not have any compressive ulnar neuropathy at the elbows. (Ex. 41).

In December 1995, claimant was examined by Dr. Puziss, orthopedist, on referral from Dr. Long. (Ex. 44). Dr. Puziss diagnosed: (1) myofascial pains, with bilateral medial humeral epicondylitis; (2) cumulative trauma disorder or overuse syndrome, right greater than left upper extremities[1]; and (3) left lateral humeral epicondylitis. (Ex. 44-3). Concurring with Dr. Long's studies and analysis, Dr. Puziss opined that claimant's right ulnar nerve dysfunction was related to the work injury. (Ex. 49).

In February 1996, Dr. Wilson, who had last examined claimant in 1993, again examined claimant. Dr. Wilson concluded that claimant had not experienced an actual worsening because, instead of a recurrence of symptoms, claimant was experiencing a different type of symptoms. Dr. Wilson also found that claimant had normal nerve studies and no strong findings for an ulnar neuropathy clinically. (Ex. 48-2). Finding claimant's nerve studies normal with no strong clinical findings for ulnar neuropathy, Dr. Wilson did not consider claimant's current condition to be work related.

Following claimant's February 1996 noncompensable right shoulder surgery, Dr. Puziss explained that his diagnoses relating to the work injury were within the scope of cumulative trauma disorder. (Ex. 51-1). He opined that these diagnoses were "work related as a direct result of claimant's work activity and are also a direct consequence of cumulative trauma disorder itself." Id. He opined that claimant had objective findings in the form of reduced right grip and pinch strength and mild subluxation of the right ulnar nerve at the elbow, a condition claimant did not have at the time of Dr. Wilson's examination in 1993. Dr. Puziss concluded that this mild ulnar nerve subluxation represented a worsening. Id.

Thereafter, Dr. Long opined that claimant's current condition was the same condition he had since early 1993, when he first sought treatment for his upper extremity condition. (Ex. 52). Dr. Long opined that claimant developed, as a direct result of the work he performed for the employer, "lateral epicondylitis involving both upper extremities, myofascial pain and tightness involving the forearm flexors and extensors bilaterally, and symptomatic ulnar compression neuropathy at both elbows." (Ex. 52-2). Dr. Long disagreed with Dr. Wilson's opinion that claimant had normal nerve studies and found that claimant's nerve studies demonstrated substantial worsening. (Exs. 52-2-3).

After reviewing this medical evidence, we find that Dr. Long's opinions, as supported by those of Dr. Puziss, provide the most persuasive explanation of claimant's current condition. In this regard, Dr. Long had the opportunity to examine claimant shortly after the July 1994 claim closure and to continue following his treatment since that exam. In addition, Dr. Long had an accurate history of claimant's entire course of treatment. Likewise, based on a complete medical history, Dr. Puziss provided a thorough explanation regarding claimant's current condition and its relationship to claimant's work activities and accepted condition.

In contrast, Dr. Swanson, claimant's former treating physician, had last examined claimant in September 1993. Although he reviewed some subsequent medical records, we do not consider Dr. Swanson's opinion as persuasive as those offered by Drs. Long and Puziss (physicians whose opinions were based on contemporary examinations of claimant's current condition).

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[1] On January 19, 1996, Dr. Puziss examined claimant and added the diagnoses of flexor pronator tendinitis and distal right brachialis myotendintis, which he later clarified were also within the scope of cumulative trauma disorder. (Ex. 46, 51-1).

Dr. Wilson had examined claimant both before and after the July 1994 claim closure. Nevertheless, because Dr. Wilson offered his opinion in a conclusory manner, we do not find it persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Based on the opinions of Drs. Long and Puziss, we find that claimant's current condition includes symptomatic ulnar compression neuropathy and various conditions that are either within the scope of the accepted overuse syndrome or cumulative trauma disorder or a compensable consequence of his compensable condition. (Exs. 43, 44, 46, 51, 52). Alternatively, we find that Dr. Long's opinion that claimant's current condition, including the ulnar neuropathy, was directly caused by his work activities establishes that those work activities are the major contributing cause of claimant's current condition. In other words, in light of these persuasive opinions, we conclude that claimant's current condition is compensable under either an occupational disease theory (ORS 656.802), a consequential condition theory (ORS 656.005(7)(a)(A)), or a theory that the current condition has already been accepted.

In reaching this conclusion, we recognize that neither physician expressly stated their opinion in terms of "major contributing cause." Nonetheless, it is well settled that "magic words" are not necessary to establish medical causation. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992). We consider the aforementioned principle to be particularly applicable in this case, where, without qualification, the persuasive medical opinions "directly" attributed claimant's current condition to either his accepted condition or to his work activities.

Finally, we find that Dr. Long's opinion establishes a compensable aggravation claim. 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 of an actual worsening of the compensable condition supported by objective findings." In SAIF v. Walker, 145 Or App 294, 305 (1996), the court concluded that this statute "requires that there be direct medical evidence that a condition has worsened" pathologically or symptomatically to such a degree that the condition itself has worsened.

Although Dr. Wilson stated that there was no actual worsening of claimant's compensable claim since the claim was closed on July 21, 1994, he did not explain his opinion. In addition, he did not consider ulnar neuropathy as part of the compensable claim. As explained above, we find compensable claimant's current condition, which includes ulnar neuropathy.

In contrast to Dr. Wilson's unpersuasive opinion, Dr. Long opined that claimant's nerve tests showed substantial worsening. (Ex. 52-2). In addition, Dr. Puziss opined that claimant's slight ulnar nerve subluxation represented a worsening. (Ex. 51-1). Based on Dr. Long's opinion, as supported by that of Dr. Puziss, we find that claimant's compensable condition has pathologically worsened. Thus, we conclude that his condition has "actually worsened" as required by ORS 656.273(1). In addition, we find that Dr. Long's opinion, as supported by that of Dr. Puziss, establishes that this worsening is supported by objective findings. Accordingly, we conclude that claimant has established a compensable aggravation 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 issues, 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 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 self-insured employer.

In the Matter of the Compensation of
**STUART L. COLE, Claimant**
WCB Case No. 96-03591
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
John E. Snarskis, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's injury claim for a current right knee condition. On review, the issue is compensability.

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

We do not find that Dr. Pettee reversed his opinion. (See O&O p. 4, Exs. 24, 25). Instead, we find that Dr. Pettee explained that his ultimate opinion was based on a complete history concerning claimant's unresolved preexisting right knee condition, whereas his initial opinion was not. (See Ex. 25). Nonetheless, we find Dr. Pettee's explanation unpersuasive, because he apparently neglected the history which he had (based on his own 1994 examination of claimant) regarding claimant's preexisting right knee problems. (See Ex. 17). Under these circumstances, we agree with the ALJ that Dr. Pettee's ultimate conclusion is not particularly persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

We further agree with the ALJ that the opinion of Dr. Hazel, treating physician, is persuasive. In reaching this conclusion, we particularly note that only Dr. Hazel reported claimant's history that the January 15, 1996 knee-twisting incident included feeling a "pop" in his right knee, accompanied by "persistent pain." (Ex. 19). Accordingly, based on Dr. Hazel's opinion and reasoning, we conclude, as did the ALJ, that claimant has established that his 1996 injury is the major contributing cause of his current need for treatment for his right knee. See Somers v. SAIF, 77 Or App at 263.

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 August 8, 1996 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

**Board Member Moller dissenting.**

The majority finds this claim compensable based on the opinion of Dr. Hazel. The majority reasons that Dr. Hazel's opinion is persuasive because he is claimant's treating physician. The majority further concludes that only Dr. Hazel's opinion is based on an accurate history regarding the 1996 incident and claimant's preexisting right knee condition. The majority rejects Dr. Pettee's opinion because he "apparently neglected the history which he had (based on his own 1994 examination of claimant) regarding claimant's preexisting right knee problems. (See Ex. 17)." I disagree with each of the majority's conclusions. Therefore, I dissent.

No reason exists in this case to defer to the opinion of Dr. Hazel over those of Drs. Pettee and Thompson. In fact, the latter opinions are more persuasive. To begin, claimant had two prior right knee surgeries in 1992 and 1994. These surgeries sought to repair extensive, persistent meniscal tears resulting from a work-related Washington injury. The parties agree that the issue in this case is whether claimant's need for treatment and disability is due in greater degree to his preexisting condition caused by the prior knee injury or the January 1996 work incident. See ORS 656.005(7)(a)(B).

Dr. Pettee examined claimant both in 1994 and again in 1996 following the work incident. By contrast, Dr. Hazel did not first examine claimant until after the January 1996 incident. Where the issue in dispute involves a comparison of claimant's preexisting condition with his condition after the January 1996 incident, Dr. Pettee is in a far more advantageous position to make such a comparison than is Dr. Hazel. This is particularly true in light of Dr. Hazel's limited knowledge of claimant's pre-1996 condition and his limited "treatment" of claimant after the January 1996 incident.

In this regard, so far as the record discloses, Dr. Hazel examined claimant on January 17, 1996, met with claimant to discuss his condition on January 30, 1996 following an MRI, and then saw claimant again in approximately mid-February 1996. Dr. Hazel's lack of knowledge concerning claimant's preexisting condition is apparent from his reports. At the time of his January 17 examination, Dr. Hazel reported that claimant "ended up having an arthroscopy by Dr. Burgdorff and he is not really sure what was done" and then claimant "had another arthroscopic surgery he believes in 1993 or 1994. He again is not sure what was done and never really recovered." (Ex. 19). Because he was concerned that claimant might have retorn his medial meniscus, Dr. Hazel referred claimant for an MRI.

Claimant's MRI was performed on January 23, 1996 by Dr. Feeney, radiologist. (Ex. 20). Dr. Feeney compared claimant's 1996 MRI with the results of a prior MRI performed in 1994. Dr. Feeney concluded that "the overall configuration of the meniscus is essentially the same as previously noted" and that there was "no obvious tear" and "no large recurrent tears." (Id.). In terms of abnormalities, Dr. Feeney noted effusion and "slight signal derogation" and concluded that "[i]t is possible that the patient has had partial resection of the posterior horn of the medial meniscus" although "[p]artial scarring of the remaining meniscus is also a consideration." Based either on this report or his own review of the MRI, Dr. Hazel concluded the "MRI scan does in fact show pathology of the medial meniscus," which he believed "corroborates [claimant's] symptoms." (Ex. 21)

The majority acknowledges that Dr. Hazel's opinion is largely based on a belief that claimant had "new" right knee pathology after the 1996 incident. (See Ex. 22-1). However, as noted above, Dr. Feeney read the 1996 MRI and noted that the overall configuration of claimant's meniscus "is essentially the same as noted previously." (Ex. 20). The accuracy of Dr. Hazel's knowledge regarding the extent and nature of claimant's preexisting condition is also doubtful because claimant's symptoms have continued uninterrupted since his 1992 injury. (See Ex. 17-7). Because these symptoms are not new findings, they do not indicate a new pathology. To the extent that Dr. Hazel's opinion depends on claimant having new symptoms and/or new pathology, it is inconsistent with the remainder of the record.

The opinions of Drs. Pettee and Thompson, on the other hand, are consistent with claimant's ongoing right knee problems and his lack of significant MRI findings. Dr. Pettee explained that his ultimate conclusion relating claimant's current right knee condition to his preexisting condition is based on the fact that claimant's right knee problems have been ongoing since 1992. (Ex. 25). Dr. Thompson considered the extent of claimant's preexisting condition in detail, noting claimant's two prior partial medial meniscectomies, his degenerative changes in the medial compartment (reported at the time of the 1994 surgery), and the MRI which revealed that very little remained of the medical meniscus after the 1992 and 1994 surgeries. (Ex. 26-2).

The opinions of Drs. Pettee and Thompson are well-reasoned and based on accurate histories. Dr. Hazel's opinion, on the other hand, is based on the unlikely premise that claimant has new right knee pathology since January 1996. I would discount Dr. Hazel's opinion, because it is inconsistent with the record. Moreover, because the persuasive medical evidence relates claimant's current right knee problems to his preexisting condition, I would conclude that the claim is not compensable.

In the Matter of the Compensation of
**ARLENE J. KOITZSCH, Claimant**
WCB Case No. 96-01318
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) directed it to pay claimant's scheduled permanent disability award at the rate of $347.51 per degree in accordance with amended ORS 656.214(1); and (2) awarded claimant's counsel an "out-of-compensation" attorney fee. On review, the issues are rate of scheduled permanent disability and attorney fees. We affirm.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Rate of Scheduled Permanent Disability

We begin by summarizing the relevant procedural facts. The claim was closed by a May 4, 1990 Notice of Closure which did not award any permanent disability benefits. Claimant requested a hearing concerning the Notice of Closure and by Opinion and Order dated March 11, 1991, a prior ALJ granted claimant 34 percent scheduled permanent disability for the right forearm. (Ex. 4). Claimant requested Board review. Pending Board review, the insurer paid claimant the award of 34 percent unscheduled permanent disability at the rate of $145 per degree. (Ex. 4a). By Order on Review dated April 14, 1992, the Board affirmed the ALJ's order. Arlene J. Koitzsch, 44 Van Natta 776 (1992).

On January 5, 1994, the Court of Appeals reversed the Board's order and remanded the matter to the Board for reconsideration. Koitzsch v. Liberty Northwest Ins. Corp, 125 Or App 666 (1994). By Order on Remand dated July 29, 1994, the Board again affirmed the ALJ's March 11, 1991 order. Arlene J. Koitzsch, 46 Van Natta 1563 (1994). On October 28, 1994, the Board issued a second Order on Remand which increased claimant's scheduled permanent disability award from 34 percent to 52 percent and awarded claimant's counsel an assessed attorney fee under former ORS 656.388(1). Arlene J. Koitzsch, 46 Van Natta 2265 (1994). The insurer requested reconsideration concerning the attorney fee issue and, on November 10, 1994, the Board issued a Third Order on Remand which adhered to its previous decision. Arlene J. Koitzsch, 46 Van Natta 2347 (1994). The insurer requested judicial review of the Board's order, assigning error to the Board's award of an assessed attorney fee. The insurer paid the increased permanent disability award at the rate of $145 per degree.

On July 19, 1995, concluding that the Board's assessed fee award was not authorized by statute, the Court of Appeals reversed the Board's order and remanded the matter to the Board for reconsideration. Liberty Northwest Ins. Corp. v. Koitzsch, 135 Or App 524 (1995). On November 15, 1995, the Board issued its Order on Remand which withdrew the assessed fee award. Arlene J. Koitzsch, 47 Van Natta 1293 (1995). The November 15 order was not appealed and became final.

On February 6, 1996, claimant requested a hearing concerning the rate of permanent disability. The ALJ found that the scheduled permanent disability awarded in WCB Case Number 90-13984 did not become final until December 16, 1995 and concluded that any payment of the scheduled permanent disability award prior to that date was premature. Based on this reasoning, the ALJ concluded that claimant's award of scheduled permanent disability should be paid at the rate of $347.51 per degree pursuant to amended ORS 656.214(2).

On review, the insurer contends that the permanent disability awarded by the March 11, 1991 and October 28, 1994 litigation orders became final before the increased permanent disability rate under amended ORS 656.214(2) went into effect on June 7, 1995. It notes that it did not appeal the permanent

disability awards and that it timely paid the awards to claimant at the $145 rate in effect when the awards became final. It further argues that, because the awards became final before the effective date of the increased permanent disability rate, the increased rate was not applicable to claimant's awards. We disagree and affirm the ALJ's order.

The permanent disability payments made by the insurer pursuant to the March 11, 1991 and October 28, 1994 orders were required under the claim processing provisions of ORS 656.216 and 656.262. In Eliecer Vega, 46 Van Natta 2173 (1994), we stated that a carrier was required to pay permanent disability awarded by an Order on Reconsideration pending the claimant's appeal of the award. The carrier argued that its payment obligation was stayed pending appeal, pursuant to ORS 656.313. We disagreed, reasoning that ORS 656.313 applied to stay the payment of compensation only if the carrier appealed the award. Because only claimant appealed the award, we concluded that the carrier was required to pay the award pending the appeal.

In this case, because the insurer did not appeal the permanent disability awarded by the March 11, 1991 and October 28, 1994 orders, the "stay of compensation" provisions in ORS 656.313 did not apply to those orders, and the insurer was required to pay the awards pending appeal. Nevertheless, the rate at which permanent disability was paid by the insurer pending appeal of the order did not determine the permanent disability rate ultimately payable under the final order. Furthermore, the insurer's payment of the award at the $145 rate pending appeal did not preclude claimant from asserting that her award of permanent disability benefits should be paid at the increased rate under amended ORS 656.214(2). We base our conclusions on the following reasoning.

Amended ORS 656.214(2) provides that scheduled permanent disability awards are payable at a rate of $347.51 per degree. We have held that amended ORS 656.214(2) is applicable to awards of scheduled permanent disability where the claimant was injured prior to January 1, 1992. See Randy L. Dare, 48 Van Natta 1230 (1996). In Dare, we relied in part on the Court of Appeals' holding in Volk v. America West Airlines, 135 Or App 565 (1995), that the 1995 Act (Senate Bill 369) was intended to apply retroactively unless there was a specific exception to retroactive application. The court's holding was based on the language of section 66 of the Act, which provides:

Subsection 66(1) states:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act." (Emphases supplied.)

One of the exceptions to retroactive application of the 1995 Act is set forth in subsection 66(5)(a), which provides:

> "The amendments to statutes by this Act and new sections added to ORS Chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act." (Emphasis supplied.)

Based on the language in subsections 66(1) and (5)(a), the Volk court concluded that it was the legislature's intention to apply the 1995 Act retroactively to Board orders for which the time to appeal had not yet expired on the effective date of the Act (i.e., June 7, 1995) or, if the case had been appealed, to any case that was still pending before the court on the effective date of the Act. Volk, 135 Or App at 572-73. The court noted that its interpretation of section 66 was supported by legislative history. In particular, the court quoted the following statements by Representative Mannix, a sponsor of Senate Bill 369:

> "[T]he retroactivity also applies to cases in which a final order has not yet issued in litigation. There's a bunch of cases in the system right now that have been decided by different factfinders under two or three different versions of the law depending on whether the Board interpretation or the Court of Appeals' interpretation or the Supreme Court interpretation was in effect at that time and this says 'this law applies to everything no matter where it is unless you have already been to court, had it decided

> and there's a decision been rendered and the decision is not subject to being appealed anymore.' Otherwise, except with the exceptions here, this is the law for everybody and we'll go out and apply it whether it's pro-worker or pro-employer." 135 Or App at 571 (quoting Tape Recording, Senate Committee on Labor and Governments Operations, SB 369, February 17, 1995, Tape 49, Side B at 187) (Emphasis supplied).

Consistent with the court's decision in Volk and our holding in Dare, we conclude that the 1995 Act, including amended ORS 656.214(2), apply retroactively to "claims" in existence on June 7, 1995, the effective date of the Act, "regardless of the date of injury." Because claimant's accepted 1988 injury claim was in existence on that date, the Act applies retroactively to her claim unless there is a specific exception to retroactive application. As in Volk, the only potentially applicable exception is set forth in subsection 66(5)(a) of the Act. As the court held in Volk, however, that exception applies only to matters in which a decision had been rendered and not subject to further appeal.

Here, the matter in dispute is the rate of claimant's scheduled permanent disability award. The issue, therefore, is whether the rate of her award was a "matter for which an order or decision ha[d] become final" on or before June 7, 1995. We conclude it was not.

Our conclusion is based on the finding that an order or decision regarding claimant's permanent disability did not become final until after the effective date of the Act. As the Volk court observed, the text of the 1995 Act does not provide an answer as to when an order or decision becomes final; however, the court noted that there was contextual guidance in ORS 656.295(8) which provides:

> "An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.298."

Considered in the context of ORS 656.295(8), the Volk court concluded that the legislature intended to apply the 1995 Act retroactively to Board orders for which the time to appeal had not yet expired or, if the case had been appealed, to any case that was still pending before the court. 135 Or App at 569.

Here, on June 7, 1995, the effective date of the 1995 Act, the Board's November 10, 1994 Third Order on Remand in WCB Case No. 90-13984 had been appealed by the insurer and was pending before the Court of Appeals. Although the insurer's appeal was limited to the attorney fee issue, the November 10, 1994 order nevertheless was not "final" within the meaning of ORS 656.295(8) and section 66 of the 1995 Act. A Board order is not "final" so long as "one of the parties" timely appeals to the court for judicial review. Thus, the fact that the insurer's appeal was limited to the attorney fee issue is immaterial to the finality of the Board's order. Due to the insurer's appeal of the Board's order, the order did not become final until after the effective date of the Act.[1] We conclude, therefore, that the exception in subsection 66(5)(a) to retroactive application of the Act does not apply to the prior "extent of disability" litigation. Accordingly, claimant is entitled to payment of her scheduled permanent disability award at the increased rate of $347.51 pursuant to amended ORS 656.214(2).

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[1] Citing Price v. SAIF, 296 Or 311 (1984), the insurer notes that an order which addresses two separate aspects of the same claim may finally determine one issue but not the other. The insurer argues that, because its appeal of the Board's November 10, 1994 order was limited to the attorney fee award only, the "extent of disability" aspect of the case was finally determined. We disagree. The Supreme Court in Price was reviewing a Board order that had two separate components; the order affirmed the carrier's partial denial of a heart condition but also remanded to the ALJ for a determination of the extent of disability of the accepted back condition. The Court concluded that the Board's order was appealable to the Court of Appeals on the compensability (of the heart condition) issue, but it was not appealable on the "extent of disability" issue. Based on our reading of Price, we conclude that the Court was not addressing the finality of the Board's order within the meaning of ORS 656.295(8); rather, the Court was determining whether the Board's order was a "final and appealable" order over which the Court of Appeals properly had appellate review jurisdiction. Because the Court was addressing a different issue from the one we face here, Price is inapposite.

Attorney Fee

The insurer contends that the ALJ was without authority to award an "out-of-compensation" attorney fee in the June 5, 1996 Amended Opinion and Order, because the ALJ had lost jurisdiction over this matter due to the insurer's request for Board review, at the time the Amended Opinion and Order issued. We agree that the ALJ's Amended Opinion and Order was without legal effect and thus the ALJ lacked the authority to award an "out-of-compensation" attorney fee. See Jack L. Nicholas, 46 Van Natta 2207 (1994). However, we have the authority to award an "out-of-compensation" attorney fee based on our order. Consequently, claimant's counsel is awarded 25 percent of the increased compensation created by the ALJ's order, as affirmed by this order, not to exceed $2,800, payable directly to claimant's counsel. See ORS 656.386(2); OAR 438-015-0040(1).

Finally, 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 increased rate issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this 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 May 22, 1996 is modified in part and affirmed in part. That portion of the ALJ's order which failed to award an "out-of-compensation" attorney fee is modified. Claimant's counsel is awarded 25 percent of the increased compensation created by the ALJ's order, as affirmed by this order, not to exceed $2,800, payable directly to claimant's counsel. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

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June 26, 1997 Cite as 49 Van Natta 850 (1997)

In the Matter of the Compensation of
**ROBERT D. MILLER, Claimant**
WCB Case No. 96-02063
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Yturri, Rose, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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

We adopt and affirm the ALJ's order.

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 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 November 7, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, payable by the self-insured employer.

**Board Member Bock specially concurring.**

I agree that claimant has established a compensable claim under the facts of this case. I also agree with the legal reasoning expressed by the ALJ, whose opinion and order we have adopted, in order to reach that determination. I write separately in order to articulate more generally why I believe this case to be correctly decided and to acknowledge the degree to which "arising out of and in the course of employment" cases can be difficult to determine in any manner that provides precedential guidance to employers, workers and insurers.

Here, claimant's injury occurred in an employer-controlled parking lot just prior to commencement of his job shift. His injury is thereby deemed to have occurred during the course of his employment. The employer does not contend to the contrary. However, the employer does argue that claimant's injury did not arise out of his employment. We have, I believe, correctly found to the contrary.

An injury arises out of employment when there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). Claimant's injury resulted from the apparently innocuous activity of reaching down to the floor board of his pickup truck to retrieve his work gloves. Understandably, the employer argues that, given the nonstrenuous nature of this activity, claimant's injury is not causally related to his work. The employer proceeds to describe the occurrence of claimant's injury as fortuitous. As support for its argument that claimant has failed to sustain his burden of proof, the employer cites to our decisions in Margaret Scott, 47 Van Natta 938 (1995) (claimant noncompensably injured in parking lot when she turned quickly and struck a support pillar) and James R. Montoya, 48 Van Natta 1841 (1996) (claimant's Achilles tendon injury not compensable when walking up a flight of stairs at work).

Although not cited by the employer in its appellant briefs because of its recent issuance, a decision by the Court of Appeals that could also be argued to support the employer's decision is Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997). In Johnson, the court affirmed our decision in James D. Johnson, 48 Van Natta 303 (1996), where we concluded that a knee injury did not arise out of employment when it occurred while the claimant took a step to return to his work task after retrieving a part from a parts bin and then stopping to speak with a co-worker about a work-related subject.

The medical evidence in this case is virtually uncontradicted in concluding that claimant's injury was the direct and sole cause of his activity of reaching for his work gloves. If, for example, rather than retrieving his work gloves claimant had been in the process of lifting a heavy chainsaw from the bed of his truck when injured, there would be little question but that his injury arose out of his employment.

Many disqualifying factors have been added to the definition of a compensable injury -- ORS 656.005(7) -- during the last several legislative sessions. The expressed intent of those exceptions has been to draw a clearer line between those injuries that appropriately should be compensated through the workers' compensation system and those injuries that more appropriately belong outside of the system. None of those exceptions is applicable here.

In the Matter of the Compensation of
**RICKY MINER, Claimant**
WCB Case No. 94-14306
ORDER ON REMAND
Emmons, Kropp, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Miner v. Oregon Metallurgical Corp., 142 Or App 153 (1996). Citing Volk v. America West Airlines, 135 Or App 565 (1995), rev den 322 Or 645 (1996), the court has reversed and remanded for reconsideration.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact and briefly summarize the relevant facts as follows.

Claimant sustained a compensable injury to his low back which was accepted as a nondisabling lumbar strain. Claimant's physician, Dr. Irvine, released claimant to modified work. Claimant missed no time from work and lost no wages as a result of the injury. On December 1, 1993, Dr. Irvine reported that claimant was medically stationary with no impairment. Claimant sought reclassification of his claim to disabling. A Determination Order and Order on Reconsideration declined to reclassify claimant's claim.

## CONCLUSIONS OF LAW AND OPINION

Relying on Brenda Guzman, 46 Van Natta 2161 (1994), which was decided under the law in effect prior to the 1995 statutory amendments, the ALJ ordered that claimant's injury claim be reclassified as disabling. On review, relying on amended ORS 656.005(7)(c), we reversed and found that claimant's claim was nondisabling. Ricky Miner, 47 Van Natta 1649 (1995).

Claimant petitioned for judicial review of our order. Citing Volk v. America West Airlines, 135 Or App 565 (1995), rev den 322 Or 645 (1996), the court has reversed and remanded for reconsideration.

Having received supplemental briefs from the parties on remand, we proceed with our reconsideration. Claimant asserts that this case must be remanded to the ALJ for additional evidence because ORS 656.005(7)(c) has created a new standard for establishing a disabling injury. SAIF argues that the record does not establish a reasonable expectation of permanent disability due to the injury. SAIF further asserts that ORS 656.005(7)(c) did not create a new legal standard and that, consequently, remand is inappropriate.

ORS 656.005(7)(c) provides: "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury." In Karren S. Maldonado, 47 Van Natta 1535 (1995), we held that to establish a disabling injury under amended ORS 656.005(7)(c), "it is not enough that a claimant be limited to modified work; there also must be entitlement to temporary disability benefits or a reasonable expectation of permanent disability."

Here, claimant lost no time from work and, therefore, is not entitled to temporary disability. Thus, claimant's claim is not disabling under amended ORS 656.005(7)(c) unless there is a reasonable expectation of permanent disability.

Dr. Irvine opined on December 1, 1993 that claimant was "medically stationary presently with no impairment. However, as you can easily recognize from the CT scan report attached that he may have problems with this in the future." (Ex. 9). In June 1994, Dr. Irvine indicated that claimant was medically stationary, but was "at high risk for spontaneous material worsening and may require further medical or surgical intervention in the future as a natural course of the injury." (Ex. 12). In July 1994, Dr. Irvine reported that claimant "has no limit in range of motion. No loss of strength or [sic] does he have limitation in his activities at this time." (Ex 13).

Dr. Irvine's opinion supports the potential for a future aggravation claim and additional medical treatment. However, Dr. Irvine's observation does not establish a reasonable expectation of permanent disability.

With regard to claimant's request for remand for additional evidence under amended ORS 656.005(7)(c), we note that we have previously rejected similar requests in Sharman R. Crowell, 48 Van Natta 768, on recon 48 Van Natta 1273 (1996) and Janice K. Ott-Pettry, 48 Van Natta 525 (1996). In Ott-Pettry, the claimant argued that under former OAR 436-30-045(5)(b), the administrative rule in effect at the time of her hearing, she could prove that her claim was disabling only with evidence of an actual entitlement to permanent disability. Because amended ORS 656.005(7)(c) requires a "reasonable likelihood of permanent disability," the claimant argued that the claim should be remanded in order to provide her with an opportunity to comply with the "reduced burden of proof."

We reasoned that, in order to merit remand for additional evidence, such evidence could not have been obtainable at the time of hearing. We found that the claimant in Ott-Pettry could have produced evidence that satisfied the standard provided in the administrative rule and that this approach would likely have produced evidence sufficient to also satisfy the amended statute. We concluded that the fact that the claimant chose not to submit such evidence did not mean that the additional evidence was not obtainable at the time of hearing.

Here, the record does contain evidence addressing the likelihood of a permanent disability award. Thus, the presentation of evidence designed to satisfy the higher standard in former OAR 436-30-045(5)(b) would likewise be sufficient to address the lesser standard provided in the amended statute. Accordingly, we find that evidence regarding whether there was a reasonable expectation of permanent disability was obtainable at hearing. In fact, because Dr. Irvine specifically addressed the likelihood of permanent impairment, we find that the record is completely developed with regard to the "reasonable expectation" standard. See Sharman R. Crowell, 48 Van Natta at 768 (Board declined to remand for additional evidence under ORS 656.005(7)(c) where there was medical evidence that the claimant would have no permanent impairment). Consequently, we reject claimant's assertion that there is a compelling reason to remand in this case.

Accordingly, after reconsidering this matter, we continue to adhere to our September 15, 1995 order which found that claimant's claim was properly classified as nondisabling.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JAMES W. PORTER, Claimant**
Own Motion No. 97-0256M
OWN MOTION ORDER
Richard A. Sly, Claimant Attorney
EBI Companies, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable left knee sprain and medial meniscus injury. Claimant's aggravation rights on that claim expired on October 19, 1982. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

In an April 14, 1997 report, Dr. Baldwin, claimant's treating physician, recommended claimant undergo left knee arthroscopy and patellar shave. 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).

Claimant was not working at the time of disability. Therefore, pursuant to the Dawkins criteria above, claimant must provide persuasive evidence that he was willing to work, and that he was either seeking work or unable to work because of the compensable injury during the period in question. Claimant has the burden of proof on this issue.

In an April 14, 1997 chart note, Dr. Baldwin noted that claimant was attending school to study for "mortuary work." In a May 16, 1997 letter, the insurer asked Dr. Baldwin how long he anticipated claimant would require time loss. Dr. Baldwin responded that, subsequent to surgery, claimant "[m]ay return to school after one week." Thus, the record indicates that claimant was attending school, taking vocational-type courses at the time of disability. Furthermore, claimant submitted a June 9, 1997 notarized statement in which he asserted that he was willing to work at the time of disability. On this record, we conclude that claimant has established that he was willing to work at the time of disability. See Dawkins v. Pacific Motor Trucking, 308 Or at 254.

In his June 9, 1997 statement, claimant stated that:

> "I left [my last] job due to disagreements with my boss. At that time I decided to take some time off to work on some personal business."

Considering claimant's statements, we conclude that claimant voluntarily left his prior employment for reasons other than the compensable injury. See Nancy Spain, 47 Van Natta 1447 (1995).

However, although he quit his prior job for reasons unrelated to the compensable injury, if claimant can establish that he re-entered the work force prior to the time of disability, he may still qualify for temporary disability compensation. See SAIF v. Stephen, 308 Or 41 (1990). Because claimant has established his willingness to work, in order to prove that he re-entered the work force after he quit his job, claimant must further establish either that he again sought work after he quit his job, or that his compensable injury made it futile for him to work or to seek work at the time of disability.

In his June 9, 1997 statement, claimant declared that his last date of work was December 1, 1996. Claimant further stated that:

> "So from the time of Dr. Baldwin's findings, I did not see how much good it would do to seek employment just to loose [sic] a job.
>
> "Therefore I ceased seeking employment that I normally would have looked for until I became medically stationary. Therefore I was willing to work but not looking for work because my compensable injury made it impossible for me to obtain and perform any type of work for which I was qualified for by age, education and work experience."

Based on claimant's above statements, we conclude that he was not seeking work at the time of disability. See Dawkins v. Pacific Motor Trucking, 308 Or at 254.

In the alternative, claimant contends that it was futile to seek work prior to his surgery because of the compensable injury. However, claimant's contention that any job he might find would soon be lost because of the compensable injury, is unpersuasive in light of Dr. Baldwin's opinion that claimant could return to school within just one week after surgery. Furthermore, the record does not indicate that claimant was unable to continue working prior to surgery, but he did not work or seek work for nearly six months after leaving his job.

It appears that claimant was attending school to learn a different kind of work. However, the record does not establish that it was necessary that claimant do so to accommodate his compensable injury, or that he left his former job to pursue training. Moreover, the record does not establish that he was unable to work at his previous job because of his compensable injury. Rather, the record establishes that claimant left his job for "personal" reasons. Compare Dennis G. Hansen, 48 Van Natta 1071 (1996) (the claimant established that he did not voluntarily leave the work force when he quit his job in order to enter a retraining program, because his compensable injury rendered him unable to work at his former job).

Claimant did not leave his former job because he was unable to perform the duties due to the compensable injury, therefore, it follows that claimant's "retraining" was not undertaken because the compensable injury required him to find another type of work. The record does not indicate in what type of work claimant was previously engaged. However, claimant did not contend that he left that work because he was unable to perform the work. Rather, claimant stated that he left because of disagreements and personal reasons. There is no report from an employer, a vocational consultant or a physician which would support that claimant required retraining before re-entering the work force. Therefore, we conclude that claimant's compensable injury did not render him unable work at his previous employment at the time of disability, nor did it prevent him from re-entering the work force prior to the time of disability. See Victoria J. Williams, 46 Van Natta 2496 (1994) (the claimant quit her job and returned to school, but did not establish that she was in the work force nor eligible for temporary disability compensation at the time of her subsequent surgery).

On this record, we are not persuaded that it was futile for claimant to work or to seek work because of the compensable injury at the time of disability. See Dawkins v. Pacific Motor Trucking, 308 Or at 254; Victoria J. Williams, 46 Van Natta at 2496.

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.

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June 26, 1997 Cite as 49 Van Natta 855 (1997)

In the Matter of the Compensation of
**CHRISTOPHER W. WELSH, Claimant**
WCB Case No. 96-04084
ORDER ON REVIEW
Malagon, et al, 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) McWilliams' order that upheld the SAIF Corporation's denial of claimant's low back condition. It its respondent's brief, SAIF challenges that portion of the ALJ's order that assessed an attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and attorney fees. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

We adopt and affirm that portion of the ALJ's order concerning this issue.

### Attorney Fees

After concluding that claimant did not prove compensability, the ALJ found SAIF's denial unreasonable because it was not timely issued. Although deciding that, in the absence of any "amounts then due," claimant was not entitled to a penalty under ORS 656.262(11)(a), the ALJ awarded an attorney fee under ORS 656.382(1). SAIF challenges this portion of the order, asserting that, because the ALJ found that the denied claim was not compensable, an attorney fee could not be awarded.

ORS 656.382(1) in part provides that, when a carrier "unreasonably resists the payment of compensation," the carrier shall pay a reasonable attorney fee to claimant's attorney. As the court explained in SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993), an attorney fee cannot be awarded under the statute when the denied claim is found not compensable because there is no "compensation" which the carrier can unreasonably resist paying. Consequently, we reverse the ALJ's award of an attorney fee under ORS 656.382(1).

ORDER

The ALJ's order dated December 13, 1996 is affirmed in part and reversed in part. That portion of the order awarding an attorney fee under ORS 656.382(1) is reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**WONDER WINDOM-HALL, Claimant**
WCB Case No. 90-06799
ORDER ON REMAND
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al, Defense Attorneys

This case is on remand from the Court of Appeals. Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996), rev den 324 Or 513 (1997). The court reversed that portion of our prior order finding that the self-insured employer "back-up" denied several vestibular disorders, Wonder Windom-Hall, 47 Van Natta 1077 (1995). The court further remanded for reconsideration of the compensability of claimant's perilymph fistulas condition.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a seamstress in a department store. In early 1989, the store underwent remodeling. In July 1989, claimant sought treatment after experiencing a period of vomiting, dizziness, fatigue, and headache. Claimant filed an 801 form stating that the nature of the injury was headache, nausea, and dizziness resulting from "prolonged exposure to fumes from roofing." (Ex. 1). The employer indicated that it accepted the claim. (Id.) Subsequently, the employer denied payment for particular medical bills, stating that it had accepted only a claim for "toxic exposure to organic solvents." (Exs. 33, 47, 50, 52).

On review, we agreed with claimant that, because the employer accepted a claim for headache, nausea, and headache, and such conditions constituted symptoms of claimant's diagnosed vestibular disorders of hydrops, benign paroxysmal and positional nystagum (BPPN), and perilymph fistulas, the employer's acceptance encompassed the vestibular disorders. 47 Van Natta at 1007-08. Therefore, we treated the employer's denial of such conditions as a "back-up" denial and required the employer to prove under ORS 656.262 that the vestibular disorders were not compensable. We further found that the employer carried its burden of proof with regard to hydrops and BPPN but not perilymph fistulas. Id. at 1008-09.

The court disagreed with our analysis concerning the employer's acceptance, finding that it was qualified as a matter of law and "limited to those symptoms caused by prolonged exposure to fumes from roofing." 144 Or App at 98. The court nevertheless affirmed our conclusion concerning the compensability of hydrops and BPPN, finding that "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." Id. at 99. Because we found the perilymph fistula condition compensable under an incorrect burden of proof,

however, the court remanded for us 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." Id.[1]

Dr. Black, neuro-otologist, treated claimant and performed surgery for a perilymph fistula. Dr. Black indicated in several reports that claimant's perilymph fistula developed as a result of severe or intractable episodes of vomiting. (Exs. 58A-3, 59, 66-1, 66-3). Because Dr. Black also found that the episodes of vomiting were caused by exposure to fumes and the court explained that the employer's acceptance was limited to prolonged exposure to fumes, we analyze claimant's perilymph fistula condition as a consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (holding that, when a condition or need for treatment is caused by the compensable condition, as opposed to the industrial accident, the major contributing cause standard is applied). Consequently, claimant must prove that her compensable injury was the major contributing cause of the perilymph fistula condition. Id.

In evaluating the persuasiveness of medical opinions, we generally defer to the treating physician's opinion, absent a persuasive reason not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no reason not to defer to Dr. Black's opinion that claimant's vomiting was the major contributing cause of the perilymph fistula. As a neuro-otologist, Dr. Black has expertise in deciding the cause of such a condition and, having treated claimant, is familiar with her condition. Thus, we find that Dr. Black's opinion is more persuasive than the rebutting medical opinions stating only that Dr. Black's opinion is "speculative" and not supportable. (Ex. 69-46, Tr. 515).

Consequently, based on Dr. Black's opinion, claimant carried her burden of proving compensability of her perilymph fistula. ORS 656.005(7)(a)(A). Because claimant has finally prevailed over the employer's denial of the perilymph fistula, she is entitled to an attorney fee for her attorney's efforts at every level of review concerning this issue. ORS 656.386(1), 656.388(1).

We consider the factors set forth in OAR 438-015-0010(4) in deciding a reasonable attorney fee. These factors are:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

The time devoted to this case was substantial, including the initial hearing, initial Board review, another hearing on remand from the Board, Board review after remand, review by the Court of Appeals, and a request for review by the Supreme Court. The complexity of the issue, value of the interest and benefit secured for claimant concerning the perilymph fistula are relatively average.[2] There is a risk that claimant's attorney will go uncompensated and there was no assertion that the compensability of the perilymph fistula was a frivolous issue. Based on these factors, we find that a reasonable fee for claimant's attorney's services is $5,000, payable by the self-insured employer.

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[1] Our Order on Review also found that claimant had the burden of proving compensability of toxic encephalopathy and dysthymia conditions and that such conditions were not compensable. 47 Van Natta at 1010. The court found that substantial evidence supported such findings and affirmed that portion of the order. 144 Or App at 100.

[2] Because claimant did not finally prevail over the employer's denial of her hydrops and BPPN conditions, she is not entitled to an attorney fee for services devoted to those issues.

Accordingly, on reconsideration from the Court of Appeals, we reverse that portion of the ALJ's order that upheld the self-insured employer's denial of claimant's perilymph fistula condition. The employer's denial of such condition is set aside and the claim is remanded for processing according to law. For services concerning the compensability of the perilymph fistula, claimant's attorney is awarded an assessed fee of $5,000, to be paid by the employer.

IT IS SO ORDERED.

**Board Member Haynes dissenting.**

I disagree with the majority that Dr. Black's opinion carries claimant's burden of proof. His opinion consists of the following statements: "It may well be that [claimant] developed perilymph fistulas from severe vomiting." (Ex. 58A-3); "It should also be kept in mind that [claimant] had intractable vomiting following exposure to toxic fumes. I suspect that the source of the suspected [perilymph fistula] * * * is the marked vomiting." (Ex. 59); affirmatively responding to the question whether he believed that "the major cause of the claimant's vestibular disorders was her vomiting caused by exposure to noxious chemical fumes on the job at Nordstroms." (Ex. 66-1); and, finally, stating that "severe vomiting has been reported as a cause for perilymph fistulas. I have also seen patients in my practice who have developed perilymph fistulas (PLFs) after vomiting." (Ex. 66-3).

Obviously, Dr. Black's opinion is entirely conclusory because it provided no explanation how vomiting caused claimant's perilymph fistula. As the majority notes, we generally defer to the treating physician's opinion, absent persuasive reasons to the contrary. Weiland, 64 Or App at 814. A persuasive reason includes whether the treating physician's opinion is well-reasoned. Somers v. SAIF, 77 Or App 256, 263 (1986). Here, Dr. Black's opinion does not even qualify as ill-reasoned since it contains no reasoning. I find this defect especially fatal since it is rebutted by other medical opinions characterizing Dr. Black's opinion as "speculative" and not supportable in view of the common occurrence of vomiting and the rare development of perilymph fistulas. (Ex. 69-46, Tr. 515).

For these reasons, I dissent.

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In the Matter of the Compensation of
**ROSA ALCAZAR, Claimant**
WCB Case No. 96-00499
ORDER ON REVIEW
Quintin Estell, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she fell at work on October 6, 1995, and that such injury resulted in low back and coccyx pain. The ALJ found claimant to be an unreliable witness and concluded that she did not prove compensability. Claimant asserts that her testimony is credible and this evidence, along with medical evidence supporting the claim, carries her burden of proof. We agree with claimant.

We first note that the ALJ did not base her credibility finding on demeanor. Thus, we do not defer to her finding, but perform our own evaluation based on the entire record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Claimant testified that she slipped and fell in front of a sink and then sought treatment from the plant "nurse." (Tr. 12-13). Claimant explained that the "nurse" offered her Tylenol and she declined it because she thought it would not be effective. (Id.) Claimant further testified that she continued working while experiencing low back pain. (Id. at 14-15).

Gregory Atkins, the employer's health and safety coordinator and an emergency medical technician, testified that he saw claimant on October 6, 1995 and, after learning that she had fallen, examined claimant's clothes and found them to be dry and unsoiled. (Tr. 43). Mr. Atkins also testified that he found claimant to be in no distress. (Id.) According to Mr. Atkins, he offered to have a female attendant examine claimant and claimant declined. (Id. at 43-44).

On October 17, 1995, claimant saw Dr. Renquist, a chiropractor. Dr. Renquist documented that claimant slipped and fell on a wet floor on October 6, 1995 while washing her hands at work, feeling immediate low back pain. (Ex. 1). Dr. Renquist diagnosed an acute lumbosacral sprain/strain and released claimant to modified work in the cafeteria, which allowed claimant to sit or stand as she desired. (Ex. 4).

On November 7, 1995, claimant saw Dr. Larson, a physician, who reported that claimant "fell at work area in hand - washing area" on October 6, 1995 on her tailbone. (Ex. 14). Dr. Larson also reported that claimant was pregnant. (Id.)

On November 16, 1995, claimant was examined by consulting orthopedic surgeon, Dr. Ballard, who reported that claimant "fell while at work, landing directly on to her tailbone." (Ex. 18). Dr. Ballard diagnosed "resolving contusion to her coccyx." (Id.)

On December 18, 1995, claimant saw examining physicians Dr. Reimer and Dr. Fuller, who reported that "on 10/6/95 [claimant] slipped on a flat concrete floor, falling, and landed in a sitting position." (Ex. 22-1). The physicians diagnosed a contusion of the coccyx. (Id. at 3).

Finally, on March 19, 1996, examining physician Dr. Duff diagnosed a lumbosacral contusion and strain after recording a history that claimant slipped and fell on October 6, 1995 after washing her hands at work. (Ex. 26).

The ALJ based her finding that claimant was unreliable on the lack of eyewitness corroboration of the fall at work and claimant's rejection of the medical attention offered by Mr. Atkins, as well claimant's report to Dr. Mata on November 23, 1995 that she was in exquisite pain and unable to perform the modified cafeteria job and her fear that she would be unable to work throughout her pregnancy. (Ex. 21). The ALJ also cited claimant's failure to consistently treat with one physician and her tendency to seek out another doctor after time loss authorization expired.

We agree with the ALJ that there are reasons for doubting claimant's credibility. In particular, it appears that claimant tended to exaggerate her pain, claiming that she continued to experience extreme low back pain beyond the time that the physicians thought her condition would have resolved. (Exs. 18, 22, 26, 27). Such factors, however, concern the extent of claimant's injury rather than its occurrence. Claimant's testimony that she slipped and fell at work is supported by the fact that she immediately sought medical attention at work from Mr. Atkins and consistently reported such history to the physicians. Relying on this history, all the physicians diagnosed an injury to claimant's coccyx, thereby indicating that the mechanism of injury was consistent with claimant's condition.

Finally, we find Mr. Atkin's testimony insufficient to overcome the evidence establishing the occurrence of the slip-and-fall. In particular, we are not convinced that Mr. Atkin's observation that claimant's clothes were dry and unsoiled and claimant's rejection of the Tylenol necessarily establishes that claimant did not fall. Rather, based on the evidence cited above, we conclude that claimant carried her burden of proving her injury by a preponderance of the evidence. 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 $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate 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 August 26, 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 an assessed fee of $3,000, to be paid by the insurer.

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In the Matter of the Compensation of
**ROBERT L. BEATTY, Claimant**
WCB Case No. 95-09923
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
David J. Lefkowitz, Defense Attorney

Reviewed by Board Members Bock and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its denial of claimant's occupational disease claim for a mental disorder; and (2) awarded a $5,500 attorney fee for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant worked as a deputy patrol officer for Jefferson County. In August 1994, he was temporarily transferred to corrections to work in a city jail. Effective January 1995, the transfer was made permanent.

In May 1995, claimant was hospitalized for chest pains and shortness of breath. In June 1995, he was referred to James Henson, a social worker, for symptoms of depression.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant proved his claim for a mental disorder. In particular, the ALJ found that claimant proved he was treated "differently" by management from his coworkers and that it was not "generally inherent that certain individuals will be treated differently by their supervisors when that treatment is not for corrective or disciplinary reasons." The employer challenges the ALJ's order, asserting that there is no persuasive medical evidence supporting the claim and at least some of the incidents relied upon by claimant are generally inherent in every working situation or constitute reasonable disciplinary, corrective or job evaluation actions.

Examining psychiatrist Dr. Turco found that claimant had an "Occupational Problem" related to administrative difficulties; thus, Dr. Turco found no evidence of a psychiatric disorder. (Ex. 19-8).

Mr. Henson first indicated that "the major cause of [claimant's] depression is biochemical, and that his employment is a contributing cause not the only or primary cause of the depression." (Ex. 21). Dr. Lieuallen, a physician who treated claimant's coronary symptoms, indicated that he deferred to Mr. Henson concerning the cause of the claimant's depression. (Ex. 22).

Subsequently, however, Dr. Lieuallen reported that "work stress is at least 51% of the cause of [claimant's] depression." (Ex. 22A). Dr. Lieuallen also subsequently indicated that claimant did not describe events at work in great detail. (Ex. 28).

After receiving the legal definition of "major contributing cause," Mr. Henson reported:

> "This is a complex case, and not easily reduced to three work phrases or percentages. Over all, I believe that there are at least three contributing areas of consideration. I believe that stress on the job precipitated this major depressive episode, and that he

> might well have never experienced this depression without the very significant workplace stress. I do not believe that [claimant's] depression was of a simple reactive type. Additional contributing factors include personal identity issues and probable biochemical component. In terms of identity, [claimant] has been very serious about work and about the importance of being a law enforcement officer. Some times he may have overly identified with this job, to the neglect or oversight of other parts of his personhood. Therefore, when he recieved [sic] critism [sic] and began to fear for his carrier [sic] these stress factors took a very heavy toll on [claimant] emotionally.
>
> "For the above reason, I believe it is clinically accurate to say that [claimant's] depression was more than 51% work stress caused. Given the legal definition of Major Contributing Cause, I believe that it is accurate to say that work related stress was the major contributing cause of [claimant's] depression." (Ex. 22B).

Finally, Dr. Hyde, psychiatrist, evaluated claimant on Dr. Lieuallen's referral. According to Dr. Hyde, claimant "suffered from a clinical depression from about midsummer 1994 until June 1995." (Ex. 30-2). Dr. Hyde also reported that the "depression [claimant] was experiencing and the adjustment order which he continues to have, appear to be related to stress at work and the ongoing stress he feels when communicating with his superiors, or even thinking about his difficulties in the past year and a half." (Id.)

We first find unpersuasive the opinions of Dr. Lieuallen and Dr. Hyde. Dr. Lieuallen did not treat claimant for his depression and has indicated a very limited knowledge concerning work events. Similarly, Dr. Hyde reported that he had not reviewed the medical records or spoken with Mr. Henson. Both Dr. Lieuallen and Dr. Hyde provided conclusory opinions. Consequently, we find their opinions neither well-reasoned nor based on a complete history and give them little weight. See Somers v. SAIF, 77 Or App 259 (1986).

We also find Mr. Henson's opinion inadequate to carry claimant's burden of proof. First, Mr. Henson did not explain why his opinion changed from attributing claimant's condition in major part to biochemical factors to work conditions. Furthermore, in explaining the effect of "job stress" on claimant's condition, Mr. Henson states that this factor "precipitated" claimant's depression without otherwise explaining why work conditions are the major contributing cause of claimant's depression. Thus, Mr. Henson equates the "precipitating cause" with the "major contributing cause," which is not sufficient to meet claimant's burden of proof. 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"); Alec E. Snyder, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contributors).

Consequently, we conclude that there is no persuasive medical evidence that employment conditions were the major contributing cause of claimant's depression. We further conclude that claimant failed to show that the employment conditions relied upon by claimant were not generally inherent in every working situation or other than reasonable disciplinary or corrective actions.

Claimant testified to numerous job conditions which he perceived as showing an attempt by his supervisors to harass him and make him resign from his job. These conditions included a greater amount of revision assignments for his reports than other officers, (Tr. 53 (Day 2)), a failure to order particular body armor, (id. at 56), failure to assign claimant a new vehicle, (id. at 59), closer monitoring of overtime than other officers, (id. at 60), more frequent evaluations than other officers, (id. at 75), procedurally improper investigation into a car accident, (id. at 71), the transfer to the jail, (id. at 62-63), and investigation for possible fraudulent overtime request, (id. at 84).

Initially, we disagree with the ALJ that claimant was treated differently in all the instances cited or that some of the cited job conditions did not qualify as corrective or disciplinary actions. When claimant transferred to the jail, he was given more frequent evaluations (from annually to semiannually) by his supervisor, Sergeant Jack Jones. There was testimony from Undersheriff Jim Adkins that the "standard" was yearly evaluations for nonprobationary employees. (Id. at 185). Sergeant Jones explained, however, that, up until the hearing, he had understood that evaluations for nonprobationary employees were to be semiannual and he had evaluated all his employees based on this schedule. (Id. at 249, 251). Based on such testimony, we find that claimant's more frequent evaluations were no different than the other employees at the jail and based on a misunderstanding by claimant's supervisor.

When claimant was a patrol officer, Undersheriff Adkins (who was the supervising sergeant at that time), reviewed and edited all the deputies' reports, as well as the sheriff's reports, sending them back for correction and revision. (Id. at 152). Thus, claimant's reports were not singled out for revision. Furthermore, although Undersheriff Adkins testified that he probably sent back claimant's and another deputy's reports more often, he did so because they were in more need of revision. (Id. at 155).[1] Based on such testimony, we conclude that Undersheriff Adkins' conduct concerning reports constituted reasonable corrective action.

Claimant also testified, however, that the transfer to the jail and the overtime request matter were the "one-two punch" that caused him to become convinced that his job performance would be relentlessly criticized and found wanting. (Id. at 114, 134). Thus, we find these employment conditions form an important part of claimant's mental stress claim.

Sheriff Throop testified that, in 1994, the jail suffered a "manpower shortage" because two corrections deputy positions were not filled and another corrections deputy was on medical leave. (Id. at 334). Sheriff Throop explained that, because there was no eligibility hiring list for the jail, he had to place a patrol deputy to work in the jail to maintain adequate coverage. (Id. at 335). Both Sheriff Throop and Undersheriff Adkins testified that, out of the four patrol deputies, three had previously worked in the jail and the remaining deputy was a recent hire. (Id. at 167, 336). The new deputy was not chosen because he did not have experience as a corrections officer. (Id.) Out of the three remaining deputies, one was the new DARE officer, and Sheriff Throop did not want to interfere with that program. The other officer had stated that he would be quitting in the near future. (Id. at 167, 337). Sheriff Throop further explained that he considered claimant the most appropriate choice because he effectively dealt with arrested people. (Id. at 337-38). Sheriff Throop also explained that claimant's transfer to the jail became permanent because he could not attract experienced people to apply for the corrections positions. (Id. at 344-45).

We have held that it is generally inherent in every working situation for an employer to transfer an employee if such decision is reasonable and not outside the course of ordinary business. Robert J. Douglass, 48 Van Natta 374 (1996); cf. James I. Weathers, 48 Van Natta 1144 (1996) (the claimant's transfer was contrary to the union contract and, thus, unreasonable and not generally inherent). Here, there is no contention that claimant's transfer was contrary to his employment contract or the employer's policies; on the contrary, the employer's decision was upheld in a grievance proceeding. Furthermore, we find Sheriff Throop's explanation for choosing claimant, rather than the other patrol deputies, for the transfer. Consequently, we conclude that this event is generally inherent in every working situation. Robert J. Douglass, supra. We now consider the event concerning claimant's overtime request.

During the time claimant worked at the jail, he was allowed to work as a reserve patrol officer for the city; because his job in corrections was with the county, claimant's work for the city was paid from a separate budget. On April 27, 1995, claimant was subpoenaed and testified before a grand jury concerning work he performed as a reserve patrol officer. On that same date, claimant submitted a request for overtime to his supervisor at the jail, Sergeant Jones. On May 1, 1995, claimant's unsuccessful grievance hearing over the transfer to the jail occurred. On May 2, 1995, Sergeant Jones disapproved the overtime request, noting that it was for city work.

According to claimant, the city police chief contacted him and told claimant that the overtime request should have been submitted to the city and not the county. (Tr. 84 (Day 2)). Claimant then called Sergeant Jones, who told claimant that he had already disapproved the request. (Id. at 85). Sergeant Jones refused claimant's request to return the overtime request for submission to the city and told claimant they would discuss the matter at a later time. (Id.)

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[1] We are not persuaded by the witnesses who testified in support of the quality of claimant's reports. One witness was a deputy district attorney, and had reviewed claimant's reports only after they had been edited and revised. Another witness was claimant's city reserve patrol supervisor, who could not compare claimant's reports to the other patrol officers supervised by Undersheriff Adkins. A third witness apparently quit before Undersherrif Adkins was promoted to sergeant and began reviewing claimant's reports. (Tr. 132 (Day 1)). Although the final witness worked during the time Undersheriff Adkins was the supervising a sergeant and testified that he reviewed claimant's reports when he performed as the acting sergeant, he could not specify when he was the acting sergeant. (Id. at 82-83). Thus, we are not convinced that this witness' turns as acting sergeant corresponded with Undersheriff Adkins' term as sergeant.

When claimant returned to work and met with Sergeant Jones, claimant explained that he had mistakenly submitted the request to the county rather than the city and that the action was merely an oversight. (Id. at 86). According to claimant, Sergeant Jones indicated that he believed claimant and that he could not predict the outcome but that claimant could be terminated for cause and never work in law enforcement again. (Id. at 87). Sergeant Jones similarly testified that, during this meeting, he warned claimant to be careful because, if claimant was terminated for just cause based on fraud, claimant would be unable to become certified for patrol. (Id. at 237). Sergeant Jones also stated that he would be recommending that claimant receive a two to three day suspension for submitting an inaccurate time sheet. (Id.)

The next day, claimant began experiencing chest pains and was hospitalized. Claimant was not released for work until November 1995. When claimant failed to request reinstatement to his previous position in corrections, the county notified him that it considered claimant as having voluntarily quit his employment.

We consider Sergeant Jones' conduct with the overtime request and time sheet to constitute corrective or disciplinary action. As Sergeant Jones testified, the meeting was to discuss the "disciplinary issues that were at hand." (Id. at 235).[2] Sergeant Jones used the meeting to investigate whether claimant committed fraud and informed him of his own disciplinary recommendation as well as the possibility that claimant could be terminated over the matter. Thus, the incident can be considered in claimant's mental stress claim only if it was not reasonable. ORS 656.802(3)(b).

Sergeant Jones stated that he took the overtime request matter very seriously because the Sheriff had terminated a previous employee for fraud. (Id. at 233). Sergeant Jones also explained that he recommended a suspension because, even if claimant had submitted the overtime request and time sheet in error without any intent to defraud, he considered such an omission important. In particular, it showed a lack of preparation because testimony would require identifying "who you're working for and what you were doing" thus requiring claimant to state that he had been working for the city. (Id. at 253). Sergeant Jones also found it significant that claimant had worn his county uniform while testifying, then changed to his city uniform after returning from the grand jury proceeding. (Id. at 236).

Based on Sergeant Jones' testimony, we find his corrective or disciplinary actions to be reasonable. Claimant himself conceded that the overtime request should have been submitted to the city and not the county. Thus, claimant's conduct was contrary to policy and subject to discipline.

In summary, we conclude that the transfer to the jail was generally inherent in every working situation and claimant's treatment concerning the overtime request/time sheet matter, as well as the report revisions, constitute reasonably corrective or disciplinary actions. Because none of the medical reports provide that the remaining conditions cited by claimant are the major contributing cause of his depression, we conclude that claimant failed to carry his burden of proof, whether or not those conditions can be considered under the statute. Thus, we conclude that claimant failed to prove his claim for a mental disorder. ORS 656.802(3).

## ORDER

The ALJ's order dated December 20, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] During this meeting, Sergeant Jones also informed claimant that he was recommending a letter of reprimand for claimant's failure to attend a mandatory staff meeting.

In the Matter of the Compensation of
**HOWARD L. BROWNE, Claimant**
Own Motion No. 96-0211M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Michael Bruce, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 14, 1997 Own Motion Order, as reconsidered on April 15, 1997, in which we authorized the reopening of claimant's 1982 injury claim for the payment of temporary disability benefits because he established that his compensable condition required surgery or hospitalization. With its request for reconsideration, SAIF contends claimant is not entitled to temporary disability benefits because he retired from the work force prior to surgery.

## FINDINGS OF FACT

On August 10, 1982, claimant injured his low back. SAIF accepted claimant's L4-5 disc condition. Claimant's aggravation rights on that claim expired on February 11, 1990.

On April 25, 1996, SAIF issued a denial of the compensability of claimant's current L3-4 lateral recess stenosis condition. SAIF agreed that claimant's current condition required surgery, and that claimant was in the work force at the time of disability.

On June 27, 1996, the Board postponed action on the Own Motion request, pending the outcome of litigation on related matters at the Hearings Division. (WCB Case No. 96-05769). In a January 28, 1997 Stipulation and Disputed Claim Settlement Agreement, the parties agreed that SAIF's denial of claimant's L3-4 condition remained in full force and effect, that claimant's request for hearing was dismissed with prejudice, and that the agreement settled all issues raised or raisable.

On February 14, 1997, the Board issued an Own Motion Order, in which we acknowledged the parties' January 28, 1997 agreement, and concluded that the current condition for which claimant requested Own Motion relief, remained in denied status. Contending that his May 28, 1996 surgery was to multiple levels of his back, including his compensable L4-5 disc, claimant requested reconsideration of our order. Claimant submitted a May 28, 1996 operative report from Dr. Grewe, his treating physician, in which Dr. Grewe noted that claimant's operation encompassed bilateral, four level, L2 through S1 decompression laminotomies and foraminotomies. In addition, claimant submitted a May 13, 1996 letter from SAIF, in which it advised that it was responsible for the L4-5 level of claimant's May 28, 1997 surgery, and that Dr. Grewe's office was separating charges for claimant's surgery and recuperation "based on our companies[']' respective responsibility." SAIF did not respond to claimant's motion or to our March 18, 1997 Own Motion Order of Abatement which had granted it an opportunity to present its position.

On April 15, 1997, we issued our Own Motion Order on Reconsideration, in which we concluded that claimant's compensable L4-5 disc injury had worsened requiring surgery, and we authorized temporary disability compensation for the surgical procedure performed on claimant's compensable condition.

On May 13, 1997, SAIF requested reconsideration of our order, contending that "[a]t the time of the response to the Own Motion request, claimant was still employed." SAIF further contended that "[b]y the time of claimant's surgery on May 28, 1996, claimant had retired from the workforce." We abated our prior order to allow claimant sufficient time to respond to SAIF's contention.

In a May 29, 1997 response, claimant asserted that: (1) SAIF's motion regarding the work force issue was not timely filed; and (2) claimant had not removed himself from the work force. Claimant submitted evidence that, although retired from his job with the state, he formed his own business for which he is licensed and certified. SAIF has not responded to claimant's submissions. Therefore, we will proceed with our review of the record.

## CONCLUSIONS OF LAW AND OPINION

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other

treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id. Claimant has established that his compensable L4-5 injury worsened requiring the May 28, 1996 multi-level surgery.

On January 25, 1996, SAIF received claimant's request for Own Motion relief. In its April 25, 1996 recommendation, SAIF agreed that claimant was in the work force at the time of disability.[1] Claimant underwent surgery on May 28, 1996.

On January 28, 1997, Administrative Law Judge (ALJ) T. Lavere Johnson approved the parties' agreement, which addressed claimant's current L3-4 condition, and found that all issues raised or raisable were agreed upon.

Here, SAIF first raised the issue of claimant's work status on May 13, 1997, when it requested reconsideration of our April 15, 1997 order. When claimant requested reconsideration of our February 14, 1997 Own Motion Order, SAIF was afforded the opportunity to respond to claimant's entitlement to time loss. It did not choose to do so. Furthermore, after SAIF raised the issue and when claimant submitted evidence that he was self-employed at the time of surgery, SAIF again did not choose to respond regarding whether or not it agreed that the newly submitted evidence established that claimant remained in the work force at the time of disability.

As a general rule, we do not consider issues that are raised for the first time on reconsideration. See Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7, 13 (1994); Marcia G. Williams, 49 Van Natta 313, on recon 49 Van Natta 612 (1997). In light of such circumstances, we are not inclined to consider SAIF's belated challenge to claimant's "work force" status. In any event, we need not resolve that question because, even if we were to consider SAIF's contention that claimant was not in the work force at the time of his surgery, we would conclude from the record that claimant is entitled to TTD beginning the date of his surgery. Our conclusion is based on the following reasoning.

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 who was in the work force at the time of worsening, but who voluntarily left the work force prior to surgery, was not in the work force at the time of disability for purposes of qualifying for temporary disability compensation. See John R. Johanson, 46 Van Natta 2463 (1994); Fred Vioen, 48 Van Natta 2110 (1996). However, a claimant who, although subsequently retired, continued to work at the time of surgery, was considered to be in the work force at the time of disability. See Robert D. Hyatt, 48 Van Natta 2202 (1996). Furthermore, although a claimant has voluntarily left the work force, the claimant may qualify for temporary disability benefits if the claimant can establish that he re-entered the work force at the time of disability, or that voluntary withdrawal from the work force was not permanent. See Dean L. Watkins, 48 Van Natta 60 (1996).

Here, claimant submitted evidence that, although he retired from his job with the state, he re-entered the work force as an electrical and educational services consultant, and obtained a license and certification to do so. Finally, claimant asserts that he has been working part time for the Joint Apprenticeship Training Council since prior to his retirement from his state job until the current time. This evidence has not been rebutted. Thus, claimant has established that he remained in the work force at the time of disability.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our February 14, 1997 and April 15, 1997 orders in their entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We conclude that the April 25, 1996 Carrier's Own Motion Recommendation Form is SAIF's "response to the Own Motion request" to which SAIF refers in its motion to reconsider.

In the Matter of the Compensation of
**HOWARD W. COCKERAM, Claimant**
WCB Case Nos. 96-04377 & 95-12056
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the SAIF Corporation's denial of claimant's L4-5 herniated disc condition; (2) found that claimant's low back injury claim was not prematurely closed; and (3) declined to assess a penalty for allegedly unreasonable claims processing. On review, the issues are premature closure, compensability and penalties.

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

Claimant argues that the ALJ incorrectly found that his claim was not prematurely closed. Specifically, claimant argues that, at the time his treating doctor, Dr. Higgins, found him medically stationary, Dr. Higgins had not seen him for over five weeks. Moreover, claimant argues that Dr. Higgins had previously referred claimant to Dr. Densmore for consultation and treatment.

We conclude that, although claimant appears to suggest that Dr. Higgins was not his treating physician at the time of claim closure, the record does not support such a finding. We are unable to find evidence that claimant completed a change of attending physician form. Moreover, the evidence relied on by claimant does not support such a conclusion. Furthermore, Dr. Densmore has not commented on claimant's medically stationary status, while Dr. Camp has similarly not challenged the claim closure. Accordingly, we affirm the ALJ's order on the issue of premature closure.

With respect to the issue of compensability of the L4-5 condition, claimant contends that the ALJ erred in finding that SAIF was not barred from denying compensability. Claimant argues that, by previously submitting the issue of reimbursement for L4-5 surgery to the Department for a decision, SAIF conceded that there was no issue of compensability. Accordingly, claimant argues that SAIF is now barred from contesting compensability. As authority, claimant cites to OAR 436-010-0008(10), which requires a certification that there is no causation issue when a matter is submitted to the Department for a decision.

We first note that the applicable rule in this case is actually former OAR 436-10-046(5) (WCD Admin. Order 94-064, effective February 1, 1995). This rule provided that, when an insurer disputes medical treatment, the insurer must, "[c]ertify that the relatedness of the treatment to the compensable injury is not at issue and that no denial has been or will be issued before the director publishes an order." Former OAR 436-10-046(5)(b).

Accordingly, the rule prohibits the carrier from denying compensability before the Director issues an order. Therefore, because the issue was not, and could not have been, litigated prior to the Director's order, SAIF was not "barred" from subsequently denying compensability. Finally, there is no prohibition in the statutes which prevented SAIF from subsequently denying the compensability of claimant's L4-5 condition. Therefore, we agree with the ALJ that the Director's order did not bar SAIF's denial.

Claimant argues that, if preclusion does not apply, he has established the compensability of the L4-5 condition, on the merits of the claim. To support his contention, claimant relies on the medical opinions of Dr. Miller (Ex. 41) and Dr. Camp (Exs. 42, 46, 47). After reviewing the medical opinions relied on by claimant, we disagree that the opinions establish compensability.

As noted by the ALJ, claimant is required to prove that, pursuant to ORS 656.005(7)(a)(B), the compensable injury is the major contributing cause of the disability or need for treatment of the "combined condition." Here, however, Dr. Miller has not discussed the contribution of claimant's degenerative condition, nor has he expressed an opinion that the work injury is the major contributing

cause of the combined condition. (Ex. 41). Similarly, we find that Dr. Camp's opinion also lacks such explanation or analysis. (Ex. 48). See Dietz v. Ramuda, 130 Or App 397 (1994) (Determining major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause).

Finally, claimant argues that he is entitled to an assessed penalty for SAIF's allegedly unreasonable claims processing. However, we have found that the underlying claim is not compensable. Therefore, there has been no unreasonable resistance to the payment of compensation. James P. Mishler, 48 Van Natta 2400 (1996). 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 September 16, 1996 is affirmed.

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June 27, 1997 Cite as 49 Van Natta 867 (1997)

In the Matter of the Compensation of
**DAVID A. DONNELLY, Claimant**
WCB Case Nos. 94-13449, 94-13398, 94-13448 & 94-13399
ORDER ON REVIEW
Quintin Estell, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside Liberty Northwest Insurance Corporation's denial of compensability for claimant's low back condition except at L6-S1; and (2) upheld the SAIF Corporation's denial of compensability for the same condition. SAIF cross-requests review of those portions of the order that: (1) upheld Liberty's denial of responsibility for the L6-S1 condition; and (2) set aside SAIF's denial of responsibility for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer as a well driller since 1988. In April 1990, Liberty accepted a nondisabling claim for lumbosacral strain resulting from a December 1989 industrial injury. Effective October 1992, the employer's workers' compensation coverage changed from Liberty to SAIF. In August 1994, claimant again sought treatment for his low back; an MRI showed degenerative disc disease throughout the spine.

Liberty denied compensability and responsibility of claimant's entire back condition. SAIF conceded compensability of claimant's condition at L6-S1,[1] but denied compensability of the remaining back and denied responsibility of claimant's entire low back condition.

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[1] The ALJ decided that, because claimant has a sixth vertebra, a diagnosed disc herniation was located at L6-S1. We note that, although claimant does have six lumbar vertebra (a congenital anomaly), the medical record inconsistently refers to L5-S1 and L6-S1 as the source of claimant's low back symptoms. (See Exs. 26, 28). Thus, we are not convinced that any disc herniation is located at L6-S1, as opposed to L5-S1. However, for purposes of consistency, we will refer to L6-S1 as requiring treatment.

The ALJ first decided that the most persuasive medical opinion showed that the condition causing claimant's need for treatment and disability was degenerative disc disease and disc herniation at L6-S1 and, thus, limited his analysis to such condition. Applying ORS 656.308(1), the ALJ concluded that claimant had proved a new occupational disease. Finally, the ALJ applied the last injurious exposure rule to determine responsibility because Liberty and SAIF were successive insurers following the 1990 claim. Under that analysis, the ALJ concluded that SAIF was responsible for the L6-S1 disc condition.

Claimant disagrees with the ALJ's limited compensability analysis and contends that his entire lumbar spine condition should be found compensable. SAIF asserts that ORS 656.308(1) does not apply and that the last injurious exposure rule (LIER) alone is determinative for deciding responsibility. According to SAIF, under LIER, Liberty is liable for claimant's condition at L6-S1. We first address compensability. See Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 76 (1994).

Compensability

The record contains numerous opinions concerning claimant's low back condition.[2] Claimant's treating physician, Dr. Radzik, diagnosed claimant as "most likely" having "degenerative arthritis of the lumbosacral spine, possibly secondary to injury; this indicates an old injury as it takes time to develop arthritis" and "lumbar strain." (Ex. 15).

Examining orthopedic surgeon, Dr. Farris, diagnosed chronic lumbar strain and diffuse degenerative disc disease of the lumbar spine. (Ex. 18-4). Dr. Farris found that a "portion of this degenerative disc disease is undoubtedly related to the natural aging process but I would consider [claimant's] work as a well driller to [be the] major contributing cause of his chronic low back condition." (Id.) Dr. Farris also reported that the degenerative disc disease "is the major contributing cause of his need for treatment but I would trace the degenerative disc disease back to the original injury of 1989." (Id. at 5).

Examining physicians Dr. Martens, orthopedist, and Dr. Weller, neurologist, diagnosed "recurrent lumbosacral strain, by history, since December 13, 1989 work injury, with last recurrent in early August 1994" and "degenerative spondylosis, thoracolumbar spine." (Ex. 25-4). The panel found the major contributing cause to be the "degenerative change of the lumbar spine and the work activities." (Id.)

Finally, examining orthopedist, Dr. Laycoe, diagnosed "chronic mechanical low back pain secondary to degenerative disc disease, lumbosacral level." (Ex. 26-6). According to Dr. Laycoe, the source of claimant's symptoms was "from degenerative disc disease at the lumbosacral junction." Dr. Laycoe further explained that claimant's work activities put "significant stress" on the L6-S1 disc, resulting in an "accelerated pattern of deterioration." (Id. at 7). Dr. Laycoe believed that "the 1989 episode represents the first documentable symptomatic presentation of his degenerative disc disease." (Id.).

In a follow-up "check-the-box" report, Dr. Laycoe indicated that the degenerative disc disease at all levels except L6-S1 was caused by aging and that the condition at L6-S1 was in major part caused by work activities. (Ex. 28-1).

Finally, during a deposition, Dr. Laycoe reiterated his opinion that the source of claimant's symptoms since 1989 was the degenerative disc disease at L6-S1 and such condition was in major part caused by work activities. (Ex. 30-25, 34). Dr. Laycoe also stated that the remaining lumbar spine condition was not symptomatic and, furthermore, he could not state whether the major contributing cause was work activities or the natural progression of degenerative disc disease. (Id. at 26).

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[2] We agree with claimant that compensability should not be limited to L6-S1. From the beginning, claimant has asserted compensation for his entire lumbar spine. Liberty and SAIF's denials also addressed the whole lumbar spine. Thus, we consider the "claim" to include the entire lumbar spine and not merely the condition at L6-S1.

In evaluating medical opinions, we rely on those that are well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 263 (1986). We agree with the ALJ that Dr. Laycoe provided the most persuasive opinion. Dr. Laycoe explained how claimant's work put stress on the disc at L6-S1, causing the degenerative disc disease to worsen and become symptomatic. The remaining opinions are conclusory and lack the reasoning contained in Dr. Laycoe's opinion. Furthermore, Dr. Radzik indicated only a possibility that claimant's "degenerative arthritis" was caused by an "old injury" and the panel of Dr. Martens and Dr. Weller did not delineate between whether degenerative change or the work activities was the major contributing cause.

Consequently, based on Dr. Laycoe's opinion, we conclude that claimant proved his condition at L6-S1 to be compensable. ORS 656.802(2). Because Dr. Laycoe did not establish that claimant's condition at the remaining levels was in major part caused by work activities, we further conclude that claimant did not carry his burden of proof with the remaining part of the lumbar spine. Id. We proceed to determine which carrier is responsible for the L6-S1 condition.

Responsibility

All parties concur, and we agree, that the last injurious exposure rule, rather than ORS 656.308(1), is the appropriate analysis for determining responsibility. ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. * * *"

In order for the statute to be triggered, there must be an accepted claim for the contested condition, for which some employer is responsible. SAIF v. Yokum, 132 Or App 18, 23 (1994).[3] Thus, the statute does not apply in an initial claim context, since no employer is responsible until responsibility is fixed. Id. Rather, it is appropriate to determine responsibility by applying the last injurious exposure rule. Id. at 25. Although claimant has an accepted claim for lumbosacral strain, this proceeding concerns the initial claim for lumbosacral degenerative disc disease at L6-S1. Consequently, ORS 656.308(1) is not applicable. Instead, we determine responsibility for the L6-S1 condition under the last injurious exposure rule.

As a rule of proof, the last injurious exposure rule operates to relieve the claimant of the burden of proving actual medical causation as against any particular employer or insurer, Bracke v. Baza'r, 293 Or 239, 246 (1982), 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. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

As explained above, Dr. Laycoe thought that the 1989 injury represented the "first documentable symptomatic presentation of his degenerative disc disease." Dr. Farris similarly "traced" the degenerative disc disease back to the 1989 injury. Based on such evidence, we find that claimant first received treatment for the compensable condition in 1989 before experiencing time loss in 1994. Consequently, initial responsibility for the condition at L6-S1 is assigned to Liberty, since it was the insurer at the time of the 1989 injury. Liberty can shift responsibility to SAIF, however, if subsequent employment conditions during SAIF's period of coverage independently contributed to the cause or worsening of the condition. Bracke, 293 Or at 250; Timm, 125 Or App at 401.

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[3] The Yokum court examined ORS 656.308(1) before it was amended by the 1995 Legislature. Because those portions of the statute relevant to its application in Yokum and this case were not changed, however, we consider the court's holding in Yokum to be unaffected by the 1995 amendments.

According to Dr. Laycoe, employment conditions before October 1992, when SAIF became the employer's insurer, contributed in greater part to the condition at L6-S1 in comparison to the claimant's work after that date. (Ex. 28-2). Dr. Laycoe further indicated that "each year of [claimant's] employment has carried the same detrimental effect." (Id.) We understand such evidence as showing that claimant's work after October 1992 "detrimentally affected" claimant's condition at L6-S1 by independently contributing to its cause or worsening. Thus, we conclude that responsibility is shifted to SAIF.

Attorney Fees on Review

SAIF cross-requested review of that portion of the ALJ's order which set aside its responsibility denial of claimant's L6-S1 condition. Because we have not disallowed or reduced compensation awarded by the ALJ's order, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding his reply to SAIF's cross-appeal 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), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to a fee for services on review concerning his unsuccessful request for review because he did not finally prevail regarding this matter. See ORS 656.386(1).

ORDER

The ALJ's order dated June 27, 1996 is affirmed. For services on review concerning SAIF's cross-appeal, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**LAURA A. DOUGLAS, Claimant**
WCB Case No. 96-04459
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Ronald Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's occupational disease claim for her left epicondylitis condition. In her respondent's brief, claimant contests that portion of the ALJ's order that did not assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

The ALJ found that claimant's left elbow epicondylitis symptoms arose prior to claimant's cessation of work for the employer and that claimant's repetitive work activity for the employer was the major contributing cause of the left elbow epicondylitis. On review, the employer argues that claimant's left elbow symptoms did not arise out of her employment since no mention is made of left elbow symptoms prior to November 1995 when claimant was laid off work.

As the ALJ found, the histories taken by the physicians are consistent with claimant's testimony that she experienced mild left elbow symptoms before she left work and that these symptoms worsened after her right arm was casted to treat her accepted right elbow epicondylitis. There is no evidence that persuades us that claimant's testimony regarding the onset of her left-sided symptoms is not credible. The fact that no mention is made of left-sided symptoms prior to November 1995 is adequately explained by the fact that these symptoms were mild and did not require treatment until after the right arm was casted.

In addition, the medical evidence is uncontroverted that the major contributing cause of claimant's left elbow epicondylitis was her work activities at the employer. In this regard, Dr. Coale, claimant's treating physician, is familiar with claimant's work as a crane operator, and opined to a reasonable medical probability that the major contributing cause of claimant's left elbow epicondylitis was claimant's work activities. Dr. Coale's opinion is supported by the opinions of Drs. Vessely, Aversano and Rosenbaum.

Based on this record, we find that claimant's left-sided epicondylitis arose prior to claimant leaving work for the employer. Moreover, no physician attributes claimant's condition to her work activities after January 1996 when claimant began working as a crane operator for another 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 regarding 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.

## ORDER

The ALJ's order dated October 9, 1996 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

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In the Matter of the Compensation of
**BARBARA JOHNSON, Claimant**
WCB Case Nos. 95-07224 & 95-05888
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that: (1) admitted post-reconsideration evidence at a hearing regarding an Order on Reconsideration; and (2) found claimant entitled to permanent total disability (PTD) benefits. On review, the issues are constitutionality, evidence and permanent total disability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact from page 5 through the first two sentences of the second to last paragraph on page 8. We also adopt the section of the ALJ's order on page 2 which sets out the stipulations of the parties. We do not adopt findings which are based on "post-reconsideration" evidence.

## CONCLUSIONS OF LAW AND OPINION

### Preliminary Evidentiary Matter

Finding that the evidentiary limitations of ORS 656.283(7) violated claimant's procedural due process rights under the Fourteenth Amendment of the United States Constitution, the ALJ admitted and considered "post-reconsideration" order documentary and testimonial evidence in determining whether claimant was permanently and totally disabled.

In Virginia McClearen, 48 Van Natta 2536 (1996), which issued subsequent to the date of the ALJ's order, we addressed the admissibility of "post-reconsideration" order evidence in permanent total disability (PTD) cases. In McClearen, we held that where a case has undergone the reconsideration

process set forth in ORS 656.268, PTD is an "issue regarding a * * * determination order" within the meaning of ORS 656.283(7).[1] On this basis, we found that the statutory exclusion in ORS 656.283(7) applied to hearings on reconsideration orders involving PTD issues. We further held that ORS 656.287(1) provides a limited exception to the evidentiary limitation of ORS 656.283(7). We interpreted ORS 656.287(1) as a grant of authority to admit vocational reports at hearing where the reports were previously submitted at the reconsideration proceeding; and where the vocational consultant whose report is being offered into evidence is available for testimony and cross-examination at hearing upon request by the adverse party.

Here, the parties have stipulated that the "reconsideration record" includes Exhibits 1 through 67; 7A through 48C and 64A. (Tr. 7). Based on our holding in McClearen, only these exhibits are admissible and can be considered. Thus, Exhibits 68 through 78 are inadmissible "post-reconsideration" evidence pursuant to ORS 656.283(7). Virginia McClearen, 48 Van Natta at 2537. Claimant testified at hearing as did two vocational experts. Because the reconsideration record contains no reports from the vocational experts who testified at hearing, that testimony, as well as claimant's testimony, is inadmissible and may not be considered. Id at 2539.

Constitutionality of Evidentiary Limitation

Claimant contends that the limitation against "post-reconsideration" evidence in ORS 656.283(7) denies her procedural due process in violation of the Fourteenth Amendment of the United States Constitution. We have previously addressed and rejected a similar argument in George D. Koskela, 49 Van Natta 529 (1997). In Koskela, the claimant argued that because he was seeking PTD benefits instead of permanent partial disability (PPD) benefits, "due process" required an evidentiary hearing and the right to confront and cross-examine witnesses.

We agreed that the claimant's interest in PTD was more significant than the interest in PPD benefits. However, notwithstanding the differences between PTD and PPD, we found that procedures during the reconsideration process are sufficient to guard against an erroneous deprivation of the claimant's interest in PTD benefits. After considering the reconsideration procedures, including the right to submit information into the reconsideration record, the opportunity to correct or clarify information in the record that was erroneous and the right to an examination by a medical arbiter, we found that the reconsideration procedures enable claimant to present in writing the lay, medical and vocational evidence supporting entitlement to PTD benefits. Specifically, we concluded that the claimant had the right to present essentially the same evidence on reconsideration which he sought to present at hearing, albeit in a different form.[2]

Moreover, we specifically rejected the contention that oral testimony is necessary for a claimant to establish willingness to seek employment and make reasonable efforts to obtain such employment. We found that such evidence could be presented on reconsideration by affidavit. We concluded that the evidentiary limitation of ORS 656.283(7) is on the form and timing, not the content, of the evidence relative to the PTD issue.

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[1] ORS 656.283(7) provides, in relevant part: "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing * * *." We have previously interpreted the evidentiary limitation in ORS 656.283(7) to prohibit the admission at hearing of evidence concerning the extent of a claimant's permanent partial disability (PPD), which was not previously submitted at reconsideration. See Joe R. Ray, 48 Van Natta 325 (1996). In addition, we rejected the claimant's argument that the prohibition of "post-reconsideration" evidence under amended ORS 656.283(7) violated his procedural due process rights under the Fourteenth Amendment to the United States Constitution. We reasoned that, although the claimant's entitlement to PPD is a constitutionally significant (i.e., "property") interest, the procedures afforded during the reconsideration process were sufficient to guard against an erroneous deprivation of his interest in PPD.

[2] We found that testimony of claimant's lay and expert witnesses could have been presented by sworn affidavits at the time of reconsideration.

Here, as in Koskela, we find that claimant had the opportunity to present her position and evidence fully at the reconsideration proceeding. Thus, we find, as we did in Koskela, that there was a low risk of erroneous deprivation of her interest in PTD benefits. Accordingly, although ORS 656.283(7) affords less process than was previously available, we are not persuaded that the statutory limitation violates claimant's right to due process under the Fourteenth Amendment to the U.S. Constitution.

Permanent Total Disability

ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." Claimant contends that she is entitled to permanent total disability (PTD) under the "odd-lot" doctrine. Under that doctrine, a disabled person with some residual physical capacity may still be permanently and totally disabled due to a combination of her physical condition and nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market. Clark v. Boise Cascade Co., 72 Or App 397 (1985). However, unless claimant's physical incapacity in conjunction with her nonmedical factors renders a work search futile, she must also establish that she has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988). 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).

This record does not establish that, but for the compensable injury, claimant is willing to seek regular and gainful employment or that she has made reasonable efforts to obtain employment. Although possible jobs have been identified within claimant's limitations, claimant has made no efforts to obtain employment. Moreover, some vocational evidence in the record suggests that claimant is unwilling to return to work. Accordingly, on this record, claimant has not established that she is willing to seek employment. Under such circumstances, we find that claimant has not established entitlement to PTD benefits.

Extent of Scheduled and Unscheduled Permanent Disability

Claimant raises no specific arguments on review regarding scheduled and unscheduled permanent disability. At hearing, however, claimant sought increases in her scheduled and unscheduled awards.

We have reviewed the Appellate Reviewer's explanatory notes and the impairment findings concurred in by the attending physician. After reviewing the Department's calculations, we agree with the Order on Reconsideration's awards of scheduled and unscheduled permanent disability. Accordingly, we affirm the Order on Reconsideration awards of scheduled and unscheduled permanent disability.

Rate of Scheduled Permanent Disability

At hearing, claimant also raised the rate of scheduled permanent disability. SAIF, through its counsel, conceded that if claimant's permanent disability was not increased, the rate at which the award is paid should be increased. (Tr. 3). Accordingly, we accept SAIF's concession, and direct that the Order on Reconsideration's award of scheduled disability be paid at the higher rate.

ORDER

The ALJ's order dated April 25, 1995 is reversed. The Order on Reconsideration is affirmed. The ALJ's "out-of-compensation" attorney fee award also is reversed.

In the Matter of the Compensation of
**SERAFIN C. LOPEZ, Claimant**
WCB Case No. 95-13600
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
John M. Pitcher, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that increased claimant's scheduled permanent disability for loss of use or function of the left knee from 5 percent (7.5 degrees) as awarded by an Order on Reconsideration, to 19 percent (28.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," and offer the following summary.

In 1989, claimant suffered a left knee injury off work. On July 26, 1989, Dr. Poulson repaired a rim tear of the left lateral meniscus. During claimant's post-surgery rehabilitation, claimant's physical therapist reported right knee joint noise and pain.

On June 9, 1994, claimant sustained a compensable left knee twisting injury at work. On March 13, 1995, Dr. Roberts performed a left knee arthroscopy and meniscectomy. After a closing examination, Dr. Roberts noted that claimant had full range of motion, no effusion, and no medial joint tenderness. He opined, "The only impairment [claimant] has is loss of a portion of his medial meniscus." (Ex. 6).

A July 17, 1996 Determination Order closed the claim and awarded 5 percent scheduled permanent disability. Claimant requested reconsideration and a medical arbiter was appointed.

Dr. Neumann, medical arbiter, noted that claimant believed that he had "returned to the status of his knee just prior to the injury of September 6, 1994 [sic]" and that he was working full time without restrictions. (Ex. 9-4). Dr. Neumann measured claimant's left knee range of motion and reported 120 degrees and zero degrees extension. The findings were considered valid. Dr. Neumann also opined that, although claimant did have limited use of his left knee, it was due to the 1989 injury rather than the 1994 injury. (Id.).

## CONCLUSIONS OF LAW AND OPINION

### Range of Motion

The ALJ found claimant entitled to a rating of 11 percent for lost left knee range of motion, based on the medical arbiter's measurements, application of OAR 436-035-0007(22), and a finding that claimant's right knee had a history of injury or disease. We disagree.

OAR 436-035-0007(22) provides, in pertinent part: "The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease."

We have interpreted a similar rule (former OAR 436-35-007(16)) to require evidence of injury or disease to the contralateral joint sufficient to preclude a comparison of that joint to the injured body part, before the contralateral joint comparison rating method is bypassed. See William L. Fishbach, 48 Van Natta 1233 (1996); see also OAR 436-035-0007(22)(b).

Here, the only evidence indicating prior injury to claimant's right knee is a 1989 physical therapist's report indicating right knee dysfunction and pain. (Ex. 2A). However, in the absence of persuasive medical evidence indicating that claimant's right knee does have a history of injury or disease, we find the therapist's 1989 report, without more, is insufficient to establish that claimant's right knee "has a history of injury or disease" for purposes of rating his left knee impairment under

OAR 436-035-0007(22). Under these circumstances, we conclude that claimant's left knee range of motion is properly rated by comparing it to his right knee. Thus, because claimant's range of motion is the same in both knees, he is not entitled to a rating on this basis under the standards. (Ex. 9-3-4). See Fishbach, 48 Van Natta at 1233.

Chronic Condition

The ALJ declined to rely on Dr. Neumann's opinion that claimant's limited use of his left knee results from the 1989 off-work injury, rather than the 1994 work injury, because it was based on claimant's opinion that his knee had returned to its pre-1994 injury status by the time of the arbiter's examination. (See Ex. 9-4). The ALJ stated, "In spite of [Dr. Neumann's] express comments, I find the doctor's other statements actually compel a decision that claimant does have an inability to repetitively use his left knee and that it stems from his accepted condition." (Opinion and Order, p.5). We disagree.

To be entitled to permanent disability compensation for a scheduled chronic condition, claimant must establish, by a preponderance of persuasive medical evidence, that he is significantly limited in the repetitive use his left knee due to a chronic medical condition. See OAR 436-035-0010(5). 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 those findings as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550 (1997). However, where the 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).

In this case, Dr. Roberts, treating surgeon, opined that the only injury-related impairment claimant has is loss of a portion of his medial meniscus. (Ex. 6). Dr. Neumann, medical arbiter, opined that claimant's left knee chronic condition results from the 1989 off-work injury, not the 1994 injury. We find these opinions consistent with one another and persuasive. Under these circumstances, claimant has not established entitlement to a rating for a chronic left knee condition under this claim.

ORDER

The ALJ's order dated August 26, 1996 is reversed. The Order on Reconsideration, which awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left knee, is affirmed. The ALJ's attorney fee award is reversed.

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In the Matter of the Compensation of
**LARRY D. NORTHEY, Claimant**
WCB Case No. 96-08182
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) awarded claimant temporary disability benefits from January 13, 1995 through August 23, 1995; (2) awarded temporary disability benefits from May 23, 1996 through August 25, 1996; (3) assessed a penalty for the insurer's unilateral termination of temporary disability payments on May 23, 1996; (4) assessed a penalty for the insurer's failure to pay compensation timely from January 13, 1995 through August 23, 1995; and (5) awarded attorney fees out of the increased award of compensation. On review, the issues are temporary disability, penalties 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 changes. We change the last two paragraphs of the findings of fact to read:

> "On April 25, 1996, Dr. Johnson testified that claimant had not been able to perform his regular work since his 1994 injury. (Ex. 19A).
>
> "By Opinion and Order dated July 9, 1996 in WCB No. 96-00461, a prior ALJ found that '[e]ver since his injury on October 11, 1994, [claimant] has had constant low back pain and he has been unable to return to his regular work.' (Ex. 20-2)."

## CONCLUSIONS OF LAW AND OPINION

Temporary Disability from January 13, 1995 through August 23, 1995

Claimant injured his low back on October 11, 1994. On December 9, 1994, Dr. Johnson reported: "Work release given to [claimant] for NO WORK temp. until seen by Dr. Nancey Maloney for continued care/rehab." (Ex. 7-1). He indicated that claimant's condition was not improving. Dr. Johnson reported:

> "I think at this point the best direction for him to go would be to a rehab physician. Ongoing pain control may be a problem. The biggest problem I see is him returning to work. Dr. MacCloskey had taken him off work. I would honor this and I would continue his off work status until he has a chance to see Dr. Maloney or Stewart. I will be referring the patient for their ongoing care and I will request changing physicians at that time." (Ex. 7-2).

The ALJ found that the purpose of Dr. Johnson's December 9, 1994 time loss authorization was to extend the time loss authorization to allow the consulting physician to make recommendations. The ALJ found that, although Dr. Maloney suggested a return to modified work, the employer did not offer any modified work. The ALJ reasoned that Dr. Johnson's December 1994 report did not indicate an expected end of disability, but merely a continuing disability that could be modified by new information from the consulting physician. The ALJ concluded that Dr. Johnson did not "cease" to authorize time loss during the period from January 23, 1995 through August 23, 1995.

The insurer argues that the ALJ erred by concluding that Dr. Johnson's December 9, 1994 time loss authorization was open-ended. The insurer asserts that claimant's entitlement to time loss ended on January 25, 1995, the day he saw Dr. Maloney.

Under ORS 656.262(4)(a), an attending physician authorizes the payment temporary disability compensation. There is no dispute that Dr. Johnson was claimant's attending physician.

Dr. Johnson first examined claimant on November 25, 1994, and authorized a work release for two weeks. (Ex. 5). As we mentioned earlier, Dr. Johnson authorized a work release on December 9, 1994 "until seen by Dr. Nancey Maloney for continued care/rehab." (Ex. 7-1). Dr. Johnson stated that he was continuing Dr. MacCloskey's "off-work" status "until [claimant] has a chance to see Dr. Maloney or Stewart." (Ex. 7-2). Dr. Johnson planned to refer claimant to one of those physicians and he anticipated claimant would change physicians. (Id.)

Dr. Johnson's statements that claimant's time loss was authorized "until" claimant saw either Dr. Maloney or Stewart indicated that time loss was authorized only until that time. (Ex. 7). Dr. Johnson's December 9, 1994 chart note indicated that he was limiting the duration of the time loss because he was referring claimant to Dr. Maloney or Stewart for ongoing care. (Ex. 7-2). Furthermore, Dr. Johnson anticipated that claimant would request a change of attending physicians as a result of the referral. (Id.) Under these circumstances, we are not persuaded by claimant's argument that Dr. Johnson's December 9, 1994 time loss authorization was "open-ended." Rather, Dr. Johnson's time loss authorization was effective only until claimant saw Dr. Maloney on January 25, 1995. (Ex. 10). We conclude that claimant was not entitled to any temporary disability compensation from January 25, 1995

through August 23, 1995.[1] However, claimant is awarded temporary disability for January 13, 1995 to January 24, 1995.

We agree with the insurer that Dr. Johnson's subsequent time loss authorization on August 24, 1995 was not retroactive. On August 24, 1995, Dr. Johnson released claimant for "TEMP NO WORK." (Ex. 16-1). On that date, Dr. Johnson recommended a facet block at L5-S1 and he reported that claimant "is also being taken off work at this time as he simply can't perform the duties without a significant amount of pain at this juncture." (Id.) Dr. Johnson's reference to claimant's inability to perform his duties because of pain "at this juncture" refers to claimant's condition as of August 24, 1995. We do not construe Dr. Johnson's time loss authorization on August 24, 1995 as retroactive.[2]

The ALJ awarded penalties for the insurer's failure to pay temporary disability compensation timely for the period from January 13, 1995 through August 23, 1995. Since we have determined that claimant is not entitled to temporary disability compensation from January 25, 1995 through August 23, 1995, we reverse the ALJ's assessment of penalties for that time period.

The question remains as to whether claimant is entitled to penalties for the period from January 13, 1995 to January 24, 1995. 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).

As we discussed earlier, Dr. Johnson's December 9, 1994 time loss authorization was effective until claimant saw either Dr. Maloney or Stewart. Claimant saw Dr. Maloney on January 25, 1995. We are not persuaded that the insurer had a legitimate doubt of its liability for temporary disability compensation for the period from January 13, 1995 to January 24, 1995. Therefore, we assess penalties for that time period.

Temporary Disability from May 23, 1996 through August 25, 1996

As we discussed above, Dr. Johnson authorized time loss on August 24, 1995. (Ex. 16-1). On September 14, 1995, Dr. Johnson authorized time loss for two more weeks. (Ex. 16-2). On October 16, 1995, Dr. Johnson reported: "[Claimant] MAY NOT RETURN TO WORK. THIS RESTRICTION IS TEMPORARY. NEXT APPT: PENDING SURGERY AUTHORIZATION." (Id.) On that date, Dr. Johnson reported that claimant would benefit from a fusion at L5-S1. (Ex. 16-3).

On April 22, 1996, Dr. Johnson reported that "[w]e did not change [claimant's] work status today." (Ex. 19-1). Dr. Johnson commented that claimant wanted surgery. (Id.) Dr. Johnson also reported that claimant was given a temporary "no work" restriction. (Ex. 19-2).

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[1] In light of our conclusion, we need not address the insurer's argument that the August 7, 1995 stipulation barred claimant from raising the issue of procedural time loss for any period prior to the effective date of the stipulation.

Similarly, since we have determined that Dr. Johnson's December 1994 time loss authorization was not open-ended, we need not address claimant's argument that OAR 436-060-0020(11) applies to this case. OAR 436-060-0020(11) (WCD Admin. Order No. 96-053) provides: "If a denied claim has been determined to be compensable, the insurer shall begin temporary disability payments pursuant to ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability."

[2] Since we have determined that Dr. Johnson's August 24, 1995 time loss authorization was not retroactive, we need not address the insurer's alternative argument under ORS 656.262(4)(f) that, if the August 24, 1995 time loss authorization was retroactive, claimant would only be entitled to temporary disability compensation beginning August 10, 1995. In any event, as claimant points out, ORS 656.262(4)(f) applies to open claims. See Kenneth P. Bundy, 48 Van Natta 2501 (1996). Since the disputed time loss accrued while the claim was in denied status, ORS 656.262(4)(f) does not apply.

The stipulated facts indicate that the workers' compensation clerk in Dr. Johnson's office communicated to the insurer's claims examiner that time loss was authorized for 30 days beyond April 22, 1996. The insurer terminated claimant's temporary disability benefits on May 22, 1996, based in part on that information.

The ALJ found that the workers' compensation clerk in Dr. Johnson's office did not have the legal capacity to offer legal or medical opinions about the doctor's notes. The ALJ rejected the insurer's argument that Dr. Johnson's time loss authorization expired at the end of thirty days.

The insurer argues that it is reasonable to interpret Dr. Johnson's reference to a "temporary restriction of no work" to mean 30 days. We disagree.

Pursuant to ORS 656.262(4)(a), only the attending physician may authorize temporary disability compensation. Thus, we do not consider it reasonable for the insurer to have relied on comments from Dr. Johnson's workers' compensation clerk in determining claimant's time loss status. Moreover, although Dr. Johnson referred to the work restriction as "temporary," there is no evidence from Dr. Johnson indicating that he intended the work restriction to be effective for only 30 days. Rather, Dr. Johnson's reference to a "temporary" work restriction indicated that claimant's condition would not permanently restrict him from going back to work. In an earlier report, Dr. Johnson had indicated that claimant would benefit from a fusion at L5-S1. (Ex. 16-3). His April 22, 1996 chart note indicated that claimant wanted surgical treatment for his back. (Ex. 19-1). Under these circumstances, we are not persuaded that it is reasonable to interpret Dr. Johnson's reference to a "temporary restriction of no work" to mean 30 days. Instead, we agree with the ALJ that Dr. Johnson's April 22, 1996 work restriction was not limited to 30 days.

Penalties re: May 1996 Termination of Compensation

The ALJ concluded that the insurer's termination of compensation on May 22, 1996 was unreasonable and, therefore, claimant was entitled to penalties.

The insurer contends that penalties are not warranted because it had a legitimate doubt about its liability based on the information received from Dr. Johnson's workers' compensation clerk.

As mentioned earlier, ORS 656.262(4)(a) provides that only the attending physician may authorize temporary disability compensation. There is no evidence in the record from Dr. Johnson, the attending physician, indicating that he intended the work restriction to be effective for only 30 days. According to the stipulated facts, the insurer's claims examiner could have scheduled an appointment with Dr. Johnson to clarify the duration for the work restriction. Under these circumstances, we are not persuaded that the insurer had a legitimate doubt about its liability for the temporary disability benefits. Consequently, we affirm the ALJ's penalty assessment concerning the insurer's unilateral termination of temporary disability effective May 22, 1996.

## ORDER

The ALJ's order dated December 13, 1996 is modified in part and affirmed in part. In lieu of the ALJ's temporary disability award between January 13, 1995 and August 23, 1995, claimant is awarded temporary disability for January 13, 1995 to January 24, 1995. Claimant's "out-of-compensation" attorney fee and the ALJ's penalty assessment for that period shall be modified accordingly. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
**VIRGIL A. RAY, Claimant**
WCB Case No. 96-02940
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that awarded temporary disability from June 1, 1995 through July 26, 1995. On review, the issue is temporary disability. We reverse.

## FINDINGS OF FACT

We adopt the parties' stipulated facts as set forth in the ALJ's order.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable lumbosacral injury on October 8, 1990. The claim was last closed by a May 25, 1995 Determination Order which awarded temporary disability benefits from December 1, 1993 through March 20, 1995 and found claimant medically stationary on March 20, 1995. Dr. Maurer, claimant's attending physician, referred him to a urologist, Dr. Bulkly, on May 8, 1995, after claimant developed symptoms of loss of bladder and bowel control. Drs. Bulkly and Maurer shared the concern that claimant's symptoms might not be attributable to a focal L5-S1 lesion, raising the possibility of multiple sclerosis or brain injury. Dr. Maurer referred claimant to Dr. Sullivan, a neurologist. On June 15, 1995, Dr. Maurer wrote the following letter to the insurer:

> "To Whom it May Concern:
>
> "I am asking [claimant's] claim be reopened given new symptoms and findings that have emerged over the last two weeks. It has been two weeks ago that [claimant] developed bladder symptoms that have been suggestive of a neurologic problem. He is currently in a diagnostic work-up by Dr. Bulkly, an Ashland urologist, to sort these symptoms out.
>
> "I feel it is also imperative that Mr. Ray again be seen by Dr. Sullivan as it may be related to his initial closed head trauma. If there are questions in this regard, please advise."

On July 27, 1995, Dr. Maurer wrote the following letter:

> "To Whom it May Concern;
>
> "* * * * *
>
> "[Claimant] in my opinion has experienced a worsening in his condition that is felt to be related to his work-incurred injury.
>
> "Specifically, [claimant] developed symptoms of loss of urinary bladder control which, in the fact of his previously demonstrated neurologic loss of bowel control, strongly suggested worsening of his underlying neurologic condition and warranted additional evaluation. It was because of this worsening that his claim was requested to be reopened so that appropriate urologic and neurologic assessment could be made in light of these changes. "Please advise if there are any questions regarding this request for reopening of [claimant's] workers' compensation claim."

The insurer received Dr. Maurer's July 27, 1995 letter on August 4, 1995 and resumed time loss payments on August 10, 1995 for the period from July 27, 1995 through August 3, 1995 and made substantially timely payments of time loss thereafter. On August 24, 1995, Dr. Maurer signed a form

2837, Notice of Claim for Aggravation authorizing time loss from June 1, 1995. On September 15, 1995, the insurer accepted claimant's aggravation claim, as well as an additional condition of L5-S1 disc herniation. The insurer amended its acceptance to include fecal incontinence on July 16, 1996. As of the date of the ALJ's order, the claim remained open.

The ALJ found that claimant's attending physician, Dr. Maurer, authorized temporary disability in the June 15, 1995 letter to the insurer. On this basis, the ALJ awarded temporary disability from June 1, 1995 to June 26, 1995. The insurer asserts that Dr. Maurer's June 15, 1995 letter does not address claimant's ability or inability to work and does not amount to an authorization of time loss for purposes of ORS 656.262(4)(f). Claimant argues that "magic words" are unnecessary and that Dr. Maurer's letter was sufficient to constitute an authorization of time loss.

A claimant's entitlement to temporary disability for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician. ORS 656.262(4)(f); Gerald A. Zeller, 48 Van Natta 501, on recon 48 Van Natta 735 (1996).

Here, we agree with the insurer that Dr. Maurer's June 15, 1995 letter is not sufficient as a time loss authorization. In this regard, it does not address whether claimant is disabled from working. At most, the June 15, 1995 letter indicates that claimant has new symptoms which require a diagnostic work-up. The letter does not, however, authorize temporary disability or state that claimant has been taken off work or is unable to work. Under such circumstances, we reverse the ALJ's order awarding time loss from June 1 through June 26, 1995.

We note that our conclusions pertain only to claimant's entitlement to procedural temporary disability during an open claim. Although a worker's procedural entitlement to temporary disability is contingent on the attending physician's authorization, substantive entitlement to temporary disability is determined at claim closure and is proven by a preponderance of the evidence in the entire record showing that the worker was disabled due to the compensable claim before being declared medically stationary. Shannon M. Oliver, 48 Van Natta 386 (1996).[1]

ORDER

The ALJ's order dated November 25, 1996 is reversed.

[1] Although a signatory to this order, Member Moller directs the parties to his dissenting opinion in Kenneth P. Bundy, 48 Van Natta 2501 (1996), as regards the dicta in this order that discusses claimant's partial future entitlement to substantive temporary disability.

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In the Matter of the Compensation of
**VERONICA M. STRACKBEIN, Claimant**
WCB Case No. 96-03694
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that: (1) held that a "post-reconsideration" medical report from claimant's prior attending physician was admissible at hearing; and (2) granted permanent total disability, whereas an Order on Reconsideration did not award unscheduled permanent disability beyond the 15 percent (48 degrees) that claimant had been previously granted. On review, the issues are evidence, permanent total disability and, potentially, unscheduled permanent disability. We reverse and reinstate the April 2, 1996 Order on Reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. However, we offer the following brief summary of the background of the claim.

On September 3, 1985, claimant was compensably injured in a motor vehicle accident (MVA), an injury that SAIF accepted as a cervical and lumbar strain. (Ex. 30). The claim was initially closed on April 27, 1987 by Determination Order that awarded no permanent disability. However, a September 22, 1987 stipulation awarded claimant 15 percent unscheduled permanent disability. (Ex. 64).

Claimant consulted Dr. Mirka, a neuro-otologist, in May 1987 for symptoms of dizziness and imbalance. Dr. Mirka diagnosed a probable inner ear concussion syndrome. (Ex. 57). After experiencing cognitive, memory and concentration difficulties, claimant sought treatment in May 1990 from a neuropsychiatrist, Dr. Erickson, who diagnosed an adjustment reaction with anxiety and depression; moderate impairment of recent memory and new learning; and cannabis dependence. (Ex. 81). Dr. Erickson attributed claimant's cognitive and memory deficits to a post-concussive syndrome related to the 1985 MVA. (Ex. 86A).

In the meantime, the claim had been reopened in November 1989. It was reclosed in August 1990 by Determination Order that awarded only temporary disability. (Ex. 85). That closure was set aside in October 1992 by a prior ALJ who held that the inner ear concussion syndrome and adjustment reaction with anxiety and depression were compensable components of the 1985 claim. (Ex. 107). The prior ALJ, however, found that any visual dependence, memory loss, concentration or cognitive difficulties related to marijuana use and/or noncompensable psychological conditions were not compensable aspects of the claim. (Ex. 107-13). In addition, the prior ALJ found several ear disorders (perilymph fistual, endolymphatic hydrops, BPPN/BPPV, tinnitus) were not compensable components of the claim. The prior ALJ's order was not appealed and became final.

In October 1992, an osteopath, Dr. Tobin, became claimant's attending physician. Dr. Tobin began aggressive osteopathic manipulation of claimant's cranium for a closed head injury related to the September 1985 MVA. (Ex. 108B). The claim was eventually reclosed by Determination Order on November 16, 1995 with no award of permanent disability. Claimant requested reconsideration for which a panel of medical arbiters was appointed. On April 2, 1996, an Order on Reconsideration issued affirming the Determination Order. (Ex. 128). Claimant requested a hearing seeking an award of permanent total disability.

## CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant was permanently and totally disabled, finding that the medical and vocational evidence established that claimant was precluded from regularly performing any work at a gainful and suitable occupation. The ALJ then addressed the issue of whether claimant's disability was due to injuries sustained in her compensable September 1985 MVA.

The ALJ noted the prior ALJ's order which determined that an inner concussion syndrome and an adjustment disorder with anxiety and depression were compensable components of the claim. Reasoning that there had been no significant change in claimant's condition since the prior ALJ's final order, the ALJ concluded that claimant's current disability was due to the compensable injury. See Harry L. Lyda, 48 Van Natta 1300 (1996).

In determining the permanent total disability issue, the ALJ also admitted into evidence a July 21, 1996 medical report from claimant's former attending physician, Dr. Erickson, issued after the April 2, 1996 Order on Reconsideration. (Ex. 129). The ALJ reasoned that the limitation on "post-reconsideration" medical evidence in ORS 656.283(7) did not apply in the context of permanent total disability.[1]

On review, SAIF contends that the ALJ incorrectly admitted Dr. Erickson's "post-reconsideration" medical report in violation of ORS 656.283(7). See George D. Koskela, 49 Van Natta 529 (1997) (rejecting constitutional challenges to retroactive application of ORS 656.283(7) in permanent

[1] ORS 656.283(7) provides, in relevant part:

"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, 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."

total disability context); Neil A. Laufer, 49 Van Natta 26, recon 49 Van Natta 146 (1997) citing Virginia McClearen, 48 Van Natta 2536 (1996) (statutory evidentiary exclusion in amended ORS 656.283(7) applies to hearings concerning permanent total disability). SAIF also asserts that the ALJ erroneously awarded claimant permanent total disability, because her permanent disability, if any, is not related to her 1985 MVA.

Consistent with the Koskela and Laufer holdings, the "post-reconsideration" report is inadmissible at hearing under ORS 656.283(7). Nonetheless, even if we considered Dr. Erickson's "post-reconsideration" medical report, we would still find that claimant is not permanently and totally disabled. That is, considering the reconsideration record, as well as Dr. Erickson's "post-reconsideration" medical report, we conclude that claimant has failed to prove that the alleged disability on which the claim of permanent total disability is based is due to her compensable 1985 injury.

ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." In order to establish permanent total disability, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). In determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by his compensable injury. See Darlene E. Parks, 47 Van Natta 2404, 2408 (1995), recon den 48 Van Natta 190 (1996) (the claimant must prove that his or her permanent total disability is due to her compensable injury). Subsequent, noncompensable conditions are not considered. Elder v. Rosboro Lumber Co., 106 Or App 16 (1991); Emmons v. SAIF, 34 Or App 603 (1978).

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994). Impairment findings from a physician, other than the attending physician, may be used, however, if those findings are ratified by the attending physician. Tektronix, Inc. v. Watson, 132 Or App 483 (1995). Consequently, in assessing the extent of claimant's permanent disability arising out of the 1985 injury, we consider the reports of claimant's attending physician, Dr. Tobin, the medical arbiters' reports and any report related to claimant's impairment that was ratified by the attending physician.[2] See Tektronix, Inc. v. Watson, supra, 132 Or App at 486.

Here, Dr. Tobin, claimant's attending osteopathic physician, declared claimant medically stationary on September 25, 1995 with diagnoses of a whiplash injury and strain/sprain of the cervical spine; post-concussive syndrome from a head injury; vertigo secondary to the MVA/injury; migraine cephalgia (mostly resolved); and resolved inner ear concussion. (Ex. 117). Based on the residuals of those injuries, Dr. Tobin recommended that claimant work at home for four to six hours and take 15 to 30 minute breaks each hour. Dr. Tobin restricted claimant to sedentary work, with no lifting over 20 pounds and no repeated bending, twisting, pushing or pulling. Id.

SAIF had claimant examined by Drs. Brown and Binder. Dr. Brown disagreed with Dr. Tobin's diagnosis of a post-concussive syndrome due to a closed head injury. (Ex. 114-12). Characterizing this as "one of the most astounding cases of pure psychiatric disturbance being interpreted as organic pathology," Dr. Brown concluded that claimant had no permanent impairment as a result of the 1985 MVA. (Ex. 114-14). Dr. Binder reached a similar conclusion, stating that claimant was capable of regular work and opining that claimant had no permanent impairment as a result of the industrial accident. (Ex. 115-16).

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[2] SAIF cites "pre-reconsideration" medical reports from the examining physicians, Drs. Binder and Brown, that address the issue of whether claimant's disability is related to her compensable injury. (Exs. 114, 115). However, Dr. Tobin, claimant's attending physician, did not concur with either report and, in fact, vigorously disagreed with the reasoning and conclusions of both doctors. (Ex. 117). Therefore, we are not inclined to consider either of those reports on review. Cf. David B. Weirich, 47 Van Natta 478 (1995) (Other than certain incomplete arbiter report exceptions, ORS 656.268(7) precludes the admission at hearing of "post-reconsideration" medical evidence, whether it concerns impairment or causation of impairment). However, we need not decide whether "pre-reconsideration" medical reports (not ratified by the attending physician) which address causation of impairment may be considered in determining permanent total disability. That is, regardless of whether we considered the medical reports of Drs. Binder and Brown, we would still conclude that claimant's current disability is not related to her compensable 1985 injury.

In response, Dr. Tobin insisted that claimant's symptoms were legitimate and organically based. Moreover, Dr. Tobin reiterated her opinion that claimant sustained a "minor" head injury during the 1985 MVA based on the results of her manipulation of claimant's cranium, as well as the fact that claimant's symptoms were consistent with a head injury and that claimant did not display her symptoms prior to the MVA. (Ex. 117A).

A three-physician medical arbiter panel examined claimant on March 12, 1996 as part of the reconsideration process. An orthopedic surgeon, Dr. Scheinburg, diagnosed chronic pain involving claimant's head, shoulder girdles, thoracic and lumbar spines, gluteal areas,and both lower extremities, the etiology of which was undetermined. (Ex. 125-6). Dr. Scheinburg stated that there were no objective findings to substantiate claimant's complaints, concluding that his findings were not valid for rating purposes. (Ex. 125-7).

Dr. Stoner, an otolaryngologist, opined that claimant's dizziness, myofascial pain and "perhaps" memory loss were reasonable conditions to attribute to the 1985 accident. (Ex. 126-3). However, claimant's "emotional liability (sic)" and inability to cooperate with the examination compromised Dr. Stoner's findings. Id.

Dr. Burt, a psychiatrist, reported that claimant's history was not consistent with a post-concussive syndrome. He concluded that claimant had no psychiatric impairment related to the compensable injury. (Ex. 127-13).

Under OAR 436-035-0007(13), on reconsideration, impairment is determined by a medical arbiter where one is used "except where a preponderance of medical evidence establishes a different level of impairment." The disability standards define "preponderance of medical evidence" as meaning "the more probative and more reliable medical opinion based upon the most accurate history, on the most objective principles and expressed with clear and concise reasoning." OAR 436-035-0005(10). See also Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

In this case, we do not find a different level of impairment from that established by the medical arbiter panel. Dr. Scheinburg concluded that the etiology of claimant's chronic complaints was unknown and Dr. Burt concluded that claimant had no psychiatric impairment due to the compensable injury. Although Dr. Stoner opined that some of claimant's symptoms could be related to the compensable injury, his findings were compromised by claimant's lack of cooperation with the examination. Based on our de novo review of the medical arbiter's reports as a whole, we do not find that they support a conclusion that claimant's impairment, if any, is related to the compensable injury.

We recognize that claimant's attending physician, Dr. Tobin, has maintained that claimant's symptoms are related to a "minor" closed head injury allegedly sustained during the MVA. However, we are not persuaded by Dr. Tobin's medical opinion. First, Dr. Tobin does not address the impact of claimant's long-term marijuana use on her symptomatology. Moreover, Dr. Tobin provides no satisfactory explanation of how claimant's "minor" head injury (even assuming that claimant struck her head during the September 1985 MVA) is still responsible for claimant's symptoms more than 10 years after the MVA. In addition, we find that Dr. Tobin's opinion relies too heavily on the temporal relationship between claimant's alleged symptoms of a closed head injury and the MVA. See Allie v. SAIF, 79 Or App 284 (1986). Because Dr. Tobin's opinion is not well-reasoned, we do not find that it constitutes a preponderance of evidence establishing a different level of impairment from that established by the medical arbiters, nor do we find that it establishes that claimant's current impairment is related to the compensable 1985 injury.[3]

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[3] We note that SAIF agreed to pay claimant 15 percent unscheduled permanent disability in a September 1987 stipulation. (Ex. 64). Moreover, Dr. Tobin opined that "perhaps" some of claimant's symptoms "could actually come from the compensable neck injury." (Ex. 117A-13). However, we are not persuaded by this aspect of Dr. Tobin's opinion because it is expressed in terms of medical possibility, not probability. Gormley v. SAIF, 52 Or App 1055 (1981). In addition, it is clear from Dr. Tobin's reports that her primary position is that claimant's alleged "minor" closed head injury is responsible for claimant's disability. Inasmuch as claimant's current claim for permanent total disability is based on a post-concussion syndrome due to an alleged head injury, and because we are not persuaded that the symptoms allegedly related to that condition are "due to" the compensable injury, we do not find that claimant's disability is related to the compensable injury.

As previously noted, Dr. Erickson submitted a "post-reconsideration" medical report that attributed claimant's current complaints to an inner ear concussion syndrome caused by the compensable injury. (Ex. 129). SAIF objects to consideration of Dr. Erickson's report, alleging that the ALJ's admission of this report violated the limitation on "post-reconsideration" evidence in ORS 656.283(7). However, we do not find it necessary to address the admissibility of Dr. Erickson's report. That is, even if we were to consider this report, we would find it is not persuasive evidence linking claimant's current disability to her compensable injury.

We agree with SAIF that Dr. Erickson fails to provide a satisfactory explanation of why he believes that claimant's vestibular complaints are related to an inner ear disorder, rather than non-compensable psychological conditions. Specifically, Dr. Erickson also depends on a temporal relationship between the onset of claimant's symptoms and the September 1995 MVA. Allie v. SAIF, supra. For these reasons, we would not find Dr. Erickson's opinion persuasive.

In conclusion, we find that claimant's current disability is not related to her compensable 1985 injury.[4] Based on claimant's compensable injury (cervical and lumbar strains, innner ear concussion syndrome and adjustment disorder with anxiety and depression) and any preexisting disability, we are not persuaded that claimant is permanently incapacitated from regularly performing gainful employment. Therefore, we reverse the ALJ's decision to award permanent total disability.[5]

ORDER

The ALJ's order dated September 9, 1996 is reversed. The April 2, 1996 Order on Reconsideration is affirmed.

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[4] The ALJ relied on our decision in Harry L. Lyda, supra, in finding that claimant's disability is related to the compensable 1985 injury. In Lyda, we held that, before a denial of a "combined" or "consequential" condition can be issued pursuant to ORS 656.262(6)(c), there must be a change in the claimant's condition or a change in circumstances. Unlike Lyda, no denial has been issued pursuant to ORS 656.262(6)(c). Moreover, there is no evidence that claimant's alleged head injury is a "combined" or "consequential" condition. For these reasons, we do not find Lyda applicable to this claim.

[5] At hearing, claimant alternatively argued for an award of unscheduled permanent disability based on the presence of an alleged "chronic condition." We decline to award claimant additional unscheduled permanent disability given our conclusion regarding the causation issue. Moreover, the medical arbiter, Dr. Scheinburg, opined that claimant did not have objective evidence of a loss of ability to repetitively use the cervical or lumbar spine due to a chronic or permanent medical condition. (Ex. 125-7). Accordingly, we conclude that the medical record does not support a finding of a "chronic condition" due to claimant's compensable 1985 injury.

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In the Matter of the Compensation of
**JULIA A. WATSON, Claimant**
WCB Case No. 96-08597
ORDER ON REVIEW
Cole Cary & Wing, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that reduced claimant's scheduled permanent disability award for loss of use or function of the left arm from 7 percent (13.44 degrees) to 3 percent (5.76 degrees) and scheduled permanent disability award for loss of use or function of the right wrist from 5 percent (7.5 degrees) to zero. On review, the issue is extent of scheduled permanent disability.

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

We agree with claimant that the SAIF Corporation, as the party requesting a hearing from the Order on Reconsideration, had the burden of proof. Roberto Rodriguez, 46 Van Natta 1722, 1723 (1994); Maria Jolley, 48 Van Natta 2316 (1996). In particular, SAIF had the burden to show by a preponderance of evidence that the standards were incorrectly applied in the reconsideration proceeding. See ORS 656.283(7). Based on the ALJ's reasoning, SAIF carried its burden. See David A. Kamp, 46 Van Natta 389, 390 (1994) (no chronic condition award when record showed only work limitations imposed to avoid likelihood of reinjury).

ORDER

The ALJ's order dated January 13, 1997 is affirmed.

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June 27, 1997 Cite as 49 Van Natta 885 (1997)

In the Matter of the Compensation of
**DAVID D. WESCHENFELDER, Claimant**
WCB Case No. 95-09522
ORDER ON REVIEW
Richard O. Nesting, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denial of his claim for a low back injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not met his burden of proof in establishing compensability. We agree; however, we base our conclusion on the following reasoning.

On review, claimant argues that he has established a compensable injury.[1] Furthermore, claimant contends that, up until the point at which he exacerbated his injury at home, this is not a complex case requiring expert medical opinion.

The courts have set forth 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 was previously 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 above factors to this case, we are not persuaded that claimant's symptoms appeared immediately after a work incident in March 1995. Specifically, even accepting claimant's testimony that he felt some back pain during work, claimant continued to work and did not seek medical treatment. Claimant testified that, due to his job requiring heavy lifting, he had often had

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[1] On review, claimant apparently asserts that he sustained an accidental injury and the correct standard is a "material contributing cause standard" pursuant to ORS 656.005(7)(a). Notwithstanding claimant's contentions, there is evidence that claimant previously experienced back problems and both his treating doctor and his operating physician have responded to questions premised on the existence of a preexisting degenerative condition. (Exs. 21, 22). Because of our conclusion that claimant has failed to meet his burden of proving "medical causation" in this case, however, we find that under the facts of this case, claimant would fail to meet his burden of proof under either standard.

similar sensations. (Tr. 13). However, claimant testified that two or three weeks after feeling back pain at work, he sneezed at home and felt lower back pain which radiated into his leg. (Tr. 15). Following that incident, claimant called his doctor to tell him that he could not get out of bed or walk, and he needed to go to the hospital. (Tr. 19). Claimant testified that it was due to his first experiencing pain "going down my leg" which caused him to seek medical treatment. (Tr. 15).

We are similarly not persuaded that claimant immediately informed his supervisor about back pain occurring after a work incident in early March 1995. Rather, claimant testified that it was not until the at-home incident that he told his superior (who was also his father) that something was wrong with his back. (Tr. 15; Ex. 14).

There is also evidence that claimant was not previously free from the type of disability involved. Specifically, claimant had sought medical treatment for his low back and informed Dr. Brett that he "had some difficulties with low back pain for several years, occasionally radiating into the left buttock." (Ex. 15). Dr. Brett described claimant's most recent condition as low back pain radiating into the left buttock, thigh and calf.

Finally, we find that there is expert medical evidence that the alleged precipitating event could not have been the cause of the injury. Dr. Brett, who performed claimant's low back surgery, reported that a preexisting degenerative disc disease, rather than any work incident, was the major contributing cause of claimant's disability and need for treatment of the low back condition. (Ex. 21).

In light of our conclusions regarding the aforementioned factors, and the occurrence of an off-work incident which led to claimant's immediate need for treatment and his subsequent surgery, we find that this is a complicated situation which requires expert medical opinion. Here, two doctors, Dr. Tayor, claimant's treating doctor, and Dr. Brett, the physician who performed claimant's surgery, have both provided opinions regarding causation.

After reviewing the two medical opinions discussing causation, we find that neither doctor had a complete and accurate history with respect to either a work incident or the off-work incident. Dr. Taylor took a history of back pain which began at work without any trauma, and which then "progressed to pain that radiated down into his left leg and into the calf." (Ex. 8). There is no indication that Dr. Taylor was aware of the off-work incident, and there is no discussion of claimant's prior low back and left leg problems. Under such circumstances, we do not find Dr. Taylor's opinion to be either accurate or persuasive. See Somers v. SAIF, 77 Or App 259 (1986); Pamela A. Burt, 46 Van Natta 415 (1994) (The treating physician's opinion was rejected on the ground that he had not considered other possible causes of the claimant's condition. Because the claimant testified that she did some lifting at home that brought on her symptoms, and the doctor was unaware of those activities, the doctor was precluded from considering whether they could have contributed to the claimant's condition).

Finally, Dr. Brett also provided an opinion on causation. Dr. Brett's opinion was premised on a belief that there was no specific injury or event that precipitated claimant's symptoms. (Ex. 21). Furthermore, there is no indication that Dr. Brett was aware of the off-work incident. Moreover, Dr. Brett has attributed claimant's condition to a preexisting degenerative disc disease. Accordingly, Dr. Brett's opinion is not sufficient to establish compensability.

Therefore, because there is no persuasive medical opinion in the record which supports compensability, we conclude that claimant has failed to meet his burden of proof. Consequently, we affirm the order of the ALJ.

## ORDER

The ALJ's order dated November 22, 1996 is affirmed.

In the Matter of the Compensation of
**ROBERT H. YOUNGER, Claimant**
WCB Case Nos. 96-03047 & 96-02703
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

SAFECO requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's aggravation claim for his current right biceps tendon condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility.

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

On review, SAFECO acknowledges that ORS 656.308(1) is applicable and that, because it has a prior accepted claim involving the same condition, it has the burden of proving that the November 1995 injury while SAIF was on the risk is a new compensable injury.

Claimant's treating doctor, Dr. Weintraub, provided the only medical opinion regarding causation. Dr. Weintraub testified that the 1991 SAFECO injury was the major contributing cause of claimant's combined condition. Dr. Weintraub described the 1995 injury as a "precipitating event" which caused the immediate need for surgery.

In SAIF v. Nehl, 148 Or App 101 (1997), the court found that the "immediate" cause of the claimant's need for treatment was the work injury and, consequently, the treatment was compensable. Id. at 106. By itself, that holding in Nehl could arguably be interpreted as overruling the court's decision in Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995). However, we recently discussed this issue and found that Nehl did not overrule the major contributing cause standard set forth in Dietz. See Gregory C. Noble, 49 Van Natta 764 (1997).

In Noble, we concluded that Nehl held that a claimant is not required to prove that a work injury is the major contributing cause of the entire combined condition; rather, he or she must prove that the work injury is the major contributing cause of the need for treatment of the combined condition. We further found that, in reaching that compensability determination, the standard for proving major contributing cause, as articulated by Dietz, remains unchanged. Noble, 48 Van Natta at 767.

Here, we do not find that Dr. Weintraub's opinion can be construed as finding that the 1995 injury was the major contributing cause of the disability or need for treatment of the combined condition pursuant to ORS 656.005(7)(a)(B). Dr. Weintraub, claimant's treating doctor, explained that, in the subsequent 1995 accident while SAIF was on the risk, claimant "re-ruptured" the same area he had ruptured in the 1991 injury which was accepted by SAFECO. (Ex. 118). Additionally, Dr. Weintraub explained, and the record shows, that claimant continued to have problems following the 1991 injury and continued to receive treatment and medication for his condition after the initial injury and surgery.

Although Dr. Weintraub stated that the 1995 incident was the "precipitating cause" of claimant's need for treatment, he further explained that in the "overall picture" the major cause was the original tendon rupture. (Ex. 118-16). Dr. Weintraub testified that, after the initial injury, claimant's tendon was never normal and, therefore, the "major problem" was the original injury.

Consequently, we conclude that Dr. Weintraub's opinion does not establish that claimant's second injury while SAIF was on the risk, when weighed against his preexisting condition, was the major cause of claimant's disability or need for treatment of his combined condition. Accordingly, we affirm the ALJ's finding that SAFECO did not prove a "new injury" and, therefore, SAFECO remains responsible for claimant's right biceps tendon condition.

ORDER

The ALJ's order dated January 16, 1997 is affirmed.

In the Matter of the Compensation of
**LORRAINE M. ESTES, Claimant**
WCB Case No. 95-08326
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Bock.

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

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

We agree with the ALJ's conclusion that Dr. Ellison rendered the most persuasive opinion in the record. As the treating surgeon, he was in the unique position to observe claimant's shoulder pathology during surgery. For that reason, we defer to his opinion regarding the nature and causation of claimant's rotator cuff tear. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). In addition, Dr. Fuller misunderstood Dr. Ellison's operative findings to read that the rotator cuff tear appeared to be degenerative. (Ex. 31A, pp. 25-26). Dr. Ellison later testified that, upon examination of claimant's rotator cuff during surgery, it appeared to be "pretty healthy looking" and not degenerative. (Ex. 32, pp. 8, 13, 23). Because Dr. Fuller's opinion was based on inaccurate findings, it must be discounted.

Claimant's attorney is entitled to an assessed attorney fee for services on Board 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 attorney fee for claimant's attorney's services on review is $1,600, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 9, 1996 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,600, payable by the self-insured employer.

# WORKERS' COMPENSATION CASES

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Cite as 325 Or 112 (1997) March 27, 1997

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Lois J. Schoch, Claimant.
Lois J. **SCHOCH**, *Petitioner on Review,*
v.
**LEUPOLD & STEVENS** and Liberty Northwest Ins. Corp., *Respondents on Review.*
(WCB 92-09982; CA A87699; SC S42890)

On review from the Court of Appeals.*

Argued and submitted November 4, 1996.

Meagan A. Flynn, of Pozzi Wilson Atchison, Portland, argued the cause and filed the petition for petitioner on review.

David O. Wilson, Eugene, argued the cause and filed the response for respondents on review.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Graber, and Durham, Justices.

VAN HOOMISSEN, J.

The decision of the Court of Appeals is reversed. The case is remanded to the Workers' Compensation Board for reconsideration of the attorney fee.

* Judicial review from the Workers' Compensation Board. 137 Or App 633, 906 P2d 870 (1995).

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**325 Or 114>** Claimant petitions for review of a Court of Appeals' decision that affirmed an order of the Workers' Compensation Board (Board) awarding an attorney fee. She argues that the order does not contain sufficient information to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee. The Court of Appeals affirmed without opinion. *Schoch v. Leupold & Stevens*, 137 Or App 633, 906 P2d 870 (1995). For the reasons that follow, we reverse and remand to the Board for further consideration of its order awarding an attorney fee.

In 1990, claimant suffered a compensable low back injury. In 1992, Dr. Berkeley, her treating physician, requested authorization for surgery. Liberty Northwest Ins. Corp. (Liberty), the workers' compensation insurer, sought review of the proposed surgery by the Director of the Department of Consumer and Business Services. ORS 656.327(1) (1991) (since amended by Or Laws 1995, ch 332, § 41).[1] On July 16, 1992, the Director found that the proposed surgery was not appropriate. Claimant requested a hearing before the Hearings Division. In case number WCB 92-09982, the administrative law judge (ALJ) affirmed the Director, concluding that the decision was supported by substantial evidence. Claimant sought Board review of the ALJ's order. In 1993, the Board reversed and remanded, ruling on the basis of the law at the time that the Hearings Division, rather than the Director, had jurisdiction to resolve the dispute about the proposed surgery and, thus, that the Director's order was not controlling. The Board remanded the matter to the AL.J to permit the parties to litigate the case under the proper standard.

**325 Or 115>** Berkeley again sought approval to perform the same surgery on claimant. Liberty denied Berkeley's request. Claimant again sought a hearing before the Hearings Division. In 1994, in case number WCB 93-09584, the ALJ found that the surgery was reasonable and necessary and awarded

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[1] ORS 656.327(1) (1991) provided in part:

"(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual * * *, and wishes review of the treatment by the director, the injured worker, insurer or self-insured employer shall so notify the parties and the director.

"(b) * * * [T]he director shall review the matter as provided in this section."

an attorney fee of $10,500 under ORS 656.382(1)[2] and 656.386(1).[3] Liberty requested review of that portion of the order that awarded the attorney fee. The Board subsequently modified the order, awarding a $5,750 assessed fee under ORS 656.386(1) and a $2,000 assessed fee under ORS 656.382(1).

On remand of WCB 92-09982, Liberty advised the ALJ that it would not appeal the merits of the decision in WCB 93-09584 and that it was no longer contesting claimant's request for surgery. Liberty requested dismissal of WCB 92-09982, arguing that it had been rendered moot by the ALJ's decision in favor of claimant's proposed surgery in WCB 93-09584. The ALJ determined that the Director's 1992 order was invalid, because the Director did not have jurisdiction over the proposed surgery, but concluded that the ALJ's 1994 ruling authorizing surgery in WCB 93-09584 rendered further consideration of WCB 92-09982 moot and dismissed that case. The ALJ also denied claimant's request for an attorney fee. Claimant sought Board review, contending that she was entitled to an attorney fee under ORS 656.386(1) for litigating the Director's July 16, 1992 order.

In January 1995, the Board agreed with claimant that the ALJ's order in WCB 93-09584 (authorizing surgery) did not render moot the issues before the ALJ in WCB 92-09982 (pertaining to the Director's 1992 order). The Board **<325 Or 115/116>** awarded claimant an attorney fee of $3,000 under ORS 656.386(1), stating:

> "After considering the factors set forth in OAR 438-15-010(4)[4] and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing, on Board review and on remand concerning the validity of the Director's July 16, 1992 order is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and

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[2] ORS 656.382(1) provides in part:

"If an insurer or self-insured employer refuses to pay compensation due under an order of an Administrative Law Judge, board or court, or otherwise unreasonably resists the payment of compensation, except as provided in ORS 656.385, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section."

[3] ORS 656.386(1) provides in part:

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

[4] OAR 438-15-010(4) provides:

"In any case where a referee or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(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."

> 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. We note that claimant is not entitled to an attorney fee for services rendered subsequent to the insurer's concession concerning the attorney fee issue."[5]

Claimant requested reconsideration and submitted an affidavit and summary of services rendered by her counsel. The summary detailed counsel's experience in workers' compensation law and documented 75.8 hours of time devoted to the case. Claimant's counsel requested $175 per hour, his usual and customary rate.[6] On reconsideration, the Board adhered to the reasoning and conclusions of its January 1995 order without further explanation. The Court of <325 Or 116/117> Appeals affirmed. We allowed review to consider whether the Board's order contains a sufficient explanation to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee.[7] *See Drew v. PSRB*, 322 Or 491, 500, 909 P2d 1211 (1996) (for "substantial evidence" review, agency must demonstrate reasoning for its conclusions).

The ALJ or the Board is required to award a "reasonable" attorney fee when a claimant finally prevails at hearing or on review of a denial of compensation. ORS 656.386(1).[8] The scope of judicial review of an award of an attorney fee in a workers' compensation case is found in Oregon's Administrative Procedures Act, ORS 183.310 *et seq*, specifically at ORS 183.482(8)(b).[9] *See* ORS 656.298(6) (so providing). The statutory directive to award a "reasonable" fee describes an exercise of discretion and, in this case, claimant argues that the Board acted outside the range of discretion delegated to it, ORS 183.482(8)(b)(A).

The attorney fee statute is a broad statement of a legislative policy that prevailing claimants' attorneys shall receive reasonable compensation for their representation. The term "reasonable" is an inexact term that expresses a complete legislative policy. That term delegates authority to <325 Or 117/118> the Board to determine, on a case-by-case basis, what constitutes a reasonable attorney fee. The agency's choice, among the range of choices available to it, must be a choice that a reasonable decision-maker would make, given the facts of the case, the interests of the parties appearing before the agency, and the policy or policies of the law that the agency's choice is intended to further. Responsibility for policy refinement under the statutes is delegated to the agency, not to the court. The court, for its part, is responsible for reviewing the agency's decision to see that it is within the range of discretion granted to the agency.

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[5] The Board's observation that Liberty had conceded the attorney fee issue was an error. Although Liberty did concede claimant's entitlement to *surgery*, it did not concede the *attorney fee* issue.

[6] On reconsideration, claimant asked the Board to increase the attorney fee award to $19,897.50. Before this court, claimant contends that her counsel is entitled to $8,312.50, for 47.5 hours at $175 per hour, which her counsel asserts represents the time that he spent on this case up to February 2, 1994, the date of Liberty's concession regarding claimant's entitlement to surgery.

[7] ORS 183.482(7) provides in part:

> "Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. * * * The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure."

[8] Since claimant's original request for attorney fees, ORS 656.386 has been amended in ways that are not material to a resolution of this case. Or Laws 1995, ch 332, § 43.

[9] ORS 183.482(8)(b) provides:

> "The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:
>
> "(A) Outside the range of discretion delegated to the agency by law;
>
> "(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or
>
> "(C) Otherwise in violation of a constitutional or statutory provision."

It is crucial that an agency's order reveal a rationale for an award of attorney fees. At a minimum, where the basis for an agency's discretionary choice is not obvious, an agency must provide sufficient explanation to allow a reviewing court to examine the agency's action in relation to the range of discretion granted by the legislature, the agency's own "rule, officially stated agency position, or a prior agency practice," and other statutory and constitutional provisions. ORS 183.482(8)(b).

In *Drew*, 322 Or at 500, in the context of judicial review under the statutory requirement that findings be supported by substantial evidence, this court stated this rule:

> "[A]gencies are * * * required to demonstrate in their opinions the *reasoning* that leads the agency from the facts that it has found to the *conclusions* that it draws from those facts." (Emphasis in original.)

*See also Ross v. Springfield School Dist. No. 19*, 294 Or 357, 370, 657 P2d 188 (1982) ("It is essential that an agency articulate in a contested case the rational connection between the facts and the legal conclusion it draws from them."). The reasons for that rule are summarized in *Williams v. SAIF, 310* Or 320, 329, 797 P2d 1036 (1990) (Unis, J., specially concurring). We turn to the analysis of the Board's order in this case under the foregoing standards.

We begin by noting the discrepancy between the amount of the attorney fee that claimant sought and the amount that the Board awarded. We assume that, in setting **<325 Or 118/119>** what it considered to be a reasonable fee, the Board considered all the factors mentioned in OAR 438-15-010(4). The Board's order states that it "particularly considered" (1) the time devoted to the case (as represented by the record and claimant's appellate briefs), (2) the complexity of the issue, (3) the value of the interest involved, and (4) the risk that claimant's counsel might go uncompensated.

The Board, however, did not explain how any of the rule-based factors that it considered, much less how any of the four factors that it "particularly considered," weighed in its decision-making process and led to the fee that it awarded. The answer is not apparent to us from a mere recitation of those factors. The Board's order recounts the lengthy and complex history of a case that began nearly three years before the Board's ruling, with Berkeley's first request to perform surgery. The factors that the Board considered reasonable could have supported an award for the full amount of counsel's request, up to the date of Liberty's concession, yet, for reasons that are not apparent, the Board awarded a much lower amount. The Board's statement, that "claimant is not entitled to an attorney fee for services rendered subsequent to the insurer's concession," could account for a portion of the difference between the attorney fee claimed and the fee awarded by the Board, but a significant and unexplained disparity nevertheless remains. *See* note 6, *above.*

A review of the fee statement submitted by claimant's counsel reveals that he claims he spent 47.5 hours between receipt of the Director's decision in 1992, through the hearing, Board review, and on remand up to the date of Liberty's concession. As claimant argues, the award of $3,000 could mean that the Board concluded that, under the circumstances, an hourly fee of about $63 was reasonable. Alternatively, the award of $3,000 could mean that the Board concluded that, under the circumstances, claimant's counsel should be compensated at his requested rate but for less than half of the time he spent on the case up to Liberty's concession. Yet, nothing in the Board's order suggests that it believed counsel's services were worth less than half his usual and customary hourly rate or that half of the time **<325 Or 119/120>** spent on the case was duplicative or unnecessary. In short, the Board gave no explanation for its award.

Claimant's counsel already had been awarded $7,750 in WCB 93-09584 dealing with the same injury. The Board may have awarded less than the requested amount on finding that the time spent on the two cases could not be a llocated between them easily. That explanation also might provide a valid basis for the Board's award. However, we cannot discern that basis from the Board's order and, thus, we cannot assume that the Board relied on it. *See Drew*, 322 Or at 499 (the fact that the Psychiatric Security Review Board might have relied on a permissible but unexpressed factual basis for its ruling could not cure PSRB's failure to demonstrate the rationale for its conclusion); *Garbutt v. SAIF*, 297 Or 148, 152, 681 P2d 1149 (1984) (court would not affirm Board's order where court could not determine whether the Board relied on a permissible factual basis or on an impermissible legal basis in reaching its opinion). Our decision in this case means only that, on the present record, the Court of Appeals could

not, and we cannot, review the reasonableness of the attorney fee award, because the Board has failed to demonstrate in its order that its decision is within the range of discretion allowed by the more general policy of the statute. ORS 183.482(8)(b)(A).

In sum, we conclude that the Board's order does not contain a sufficient explanation to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee. Accordingly, we remand the case to the Board for reconsideration of the order awarding attorney fees. ORS 183.482(8)(b)(A).

The decision of the Court of Appeals is reversed. The case is remanded to the Workers' Compensation Board for reconsideration of the attorney fee.

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Cite as 325 Or 305 (1997) May 22, 1997

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Loyd D. Long, Claimant.
**ROSEBURG FOREST PRODUCTS**, *Petitioner on Review,*
v.
**Loyd D. LONG**, SAIF Corporation, Employers Insurance of Wausau, and Industrial Indemnity,
*Respondents on Review.*
(WCB 94-06167, 94-06166, 94-06165, 94-06164, 94-06163, 94-05787, 94-04388, 94-04183, 94-02921; CA A89646; SC S43283)

On review from the Court of Appeals.*

Argued and submitted January 15, 1997.

Richard D. Barber, Jr., of Bostwick, Sheridan & Bronstein, Portland, argued the cause and filed the petition for petitioner on review.

David O. Horne, Beaverton, argued the cause and filed a brief for respondent on review Employers Insurance of Wausau.

John E. Snarskis, Portland, argued the cause and filed a brief for respondent on review Industrial Indemnity.

No appearance for respondents on review Loyd D. Long and SAIF Corporation.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Graber, and Durham, Justices.**

GRABER, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for further proceedings.

* Judicial review from the Workers' Compensation Board. 140 Or App 452, 917 P2d 1075 (1996).

** Kulongoski, J., did not participate in the consideration or decision of this case.

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**325 Or 308>** In this workers' compensation case, we are called on to consider aspects of the "last injurious exposure" rule. We hold that, when a claimant has a compensable occupational disease that is caused by working conditions at a single employer, the most recent insurer is fully responsible for the claimant's occupational disease unless that insurer proves either: (1) that it was impossible for workplace conditions at the time that it insured the employer to have caused the disease in this particular case or (2) that the disease was caused solely by employment conditions at a time when the employer was insured by one or more previous insurers.

Claimant worked for Roseburg Forest Products (RFP), in a variety of jobs, from 1960 until his retirement in September 1993. During that time, RFP had several insurance arrangements. From September 27, 1960, to November 9, 1965, RFP was insured by the State Industrial Accident Commission, predecessor to the State Accident Insurance Fund (SAIF). Then, RFP obtained insurance from the Fireman's Fund (November 10, 1965, to June 30, 1970), Employers Insurance of Wausau (July 1, 1970, to June 30, 1976), and Industrial Indemnity (July 1, 1976, to June 30, 1980). RFP was self-insured from July 1, 1980, to the present.

Claimant's employment at RFP exposed him to noise. RFP tested claimant's hearing in 1972. That test revealed that claimant suffered from significant high-frequency hearing loss in both ears. RFP began a program of hearing protection the same year. From that point on, claimant regularly wore hearing protection at work. Claimant never missed work as a result of the hearing loss. He did not seek treatment until 1989, although he noticed symptoms of hearing loss many years earlier. Claimant's pattern of hearing loss from 1972 to 1994 was consistent with the amount of loss that could be expected from the normal aging process.

Claimant filed a workers' compensation claim for bilateral hearing loss. Compensability is conceded by all parties. The parties' dispute concerns who is responsible for paying the claim. The Workers' Compensation Board (Board) concluded that RFP was responsible as a self-insured **<325 Or 308/309>** employer. The Board agreed with the administrative law judge's findings of fact and wrote:

> *"See [Beneficiaries of Strametz v. Spectrum Motorwerks,* 135 Or App 67, 897 P2d 335, *adhered to as modified* 138 Or App 9, 906 P2d 825 (1995), *rev allowed* 323 Or 153, 916 P2d 311 (1996)] (Responsibility for a claimant's condition remains with last employer/insurer whose work exposure could have caused claimant's condition)."

The Court of Appeals affirmed without opinion. *Roseburg Forest Products v. Long,* 140 Or App 452, 917 P2d 1075 (1996). We then allowed RFP's petition for review.

This court has adopted the "last injurious exposure" rule, which imposes full responsibility on the last employer, from the time of the onset of the disability, if the claimant was exposed there to working conditions that could have caused the type of disease suffered by the claimant. *Runft v. SAIF,* 303 Or 493, 499, 739 P2d 12 (1987). The last injurious exposure rule is both a rule of proof and a rule of assignment of responsibility. *Id.* at 500.

As a rule of proof, the last injurious exposure rule allows a claimant to prove the compensability of an injury without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease. *Ibid.* The claimant need prove only that the disease was caused by employment-related exposure. *Ibid.* Here, the rule of proof is not at issue, because all parties concede that claimant's hearing loss was work related and, therefore, compensable.[1]

As a rule of assignment of responsibility, the last injurious exposure rule assigns full responsibility to the last employer that could have caused the claimant's injury. *Ibid.* We are concerned in this case only with the assignment of responsibility.

**325 Or 310>** As noted, the Board in this case cited and relied on *Strametz* as the basis for its decision, and the Court of Appeals affirmed without opinion. In *Strametz,* the Court of Appeals had held that, under the last injurious exposure rule, an employer is responsible for a claimant's disability if the conditions at its workplace are of a kind that could cause the disease from which the claimant suffers, even though the employer could not have been the actual cause of the particular claimant's disease. *Strametz,* 135 Or App at 74. The first question that we address is the correctness of that holding.

This court's cases demonstrate that, as a rule of assignment of responsibility, the last injurious exposure rule imposes responsibility on the last employer that *contributed* to the worker's disease. In *Boise Cascade Corp. v. Starbuck,* 296 Or 238, 241, 675 P2d 1044 (1984), the court stated:

> "In an occupational disease context, the rule is this: If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. The result is that, once the requirement of some *contributing* exposure has been met, the last employer is liable even though the worker has not proved that the last employment was the actual cause of the disability." (Emphasis added.)

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[1] Claimant's hearing loss falls within the Occupational Disease Law, ORS 656.802 to 656.807. "An occupational disease * * * is considered an injury" under Oregon's workers' compensation law. ORS 656.804. ORS 656.005(7)(a) defines a "compensable injury" as "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death."

*See also Runft*, 303 Or at 499 ("[I]f a workers' compensation claimant has worked for more than one employer that could have *contributed* to the claimant's occupational disease, the last injurious exposure rule assigns full responsibility for payment of compensation for the disease to the last *such* employer for whom the claimant worked." (emphasis added)); *Bracke v. Baza'r*, 293 Or 239, 248, 646 P2d 1330 (1982) (similar phrasing); *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 344, 605 P2d 1175 (1980) ("The rule requires the claimant to show only that the employment environment during the relevant period *could have* [original emphasis] been a *contributory* [emphasis added] cause of the disease.").

The Court of Appeals in its *Strametz* opinion relied on *Fossum v. SAIF*, 293 Or 252, 646 P2d 1337 (1982), for its conclusion that actual contribution to a claimant's occupational disease is irrelevant in assigning responsibility. **<325 Or 310/311>** *Strametz*, 135 Or App at 71-74. The deceased worker in *Fossum* had worked for three different shipbuilders in the early 1940's, the last of which was Kaiser Company T.R.D., and had been exposed to asbestos in those jobs. Then, the decedent worked for W.R. Grasle Company (1948-67) and for Willamette Western (1969-76). Shortly after leaving Willamette Western, the decedent was diagnosed with mesothelioma. He died in 1977. His wife filed workers' compensation claims against all five employers. *Fossum*, 293 Or at 254.

This court held that Kaiser was responsible for the mesothelioma, because it was the last employment that exposed the decedent to a sufficient level of asbestos to have caused the kind of disease from which he suffered and died. *Id.* at 255-57. In a footnote, the court stated:

> "The employment at Willamette Western could not have been an actual cause of the disease because it was during the 20-year period before which actual causation must have occurred.[2] Had it been proved and found that the conditions of exposure at Willamette Western were of a kind which could have caused the disease, then under the last injurious exposure rule as described by Larson, Willamette Western *would be liable even though that employment could not have been the actual cause. See* 4 Larson, Workmen's Compensation Law § 95.21, *but see, Bracke,* n 5. Where, as here, claimant's interests are protected because all potentially causal employers are parties, it is arguable that a defense of actual impossibility should be allowed to reduce the otherwise arbitrary operation of the last injurious exposure rule. *Cf. Bracke,* n 5. Because there is no evidence of potentially causative exposure at Willamette Western or Grasle, however, we need not decide this issue." *Id.* at 256 n 1 (emphasis added).

That footnote was *dictum*. Moreover, to the extent that the footnote can be interpreted to mean that an employer may be responsible for a particular claimant's occupational disease that it could not, in fact, have caused, the court rejected that analysis in a later case.

**325 Or 312>** *Fossum* was decided two years before *Boise Cascade*, in which this court clarified the last injurious exposure rule. In *Boise Cascade*, the claimant had sustained a back injury while in the employment of Boise Cascade, the first employer, and suffered a worsening of the condition during a later employment. Without the assistance of the last injurious exposure rule, the claimant proved that employment-related events at Boise Cascade were the actual cause of the injury and, thus, that Boise Cascade was the responsible employer. In an attempt to shift responsibility to the later employer whose conditions of employment were found to be capable of causing the claimant's back problems, Boise Cascade invoked the last injurious exposure rule defensively. This court held that, when a claimant chooses to forego the benefit of the "rule of proof" aspect of the last injurious exposure rule, and instead proves that the disability was caused solely by an injury that occurred during an earlier employment, that earlier responsible employer cannot use the rule to shift responsibility to a later employer. *Id.* at 243. The court stated:

> "[The last injurious exposure] rule does not prevent a worker from proving that an earlier employment caused the disability; *nor does it prevent an employer from proving that the claimant's disability was caused by a different employment* or that the disability did not arise from any work-related injury.

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[2] In *Fossum*, the court noted that mesothelioma does not develop until 20 years or more after exposure to asbestos. 293 Or at 254-55.

> "In a procedural context, if a worker presents substantial evidence of successive work-related injuries causing disability, a prima facie case for recovery from the last employer is made out. *Either or any employer against whom a claim is made still can present evidence to prove that the cause of the worker's disability is another employment or a cause unrelated to the employment.*" *Id.* at 244-45 (emphasis added).

In a footnote, the court explained:

> "In some cases, a worker might assert a disability claim against two employers and establish the claim against the later employer by application of the last injurious exposure rule. *That would not prevent the later employer from proving that the earlier employment was the sole cause in fact of* **<325 Or 312/313>** *the disability, in which event the earlier employer would be liable to the worker.*" *Id.* at 244 n 3 (emphasis added).

In other words, under *Boise Cascade,* when a worker invokes the last injurious exposure rule to establish a *prima facie* case against the last employer, that employer may avoid responsibility by proving that the disability in a particular case was caused solely by conditions at one or more previous employments. Such a showing shifts responsibility to the specified employer or employers.

By the same logic, the later employer may prove that its working conditions could not possibly have caused the particular claimant's occupational disease. By making that latter kind of showing, the employer may avoid responsibility without proving which previous employer actually caused the injury. Such a showing shifts responsibility to the next most recent employer.

In summary, under this court's prior precedents, once compensability is established, an employer that otherwise would be responsible under the last injurious exposure rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case or (2) that the disease was caused solely by conditions at one or more previous employments.

Here, claimant was employed by only one employer, not multiple employers. Accordingly, we must decide whether the foregoing aspect of the last injurious exposure rule applies to successive insurers of a single employer.

The case in which this court adopted the last injurious exposure rule involved a dispute about which of two successive insurers for the claimant's one employer was responsible for the claimant's injury. *Inkley,* 288 Or at 337. In *Inkley,* the claimant had suffered a hearing loss over a period of time, and it was uncertain whether employment under the last insurer actually caused any additional hearing loss. *Id.* at 344. Applying the last injurious exposure rule, this court held that the last insurer would be responsible for the entire disability if the employment conditions at the time were such **<325 Or 313/314>** that they could have contributed to the disability. *Id.* at 345-46. The rule was applied in *Inkley* both as a rule of proof and as a rule of assignment of responsibility. *See Bracke,* 293 Or at 246 (so stating). This court also stated in *Runft,* 303 Or at 499 n 2, that the last injurious exposure rule applies "to cases in which an employer is successively insured by two or more carriers."[3]

Additionally, this court has stated that the function of the last injurious exposure rule is to "spread [ ] liability fairly among employers by the law of averages and * * * reduc[e] litigation." *Bracke,* 293 Or at 248. When dealing with multiple employers, the rule aids in determining which of them is to be financially responsible. Similarly, when dealing with multiple insurers, the rule is useful in determining which of those insurers is to be financially responsible. The rule serves the same risk-spreading function whether multiple employers or multiple insurers are involved.

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[3] *See also* Arthur Larson, 4 *Workmen's Compensation Law* § 95.20, at 17-157 to 17-158 (1996) ("The 'last injurious exposure' rule in successive-injury cases places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability. This rule * * * is the majority rule in successive insurer cases * * *.").

We conclude that the last injurious exposure rule applies to successive insurers of a single employer. As applied in that context, the rule makes the last insurer of an employer fully responsible for the claimant's occupational disease unless that insurer proves either: (1) that it was impossible for workplace conditions at the time that it insured the employer to have caused the disease in this particular case or (2) that the disease was caused solely by employment conditions at a time when the employer was insured by one or more previous insurers.

Because the Workers' Compensation Board applied a different legal standard than that stated in this opinion, the Board committed an error of law. Therefore, we remand this case to the Board to apply the correct legal standard, as set forth in this opinion.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Board for further proceedings.

Cite as 147 Or App 245 (1997) March 26, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard J. Taskinen, Claimant.
**QUAKER STATE OIL COMPANY** and Travelers Insurance Company, *Petitioners,*
v.
Richard J. **TASKINEN**, *Respondent.*
(93-10255; CA A87486)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted February 14, 1996; resubmitted in banc January 14, 1997.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Anita C. Smith argued the cause for respondent. With her on the brief was Estell and Associates.
DEITS, J.
Reversed and remanded to the Board with instructions to vacate its order and remand to the Director of the Department of Consumer and Business Services.
Warren, J., concurring.
Edmonds, J., concurring.

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**147 Or App 247>** In this medical services dispute, petitioners seek review of an order of the Workers' Compensation Board that held that claimant's medical services claim for proposed low back surgery was appropriate and that claimant's counsel was entitled to attorney fees. We reverse and remand to the Board with instructions to vacate the Board's order and remand to the Director of the Department of Consumer and Business Services[1] (Director) for further proceedings.

This medical services dispute concerns the appropriateness of a ninth surgery on claimant's spine. The employer challenged this procedure and sought review by the Director pursuant to ORS 656.327. The Director issued an order disapproving the treatment. Claimant then requested a hearing before the Board's Hearings Division. A hearing was held and the administrative law judge (ALJ) concluded, relying on our decisions in *Jefferson v. Sam's Cafe,* 123 Or App 464, 861 P2d 359 (1993), *rev* den 320 Or 453 (1994), and *Niccum v. Southcoast Lumber Co.,* 123 Or App 472, 861 P2d 360 (1993), *affd* 320 Or 189, 880 P2d 923 (1994), that the Director's order was a "nullity" because jurisdiction over disputes regarding proposed medical services was vested in the Hearings Division under ORS 656.283 and not the Director under ORS 656.327. The ALJ also concluded that the surgery was a reasonable and necessary expense of the compensable injury. Employer requested Board review, and the Board held that employer was responsible for the proposed surgery. It also awarded claimant attorney fees.

Employer sought review of the Board's order by this court. After the briefs were filed in this court, but before oral argument was held, the legislature amended the workers' compensation law. Because this case was pending before the courts on the effective date of the legislation, June 7, 1995, the amended version of the law applies. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

**147 Or App 248>** ORS 656.327(2) establishes the process for review of medical services disputes. The amended version provides:

> "The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the worker and may examine the worker. Notwithstanding ORS 656.325(1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and the director shall issue an order within 60 days of the request for review. The director shall create a documentary record sufficient for purposes of judicial review. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party

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[1] At the time of the relevant events, the agency was known as the Department of Insurance and Finance.

> may request a contested case hearing before the director pursuant to ORS 183.310 to 183.550. At the contested case hearing, the administrative order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. If the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment. Review of the director's order shall be by the Court of Appeals pursuant to ORS 183.310 to 183.550."

As can be seen, under the new law, the Director has exclusive authority to initially review medical services disputes. The procedures for the development and review of the Director's order are also set forth in the statute and are changed from the prior law. Or Laws 1995, ch 332, §§ 41, 50. ORS 656.327(2) now provides that if a party is dissatisfied with the Director's determination regarding a bona fide medical services dispute, the party may request a contested case hearing before the Director and may seek further review of the Director's order in the Court of Appeals.

In this case, the procedures of the new statute described above were not followed because the amended law did not exist at the time this matter was brought before the Director. Nonetheless, because the legislature has chosen to make the new procedures apply retroactively, and because the amended procedures could alter the Director's or our analyses of the case, it is necessary to remand this case to the **<147 Or App 248/249>** Board with instructions to vacate the Board's order and to remand to the Director for further proceedings.[2]

Judge Warren asserts in his concurrence that, although he agrees with our "disposition," we are wrong in failing to acknowledge that we lack jurisdiction to review the Board's order in this case and in failing to overrule our earlier decision in *Baar*. The first problem with his assertions is that neither of those arguments are made by the parties in this case. Aside from that, his position is based on a faulty premise.

It is Judge Warren's view that we only have jurisdiction to review an order of the Director regarding a medical services dispute when the Director has conducted a contested case hearing and, accordingly, issued a contested case order. He contends that, because the order here was not issued after a contested case hearing, we lack the authority to review the Director's order. In his view, the Director's order here was an "order in other than a contested case" under the Administrative Procedures Act (APA) and, as an order in other than a contested case, review of the Director's order would first have to go to circuit court under ORS 183.484. 147 Or App at 252 n 2. Review of the circuit court order is by this court. ORS 183.500.

In reaching the conclusion that the Director's order is an order in other than a contested case and is subject to the general APA provisions concerning review of such orders, the concurrence ignores the plain language of ORS 656.327, which provides specific procedures for review of the Director's decisions on medical services disputes. As discussed above, that statute specifically provides that if a party is dissatisfied regarding a medical services issue, the party must request review of the matter with the Director. ORS 656.327(1). If the Director issues an order finding that a medical services dispute exists, ORS 656.327(2) becomes applicable. Under that provision, the Director then reviews the **<147 Or App 249/250>** matter and in that process is required to "create a documentary record sufficient for purposes of judicial review." As we have noted, if dissatisfied with the Director's decision at this point, a party may request a contested case hearing and the Director will then issue a new order following the hearing.

ORS 656.327(2) also provides that "[r]eview of the Director's order shall be by the Court of Appeals pursuant to ORS 183.310 to 183.550." Judge Warren reads this language to mean that we only may review the Director's order if a contested case hearing is held. However, that is simply not what the statute says. This court is given authority to review the "director's order[.]" There is nothing in the language of the statute that limits our direct review of the Director's order only to cases where there has been a contested case hearing.

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[2] Our disposition here is different than in *Baar v. Fairview Training Center*, 139 Or App 196, 911 P2d 1232, *rev den* 323 Or 690 (1996), because, in contrast to this case, in *Baar* there were no factual issues in dispute, nor were there any substantive changes in the applicable law that could possibly alter the director's or our analyses. Accordingly, there was no reason to remand the case in *Baar*.

Further, such a result would make little sense. Under Judge Warren's view, a party that was dissatisfied with the Director's initial decision regarding the medical services dispute could choose to opt out of the specific review process that the legislature devised for review of medical services disputes. The dissatisfied party could do this by simply not requesting a contested case hearing by the Director and seeking review of the Director's decision in circuit court. The circuit court would then review the matter. If any party was dissatisfied with the court's decision, review by this court could then be sought. It is difficult to understand why the legislature would have created a comprehensive scheme for review of medical services disputes by the Director, who presumably has expertise in this area, only to let the parties, at their option, go through an entirely different process that does not utilize the expertise of the Director and certainly does not carry out the legislature's apparent intent to expedite the worker's compensation process.

Judge Warren's assertion that we must overrule our decision in *Baar* also is based on its premise that unless the Director has conducted a contested case hearing, we lack jurisdiction to review the Director's order. As discussed above, this is wrong. Consequently, we should not overrule *Baar*.

**147 Or App 251>** Reversed and remanded to the Boa@d with instructions to vacate its order and remand to the Director of the Department of Consumer and Business Services.

**WARREN, J.**, concurring.

In this medical services dispute, on review of an order of the Workers' Compensation Board, the majority reverses and remands to the Board with instructions to vacate its order and to remand to the Director for further proceedings. I concur with the majority's disposition, but disagree with the route it takes to arrive there. Although the parties do not raise the question of jurisdiction, we have the duty to do so on our own. The majority fails to acknowledge that the Board had no jurisdiction to consider the Director's order, that we have no jurisdiction to consider the Board's order and that *Baar v. Fairview Training Center*, 139 Or App 196, 911 P2d 1232, *rev den* 323 Or 690 (1996), to the contrary, is simply wrong. The majority concludes that this case is distinguishable from *Baar*. 147 Or App at 249 n 2. *Baar* is not distinguishable and we should overrule it.

Jurisdiction over disputes regarding proposed medical services is now vested exclusively in the Director under the amended statute. ORS 656.327(2). Judicial review of the Director's decision is vested in the Court of Appeals, but only for those cases in which the Director has first conducted a contested case hearing. The statute directs that our review of an order from the Director shall be according to the provisions of ORS 183.310 to ORS 183.550, and ORS 183.482 only gives us authority to review orders in contested cases.[1] In this case, the Director did not conduct a contested case hearing, rather, we are presented with an order from a hearing that the Board conducted. Because judicial review is exclusively in this court from a Director's order in a contested case, it follows that the Board had no review authority and we do not have a reviewable order.

This case is presented in the same procedural posture as *Baar*. In *Baar*, we took review of the case even though **<147 Or App 251/252>** it was the Board, and not the Director, that had conducted a hearing. That approach was erroneous because it overlooked the limited grant of jurisdiction that we have under ORS 183.482. In essence, we reviewed an order in other than a contested case; the authority to review those orders is vested in other courts and not the Court of Appeals.[2] We had no authority to review the Board's order in *Baar* because the Director had not conducted a contested case hearing. Our attempt to achieve judicial economy in *Baar* was misguided and misleading because it skipped a statutory condition precedent to our jurisdiction and misdirects these and other litigants from the correct procedure (a Director's order in a contested case). We were without authority to ignore that condition, and thus, *Baar* should be overruled.

For these reasons I concur only in the result in this case.

Armstrong, J., joins in this concurrence.

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[1] ORS 183.482(1) provides, in part:

"(1) Jurisdiction for judicial review of contested cases is conferred upon the Court of Appeals."

[2] ORS 183.484(1) provides that"[j]urisdiction for judicial review of orders other than contested cases is conferred upon the Circuit Court for Marion County and upon the circuit court for the county in which the petitioner resides or has a principal business office."

**EDMONDS, J.**, concurring.

I do not agree with the majority's interpretation of ORS 656.327(2). The majority believes that our review is not predicated on a contested case order. It says, "There is nothing in the language of the statute that limits our direct review of the Director's order only to cases where there has been a contested case hearing." 147 Or App at 250. A reading of the statute on its face demonstrates that the majority is wrong. The language of the statute establishes procedures in a chronological order[1] for deciding the appropriateness of **<147 Or App 252/253>** medical services and directs the Director to hold a contested case hearing procedure when any party is dissatisfied with the initial order. Judicial review of the "director's order" in the statute means review of the order of the Director that results from the contested case hearing.

Nonetheless, the majority arrives at the correct result. In my view, our decision in *Barr v. Fairview Training Center*, 139 Or App 196, 911 P2d 1232, *rev den* 323 Or 690 (1996), was prompted by judicial economy. Because what was involved in that case was a question of law that had already been decided by the Director under language that remained unchanged in the amended statute, it served no purpose to remand the case for a contested case hearing. In this case, the question is a factual one: whether surgery on claimant's spine is reasonable and necessary. Reluctantly, I agree with the majority that ORS 656.327(2) as amended in 1995 requires us to remand this case. My reluctance is expressed more fully by the following discussion.

Under the Constitution, the legislature and the judiciary are equal branches of government. It is the function of the legislature to legislate and the function of the courts to adjudicate. Part of the judicial function of this court is to review adjudications by administrative tribunals that involve interpretations of statutes enacted by the legislature. The guiding light before us in that particular task is to effectuate the over-all purpose of the applicable law. This part of my opinion is about the conflict that the legislature has created between the mandate of carrying out the purposes of the workers' compensation law for the benefit of employers and workers alike and its direction to apply its amendments retroactively to cases that have been adjudicated previously. It is also about legislative encroachment on the function of judicial review of administratively-made decisions through the vehicle of retroactive legislation.

In the area of workers' compensation law, the legislature has promulgated an administrative process that both legislates and adjudicates. The result is a blend that reflects the ebb and flow of the political process. However, the legislature's actions also affect human beings with significant needs, and if remedies and the finality of adjudication are at **<147 Or App 253/254>** the temporal whim of the prevailing view in the legislature, the integrity of the system suffers as well as those involved in it. At the core of any well-conceived legislation is the need to provide substantive law and procedures that produce certainty and finality, *i.e.*, factual determinations on which litigants can rely.

On the other hand, judicial review of workers' compensation cases is intended to be a mechanism that affords review of administrative decisions, even though the scope of review is often misunderstood by those involved in the system. Judicial review does not exist to correct the mistakes of the legislature or to relitigate the facts of each claim. For us to assume those functions would be to violate the principle that we and the legislature and its agencies are co-equal branches of government. Rather, judicial review endeavors to ascertain whether a particular application of the administrative process has complied with the applicable law. The majority has carried out that task correctly in this case by its decision to remand the case to the Director, but the parties must feel that they are encased in a washing machine in an unending spin cycle because of the continuous changes to the law made by the legislature and its direction that its amendments be applied retroactively. The facts of this case illustrate my point.

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[1] The statute first provides for the Director to issue an order after a determination has been made. The statute then provides:

> "If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a *contested case hearing before the director* pursuant to ORS 183.310 to 183.550. At the contested case hearing, the administrative order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. If the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment. Review of the director's order shall be by the Court of Appeals pursuant to ORS 183.310 to 183.550." (Emphasis supplied.)

The issue to be resolved in this case should have been a simple question of fact that was subject to judicial review for substantial evidence. In 1992, claimant's physician proposed that claimant undergo surgery. This litigation started out before the Director of the Department of Consumer and Business Services, who disapproved the request for proposed surgery. Resolution of the issue required choosing between conflicting medical opinions to determine whether the proposed surgery was reasonably and medically necessary. No physician doubts that claimant experiences pain. The medical issue was whether the proposed surgery would be effective in relieving claimant's ongoing pain and whether it would endanger other segments of claimant's spine. It is now 1997 and the parties still do not have a final answer, due in part to the legislature's choice to make its **<147 Or App 254/255>** 1995 amendments retroactive and applicable to cases pending on review. As discussed below, the legislature has effectively undone lawfully authorized factual determinations by the Administrative Law Judge (ALJ) and the Board by its amendments.

When claimant appealed the Director's decision to the Hearings Division of the Board, the ALJ and the Board found for claimant. Under our holding in *Jefferson v. Sam's Cafe,* 123 Or App 464, 861 P2d 359 (1993), *rev den* 320 Or 453 (1994), they had jurisdiction to make those rulings. In that case, we held that, pursuant to former ORS 656.327(1), the legislature had given the Board jurisdiction over disputes about proposed medical services. After the Board rendered its decision in this case, employer sought review in this court. While review was pending, the legislature enacted Oregon Laws 1995, chapter 332, section 41, to provide for exclusive administrative review by the Director. The effect of that enactment changed the entire focus of this case from a dispute about medical services, which had already gone on too long, to a dispute over jurisdiction. It placed the subject of disputes over proposed medical services solely within the jurisdiction of the Director and required that its provisions, including administrative review through a contested case proceeding, be applied retroactively.

When the Board decided this case, it had jurisdiction, for all legal intents and purposes, and the case was ripe for judicial review. It was after the case left the Board's jurisdiction that the legislature changed the law. *See Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996) (explaining the legislature's intent to have chapter 332 applied retroactively). Chapter 332, applied retroactively, materially changed the goal posts and the playing field for the parties and encroached on the concept of judicial review. Under the former law, the Board's decision finding that the surgery was medically reasonable and necessary would have been reviewed by this court for substantial evidence. When the matter is submitted to the Director for a contested case hearing under the new law, the Director's order *disapprouing the treatment* will be reviewed for substantial evidence under ORS 656.327(2). Now, claimant is required to repeat the administrative review process **<147 Or App 255/256>** with the "deck stacked against him," because he must demonstrate that there is not substantial evidence that the proposed surgery is not reasonable and necessary.

A process intended to provide for an expeditious, final determination of disputes has gone awry. It is no wonder that some who are involved in the workers' compensation system view it as an obstacle course designed to frustrate, rather than promote, rational claims resolution. In a culture where public mistrust of government is rampant, it behooves all of us to be mindful of that perception.

It is with these misgivings that I concur.

Leeson, J., joins in this concurrence.

Cite as 147 Or App 257 (1997) March 26, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas A. McGrew, Claimant.
Thomas A. **McGREW**, *Petitioner,*
v.
**EXPRESS SERVICES, INC.** and Continental Loss Adjusting Services, *Respondents.*
(WCB No. 94-10560; CA A92832)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 30, 1997.
Robert Wollheim argued the cause for petitioner. With him on the briefs were Welch, Bruun, Green & Wollheim, Kate Donnelly and Coons, Cole, Cary & Wing.
Vera Langer argued the cause for respondents. With her in the brief was Scheminske, Lyons & Bussman, LLP.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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**147 Or App 259>** Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in failing to address issues that claimant had raised and in failing to admit evidence supporting the compensability of claimant's reactive depression condition. Because we agree with the Board's analysis, we conclude that it did not err and affirm its order.

The administrative law judge's (ALJ's) order fully explains the history of the claim, and we take our statement of facts from it. Claimant was struck by a large piece of lumber in 1987 while working for employer on the green chain. For the next several years he received conservative treatment for head and neck pain. In 1990, he began to receive treatment from Dr. Aflatooni, a psychiatrist, for psychological complaints. In 1991, Aflatooni described claimant's psychological condition as somatoform pain disorder and depression.

The claim was closed by a determination order in 1991, with an award of temporary total disability but no permanent partial disability. In an order on reconsideration, the Department of Consumer and Business Services awarded claimant 34 percent unscheduled permanent partial disability for reduced cervical range of motion and organic brain injury. Claimant requested a hearing, seeking a determination that the claim had been prematurely closed or, alternatively, that he suffered additional permanent partial disability. He continued to receive treatment from Aflatooni for his psychological symptoms.

In a deposition of April 30, 1992, Aflatooni testified that claimant was suffering from somatoform pain disorder and depression, which he described as "reactive depression," and which he believed was connected to claimant's 1987 injury, as a response to the trauma and subsequent loss of work and functional capacity.

In June 1992, claimant and employer entered into a stipulation with regard to the request for hearing that claimant had filed after the reconsideration order. In the stipulation, the parties noted the current issues between them: permanent partial disability, permanent total disability, and **<147 Or App 259/260>** premature closure of the claim for somatoform pain disorder. The parties agreed that, in lieu of going to hearing, employer would reopen the November 1987 claim as of the date of Aflatooni's deposition and begin payment of temporary total disability "for the worsening of the somatoform pain disorder." The stipulation stated that the parties agreed that their settlement was based in part on Aflatooni's deposition and that it resolved all issues raised or which could have been raised at the time of settlement. The July 10, 1992, order approving the settlement expressly dismissed with prejudice all issues that could have been raised as of the date of approval of the settlement.

Claimant continued to receive treatment from Aflatooni for his psychological symptoms, which Aflatooni continued to characterize as somatoform pain disorder and depression. In March 1993, Dr.

Parvaresh, a psychiatrist, reported that claimant's psychological condition was medically stationary. In May 1993, Aflatooni concurred in that opinion. Claimant continued to receive treatment from Aflatooni until the end of 1993.

On December 23, 1993, the Department issued a determination order that again closed claimant's November 1987 injury claim, with an award of temporary total disability from April 30, 1992, through March 25, 1993, but no additional permanent disability. Claimant requested reconsideration. He was examined by a panel of medical arbiters. On August 26, 1994, the Department issued an order on reconsideration affirming the December 23, 1993, determination order. Claimant requested a hearing.

At the hearing, claimant raised the questions of premature closure of the claim and the extent of his permanent partial disability. After the hearing, in his written closing argument, claimant contended for the first time that his reactive depression is a separate compensable condition. In February 1995, claimant deposed Aflatooni, and submitted the deposition into the hearing record, asking the ALJ to consider the compensability of the reactive depression condition, which employer had never accepted or denied. In that deposition, Aflatooni gave his opinion that claimant had become medically stationary in November 1993, instead of in March **<147 Or App 260/261>** 1993, as had been determined by the Department. Claimant also asked the ALJ to consider two letters from Aflatooni, both written after the hearing and addressing the compensability of claimant's reactive depression.

The ALJ and the Board agreed with employer that claimant is precluded from asserting the compensability of the reactive depression condition by virtue of the parties' July 1992 stipulation. We also agree with employer. Before the parties' stipulation and as early as January 1991, Aflatooni had indicated that claimant was suffering from reactive depression. The July 10, 1992, order approving the stipulation dismissed with prejudice claimant's request for hearing as to all issues raised and all issues that could have been raised as of the date of the stipulation's approval. The ALJ and the Board correctly concluded that the stipulation and order encompassed the reactive depression. *Good Samaritan Hospital v. Stoddard,* 126 Or App 69, 867 P2d 543 (1994).

Because the Board concluded that claimant was barred from raising the compensability of the reactive depression, it did not address claimant's contention that 1995 legislative changes to ORS 656.262(6)(d), ORS 656.262(7)(a) and ORS 656.268 apply and permit him to raise the compensability of his reactive depression at any time. As the Board implicitly concluded, each of claimant's arguments depends on the assumption that claimant is legally permitted to establish the compensability of the reactive depression. Apart from any subsequent statutory changes that may permit a claimant to assert the compensability of a new medical condition there is no doubt that the parties' 1992 stipulation disposed of claimant's reactive depression condition, by its plain and unambiguous terms. *Taylor v. Cabax Saw Mill,* 142 Or App 121, 919 P2d 527 (1996); *see Pollock v. Tri-Met, Inc.*, 144 Or App 431, 435, 927 P2d 117 (1996). The compensability of the reactive depression may not be raised now, either as a new claim or as a medical sequela to the original accepted condition.

Affirmed.

Cite as 147 Or App 406 (1997) April 16, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paula A. Granner, Claimant.
**Paula A. GRANNER**, *Petitioner,*
v.
**FAIRVIEW CENTER** and SAIF Corporation, *Respondents.*
(95-01626; CA A91875)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 16, 1996.

Robert Wollheim argued the cause for petitioner. With him on the brief were Welch, Bruun, Green & Wollheim, and Randy Elmer and Emmons, Kropp, Kryger et al.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DE MUNIZ, J.

Affirmed.

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**147 Or App 408>** Claimant seeks review of an order of the Workers' Compensation Board upholding SAIF's denial of her claim for compensation. The issue is whether SAIF is precluded from denying her claim for her current condition due to its earlier acceptance of her on-the-job injury. We review for substantial evidence and errors of law, ORS 183.482(7) and (8); ORS 656.298(6), and affirm.

Claimant has a congenital bilateral knock knee[1] deformity. Prior to 1990, she suffered recurrent right knee patellar dislocations, three of which required a physician to relocate the patella. In October 1990, claimant slipped on a wet floor while working for employer and again suffered a right knee patella dislocation. SAIF accepted the "right patella dislocation" and closed the claim in December 1990, awarding only temporary disability benefits. After the injury, claimant continued to experience pain and swelling in the knee. In June 1994, claimant began treatment with Dr. Gallagher, who diagnosed, among other things, chronic right patella dislocation and subluxation. Gallagher recommended that claimant have knee surgery, and claimant sought to reopen her claim. SAIF denied the current right knee condition on the grounds that her preexisting knock knee deformity, and not her injury, was the major contributing cause of her current condition. Claimant then requested a hearing.

Two medical experts gave opinions that claimant's preexisting condition is the major cause of her current need for treatment. Gallagher, as claimant's treating physician, agreed with that diagnosis. However, he also explained the cause of her 1990 injury:

> "The major cause of the right patella dislocation suffered by [claimant] on October 18, 1990 was her preexisting patella malalignment and hypermobility and that SAIF Corporations's acceptance of the right patella dislocation would have included, from a medical standpoint, the preexisting patella misalignment and hypermobility as a **<147 Or App 408/409>** major cause thereof. Further, since she has suffered no further dislocations of the patella since that time, but has continued to experience pain and discomfort in that knee, the October 18, 1990 claim remains the major cause of her ongoing complaints and need for medical attention."

Relying on Gallagher's opinion, the administrative law judge (ALJ) found that the dislocation "was more in the nature of a symptom of an underlying preexisting condition and that the dislocation could not and would not have occurred without the underlying condition." The ALJ then concluded that SAIF had previously accepted the underlying condition as part of the original 1990 injury and set aside the denial.

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[1] According to the record, persons with knock knee tend to have lateral patellar subluxations. A subluxation is a partial dislocation. *Stedman's Medical Dictionary* 1152-53 (illus 23d ed 1976).

The Board disagreed,[2] stating:

> "Although Dr. Gallagher believes that from a medical standpoint SAIF's acceptance should have included claimant's preexisting right knee condition, that belief does not establish that SAIF did in fact accept the preexisting condition. Rather, the record establishes that SAIF only accepted a right patellar dislocation. Consequently, we conclude that SAIF's acceptance did not include claimant's preexisting right knee malalignment and hypermobility." (References to exhibits omitted.)

The Board then concluded that, because SAIF did not accept claimant's preexisting right knee condition and because that preexisting condition combined with the accepted dislocation, claimant must show that the October 1990 injury is the major contributing cause of her current need for treatment. ORS 656.005(7)(a)(B). The Board found that there was no persuasive medical evidence that would support such a finding and reinstated SAIF's denial.

The only issue presented on review is whether claimant's preexisting condition was within the scope of SAIF's acceptance of her 1990 injury. If it was, then SAIF is precluded from denying the compensability of her current condition. *Georgia-Pacific v. Piwowar*, 305 Or 494, 501, 753 P2d **<147 Or App 409/410>** 948 (1988) (*citing Bauman v. SAIF*, 295 Or 788, 794, 670 P2d 1027 (1983)).

Claimant contends that SAIF accepted the preexisting condition when it accepted the 1990 dislocation. Specifically, claimant argues that, because her preexisting condition was the major contributing cause of her previously accepted condition, SAIF necessarily accepted the preexisting condition as a matter of law.

Claimant's legal argument rests on the factual premise that her preexisting condition was indeed the major contributing cause of her 1990 injury. The Board did not specifically address that issue, and there is evidence that could support a finding either way. Because we disagree with claimant's legal argument, we will assume for discussion purposes that claimant's premise is correct.

Claimant relies on three cases to support her position that SAIF accepted her preexisting condition as a matter of law: *Piwowar*, 305 Or 494; *Ledbetter v. SAIF*, 132 Or App 508, 888 P2d 1081 (1995); and *Sperry, Inc. v. Wells*, 127 Or App 700, 874 P2d 80 (1994). She contends that those cases stand for the proposition that the acceptance of a particular condition necessarily includes the cause of that condition. We disagree.

In *Piwowar*, Georgia-Pacific accepted a claim for a "sore back." Later, it was determined that a preexisting disease (ankylosing spondylitis) caused the sore back, and Georgia-Pacific denied compensability of the preexisting disease. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." 305 Or at 501. In other words, the cause of the original injury does not determine the scope of the employer's acceptance. Instead, "the scope of acceptance corresponds to the condition specified in the acceptance notice[.]" *Id.* The court then concluded that, because Georgia-Pacific had accepted a claim for a symptom of the underlying disease, and not a separate condition, it was precluded from denying the underlying condition. *Id.*

**147 Or app 411>** The other cases claimant cites merely follow that same principle. In *Ledbetter*, SAIF was precluded from denying the claimant's underlying chronic osteomyelitis after arguing that its previous acceptance of the claimant's "right thigh condition" limited its acceptance to the symptoms brought on by his work injury. 132 Or App at 511. In *Wells*, the employer was precluded from denying the claimant's underlying condition of achalasia because the employer had previously accepted his symptoms of "reflux esophagitis and esophageal hang-up." 127 Or App at 704. Thus, as in *Piwowar*, the employers in those cases were precluded from denying the compensability of the claimants' underlying conditions because the employers' acceptances listed symptoms rather than separate conditions.

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[2] One member of the Board dissented. The dissenting member, like the ALJ, understood Gallagher's opinion to mean that the 1990 dislocation could not have happened without the preexisting condition. Consequently, he determined that claimant's right knee dislocation was a symptom of the preexisting condition.

Here, the question to be answered is the same: whether SAIF's acceptance of claimant's "right patella dislocation" was an acceptance of a symptom of her preexisting knock knee condition or an acceptance of a separate condition. That is a question of fact for the Board. *See id.*

We note that Gallagher did not refer to claimant's dislocation as a symptom. He also did not state that claimant's preexisting condition was the sole cause of the accepted dislocation; instead, he gave the opinion that it was the major cause. The Board was not required to infer from that evidence that claimant's 1990 dislocation was a symptom. It could instead find -- as it did find -- that "SAIF only accepted a right patellar dislocation," a separate condition. That finding is supported by substantial evidence, and, consequently, the Board correctly concluded that SAIF did not accept claimant's preexisting condition.

Affirmed.

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Cite as 147 Or App 475 (1997) April 16, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kerment C. Verner, Deceased, Claimant.

**LIBERTY NORTHWEST INSURANCE CORPORATION** and Glenbrook Nickel Co., *Petitioners,*

v.

**Barcy VERNER**, Beneficiary of Kerment C. Verner, Deceased, *Respondent.*

(93-10270; CA A93921)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 24, 1997.

E. Jay Perry argued the cause and filed the brief for petitioners.

Dale C. Johnson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LEESON, J.

Affirmed.

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**147 Or App 477>** Employer seeks review of a Workers' Compensation Board (Board) order on remand, *Liberty Northwest Ins. Corp. v. Verner,* 139 Or App 165, 911 P2d 948 (1996) (*Verner II*), holding that decedent's claim is compensable. The dispositive issue is whether substantial evidence supports the Board's finding that decedent worked in temperatures of 110 degrees or greater on the day that he died. We affirm.

On the day of his death, decedent was assigned to remove heavy equipment from an ore dryer. After lifting and carrying the equipment for approximately two and one-half hours, decedent became nauseated and had to stop working in the dryer. He was reassigned to light duty and died a few hours later.[1] Claimant's expert, Dr. Hamilton, testified that a combination of an unpleasant odor, heavy physical exertion and heat caused decedent to become ill and nauseated, resulting in a loss of fluids, a severe imbalance in his electrolytes, and the collapse of his cardiovascular system. Hamilton's opinion was based on his understanding that decedent had been exposed to "excessive heat," meaning temperatures of 110 degrees or greater.

The Board determined that the claim was compensable. On review, we reversed, holding that there was not evidence in the record to support Hamilton's assumption that decedent had been working in temperatures of 110 degrees or greater and that the area in which decedent worked "was between 80 and 85 degrees." *Liberty Northwest Ins. Corp. v. Verner,* 135 Or App 551, 555, 899 P2d 751 (1995) (*Verner I*). The Supreme Court, *citing Garcia v. Boise Cascade Corp.,* 309 Or 292, 787 P2d 884 (1990), vacated and remanded the case for reconsideration. *Liberty Northwest Ins. Corp. v. Verner,* 322 Or 214, 904 P2d 171 (1995). On remand, we held that the Board had not explained why it had accepted Hamilton's opinion regarding cause of death in the light of the finding that decedent had been exposed to temperatures of only 80 to 85 degrees, which, according to Hamilton, did not constitute **<147 Or App 477/478>** "excessive heat." *Verner II,* 139 Or App at 169. We remanded to the Board for that explanation.

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[1] A full exposition of the facts appears in *Liberty Northwest Ins. Corp. v. Verner,* 135 Or App 551, 899 P2d 751 (1995) (*Verner I*).

The Board reviewed the record and, based on the testimony of decedent's supervisor, Lawson, found that:

> "Dr. Hamilton's recollection of [Lawson's] testimony was consistent with [Lawson's] testimony. [Lawson] testified that the temperature where decedent was working on March 31, 1993 ranged from 60 to 110 degrees or higher, depending on the part of the dryer where decedent was working. Although [Lawson] testified that when [decedent] started complaining about being nauseous, that area was approximately 80 to 85 degrees, [Lawson] testified that the temperature would change depending on where the person was in the dryer. Because decedent was removing lifters and carrying them, he was exposed to the temperature variations in the dryer. Based on [Lawson's] testimony, we conclude that Dr. Hamilton's opinion was based on an accurate assumption that decedent was exposed to temperatures of 110 degrees or higher on March 31, 1993." (Underscoring in original; citations omitted.)

In its first assignment of error, employer contends that there is not substantial evidence in the record to support a finding that the temperature to which decedent was exposed ranged from 60 to 110 degrees or greater. It argues that "[t]he evidence is that the portion of the ore-dryer where decedent worked had a temperature between 80-85 degrees." At oral argument, employer also contended that under "the law of the case," we are bound by our holdings in *Verner I* and *II* that "one of [Hamilton's] basic assumptions [that decedent was exposed to temperatures greater than 110 degrees] is without evidentiary support." *Verner II*, 139 Or App at 168-69. *See Verner I*, 135 Or App at 555 ("There is no evidence * * * that [decedent] worked in temperatures of 110 degrees or greater.").

Claimant responds that there is substantial evidence in the record to support the Board's finding that decedent was exposed to temperatures of 110 degrees or greater and that we are not bound by our holdings in *Verner I* and *II*, because only the order now on review analyzes the evidence about the temperature to which decedent was exposed on the day that he died.

**147 Or App 479>** On review of an order of the Board, we are not to substitute our judgment for that of the Board as to any issue of fact or to set aside any finding that is supported by substantial evidence. *Garcia*, 309 Or at 295; *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). If the Board's finding is reasonable, in the light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. *Garcia*, 309 Or at 295.

Our holdings in *Verner I* and *II* were based on our review of the Board order in effect at that time. Our holdings in *Verner I* and *II* did not preclude the Board on remand from reviewing the record and making the findings of fact that appear in the order now on review. That order contains a finding that decedent was exposed to temperatures ranging from 60 to 110 degrees or greater. Substantial evidence supports that finding.

Lawson testified that the dryer had been heated to approximately 1800 degrees the night before and then allowed to cool overnight, that decedent began working at 6:00 a.m, an hour before Lawson arrived, and that the temperature at the location where decedent started complaining, over two hours after he started work, was approximately 80 to 85 degrees. Lawson also testified that "depending on where you were at and where you were working," the temperature "was up around 110--maybe even a little hotter up there." Lawson's testimony is evidence from which the Board found that decedent was exposed to temperatures ranging from 60 to 110 degrees or greater while working in the dryer on the day that he died.

Employer's second assignment of error is that the Board failed to provide a rational connection between the facts that it found and its conclusion that Hamilton's opinion about the cause of decedent's death was reliable and persuasive. The Board's order demonstrates that it weighed the medical evidence and explains why it concluded that Hamilton's opinion provided a "more than reasonable medical probability" about the cause of decedent's death.

Affirmed.

Cite as 147 Or App 550 (1997) April 23, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kim E. Danboise, Claimant.
**SAIF CORPORATION**, *Petitioner*, and WILSON CONSTRUCTION CO., *Employer*,
v.
**Kim E. DANBOISE**, *Respondent*.
(94-14711; CA A91148)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1996; resubmitted in banc March 14, 1997.
Julene M. Quinn argued the cause and filed the brief for petitioner.
John M. Oswald argued the cause for respondent. On the brief were Marianne Bottini and Bottini & Bottini, PC.
No appearance for employer Wilson Construction Co.
RIGGS, J.
Affirmed.
Warren, J., dissenting.
Landau, J., dissenting.

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**147 Or App 552>** Employer seeks review of an order of the Workers' Compensation Board affirming the award of permanent partial disability to claimant. Employer contends that the Board applied an incorrect standard of proof in evaluating the claim. We conclude that the Board applied the correct standard, and that under that standard, substantial evidence supports the Board's findings concerning the extent of claimant's impairment. Accordingly, we affirm the Board.

Claimant injured his neck in September 1993, while working for employer. Employer accepted the claim and, ultimately, the Board affirmed the administrative law judge's award of 21 percent unscheduled permanent partial disability.

The record contains ample evidence to support the Board's findings that claimant sustained a cervical injury on the job, that he had no prior physical limitations before the accident and that he has cervical impairment due to the injury. The medical arbiters found diminished cervical range of motion; although they did not recite the words "due to the compensable injury" in describing the source of claimant's impairment, their report supports a finding that claimant had impairment due to the compensable injury.

Employer's only assignment of error is that the Board applied an incorrect standard of proof. In its order on reconsideration, the Board said:

> "We agree that claimant has the burden of establishing that his cervical impairment is due to his compensable injury. *Claimant may, however, meet that burden by presenting a treating physician's or medical arbiter's report that: (1) contains impairment findings that are consistent with [his] compensable injury; and (2) does not attribute those findings to causes other than the compensahle injury. For the reasons stated in our prior order, we continue to conclude that claimant has met [his] burden under that standard.*" (Emphasis supplied.)

In employer's view, the emphasized portion of the Board's discussion shows that it has deviated from the requirement of ORS 656.214(5) that "the criteria for rating disability shall **<147 Or App 552/553>** be the permanent loss of earning capacity *due to* the compensable injury." (Emphasis supplied.) Employer and the dissenting opinion believe that the Board's "consistent with" language diminishes claimant's burden to show that his impairment is "due to" the injury. In our view, read in the context of the preceding sentence and its earlier findings, the Board's explanation of the evidence that claimant was required to produce was correct. As the Board found, the record in this case identifies no noncompensable factors that may have contributed to claimant's impairment. The Board is correct that,

when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as "consistent with" the compensable injury supports a finding that the impairment is due to the compensable injury. It is the Board's responsibility to make findings regarding claimant's impairment. It has made those findings and they are supported by substantial evidence.

Affirmed.

**WARREN, J.**, dissenting.

I join in Judge Landau's dissent and write simply to point out that the majority premises its result on a logical fallacy. To say that a finding of impairment is consistent with a compensable injury only means that it could be compensable. To say no one has said that it is not compensable does not mean that it is compensable. Here, the majority holds that when an impairment could be compensable and no one says it is not, it is compensable; that is logically fallacious.

I dissent.

**LANDAU, J.**, dissenting.

The Board began its description of the applicable standard by stating that claimant "has the burden of establishing that his cervical impairment is due to his compensable injury." That is a correct statement of the law. ORS 656.214(5). The Board then qualified that correct statement of the law with the following sentence:

> **147 Or App 554>** "Claimant may, however, meet that burden by presenting a treating physician's or medical arbiter's report that: (1) contains impairment findings that *are consistent with* [his] compensable injury; and (2) does not attribute those findings to causes other than the compensable injury."

(Emphasis supplied.) In my view, two things are clear from the foregoing sentence.

First, it is intended as a qualification of the statement of the legal standard that preceded it. I know no other meaning of the clause "[c]laimant may, *however*, meet that burden" than that the Board intended what followed to qualify the immediately preceding sentence. *See, e.g., Webster's Third New International Dictionary* 1097 (1976) (defining "however" as "in spite of that: on the other hand: BUT"); *New Shorter Oxford English* Dictionary 1272 (1993) ("however" means "for all that, nevertheless, notwithstanding; but"); Theodore Bernstein, *The Careful Writer* 218 (1978) ("however * * * throws contrasting emphasis on what precedes it").

Second, the qualification that followed is not a correct statement of the law. ORS 656.214(5) provides that claimant bears the burden of proving a causal link between the job injury and the medical impairment. *Senters v. SAIF*, 91 Or App 704, 707, 756 P2d 693 (1988); *Paige v. SAIF*, 75 Or App 160, 163, 706 P2d 575 (1985). The Board states that claimant can satisfy his burden by establishing something less than causation; claimant may prevail merely by offering evidence that is "consistent with" his claim when there is no evidence to the contrary. In my view, that is wrong. Evidence of consistency simply does not, by itself, prove causation. That is true as a matter of common sense. Evidence that washing one's car invariably is followed by a rainy day does not establish that the washing produces the rain, even in the absence of evidence of alternate causes. The same is true as a matter of law. *See, e.g., Bronco Cleaners v. Velazquez*, 141 Or App 295, 299, 917 P2d 539 (1996) (a claimant cannot rely solely on temporal correlation of exposure and symptoms to satisfy causation requirement).

It may well be that the Board can determine from the evidence in the record of this case that claimant, in fact, has satisfied his statutory burden. That is a matter for the **<147 Or App 554/555>** Board to determine by the application of the correct legal standard. *See, e.g., Liberty Northwest Ins. Corp. v. Golden*, 116 Or App 64, 69, 840 P2d 1362 (1992), *rev den* 315 Or 442 (1993) ("[b]ecause the Board used the wrong legal standard, we remand for reconsideration"). In the opinion before us, the Board did not apply the correct legal standard, and therefore, I respectfully dissent from the majority's decision to affirm.

Warren and Leeson, JJ., join in this dissenting opinion.

Cite as 147 Or App 619 (1997) April 30, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Stephen M. Snyder, Claimant.
**Stephen M. SNYDER**, *Petitioner,*
v.
**BARRETT BUSINESS SERVICES, INC.**, *Respondent.*
(Agency No.94-02568; CA A91472)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 9, 1997.
Dale C. Johnson argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson & Jensen.
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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**147 Or App 621>** Claimant seeks review of a Workers' Compensation Board order holding that, based on the attending physician's closing evaluation and the medical arbiters' report, there is no permanent impairment to claimant's low back as a result of his compensable injury. We review for errors of law and substantial evidence, ORS 656.298(6); ORS 183.482(8), and remand for reconsideration.

Claimant suffered a compensable injury on December 2, 1992, when he fell from a ladder while working for Barrett Business Services (Barrett), a self-insured employer. Sedgwick James & Company (Sedgwick), the claims processing agent for Barrett, accepted claimant's claim arising out of the fall for "[a] disabling right knee anterior tear of the medial meniscus on the right side, [and] low back and hip contusions/abrasion of the right." On December 4, claimant began treatment with Dr. Richard Matteri for his right knee and low back. On December 10, Matteri x-rayed claimant's back and noted that claimant had "mild symptoms of lumbar sprain phenomenon." He predicted resolution of claimant's conditions with the passage of time. After December 16, there is no mention in Matteri's chart notes about back complaints. Matteri continued to treat claimant for knee complaints through September 23, 1993.

On September 23, 1993, claimant was examined by Matteri in a final evaluation. His report for that date does not mention an evaluation of claimant's low back. On November 16, 1993, Matteri wrote to Sedgwick:

> "On September 23, 1993, [claimant] was declared medically stationary with no limitations or impairment as the result of his injury. I find nothing in [claimant's] right knee to indicate that he has a chronic condition limiting repetitive activity."

Sedgwick closed the claim by issuance of a Notice of Closure that awarded periods of temporary disability benefits and scheduled permanent partial disability for claimant's right knee. No award was made for claimant's low back.

**147 Or App 622>** Claimant objected to the Notice of Closure and requested that the claim be referred to a panel of arbiters. ORS 656.268(7). Claimant was examined by the panel, which noted that the accepted conditions were a right knee medial meniscal tear and a low back contusion. The panel also said that there was no medical history of a prior low back problem. Under the "Physical Examination" section of the report, the panel found loss of range of motion impairment regarding claimant's low back. It wrote:

> "Inclinometer lumbosacral range of motion reveals maximum true lumbar flexion of 52 degrees, extension 14 degrees, right lateral flexion 24 degrees, and left lateral flexion 26 degrees. The lumbar flexion test is satisfied by reproducibility criteria and the straight leg raising test."

The report concluded:

"IMPRESSION:

"1. Status postop arthroscopic partial medial meniscectomy of right knee.

"2. Lumbar strain, resolved.

"DISCUSSIONS & RECOMMENDATIONS:

*"LUMBAR SPINE:*

"1. Active ranges of lumbar motion with inclinometer are as above.

"* * * * *

"4. Based on the examination and other objective findings, [claimant] has lost 10 degrees of active flexion of the right knee but otherwise has no objective abnormality."

Based on the arbiters' findings of loss of range of motion, the Department of Consumer and Business Services (Department) issued an Order on Reconsideration that modified the Notice of Closure and granted an unscheduled permanent partial disability award for the low back equal to eight percent.[1] Both parties requested a hearing on the Order **<147 Or App 622/623>** on Reconsideration. At the hearing, claimant withdrew his request for hearing, and Barrett sought reduction of the eight percent low back award. The administrative law judge (ALJ) ruled for claimant, concluding that the arbiters' examination was a more complete assessment of claimant's condition.

Barrett appealed to the Board, which reversed the ALJ. The Board reasoned:

"OAR 436-35-007(9) provides that impairment is determined by the attending physician, or by the medical arbiter when one is used, 'except where a preponderance of medical opinion establishes a different level of impairment.' We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack,* 46 Van Natta 1631 (1994).

"Here, claimant began treating with Dr. Matteri two days after his December 1992 injury. In his initial report, Dr. Matteri noted that claimant had back pain that came on gradually by the evening of the injury. * * * On December 10, 1992, Dr. Matteri noted that claimant's back was still bothering him, and that claimant would have x-rays. On December 16, 1992, Dr. Matteri noted 'symptoms of a lumbar strain phenomena.' Following Dr. Matteri's December 16, 1992 examination, however, the record contains no further reference to claimant's low back until the January 1994 arbiter's report. * * *

"Moreover, in September 1993, claimant was specifically instructed by the carrier to see Dr. Matteri for a final evaluation. * * * In his examination, Dr. Matteri noted normal range of motion in the right knee. He also stated that claimant had no limitations as the result of the injury. * * * Dr. Matteri made no reference to claimant's back.

"The medical arbiters examined claimant on January 28, 1994. * * * They noted that claimant had had low back pain right after his December 1992 injury, but that it did not require treatment. * * * Claimant reported to the arbiters that he currently had some low back pain when sleeping.

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[1] The Order on Reconsideration also modified the scheduled disability award to 12 percent for the right knee. The only issue before us on review is the unscheduled permanent partial disability award for the low back.

**147 Or App 624>** "The arbiter's lumbosacral range of motion measurements indicated slight loss of range of lumbar motion. * * * Nevertheless, they state that, 'based on the examination and other objective findings, [claimant] has lost 10 degrees of active flexion of the right knee[,] but otherwise has no *objective abnormality*.' (Emphasis added.) * * * Notwithstanding the arbiters' statement, the Order on Reconsideration granted unscheduled permanent disability based on the arbiters' range of motion findings.

"Based on the aforementioned medical opinions, we are not persuaded that claimant sustained permanent impairment in his low back as a result of his compensable injury, particularly in light of Dr. Matteri's failure to address claimant's low back during his closing evaluation, and in light of the arbiters' reference to no objective findings. Consequently, we conclude that claimant is not entitled to an award of unscheduled permanent disability." (Citations omitted; brackets in original.)

Claimant contends that the Board erred in relying on Matteri's failure to address claimant's low back during his closing evaluation and that it misapplied OAR 436-35-007(9). ORS 656.726(3)(f)(B) provides that "[I]mpairment is established by a preponderance of medical evidence based upon objective findings." *Former* rule OAR 436-35-007(9)[2] further defines impairment as:

"Impairment is determined by the attending physician except where a preponderance of medical opinion establishes a different level of impairment. On reconsiderations, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment."

The rule sets forth the methodology for analysis when there are multiple, conflicting reports about impairment. There is no evidence that Matteri undertook to evaluate claimant's low back on September 23, and it is not clear how the Board interprets the rule. Nonetheless, there was no **<147 Or App 624/625>** evaluation of impairment within the meaning of the rule by the attending physician that was "different" from and could be weighed against the arbiters' evaluation. The only report that addressed the issue of impairment of claimant's low back was the arbiters' report, which found impairment. Thus, the Board's reliance on the rule and on Matteri's evaluation as a basis on which to conclude that claimant had not demonstrated permanent disability from his low back injury is misplaced. Because we cannot tell from the Board's opinion what its conclusion about the weight of evidence would have been, had it not considered Matteri's report and the rule, we remand to the Board for reconsideration.

Reversed and remanded for reconsideration.

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[2] This claim is governed by *former* OAR 436-35-007(9) because claimant was declared medically stationary on September 23, 1993. Subsequently, OAR chapter 436, division 35 was revised, and new disability rating standards apply to all workers medically stationary on or after June 7, 1995. *See* OAR 436-035-0003(1).

Cite as 147 Or App 649 (1997) April 30, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

**Desiree COFFEY**, *Petitioner,*

v.

**EMPLOYMENT DEPARTMENT** and Wild River Pizza Co., *Respondents.*

(95-AB-2425; CA A91402)

Judicial Review from Employment Appeals Board.

Argued and submitted October 24, 1996.

Paul Pierson argued the cause and filed the brief for petitioner.

Philip L. Schradle, Assistant Attorney General, waived appearance for respondent Employment Department.

No appearance for respondent Wild River Pizza Co.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DE MUNIZ, J.

Affirmed.

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**147 Or App 651>** Claimant seeks review of an order[1] of the Employment Appeals Board (EAB) that reversed the referee and denied unemployment benefits on the ground that claimant quit work without good cause. ORS 657.176(2)(c). We affirm.

EAB made several modifications to the referee's findings and found:

"(1) Claimant worked for employer from January 1, 1989 until she quit effective May 25, 1995. (2) Claimant quit because the job tasks were no longer appropriate for her physical condition. (3) Claimant's job duties included working the front counter, cutting pizza, cash register and kitchen duties, such as working the fry room, rolling and cutting pizza and bussing tables. (4) As a supervisory personnel claimant had the option of assigning these duties to others; however, the restaurant would often times be busy or short staffed and claimant often performed different tasks to make the operation run smoothly.

"(5) In November 1994 claimant noticed she had pain in her right hand and wrist. (6) She would take aspirin to attempt control the pain. (7) As this condition worsened, claimant began to have muscle spasms in her hand and arm. (8) Claimant would sometimes have to stop what she was doing and pack her hand in ice, employer observed this. (9) In November 1994 claimant mentioned this condition to her supervisor and nothing was done at that time to alleviate claimant's condition. (10) Finally, in an effort to assist claimant get better, employer cut her hours in half and transferred claimant to night shift. Because her hours were cut, claimant lost her health insurance coverage.

"(11) On night shift claimant would have more crew members working under her. Night shift requires less lifting and less prep work; however, [it] is a busier shift because more customers come to dine at night. (12) Even with the reduced work load claimant's condition still caused her pain. (13) At the beginning of May 1995, claimant saw **<147 Or App 651/652>** her doctor about her hand and wrist. (14) Claimant was diagnosed as having mild chronic tendinitis and repetitive movement injury. (15) Claimant's doctor removed claimant from any work starting May 3, 1995. (16) During follow-up visits the doctor noticed slight improvement in claimant's, condition; however, [he] did recommend to claimant that she seek other work that did not require repetitive movements of her right arm and hand. (17) As of May 24, 1995 claimant's doctor released claimant to return to light duty work that did not require repetitive tasks, such as pizza making or lifting.

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[1] On its own motion, EAB set aside its original order after claimant filed her petition for review with this court. After reconsideration, EAB modified its original order and again denied benefits. Throughout this opinion, we refer only to the findings and conclusions as modified after EAB's reconsideration.

> "(18) Employer had been working with their workers' compensation carrier and claimant's doctor to develop a light duty position that might fit within claimant's needs. (19) Claimant was still experiencing pain and did not feel medically ready to return to this position, even with employer's promise of light duty tasks. (20) Claimant submitted her resignation effective May 25, 1995. (21) Even though claimant had been off work since May 3, she continued to experience pain, some numbness and tingling in her hands and did not feel she could adequately perform even modified tasks for this employer at that time. (22) Claimant believed that the employer would expect her to perform work outside her light duty restrictions in her capacity as a night shift supervisor. (23) Claimant believed that two other employees, who were assigned to light duty work, often exceeded their light duty restrictions because there was so much work to be performed. (25) Claimant's doctor approved jobs such as cashiering or cleaning tables as appropriate light duty work for claimant. (26) Claimant's doctor strongly recommended that claimant look for other work that would not involve duties which required repetitive movement of her right hand or arm. (27) As supervisor of a shift, claimant could have determined which duties she performed and which she did not."

EAB then concluded that claimant had failed to prove that she quit work for good cause. ORS 657.176(2)(c).

Claimant raises multiple assignments of error. We begin with those assignments that concern EAB's findings of fact, which we examine to determine whether they are supported by substantial evidence. ORS 183.482(8)(c). We conclude that they are and briefly discuss only some of claimant's arguments.

**147 Or App 653>** Claimant argues that EAB erred in finding that employer worked with her doctor because that finding is supported only by hearsay testimony of a witness who did not talk directly to the doctor. However, hearsay is not only admissible in an administrative hearing but may constitute substantial evidence. *Reguero v. Teacher Standards and Practices*, 312 Or 402, 417, 822 P2d 1171 (1991). In addition, EAB's finding is supported by the doctor's examination notes, which explain that he had told employer that claimant could return to some light duty such as a cashier-type job. Consequently, there is substantial evidence to support EAB's finding that employer worked with claimant's doctor.

Claimant also contends that EAB lacked substantial evidence to support those findings that concluded that claimant only "believed" she could not perform light duty work and that, as a supervisor, she could have determined which duties she performed. She insists that compelling evidence supports the ALJ's findings that, due to busy times and staff shortages, claimant would have had to perform work outside her light duty restrictions. As support, she points to her own knowledge of the restaurant after over six years of working for employer and her observations of two former supervisors, Candice McCombs and Marlene Olive, who exceeded their light duty restrictions.

We disagree that the evidence was as one sided as claimant insists. Two supervisors called by employer, Karen Andreason and Robert Young, testified that when they suffered from back problems employer had accommodated their work restrictions and other employees filled in for them. Further, Olive testified that other employees could be trained to cover for an employee on light duty. The testimony of those witnesses supports the finding that claimant could have delegated work exceeding her medical restrictions. Olive also agreed that, although a new untrained employee could have performed light duty, a responsible experienced employee would fill in as needed. That suggests that exceeding work restrictions was not a practical necessity as claimant urges. Consequently, there is substantial evidence to support EAB's findings.

**147 Or App 654>** Next, we determine whether there is a rational relationship between EAB's findings and its legal conclusions. *Crane v. Employment Div.*, 118 Or App 392, 395, 847 P2d 886 (1993). Although we may disagree with EAB, we will not overturn its conclusions "so long as the reasoning is not fallacious." *Id.* (quoting *Erne v. Employment Div.*, 109 Or App 629, 633, 820 P2d 875 (1990)).

To qualify for unemployment benefits, claimant must prove that she quit for good cause. ORS 657.176(2)(c). OAR 471-30-038(4) defines good cause for voluntarily quitting work as being

> "such that a reasonable and prudent person of normal sensitivity, exercising ordinary common sense, would leave work. For an individual with a permanent or long-term 'physical or mental impairment' (as defined at 29 CFR § 1630.2(h)) good cause for voluntarily leaving work is such that a reasonable and prudent person with the characteristics and qualities of such individual, would leave work. For all individuals, the reason must be of such gravity that the individual has no reasonable alternative but to leave work."

EAB determined that claimant's regular work posed a grave situation for her. However, it was not persuaded that the prospect of light duty also presented claimant with a grave situation. Although claimant believed that Olive and McCombs had exceeded their work restrictions, EAB nevertheless concluded that there was no evidence that employer either required or was aware of those instances where they went beyond their restrictions. Instead, EAB concluded that those employees had done that work with a conscientious desire to get the work done and that claimant had no reasonable basis to assume that employer would require her to work beyond her medical limit.

EAB also stated:

> "To the contrary, the employer demonstrated a desire to work with claimant, reducing her schedule and working directly with her doctor and the employer's workers' compensation insurer to design a light duty plan or assignment that would allow claimant to continue working, within their **<147 Or App 654/655>** light duty restrictions. We are persuaded that a reasonable and prudent person would at least attempt to continue working in a light duty position, especially if the position was, as in this case, apparently approved by that individual's doctor. Claimant would have had the authority and the reasonable alternative of at least trying to perform the light duty work and assigning duties which exceeded her light duty restrictions to other employees, even during busy periods."

Claimant contends that because the referee concluded that "[c]laimant presented credible and persuasive evidence * * * that she acted reasonably," the referee also determined that claimant's statement that she felt she was in too much pain to perform even modified duty was also credible. Consequently, according to claimant, because EAB failed to expressly explain why claimant was not credible, EAB necessarily accepted the referee's credibility determination and is somehow locked into the conclusion that claimant could not physically do the work.

ORS 657.275(2)[2] requires EAB to explain why it disagrees with a referee's explicit credibility determination. Here, even assuming that the referee's conclusion amounted to an explicit credibility determination, that statute does not apply because EAB did not disagree with the referee's credibility determination. Instead, EAB accepted, without modification, the referee's findings that claimant felt she was in too much pain to work.[3] EAB simply concluded, as it was entitled to do, that it was persuaded by the doctor's contrary opinion. That conclusion goes to the weight of the evidence, not to claimant's credibility.

Claimant next argues that EAB erred in focusing on the fact that employer did not require work outside of her **<147 Or App 655/656>** medical restrictions. Further, she contends that the fact that employer worked with its insurer and claimant's doctor should not have been considered.[4] Instead, claimant insists that EAB should have considered whether a reasonable and prudent person with a

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[2] ORS 657.275(2) provides, in pertinent part:

> "Where there is evidence in the record both to make more probable and less probable the existence of any basic fact or inference, the Employment Appeals Board need not explain its decision to believe or rely on such evidence unless the referee has made an explicit credibility determination regarding the source of such facts or evidence. The Employment Appeals Board is not required to give any weight to implied credibility findings."

[3] See findings of fact numbers 19 and 21 quoted above.

[4] Claimant also insists there was no evidence to support EAB's conclusion that claimant's doctor "approved" the light duty position. We agree that concluding that the doctor "approved" claimant's "position" is a far stretch of the evidence. However, we do not need to address whether EAB erred in reaching that conclusion because it was not critical to EAB's decision.

painful condition should have continued working under a light duty schedule that she knew nothing about[5] in a situation where light duty had not existed during her six-year tenure. Claimant insists that if she had continued to work, "she would not only have posed a serious risk to her own health, but would likely have been forced to stand by helplessly while pizzas piled up and chicken dinners burned in the fryer."

Claimant's argument focuses not on her ability to do light duty work but on her ability to do the job she expected of herself. EAB's findings regarding employer working with its insurer and claimant's doctor relates to EAB's conclusion that claimant had an alternative to quitting. The fact that former employees chose to take on duties outside of their medical restrictions bears on the reasonableness of claimant's expectations that light duty was beyond her own medical restrictions and that employer would not make accommodations for her medical condition. In the light of its finding that claimant could have delegated tasks beyond her medical restrictions, EAB concluded that those expectations were not reasonable. That conclusion bears a rational relationship to its findings.

Lastly, claimant contends that EAB incorrectly applied the good cause standard by failing to consider the "suitable work factors" of ORS 657.190. We have previously stated that EAB is not required to address suitability as part of its good cause determination, *Hunt v. Employment* Dept., **<147 Or App 656/657>** 139 Or App 440, 912 P2d 425 (1996), and we need not address that issue further.[6]

Affirmed.

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[5] Employer did not discuss the light duty position with claimant because employer did not have her phone number and, when she quit, she did not talk to employer but, instead, left a short note.

[6] Claimant also argues that EAB failed to consider her as a person with a longterm disability as required under OAR 471-30-038(4). However, if EAB erred in its initial order, that error was corrected in the modified order.

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Cite as 147 Or App 678 (1997) April 30, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Cheryl T. Torkko, Claimant.
**Cheryl T. TORKKO**, *Petitioner,*
v.
**SAIF CORPORATION** and Coos County S-D #13, *Respondents.*
(Agency No. 95-01511; CA A91855)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 17, 1996.

Juli Point argued the cause for petitioner. With her on the brief was Foss, Whitty, Littlefield & McDaniel, LLP.

Michael O. Whitty, Special Assistant Attorney General, argued the cause and filed the brief for respondents.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Reversed and remanded for reconsideration.

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**147 Or App 680>** Claimant seeks review of an order of the Workers' Compensation Board that concluded that her injury was not compensable because it did not arise out of her employment. ORS 656.005(7)(a). We reverse and remand.

We quote the material facts, which are undisputed, from the Board's order:

> "Claimant is an elementary school teacher who teaches seven[-] and eight-year-olds a variety of subjects on a daily basis. On December 6, 1994, which was a regularly-scheduled work day, claimant drove to her elementary school and entered a parking lot owned and maintained by the school district. The parking lot is used almost exclusively by teachers, although it is also open to members of the public who have business at the school.

> "Claimant parked her car in her customary spot, close to an entry door to the school. She got out of her car and closed the driver's door. She then opened the left rear door in order to retrieve a bag in which she kept both school-related and personal items. Included in those items were papers she had graded the night before, as well as art supplies and other-classroom [*sic*] materials. After getting the bag, she closed the door and turned to her left to begin her walk to the door of the school. In so doing, she struck her head on the side mirror of a van that was parked in the space next to her car. That vehicle was owned by another employee of the school. The incident occurred a few minutes before the beginning of the work day.
>
> "Claimant immediately reported her injury to a custodian, the school principal and a secretary. Within a half hour, she placed an ice pack on her head and neck and then began her regular classroom duties. She filed a claim for compensation on the day of her injury. She later obtained medical services from her long-time chiropractor.
>
> "On December 28, 1994, SAIF issued a denial of claimant's claim on the basis that she was not in the course and scope of her employment at the time of her injury."

"A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services[.]" ORS 656.005(7)(a). The Supreme Court **<147 Or App 680/681>** has established a unitary test to determine whether an injury is compensable, which considers both whether the injury arose out of claimant's employment and whether it occurred in the course of it. *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994). Neither factor is dispositive. *Id.* Here, although the Board concluded that claimant's injury occurred in the course of her employment,[1] it concluded that claimant's injury was not compensable because it did not arise out of her employment.

The "requirement that the injury 'arise out of' the employment tests the causal connection between the injury and the employment." *Norpac Foods, Inc.*, 318 Or at 366. In reaching its conclusion, the Board stated that "[i]n a 'parking lot' case, that causal connection exists when the claimant's injury is brought about by a condition or hazard associated with premises over which the employer exercises some control." Because it concluded that claimant's injury arose from a hazard, the van, over which the employer had no control, it concluded that claimant's injury was not compensable.

Since the Board's decision, we have held that the compensability of injuries sustained in an employer's parking lot does not turn only on the control exercised by the employer over the condition or hazard that caused the injuries. *SAIF v. Marin,* 139 Or App 518, 913 P2d 336 (1995), *rev den* 323 Or 535 (1996). In *Marin,* the claimant was injured while he was standing in the parking lot provided for employees by his employer. *Id.* at 520. The claimant's truck had a dead battery and his supervisor had agreed to help him "jump-start" it. The supervisor's wife was moving her car closer to the claimant's truck for that purpose when her car "struck a flower box, which in turn was pushed into [the] claimant, squeezing him against his truck" and injuring him. "The employer had built the flower box that struck [the] claimant." *Id.* Citing the "parking lot" standard, the Board **<147 Or App 681/682>** concluded that the claimant's injury arose out of his employment because the employer controlled the flower box that had injured him. We reversed, explaining that

> "the Board improperly focused only on the fact that [the] claimant was injured by an instrumentality over which the employer had control. Instead, *the Board should have considered whether the totality of the events that gave rise to [the] claimant's injury was causally related to his employment.*"

*Id.* at 522 (emphasis supplied). Applying that standard, we concluded that the claimant's employment did not place him in a position to be injured by the flower box; hence, his injury did not arise out of his employment.

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[1] The Board concluded, and employer concedes, that the "in the course of employment" component is satisfied by the "parking lot rule," "which provides that injuries that occur on the employer's premises while the claimant is proceeding to or from work are 'in the course of employment.'" *SAIF v. Marin,* 139 Or App 518, 520, 913 P2d 336 (1995), *rev den* 323 Or 535 (1996). Thus, we do not address that issue on review.

Employer argues that *Marin* is inapposite to this case because

> "[t]hat case turned not on whether the employer controlled the mechanism of injury, but on whether the flower box, in its inert state, created a risk connected to employment. Here, claimant failed to prove the coworker's rear view mirror was within the employer's control."

Employer misses the central point of *Marin*: under the "arising out of" standard outlined in *Norpac Foods, Inc.*, the Board should not focus on individual factors, like control, but rather on "the totality of the events that gave rise to [the] claimant's injury." *Marin*, 139 Or App at 522.

Here, as in *Marin*, the Board improperly focused on whether the employer controlled the instrumentality that caused claimant's injury. The proper focus is on whether claimant's injury, which was caused when her head struck an object in her employer's parking lot while she was taking school materials from her car to her classroom, is causally connected with her employment.[2] If the Board concludes that it is, then claimant's injury is compensable.

Reversed and remanded for reconsideration.

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[2] If claimant had tripped over a student's backpack and been injured while entering the school building that morning, the injury presumably would have been compensable as one that arose from claimant's employment even though employer did not control the backpack that caused the injury. It is unclear when the circumstances of claimant's injury in the parking lot are legally distinguishable from those of the hypothetical injury involving the backpack. The issue is one for the Board to address in the first instance. *See generally Kammerer v. United Parcel Service*, 136 Or App 200, 901 P2d 860 (1995).

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Cite as 147 Or App 698 (1997) April 30, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Max Walton, Claimant.
**PEPSI COLA BOTTLING CO.**, *Petitioner,*
v.
**Max WALTON**, *Respondent.*
(Agency No. 94-13340; CA A91169)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 19, 1996.

Kenneth L. Kleinsmith argued the cause for petitioner. With him on the brief was Meyers, Radler, Replogle & Bohy.

Lori E. Deveny argued the cause for respondent. With her on the brief was Pozzi Wilson Atchison.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Affirmed.

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**147 Or App 700>** Employer seeks review of an order of the Workers' Compensation Board that set aside its partial denial of claimant's generalized rheumatoid arthritis condition. We review for substantial evidence and errors of law, ORS 656.298(6), ORS 183.482(8)(c), and affirm.

Claimant twisted his left ankle in 1974 while placing cases of beverages on pallets for employer. Claimant's treating physician, Dr. Rice, diagnosed an acute sprain of the left ankle and preexisting rheumatoid arthritis. Employer accepted the claim as a nondisabling left ankle sprain.

In July 1979, Dr. Burroughs reported that claimant had rheumatic disease involving several joints, including his left ankle. Burroughs concluded that claimant's condition was related to his on-the-job injury. Burroughs took claimant off work in March 1981 due to a flare-up of rheumatic disease in claimant's left ankle, right knee, hands and wrists. Employer treated Burroughs' action as a request to

reopen the claim for the 1974 injury. Employer denied that request in May 1981 on the ground that the 1974 injury had not caused a "significant worsening of [claimant's] underlying condition." In its denial, employer defined claimant's underlying condition as a "type of rheumatic disease." Claimant requested a hearing on the denial.

An administrative law judge (ALJ) set aside the denial in March 1982, concluding that the worsened rheumatic disease was a consequence of claimant's compensable ankle injury. Employer did not seek review of that order.

Burroughs continued to treat claimant from 1983 to 1991. In February 1991, Burroughs told employer that he was treating claimant for degenerative and rheumatoid arthritis, the symptoms and impairments of which were due to the 1974 ankle injury. Burroughs further advised employer that the 1974 compensable injury was the major contributing cause of the onset of claimant's diffuse joint disease.

**147 Or App 701>** In September 1994, employer issued a denial of claimant's rheumatoid arthritis. In its denial, employer reiterated its acceptance of the 1974 left ankle sprain and its obligation to provide benefits for that condition and for the degenerative traumatic arthritis in that ankle. Employer asserted, however, that those conditions were not the cause of claimant's need for treatment of his generalized rheumatoid arthritis. Claimant requested a hearing on the denial.

In February 1995, an ALJ set aside the denial and assessed a penalty against employer on the ground that the denial was unreasonable. The Board affirmed the ALJ's order. It held that employer was precluded from denying the compensability of claimant's generalized rheumatoid arthritis condition because that condition had been determined to be compensable by the March 1982 order.

On review, employer first argues that the Board erred in concluding that it was precluded from denying the compensability of claimant's generalized rheumatoid arthritis condition. Under the doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined in a valid and final decision and the determination of that issue is essential to the decision, the determination is conclusive in a subsequent proceeding between the parties, whether on the same or a different claim. *Drews v. EBI Companies*, 310 Or 134, 139-40, 795 P2d 531 (1990). Thus, whether employer is precluded from denying claimant's generalized rheumatoid arthritis condition depends on whether the compensability of that condition was litigated and determined in the March 1982 order. Employer contends that it was not and that the March 1982 order established only the compensability of claimant's left ankle arthritis.

The March 1982 order provides, as relevant:

> "I first conclude that the claim is compensable and that [employer] is liable. The weight of the medical evidence persuades that but for the original ankle injury and residuals, claimant would not have required the medical care received in 1981 and after. This is more of a 'consequential condition' case than [an] occupational disease [case]."

**147 Or App 702>** The Board concluded that "the March 1982 order establishes * * * that claimant's underlying rheumatic disease is compensably related to his August 1974 injury." Contrary to employer's assertion, there is substantial evidence in the record to support that conclusion.

In July 1979, Burroughs reported that claimant had rheumatic disease involving several joints, including the left ankle. Burroughs concluded that that illness was related to claimant's on-the-job injury. In March 1981, Burroughs took claimant off work due to left ankle, right knee, hand and wrist symptoms. Based on that medical evidence, the employer issued its May 1981 denial, which provides as relevant:

> "In reviewing the information we have, including all the medical evidence, there is no indication that your August 6, 1974 work injury caused a significant worsening of your underlying condition which has given rise to your need for this time off and medical treatment.
>
> "The underlying condition appears to be a type of rheumatic disease."

Thus, employer specifically denied responsibility for claimant's rheumatic disease. Because employer's denial did not specify a particular body part, and the medical evidence on which employer based its denial established that claimant had "rheumatic disease" in several joints of his body, the Board reasonably could conclude that the reference to "rheumatic disease" in the denial letter referred to claimant's generalized rheumatoid arthritis.

Hence, because the Board reasonably could conclude that employer denied a claim for generalized rheumatoid arthritis, there is substantial evidence to support the Board's conclusion that the March 1982 order that set aside that denial established the compensability of that condition. Accordingly, the Board properly could conclude that employer is now precluded from denying the compensability of claimant's generalized rheumatoid arthritis.

Employer next argues that, in determining that the March 1982 order establishes the compensability of claimant's rheumatoid arthritis, the Board failed to consider the **<147 Or App 702/703>** 1995 changes to the Workers' Compensation Law. Specifically, employer argues that the Board failed to consider changes to ORS 656.005(7)(a)(B), which now provides that where a compensable injury combines with a preexisting condition, a worker must establish that the compensable injury is the major contributing cause of the "disability of the combined condition or the major contributing cause of the need for treatment of the combined condition." Or Laws 1995, ch 332, § 1.

Neither the former nor the current version of ORS 656.005(7)(a)(B) applies to claimant's claim. In order for the statute to apply, a compensable injury must combine with a preexisting condition. Claimant's ankle injury and rheumatoid arthritis have previously been determined to be compensable. Employer does not contend that those compensable injuries have combined with any other condition to cause disability or a need for treatment. Hence, the Board did not err in failing to apply ORS 656.005(7)(a)(B) to this case.

In its final assignment of error, employer argues that the Board erred in assessing a penalty against it for unreasonably denying compensation for claimant's generalized rheumatoid arthritis. We deny that assignment of error without discussion.

Affirmed.

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Cite as 147 Or App 710 (1997) April 30, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Fred D. Justice, Claimant.
**Fred D. JUSTICE**, *Petitioner,*
v.
**INTERNATIONAL PAPER**, *Respondent.*
(90-05033; CA A88233)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 10, 1996.
Robert Wollheim argued the cause for petitioner. On the brief were Christine I. Jensen and Malagon, Moore, Johnson & Jensen.
Paul L. Roess argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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**147 Or App 712>** Claimant seeks review of an order of the Workers' Compensation Board that denied his claim for permanent total disability benefits (PTD). We review for substantial evidence and errors of law, ORS 656.298(6), ORS 183.482(8)(c), and affirm.

Claimant injured his low back while working as a package stacker for International Paper Company, a self-insured employer. Employer accepted a claim for low back strain in January 1987. The claim was closed by a determination order that awarded claimant temporary and permanent disability.

Claimant requested a hearing on the disability award, contending, *inter alia,* that he was entitled to an award of PTD. After a hearing, an administrative law judge concluded that claimant was not entitled to such an award.

Claimant sought review of that decision by the Workers' Compensation Board. On review, the Board made the following findings:

> "Claimant is confined to sedentary work. He is unable to lift in excess of 10 pounds. He must frequently change positions. He is only able to stand or sit 30 minutes at [a] time. On occasion he must lie down in order to relieve symptoms.
>
> "He is capable of performing the following employments on a regular part-time basis: selected positions in retail work, trailer rental clerk, automobile rental clerk, customer service work, security guard, gate guard, ticket seller, and telephone solicitor."

Based on those findings, the Board upheld the denial of PTD benefits.

A worker is entitled to PTD if the worker establishes that she is permanently incapacitated from regularly performing work at a " 'gainful and suitable occupation'." *SAIF v. Terry,* 126 Or App 558, 560, 869 P2d 876 (1994). A "gainful occupation is one that pays wages equal to or greater than the state mandated hourly minimum wage." ORS 656.206(1)(a). A "suitable occupation is one that the worker has the ability and the training or experience to perform, or **<147 Or App 712/713>** an occupation that the worker is able to perform after rehabilitation." *Id.*

The Board concluded that claimant is able regularly to perform part-time sedentary work at a gainful and suitable occupation. Claimant does not dispute the Board's conclusion about his ability to obtain gainful employment. He contends, however, that it erred in concluding that he is able to work at a suitable occupation because, in reaching that conclusion, the Board failed to consider medical evidence that establishes that he must lie down on occasion in order to relieve symptoms. According to claimant, his need to do that prevents him from working at a suitable occupation, and the Board erred in concluding otherwise.

In finding that claimant is able to work at a suitable occupation, the Board relied on the opinion of employer's vocational expert, McGowan. McGowan testified that claimant was able to do regular part-time sedentary work, and he identified several job positions suitable for someone in claimant's condition. The Board found that claimant had the ability to do the jobs that McGowan had identified and that the jobs existed in a theoretically normal labor market.[1]

Claimant contends that the Board erred in relying on McGowan's opinion because his opinion failed to consider that claimant had to lie down on occasion to relieve symptoms. However, contrary to claimant's assertion, the record reflects that McGowan was aware of that evidence. In addition, claimant's treating physician, Dr. Crocker, testified that claimant is able to do part-time sedentary work with restrictions and that it would benefit him to work within his physical limitations. Thus, there is substantial evidence in the record to support the Board's conclusion that claimant is able to work at a suitable occupation. We therefore affirm the Board's order denying claimant's claim for PTD.

Affirmed.

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[1] OAR 439-30-055(1)(b) defines "suitable occupations" as

> "those types of general occupations that exist in a theoretically normal labor market which is located within a reasonable geographic distance [of the disabled worker], being either full-time or part-time in duration * * *."

Cite as 148 Or App 1 (1997) May 7, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas R. Williams, Claimant.
**BARRETT BUSINESS SERVICES**, *Petitioner,*
v.
**Thomas R. WILLIAMS**, Gibson Steel Fabricating, SAIF Corporation, and Morgan Manufacturing/Nicolai Door, *Respondents.*
(WCB Nos. 94-03163, 94-03162, 93-05344; CA A93904)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 17, 1997.
Scott H. Terrall argued the cause for petitioner. With him on the brief was Terrall & Associates.
Charles Duncan argued the cause and filed the brief for respondent Thomas R. Williams.
Paul L. Roess argued the cause for respondents Gibson Steel Fabricating and SAIF Corporation. With him on the brief were Frank A. Moscato and Moscato, Skopil & Hallock.
Jerald P. Keene argued the cause and filed the brief for respondents Morgan Manufacturing/Nicolai Door.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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**148 Or App 3>** Employer Barrett Business Services (Barrett) seeks review of an order of the Workers' Compensation Board, contending that the Board erred in determining that it, rather than Nicolai Door, an earlier employer, is responsible for claimant's shoulder condition. The case presents an issue of first impression concerning the interplay of ORS 656.308(1) and the last injurious exposure rule. In our view, the Board applied the correct legal analysis when it held that a single case can involve both ORS 656.308(1) and the last injurious exposure rule. Additionally, substantial evidence supports the Board's findings as to the assignment of responsibility. Accordingly, we affirm the Board.

Claimant suffered two compensable left shoulder injuries, in 1987 and 1988, while working for Nicolai Door. He had surgery after the second injury, and the claim was closed. Claimant did not return to work for Nicolai, but over the years he had numerous other employers. In May 1992, he went to work for Barrett at Cone Lumber. Cone Lumber terminated claimant's placement there when claimant asked his supervisor for approval to see a doctor with regard to shoulder pain. In January 1993, while unemployed, claimant was in a motorcycle accident that caused some shoulder pain. His symptoms resolved, but claimant's doctor recommended diagnostic tests to evaluate the underlying shoulder condition. In March 1993, claimant filed an aggravation claim with Nicolai. Nicolai denied the claim on the ground that claimant's aggravation rights had expired. Claimant began to work for Gibson Steel Fabricating in May 1993, but was let go in October 1993. Subsequent medical reports were treated by Nicolai as a new injury claim and it issued a disclaimer of responsibility, naming Barrett and Gibson as potentially responsible employers. They each denied the claims.

Because claimant had a previously accepted injury at Nicolai involving the same shoulder, the Board correctly held that the claim must initially be analyzed under ORS 656.308(1), which provides, in part:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future **<148 Or App 3/4>** compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

The Board found that claimant's shoulder condition is compensable as a new occupational disease because of his years of employment after his employment at Nicolai. That finding is supported by substantial evidence. The Board reasoned that, because claimant's work exposure after Nicolai was the

major contributing cause of his injury, responsibility shifts from Nicolai to a later employer. The medical evidence did not say, however, that claimant's new condition was caused by one of his subsequent employments but rather that it was caused by a combination of his employments after Nicolai. Accordingly, in determining which of the later employers should be responsible for the claim, the Board applied the last injurious exposure rule and held that responsibility should lie with Barrett, claimant's last employment before he sought treatment in 1993.

Barrett argues that the Board has impermissibly intertwined the provisions of ORS 656.308(1) with the last injurious exposure rule. In Barrett's view, because no single subsequent employment is the major contributing cause of claimant's condition, responsibility remains with Nicolai. We think that the Board's analysis is the correct one. Contrary to the position taken by employer, the Supreme Court's opinion in *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993), specifically 318 Or at 9 n 3, does not hold that ORS 656.308(1) eliminates the application of the last injurious exposure rule in every case involving a previously accepted injury. The court said that one of the purposes of the enactment of ORS 656.308(1) was to overturn a line of cases requiring a shifting of responsibility if a subsequent employment has contributed materially to the worker's injury, in order to "make it more difficult to transfer responsibility for a condition or disability to a subsequent employer." Here, there is no dispute that the subsequent employment was the major contributing cause of claimant's new occupational disease. Accordingly, under **<148 Or App 4/5>** ORS 656.308(1) and *Drews*, Nicolai, is relieved of further responsibility for its previously accepted claim. The new occupational disease is concededly compensable, but no employer has processed it to acceptance. Neither ORS 656.308(1) nor *Drews* makes provision for determining initial responsibility for a new compensable condition as among a claimant's subsequent multiple employments. The Board correctly turned to the last injurious exposure rule for the purpose of determining which among claimant's multiple employers after Nicolai is responsible for the condition. Its findings are supported by substantial evidence.

Affirmed.

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Cite as 148 Or App 6 (1997) May 7, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bradley S. Parker, Claimant.
**FOSTER WHEELER CONSTRUCTORS, INC.**
and Liberty Northwest Insurance Corporation, *Petitioners,*
v.
**Bradley S. PARKER**, *Respondent.*
(94-07649; CA A91873)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 10, 1996.

Patricia Nielsen argued the cause for petitioners. With her on the brief was Mannix, Nielsen, Yunker & Crawford, P.C.

Allison Tyler argued the cause and filed the brief for respondent.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Affirmed.

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**148 Or App 8>** Employer seeks review of an order of the Workers' Compensation Board requiring employer to pay temporary total disability (TTD) compensation for a seven-week period, from June 7, 1994, to July 28, 1994, and assessing a penalty for employer's unreasonable delay in paying the TTD. The crux of employer's case is that it should not be required to pay TTD because, sometime after the seven-week period, it was determined that claimant already had become medically stationary and thereby became ineligible for the benefits. Claimant argues, and the Board held, that it does not matter that claimant later was found to have been medically stationary. We agree with claimant and the Board and therefore affirm.

Unfortunately, the relatively straightforward legal issue presented by this case comes to us packaged in a fairly complicated factual posture. We state those facts that are relevant as found by the Board.

In July 1992, claimant injured his left elbow while working for employer as a boilermaker. He first sought treatment in October 1992, from Dr. Swanson, who restricted claimant from doing any high rigging work for at least one month. Claimant stopped working. In January 1993, employer accepted claimant's injury as a disabling claim for left elbow epicondylitis and began paying claimant temporary partial disability, beginning November 3, 1992. In April 1993, Swanson concluded that claimant was not expected to be medically stationary for another three to six months and restricted claimant to work not involving his left hand. In July 1993, Swanson reported that claimant would have permanent impairment and would not be able to return to regular work without surgery. He released claimant to light-duty work, restricting claimant from any repetitive use of his left arm.

In August 1993, employer issued a back-up denial, based on what it believed to have been material misrepresentations about claimant's past medical history. Employer stopped paying time-loss benefits. Claimant worked at two temporary, light-duty jobs in September 1993, and October **<148 Or App 8/9>** 1993, for six and three days respectively. Following that, he remained unemployed.

Meanwhile, claimant challenged employer's back-up denial. By order dated June 7, 1994, administrative law judge (ALJ) Peterson set aside the denial and ordered the claim to remain in accepted status. Employer appealed that order to the Board. While the appeal was pending, employer did not resume payment of time-loss benefits. At that point, however, there had been no determination that claimant had become medically stationary or that he had been released for regular work. Employer nevertheless believed that claimant's return to work in September and October of the previous year entitled it to terminate unilaterally the payment of such benefits. Claimant requested a hearing on employer's refusal to pay time-loss benefits.

On July 28, 1994, claimant saw employer's doctor, who reported that claimant was medically stationary and released him for regular work. Claimant's own doctor concurred in that report. Claimant returned to work shortly thereafter, and the claim was closed by determination order awarding benefits for time loss from October 1992, through July 28, 1994. Employer sought reconsideration of the determination order, arguing that claimant actually had become medically stationary even earlier, in August 1993.

On December 14, 1994, while the reconsideration of the determination order closing the claim and review of ALJ Peterson's order overturning the back-up denial still were pending, ALJ Thye held that employer was obligated to pay time-loss benefits through the medically stationary date of July 28, 1994, because, under ORS 656.313(1)(a)(A), time-loss benefits must continue to be paid until the earlier of either the date of closure or the date the order being appealed is reversed. Because the Board had not yet ruled on ALJ Peterson's order, the date of closure was, ALJ Thye concluded, the earliest date that employer could cease paying time-loss benefits.

Three weeks later, the department issued its decision on employer's request for reconsideration of the determination order closing the claim as of the July 28, 1994 medically stationary date. The department agreed with employer **<148 Or App 9/10>** and held that claimant became medically stationary on August 11, 1993. That decision was affirmed by ALJ Schultz, and claimant did not seek Board review. In May 1995, the Board affirmed ALJ Peterson's order overturning the back-up denial.

The Board then took up review of ALJ Thye's order requiring employer to pay time-loss benefits until July 28, 1994. Employer argued that, in the light of the subsequent order of ALJ Schultz, finding that claimant became medically stationary on August 11, 1993, it cannot be required to pay time-loss benefits beyond that date. In the alternative, it argued that it cannot be required to pay time-loss benefits beyond September 1993, at the latest, because that is when claimant returned to work. The Board rejected both arguments and upheld ALJ Thye's order requiring payment of time-loss benefits to July 28, 1994, and awarding penalties. It is that Board order that employer now asks us to review.

Employer asserts the same arguments to us that it asserted to the Board. It first contends that, when claimant returned to work in September 1993, his entitlement to time-loss benefits ended under ORS 656.268, and, because he never "reestablished" his entitlement to those benefits, employer thereafter was under no obligation to pay them. We disagree. ORS 656.268 provides, in relevant 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 gives the worker a written release to return to regular employment;
>
> "(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

Under that statute, if a worker returns to regular or modified work, the obligation to pay TTD benefits ceases. That is not the end of the matter, however. ORS 656.268(3)(a) does not exist in a statutory vacuum. ORS 656.212 and related implementing regulations provide that, when a worker who has **<148 Or App 10/11>** returned to modified work remains partially disabled and is not medically stationary, the obligation to pay temporary *partial* disability (TPD) continues. In that regard, the version of OAR 436-60-030(11) that applied at the relevant time provided, in part:

> "Temporary partial disability compensation * * * shall continue until * * * [t]he 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. * * * *The worker is entitled to temporary total disability compensation as of the date the job is no longer available."*

(Emphasis supplied.) In other words, returning to modified work relieves employer of the obligation to pay one type of time-loss benefits, TTD, and only for so long as the claimant continues at the modified work. When the modified work is no longer available, the worker again becomes entitled to TTD, until he or she is no longer entitled to the benefits under ORS 656.268.

In this case, claimant was entitled to receive, and was receiving, TTD before he took the six-day job in September 1993, and the three-day job in October of the same year. Under ORS 656.268(3)(a), that relieved employer of the obligation to pay TTD. But because claimant had not yet been released for regular work, he was entitled to TPD under ORS 656.212. When the temporary jobs were no longer available, claimant remained unemployed and not yet released for regular work and, under OAR 436-60-030(11), he once again was entitled to TTD, without having to "reestablish" his entitlement. Thus, at the time of the hearing before ALJ Peterson, and later at the time of the issuance of his June 7, 1994 order, claimant was entitled to TTD. Under ORS 656.313(1)(a)(A), benefits that accrue from the date of such an order are not stayed pending an appeal of the order.

Employer insists that, even if that is so, it did not pay those benefits, and since then, it has been determined conclusively that claimant became medically stationary nearly a year before that. Relying on our opinion in *Lebanon Plywood v. Seiber,* 113 Or App 651, 833 P2d 1367 (1992), **<148 Or App 11/12>** employer argues that the Board cannot order it to pay benefits to which claimant was not entitled. Again, we disagree. ORS 656.313(1)(a)(A) provides that, among other things, requesting Board review of an ALJ's order stays the payment of the compensation appealed except for

> "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."

(Emphasis supplied.) In *Lebanon Plywood,* the claimant, who had been receiving temporary disability benefits, had become medically stationary, but the claim was not closed until months later due to processing delays. There was no appeal, however, until long after the closure. Thus, no benefits accrued from the date of the order, and the exception to the stay described in ORS 656.313(1)(a)(A) did not apply.

In contrast, in *Anodizing, Inc. v. Heath,* 129 Or App 352, 879 P2d 218 (1994), the claimant's temporary disability benefits were due the date that they were ordered by the ALJ. When the employer appealed the order, the exception to the stay that is described in ORS 656.313(1)(a)(A) did apply, as the claimant accrued benefits during the pendency of the appeal, even though ultimately it was determined that the claimant was not entitled to them.

This case is controlled by *Anodizing*, not *Lebanon Plywood*. When ALJ Peterson issued his order on June 7, 1994, claimant was entitled to TTD, as we have described. Thus, his entitlement to those benefits accrued during the pendency of the appeal. The fact that, at some later date, claimant ultimately was determined not to have been entitled to the benefits does not relieve employer of the obligation to pay them in accordance with the statute. We conclude therefore that the Board correctly determined that claimant was entitled to TTD payments from June 7, 1994, and that it correctly awarded a penalty and attorney fees for the failure to pay those benefits.

Affirmed.

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Cite as 148 Or App 21 (1997) May 7, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

**Michael G. VAN DRIMMELEN**, *Appellant*,
v.
**Rick BERLIN**, *Respondent*.
(90C11447; CA A91674)

Appeal from Circuit Court, Marion County.
Albin W. Norblad, Judge.
Argued and submitted September 24, 1996.
J. Michael Alexander argued the cause for appellant. With him on the briefs was Burt, Swanson, Lathen, Alexander, McCann & Smith, P.C.
Brad G. Garber argued the cause for respondent. With him on the brief was Meyers, Radler, Replogle & Bohy.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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**148 Or App 23>** At issue in this case is whether a worker who is otherwise subject to an exemption from tort liability for injuries that he caused to another worker while on the job may be subject to tort liability because the employer failed to provide workers' compensation coverage. We conclude that a coworker's exemption from liability does not depend on the employer's compliance with the requirement to provide workers' compensation coverage.

Plaintiff was injured on the job when a coworker dropped a load of steel on him from a forklift. At the time, plaintiff's employer was not in compliance with the workers' compensation laws, that is, the employer did not provide workers' compensation insurance and did not qualify as a self-insured employer. Plaintiff filed a workers' compensation claim and the State Accident Insurance Fund Corporation (SAIF), pursuant to its statutory obligation to provide coverage for employees of noncomplying employers, accepted the claim.[1] Plaintiff ultimately was awarded a total of approximately $35,000 in workers' compensation benefits.

Plaintiff then initiated this negligence action against his employer and the coworker. The employer declared bankruptcy and was dismissed from the case, leaving the coworker as the only defendant. Defendant moved for summary judgment on the ground that plaintiff's sole remedy lay in obtaining workers' compensation benefits. The trial court agreed, granted the motion and entered judgment dismissing the claims against defendant.

On appeal, plaintiff argues that the trial court erred in granting defendant's summary judgment motion. According to plaintiff, coworkers are entitled to an exemption from tort liability for on-the-job injuries they cause only to the extent that the employer is subject to the exemption, and, in **<148 Or App 23/24>** this case, the employer was not subject to the exemption because it had failed to provide

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[1] At the time of plaintiff's injuries, ORS 656.054(1) provided that the director of the Department of Consumer and Business Services must refer claims for injuries while working for a noncomplying employer to SAIF. The statute was amended in 1995 and now provides that such claims are to be referred to an "assigned claims agent" with whom the director contracts to manage such claims. ORS 656.054(1) and (9).

workers' compensation coverage. Defendant agrees that the employer may not claim the exemption from tort liability unless it has complied with the statutory obligation to provide workers' compensation coverage. He argues that he nevertheless is not subject to tort liability because the employer's noncompliance is beside the point. Defendant argues that, under ORS 656.054, when an employee working for a noncomplying employer is compensably injured, he is entitled to benefits "as if the employer had complied" with the obligation to provide coverage. If the employer in this case had complied, defendant argues, he would have been subject to the exemption from tort liability; therefore, under ORS 656.054, he is subject to the exemption from tort liability. Plaintiff offers no reply to defendant's argument except to reiterate the position that exemption from liability is generally conditioned upon compliance with the statutory obligation to provide coverage.

The dispute thusly framed requires us to ascertain the intended meaning of the workers' compensation statutes, which we accomplish by looking first to the text of the statutes in context and, if necessary, to legislative history and other interpretive aids. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). The text of ORS 656.017(1) provides:

> "Every employer subject to this chapter shall maintain assurance with the director that subject workers of the employer and their beneficiaries will receive compensation for compensable injuries as provided by this chapter and that the employer will perform all duties and pay other obligations required under this chapter, by qualifying:
>
> "(a) As a carrier-insured employer; or
>
> "(b) As a self-insured employer * * *."

ORS 656.018 then provides, in relevant part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries * * * that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the **<148 Or App 24/25>** employer on account of such conditions or claims resulting therefrom * * *.
>
> "* * * * *
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter * * * are in lieu of any remedies they might otherwise have * * * against the worker's employer * * *.
>
> "(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the self-insured employer's claims administrator, the department, and the contracted agents, employees, officers and directors of the employer * * * [.]"

There can be no question that, in accordance with the two quoted statutes, only an employer "who satisfies the duty required by ORS 656.017(1)" is entitled to the exemption from tort liability described in ORS 656.018(1). Likewise, there can be no question that coworkers are entitled only to "the exemption from liability given an employer under this section," that is, an employer who has satisfied the duty to provide coverage in accordance with ORS 656.017(1). Those statutes, however, are not the only ones that pertain to the issues at hand. Two others also must be considered to complete the picture of the statutory framework within which an injured worker for a noncomplying employer may recover for his or her on-the-job injuries.

> First, ORS 656.054(1) provides, in part:
>
> "A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter."

The worker obtains such compensation from an assigned claims agent--in this case, SAIF--which, in turn, may initiate an action against the noncomplying employer to recover the benefits paid to the worker.

Second, ORS 656.578 provides that, even though the worker who has been compensably injured while working for a noncomplying employer may obtain workers' compensation benefits, he or she also may elect to recover damages from the noncomplying employer:

> **148 Or App 26>** "If a worker of a noncomplying employer receives a compensable injury in the course of employment, * * * such worker * * * shall elect whether to recover damages from such employer * * *."[2]

In that case, the assigned claims agent has a statutory lien against any damages that are recovered to offset the compensation already paid to the injured worker. ORS 656.580(2).

Those additional statutes reveal a different picture concerning the effect of the exemption statutes. While it may be true, as plaintiff suggests, that under ORS 656.018(1) and (3), the employee's exemption from tort liability is derivative of the employer's, that reading of the statutes is incomplete. ORS 656.054 also provides that, when a worker is compensably injured while working for a noncomplying employer, he or she recovers compensation *"as if the employer had complied"* with the conditions that entitle complying employers to the exemption. Thus, if an employer had complied with the requirement of providing workers' compensation coverage, the coworker would be entitled to the immunity from tort liability that flows from that compliance under ORS 656.018(1) and (3). And, while ORS 656.578 expressly authorizes the worker to bring a tort action against the noncomplying employer, its authorization to initiate such actions does not extend to coworkers or any others who would be subject to immunity if the employer had complied with its statutory obligation to provide its workers with coverage. Taken together, the statutes provide that, when a worker has been compensably injured while working for a noncomplying employer, (1) the worker is entitled to workers' compensation benefits from the assigned claims agent under ORS 656.054; (2) the worker is entitled to elect to sue the noncomplying employer and retain any damages in excess of the assigned claims agent's lien for compensation paid to the worker; but (3) the worker cannot sue a coworker, both because, under ORS 656.018(3) and ORS 656.054, the coworker would have **<148 Or App 26/27>** been entitled to claim the statutory exemption from tort liability and because ORS 656.578 does not authorize tort actions against employees of noncomplying employers.

That reading of the statutes only makes sense. To read them otherwise would mean that a coworker who negligently causes a compensable injury while working for a complying employer is treated differently from a coworker who does precisely the same thing while working for a noncomplying employer, when the noncompliance is entirely the fault of the employer, not of the coworker. Moreover, to read the statutes otherwise would effectively alter the statutory authorization expressed in ORS 656.578. That statute authorizes a worker to elect to sue a noncomplying employer for on-the-job injuries. It does not authorize the worker to sue coworkers as well. Indeed, if we were to read the statutes to permit tort recovery against coworkers, we would be required, by the same reasoning, to read the statute to authorize similar actions against all other nonemployers who are otherwise entitled under ORS 656.018(3) to the employer's exemption from tort liability, including the employer's insurer, the department, officers and directors of the employer and others. ORS 656.578(1) simply does not say that, and we are not at liberty to write such additional authority into the statute. ORS 174.010.

Turning to the facts of this case, it is undisputed that plaintiff's and defendant's employer was a noncomplying employer at the time of plaintiff's injuries. Plaintiff was thus entitled under ORS 656.054 to workers' compensation coverage "as if the employer had complied" with the obligation to provide coverage. Plaintiff also was entitled, under ORS 656.578, to sue his noncomplying employer for damages resulting from the on-the-job injury. He was not, however, entitled to sue his coworker. The trial court therefore correctly concluded that defendant was entitled to judgment as a matter of law and correctly granted defendant's motion for summary judgment on that ground.

Affirmed.

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[2] ORS 656.578 also provides that, when a worker receives an injury as a result of the negligence or wrong of a third person who does not work for the same employer, the worker may seek a remedy against the third person as well. In this case, plaintiff was not injured as a result of the negligence of a third person, and that portion of the statute does not apply.

Cite as 148 Or App 28 (1997) May 7, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rodrick L. Cotner, Claimant.
**LIBERTY NORTHWEST INSURANCE CORPORATION** and F.D. Thomas, Inc.,
*Petitioners,*
v.
**Rodrick L. COTNER**, *Respondent.*
(94-13000, 95-02202; CA A90730)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1996.
Darren W. Lee argued the cause and filed the brief for petitioners.
Robert Wollheim argued the cause for respondent. With him on the brief were Welch, Bruun, Green & Wollheim, Christopher D. Moore and Malagon, Moore, et al.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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**148 Or App 30>** Employer seeks review of an order of the Workers' Compensation Board (Board) awarding claimant temporary disability benefits, arguing that the Board lacked authority to order the payment of benefits beyond the date that claimant became medically stationary. The Board held that, under ORS 656.313(1)(a)(A), employer is obligated to continue paying temporary disability benefits until the date of closure. We hold that ORS 656.313(1)(a)(A) requires employers to pay only temporary disability benefits "that accrue from the date of the order appealed" and does not itself create entitlement to such benefits. Because at the time of the order appealed claimant already had become medically stationary, no benefits were accruing at that point, and employer was not obligated to pay those benefits pending the appeal. Accordingly, we reverse and remand for reconsideration.

The parties stipulated to the facts, of which the following are relevant to our review. On October 23, 1992, claimant filed a claim for injuries to his lower back. Employer denied the claim, and claimant timely requested a hearing. Claimant meanwhile underwent back surgery and, on December 1, 1993, his attending physician declared him medically stationary and released him for modified work. On August 23, 1994, the administrative law judge (ALJ) issued an opinion and order setting aside employer's denial. Employer requested Board review. While review was pending, however, employer paid no temporary disability benefits. Claimant requested a hearing, seeking payment of those benefits. Meanwhile, on January 10, 1995, employer issued a notice of closure, awarding claimant temporary disability benefits through December 1, 1993, claimant's medically stationary date. Employer did not pay temporary disability benefits beyond December 1, 1993. On April 12, 1995, the Board affirmed the ALJ's order setting aside insurer's denial, and that order was not appealed. On June 9, 1995, the ALJ ordered employer to pay temporary disability benefits from the appeal of the ALJ's August 23, 1994 order through January 10, 1995. The Board adopted and affirmed the ALJ. It is that order that employer challenges on review.

**148 Or App 31>** Employer argues that, under ORS 656.313(1)(a)(A), the exception to the stay of payment of benefits pending an appeal of an ALJ's order applies only to benefits "that accrue from the date of the order appealed from." According to employer, under ORS 656.268, a claimant is entitled to temporary disability payments only until he or she becomes medically stationary. Because at the time of the ALJ's August 23, 1994, order in this case claimant already had become medically stationary, employer concludes, no temporary disability benefits accrued from that date, and none were due claimant. Claimant argues, and the Board concluded, that, regardless of whether claimant already had become medically stationary at the time of the issuance of the ALJ's order, ORS 656.313(1)(a)(A) *itself* creates an obligation to pay temporary disability benefits following the request for review of the ALJ's order.

ORS 656.313(1) provides for a stay of the payment of benefits in the event of a request for, among other things, Board review of an ALJ's order awarding compensation. ORS 656.313(1)(a)(A) then provides an exception to that general rule that applies to:

> "[t]emporary disability benefits *that accrue from the date of the order appealed from* until closure * * *, or until the order appealed from is itself reversed, whichever event first occurs."

By its terms, the statute does not create entitlement to benefits while review is pending. Instead, it requires the continued payment of benefits "that accrue from the date of the order appealed from," that is, benefits to which the claimant otherwise is entitled. Indeed, if, as claimant and the Board conclude, the statute itself creates entitlement to temporary disability benefits, then the qualifying language "that accrue from the date of the order appealed from" serves no purpose. In the absence of persuasive evidence to the contrary, we do not so easily conclude that the legislature intended its enacted language to have no meaning. *See Phelps and Nelson,* 122 Or App 410, 415, 857 P2d 900 (1993), *rev den* 318 Or 326 (1994) ("Whenever possible, we avoid construing statutes in a manner that renders one or more of their provisions meaningless.").

**148 Or App 32>** Claimant insists that, under our decision in *Anodizing, Inc. v. Heath,* 129 Or App 352, 879 P2d 218 (1994), we must construe the statute to have created a right to continued payment of temporary disability benefits. We disagree. In *Anodizing,* unlike this case, at the time of the order of which the employer sought review, the claimant was not medically stationary. In fact, in *Anodizing,* unlike this case, the claimant was "statutorily entitled to payment of temporary [disability] benefits" precisely because it had not yet been determined conclusively when claimant had become medically stationary. *Id.* at 356-57.

Nor is our decision in *Foster-Wheeler Const. v. Parker,* 148 Or App 6, ___ P2d ___ (1997), to the contrary. In that case, at the time of the ALJ's order that was the subject of the employer's request for review, the claimant was statutorily entitled to payment of temporary disability benefits. Therefore, he was entitled, under ORS 656.313(1)(a)(A), to continued payment of those benefits while review was pending.

In this case, at the time of the ALJ's order, claimant already had become medically stationary and had been released to modified work, and no temporary disability benefits were accruing. Accordingly, because ORS 656.313(1)(a)(A) itself does not create entitlement to such benefits, the Board lacked authority to order employer to pay them while review was pending.

Reversed and remanded for reconsideration.

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Cite as 148 Or App 101 (1997) May 21, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael T. Nehl, Claimant.
**SAIF CORPORATION**, *Petitioner,* and DEPARTMENT OF CORRECTIONS, *Employer,*
v.
**Michael T. NEHL**, *Respondent.*
(95-03780; CA A92311)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 19, 1996.

Michael O. Whitty, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Robert Wollheim argued the cause for respondent. With him on the brief were Welch, Bruun, Green & Wollheim and Christopher D. Moore and Malagon, Moore et al.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Affirmed.

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**148 Or App 103>** In this workers' compensation case, SAIF Corporation (SAIF), as the employer's insurer, seeks review of an order setting aside its denial of claimant's low back injury claim. The Board held that surgery to repair claimant's preexisting spine fusion hardware was compensable under ORS 656.005(7)(a)(B) because his on-the-job injury constituted the major contributing cause of claimant's need for treatment for his combined condition. We affirm.

We take the facts from the administrative law judge's (ALJ) findings of fact, which the Board adopted on its review and which SAIF does not challenge. Claimant began employment as an Adult Parole and Probation Officer with the State of Oregdn in the late 1970's. In 1992, he sustained a noncompensable low back injury and underwent a left L3-4 microdiscectomy. In January 1993, he experienced a recurrent disk herniation and a second L3-4 microdiscectomy was performed in October 1993. Claimant experienced ongoing low back and left leg symptoms that were diagnosed as "status post repeat L3-4 discectomy and spondylolysis of L5." Claimant's symptoms did not improve, and he underwent a surgical fusion from L3 to the sacrum with the installation of Steffe plates, which were secured to the spine with screws. Claimant continued to experience ongoing, constant low back aching and left leg pain after the fusion but returned to work nonetheless.

On January 10, 1995, claimant's treating physician examined him after he complained of continuous low back and left, leg pain plus bilateral hip and groin pain. Physical therapy was prescribed and x-rays were taken on February 6, 1995.

On February 8, 1995, claimant squatted to talk with a mental health patient. When he stood up, he experienced a change in his back pain. Later that day, claimant attempted to help the same patient to her feet. Again, claimant experienced a different sensation in his back. Following a tense encounter with the patient, claimant began to notice more intense pain in his low back. He then experienced more back, buttock and thigh pain on the right side than was typical for **<148 Or App 103/104>** him at that time. On February 14, 1995, claimant filed a claim for low back injury. SAIF denied the claim by letter dated March 13, 1995.[1]

On March 13, 1995, claimant was examined by Dr. Misko and x-rays were taken. Claimant was found to have loss of bone around the screws in the L3 vertebrae. In June 1995, he underwent a fourth surgery on his low back.

After a hearing, the ALJ set aside SAIF's denial because "claimant's otherwise compensable on-the-job injury was the major contributing cause of the need for treatment of his combined low back condition."[2] ORS 656.005(7)(a)(B).[3] SAIF sought review before the Workers' Compensation Board (the Board), which adopted and affirmed the ALJ's order. This petition followed.

We review the Board's legal conclusions for errors of law, ORS 183.482(8)(a), and determine whether its findings are supported by substantial evidence in the record. ORS 183.482(8)(c).

On review, SAIF argues that the Board erred in its application of the "major contributing cause" standard under ORS 656.005(7)(a)(B). Claimant responds that the Board properly applied the statute and that its findings are supported by substantial evidence.

**148 Or App 105>** The Board, in adopting and affirming the ALJ's order, explained its application of the statute as follows:

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[1] SAIF's denial letter states, in pertinent part:

"You filed a claim for an alleged injury to your low back which you believe occurred on or about February 8, 1995, while you were employed at Department of Corrections.

"We have reviewed the information we have obtained and find that your work activity for [the] Department of Correction[s] is not the major contributing cause of the development of your alleged possible displacement of [pedicle] screw[s] around L3."

[2] The ALJ's order also awarded claimant attorney fees and claimant cross-requested review by the Board of that portion of the ALJ's order. That issue is not before us.

[3] ORS 656.005 (7)(a)(B) provides:

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

> "The focus of the fact finder in determining the applicability of ORS 656.005(7)(a)(B) is on the entire combined condition. It requires a determination of the relative contributions to the need for treatment of the combined condition or to the disability arising from the combined condition.
>
> "Here, the existence of claimant's claimed combined condition is undisputed. So is the fact that claimant's combined condition required medical treatment. The evidence establishes those facts without contradiction.
>
> "* * * In this case the 'combined condition' is claimant's post surgical low back with loosened hardware.
>
> "It is important to note in this case that the surgical treatment being claimed (the surgical repair of the failed fusion instrumentation) is directed at a very specific and limited part of claimant's 'combined condition.'* * *
>
> "ORS 656.005(7)(a)(B), and the legislative history behind that provision, make clear that if claimant's otherwise compensable injury is the major contributing cause of the specific need for treatment of claimant's combined condition, then that treatment is compensable. That is true even though claimant's disability may not have been caused in major part by the otherwise compensable injury." (Footnote omitted.)

SAIF contends that the Board misapplied the statute because it ignored claimant's "entire" condition and dealt only with the question of what caused the loosened screws. The problem with that approach, SAIF maintains, is that it "emphasizes the event that precipitated claimant's need for medical treatment, and not the entire collection of events and [factors] that contributed to the [cause of the need for medical treatment of his combined condition]." SAIF argues that claimant must show that *his entire combined condition,* not just his *specific need for treatment,* was caused in major part by his on-the-job injury. In that light, SAIF maintains that claimant's surgical treatment is not compensable because claimant's preexisting low back condition, which encompasses three surgeries, the installation of the screws and his **<148 Or App 105/106>** ongoing low back, leg and groin pain, greatly outweighs the relative contribution of his on-the-job injury to the causation of claimant's entire low back condition.

According to SAIF, the issue here is whether the term "combined condition" is limited to the condition for which claimant seeks treatment or whether it also encompasses all of claimant's preexisting low back problems. The Board concluded that the focus of the statute was on claimant's specific need for treatment and thus that the treatment is compensable if the on-the-job injury causes, in major part, claimant's immediate need for treatment, even though claimant's entire condition may not have been caused in major part by the on-the-job injury. The Board is correct.

The statute provides that the on-the-job injury must be the major contributing cause of *the need for treatment,* not the major contributing cause of the combined condition. *Accord Robinson v. SAIF,* 147 Or App 157, 162, ___ P2d ___ (1997) ("The Board also did not err in finding that claimant failed to establish that his work injury was the major contributing cause of his need for treatment"). That is consistent with ORS 656.245(1)(a), which now provides, in part:

> "[F]or * * * combined conditions described in ORS 656.005(7), the insurer or self-insured employer shall cause to be provided only those medical services directed to medical conditions *caused in major part by the injury."* (Emphasis supplied.)

It is evident that the Board, in affirming the ALJ, was referring to ORS 656.245(1) when it said: "It is important to note in this case that the surgical treatment being claimed (the surgical repair of the failed fusion instrumentation) is directed at a very specific and limited part of claimant's 'combined condition.'" The Board used the correct test. We conclude that, regardless of the extent of claimant's underlying condition, if the immediate cause of claimant's need for treatment is an on-the-job accident, the treatment is compensable.

Affirmed.

Cite as 148 Or App 263 (1997) May 28, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rosendo M. Valencia, Claimant.
**SAIF CORPORATION** and Young & Morgan Lumber, Inc., *Petitioners,*
v.
**Rosendo M. VALENCIA**, *Respondent.*
(95-08087; CA A92897)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 17, 1997.
Julene M. Quinn argued the cause and filed the brief for petitioners.
Max Rae argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Affirmed.
Landau, J., dissenting.

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**148 Or App 265>** SAIF seeks review of a Workers' Compensation Board order holding that claimant's right shoulder condition is a compensable consequential condition of a previously accepted left shoulder claim. We review for substantial evidence, ORS 183.482(8)(c), and affirm.

At the hearing, the issue was whether claimant's compensable left shoulder injury in 1994 was the major contributing cause of his right shoulder overuse syndrome. The only medical evidence was provided by Dr. Rand, claimant's treating physician, who expressed his opinion regarding causation in response to questions posed by claimant's attorney. Rand's opinion is reproduced below:

> To: William Rand, MD
>
> From: Max Rae, AAL, 363-5424, Fax: 363-5460
>
> Re: Rosendo Valencia
>
> A simple, hand written response on this sheet and faxed back to me would be sufficient. The hearing is at 9:00 tomorrow morning. My fax machine in left on at all times
>
> Is it more probable than not that Rosendo's favoring of his left shoulder is the major contributing cause of his right shoulder problem? Is it otherwise more probable than not that the right shoulder problem was caused in major part by the work at Young and Morgan or the left shoulder injury?
>
> Thank you for your help.

Based on Rand's opinion, the administrative law judge (ALJ) concluded that claimant had established a compensable claim and the Board affirmed.

SAIF contends that substantial evidence does not support the ALJ's finding, adopted by the Board, that Rand offered an opinion that claimant's accepted left shoulder injury was the major contributing cause of claimant's right shoulder condition. According to SAIF,

> "[t]he document does not contain a response to the question posed by claimant's attorney. The markings on the document by some unidentified individual consist of underlining and circling various words. The document does not indicate agreement or disagreement with the proposition of compensability suggested by claimant's attorney in the question posed. A reasonable person could not conclude from the **<148 Or App 265/266>** document itself, or from the record as a whole, that a medical opinion sufficiently supporting compensability exists."

Claimant responds that the ALJ's interpretation of Rand's response to the inquiry made by claimant's attorney is reasonable.

As a threshold matter, we note that SAIF made no authentication objection to Rand's opinion being admitted into evidence at the hearing, and it declined the opportunity to depose or cross-examine Rand. Consequently, the only issue is whether substantial evidence supports the finding of the ALJ and the Board that claimant's right shoulder condition developed as a consequence of his left shoulder injury.

On review of an order of the Board, we are not to substitute our judgment for that of the Board as to any issue of fact or to set aside any finding that is supported by substantial evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988).

Claimant's attorney posed two questions to Rand. The first asked whether it was more probable than not that claimant's favoring of his left shoulder was the major contributing cause of his right shoulder problem. The second asked whether it was more probable than not that claimant's right shoulder problem was caused in major part by his work for employer or by the left shoulder injury. The ALJ and the Board concluded that Rand's underlining and circling of words indicated his agreement with the first question posed by claimant's attorney. The ALJ characterized Rand's medical opinion as "sparse." Nonetheless, on this record, which consists of Rand's opinion and claimant's testimony, we conclude that substantial evidence supports the finding that claimant's favoring of his injured left shoulder was the major cause of the development of his right shoulder condition.

Affirmed.

**LANDAU, J.,** dissenting.

When we review for "substantial evidence," we are not required to affirm a factual finding if it is supported by any evidence, no matter how meager. The law requires more than that. It requires such evidence that "a reasonable mind would employ to support a conclusion." *Ruiz v. Employment* **<148 Or App 266/267>** *Division*, 83 Or App 609, 614, 733 P2d 51 (1987) (citing *Cook v. Employment Division*, 47 Or App 437, 441, 614 P2d 1193, *rev den* 290 Or 157 (1980)); *see also de St. Germain v. Employment Division*, 74 Or App 484, 488, 703 P2d 986 (1985) (substantial evidence " 'means more than "any evidence," a scintilla of evidence, or speculation' " (quoting *Cantrell v. Employment Division*, 24 Or App 215, 217, 545 P2d 143 (1976))). With that standard in mind, I find it impossible to conclude that the markings that appear on a questionnaire sent to claimant's physician, by themselves and with reference to no other testimony or evidence, constitute substantial evidence of a finding as to Dr. Rand's opinion on the issue of causation.

Claimant's attorney sent a faxed memorandum to Rand asking him to respond to two questions:

> "Is it more probable than not that [claimant's] favoring of his left shoulder is the major contributing cause of his right shoulder problem? Is it otherwise more probable than not that the right shoulder problem was caused in major part by the work at Young and Morgan or the left shoulder injury?"

Rand did not answer either question. He did not say "yes" to one and "no" to the other. He did not check either one. What he did was circle the words "not that" and the word parts "er pro." He then underlined "not that [claimant's] favo" and "cause of his right shoulder" and inserted the initials "LR" in the left margin.

Only rank speculation can make an opinion of any sort out of those markings. Certainly, it is possible that Rand intended them to mean *something*. From the markings themselves, however, it is impossible to say precisely *what* he intended them to mean. We cannot, for example, begin to tell whether the markings are intended to answer either question in the affirmative or whether the markings are instead mere indiscriminate doodles. In either event, the curious markings that appear on the attorney's questionnaire are not the sort of evidence that reasonable minds would employ to support a finding of fact, and the mere fact that the Board reached a contrary conclusion does not mean that we must do likewise.

I respectfully dissent.

Cite as 148 Or App 292 (1997) June 11, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Emily M. Bowman, Claimant.
**KIMBERLY QUALITY CARE**, *Petitioner*,
v.
**Emily M. BOWMAN**, *Respondent*.
(WCB 95-09511; CA A93880)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 24, 1997.
Jerald P. Keene argued the cause and filed the brief for petitioner.
Dale C. Johnson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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**148 Or App 294>** Employer seeks review of an order of the Workers' Compensation Board affirming an order of an administrative law judge (ALJ) and holding that claimant is entitled to a assessed attorney fee pursuant to ORS 656.386(2) for having obtained a rescission of the denial of a claim for two conditions after the filing of a request for hearing but before th hearing had been held. We conclude that the Board was correct in awarding the fee and affirm.

In January 1993, claimant filed a claim for injuries to her low back and right foot. The medical notes diagnosed right foot and ankle conditions, and made no mention of the low back. Employer accepted the claim for "right ankle sprain; right foot sprain," in March 1993. Claimant's doctors began reporting treatment for low back strain and also diagnosed right foot plantar fasciitis. Employer paid those bill under the original claim but did not accept or deny either condition.

In August 1995, claimant's counsel wrote to employer asking that the low back condition and plantar fasciitis be formally added to the accepted claim. On tha same day, he filed a request for hearing based on a *de facto* denial of those conditions. On September 22, 1995, employer submitted a form "Response to Issues" raised by the request for hearing, containing a check-the-box notation that claimant had sustained no work-related injury or disease. On October 17, 1995, employer's workers' compensation carrier responded to claimant's August 21, 1995, letter by amending its previous acceptance to incorporate both the low back strain and the plantar fasciitis.

On November 17, 1995, a hearing was held on claimant's request for hearing. The only issue was the assessment of attorney fees. Employer agreed to the assessment of a attorney fee based on inclusion of the low back strain, but objected to the fee based on the plantar fasciitis condition. The ALJ assessed a separate fee for each under ORS 656.386(1), on the ground that claimant's attorney had been instrumental in obtaining acceptance of claimant's low back condition and plantar fasciitis.

**148 Or App 295>** The Board affirmed the ALJ, holding that the plantar fasciitis had been a denied claim under ORS 656.386(1), and that attorney fees were authorized by the statute. As amended by the legislature in 1995, ORS 656.386(2) provides for an assessed fee "in all cases involving denied claims * * * where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge." For the purposes of that section,

> "a 'denied claim' is 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."

The Board found that employer's check-the-box notation on the hearing response form was a denial with respect to the conditions that had not yet been accepted, *i.e.*, the low back and plantar fasciitis. The Board's finding is supported by substantial evidence. Further, we agree with the Board's conclusion that claimant's attorney was instrumental in obtaining an acceptance of the claim. We reject employer's suggestion that the claim had not been denied because there had been no refusal to pay compensation.

Although employer had not refused to pay compensation up to the time claimant put the compensability of the conditions at issue, its notation on the response form was an express denial of the conditions on the ground that they were not related to the employment. It carried with it an implicit refusal to pay compensation in the future. Employer's argument is dependent on its underlying assumption that the conditions had been denied *de facto;* that was the case until employer's response to the request for hearing. Although the check-the-box notation did not satisfy the requirements for a denial set forth in ORS 656.262(9), it nonetheless unequivocally expressed employer's denial of compensability. When an express denial of compensability is rescinded and the claimant's attorney is instrumental in obtaining the rescission, ORS 656.386(2) provides for an award of attorney fees.

Affirmed.

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Cite as 148 Or App 296 (1997) June 11, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Roger L. Wolff, Claimant.
**SAIF CORPORATION** and Nendel's Management & Supply Co., Inc., *Petitioners,*
v.
Roger L. **WOLFF**, *Respondent.*
(WCB No. 93-06586; CA A93849)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 3, 1997.
David L. Runner argued the cause and filed the brief for petitioners.
Martin L. Alvey argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Reversed.

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**148 Or App 298>** Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred in concluding that it is precluded from denying the compensability of claimant's osteochondritis dissecans. We agree with employer that its denial is not barred, and reverse the Board's order.

Claimant compensably injured his knee in 1980. The claim was accepted as a contusion. Following surgery, the September 21, 1981, closing report of claimant's treating physician diagnosed

> "[o]steochondritis dissecans with a large fragment having been removed, with chondromalacia of the patella. *Most likely this patient had a pre-existing problem of osteochondritis dissecans* which may have resulted in the fragment having become loose at the time of his industrial injury." (Emphasis supplied.)

Specifically, the doctor concluded that claimant's injury-related impairment was "10 percent of a lower extremity." The doctor noted, "He probably has more impairment than this, but this is the portion which I feel is directly related to his accident and not a preexisting condition." The claim was closed on October 15, 1981, by a determination order awarding 10 percent permanent partial disability for the "left leg (knee)." The record contains a worksheet prepared on October 12, 1981, by the Evaluation Division with check-box notations of claimant's conditions, including "atrophy," "disabling pain," and under "other," lists "chondromalacia," and "osteochondritis." The references are unexplained, except that they are in the "scheduled" box on the work sheet.

The claim was reopened in 1986, and claimant had a second surgery. The claim was closed without an award of additional permanent disability. Claimant requested a hearing, and in February 1987 the parties reached a stipulation under which claimant received an additional 15 percent PPD. The stipulation identified the condition accepted as "left knee strain," and stated that the agreement resolved "all issues raised or raisable" at that time.

**148 Or App 299>** In 1993, claimant's physician sought authorization for a third surgery. SAIF issued a partial denial of claimant's osteochondritis dissecans. Relying on our opinions in *Messmer v. Deluxe Cabinet Works,* 130 Or App 254, 881 P2d 180 (1994), *rev den* 320 Or 506 (1995) *(Messmer I),* and *Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 915 P2d 1053, *rev den* 324 Or 305 (1996) *(Messmer II),* the Board ultimately concluded that the 1981 determination order precluded employer's denial of the osteochondritis dissecans because the order had listed osteochondritis as one of claimant's conditions.

We reject employer's invitation to reconsider our holdings in *Messmer I* and *Messmer II.* In *Messmer I,* we stated the rule that, when a determination order *awards benefits* for a condition that has not been accepted, and the employer does not appeal the determination order, the employer is barred by claim preclusion from denying that the condition is a part of the accepted claim. 130 Or App at 258. Whether the determination order includes an award for the unaccepted condition is a question of fact. Here, we conclude that substantial evidence does not support the Board's finding that the 1981 determination order awarded benefits for osteochondritis dissecans. In the first place, contrary to the Board's findings, the *determination order* did not list claimant's osteochondritis dissecans. Only the worksheet listed it. In the light of the contemporaneous closing medical report, which expressly *excluded* claimant's osteochondritis dissecans from the recommended rating of 10 percent disability, and its consistency with the 10 percent award in the determination order, we conclude that the simple listing of osteochondritis dissecans on the evaluator's worksheet as one of claimant's conditions does not support an inference that an award was made for the condition. This is especially so in the light of the fact that the disability rating rule in effect at the time authorized benefits for disabling pain, but not for the other conditions listed.

Further, in our view, the parties' 1987 stipulation, in which the parties settled "all issues raised or raisable" with regard to claimant's accepted knee condition, precludes claimant from now seeking compensation for the osteochondritis dissecans. The quoted language precludes a claim for **<148 Or App 299/300>** any condition that had been diagnosed but not accepted at the time of settlement. *Good Samaritan Hospital v. Stoddard,* 126 Or App 69, 867 P2d 543 (1994). Claimant's osteochondritis dissecans was diagnosed long before the 1987 stipulation and had not been accepted at any time. The Board erred in determining that claimant could seek benefits for it.

Reversed.

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Cite as 148 Or App 301 (1997) June 11, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marilyn Wheeler, Claimant.
Marilyn **WHEELER**, *Petitioner,*
v.
**LIBERTY NORTHWEST INSURANCE CORPORATION** and Associated Press, *Respondents.*
(WCB 94-10789; CA A93922)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 3, 1997.
Linda C. Love argued the cause for petitioner. With her on the brief was Craine & Love.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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**148 Or App 303>** Claimant seeks review of an order of the Workers' Compensation Board (Board) upholding employer's denial of her aggravation claim for a bilateral wrist, forearm and elbow condition. We affirm.

Claimant works as an editor and reporter for employer Associated Press. In 1989, employer accepted claimant's claim for tendinitis in her left wrist. In 1990, claimant was deemed medically stationary, and the claim was closed by determination order without any award of permanent disability benefits. Later in 1990, the parties entered into a stipulation that claimant would receive 5 percent permanent partial disability for tendinitis in both wrists. Also in 1990, claimant was transferred from

Oregon to North Dakota. In North Dakota, claimant's duties did not involve as much computer keyboarding, and her symptoms diminished. She had flare-ups in 1992 and 1993 that were associated with temporary increases in her workload. Claimant received no further medical treatment for the wrist problems until 1994.

In 1994, while working in North Dakota, claimant sought treatment for pain in her wrists, forearms and elbows. Claimant testified that the pain was worse than it had been in 1989, and that it had crept up her anns. She was diagnosed with fibrositis and lateral epicondylitis. Her treating physician was of the opinion that claimant's 1994 condition was related to the condition for which she had been treated in 1989, and also that claimant's work in North Dakota had worsened the condition.

Claimant filed an aggravation claim with employer's Oregon insurer, Liberty Northwest, and that claim was denied. Claimant then filed a workers' compensation claim in North Dakota, which was dismissed as untimely.[1] Claimant appealed the denial of her aggravation claim, and the administrative law judge (ALJ) upheld the denial. On review, the Board found that claimant's condition was a consequential condition and, applying ORS 656.005(7)(a)(A), found that **<148 Or App 303/304>** claimant had failed to establish that her 1989 condition was the major contributing cause of her 1994 consequential condition.

Claimant petitioned for judicial review of the Board's decision, arguing that the Board erred in analyzing her claim as a consequential condition. She argues that her condition in 1994 arose directly from her 1989 work exposure, and thus that the major contributing cause criteria that apply to claims for consequential conditions do not apply.[2] Claimant argues that the common-law rule established by this court in *Miville v. SAIF*, 76 Or App 604, 710 P2d 159 (1985), should be applied. Under *Miville*, claimant contends, if her original Oregon condition materially contributed to her later disability, the claim is compensable in Oregon even if out-of-state injuries independently contributed to the later disability. Employer responds that substantial evidence in the record supports the Board's conclusion that claimant's 1994 condition was a consequential condition, and that claimant failed to establish that her 1989 condition was the major contributing cause of her 1994 condition. Further, employer contends that the rule in *Miville* precludes recovery in this case, because the dismissal of the North Dakota claim due to untimeliness is essentially the same as claimant failing to file a claim in North Dakota.

In *Miville*, the claimant had a compensable injury in Oregon, and subsequently had another on-the-job injury to the same body part while working for another employer in another state. 76 Or App at 605. He filed an aggravation claim in Oregon, which was denied. Under the workers' compensation law at the time, if a subsequent on-the-job injury in Oregon independently contributed to the disability, responsibility would shift to the second Oregon employer. A subsequent off-the-job injury, however, would result in the initial employer remaining responsible if the initial injury remained a material contributing cause of the disability. *Id.* at 606. This court, therefore, was faced with deciding which test **<148 Or App 304/305>** should apply to a subsequent out-of-state on-the-job injury. We held that, because Oregon had no control over how or whether the subsequent injury would be compensable in another state, the claim would remain compensable in Oregon "when a claimant has suffered an on-the-job injury in another state for which he has claimed, but has not been awarded, compensation, and the medical evidence is that the original Oregon injury materially contributed to the claimant's present disability, even though the out-of-state injuries contributed independently to the present disability." *Id.* at 607.

Claimant in the present case contends that the rule of law announced in *Miville* regarding the first employment remaining responsible if that condition remains a material contributing cause of the disability applies in the present case and that although her subsequent out-of-state work contributed to her condition in 1994, the 1989 condition materially contributed to her present disability; thus, her claim is compensable. Employer contends that *Miville* precludes recovery in this case, because claimant failed to pursue a timely claim in North Dakota.

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[1] Claimant has appealed that dismissal, and her North Dakota appeal is currently in abeyance pending the outcome of this case.

[2] Claimant does not argue that ORS 656.005(7)(a)(A) (consequential conditions) should not be applied to aggravation claims. Rather, she asserts that it was misapplied to this particular claim because her 1994 condition was not a consequential condition.

We reject employer's argument that claimant's claim is precluded under the procedural rule from *Miville* because claimant is required to pursue an out-of-state claim. In *Progress Quarries v. Vaandering*, 80 Or App 160, 165-66, 722 P2d 19 (1986), this court addressed whether *Miville's* procedural requirement applied to occupational disease claims as well as accidental injury claims, and concluded that it did not. *See also Silveira v. Larch Enterprises*, 133 Or App 297, 891 P2d 697 (1995) (same). The status of claimant's North Dakota workers' compensation claim therefore does not affect the outcome in this case.

Claimant maintains that *Miville's* "material contributing cause" standard should be applied in the present case. We disagree. To the extent that the substantive rule from *Miville* retains any vitality in the light of subsequent legislative changes, *see, e.g.*, ORS 656.308(1); ORS 656.273, we conclude that it has no application in the present case. *Miville* concerned accidental injuries to the same body part. The present case concerns different occupational diseases. The **<148 Or App 305/306>** Board found that claimant's current wrist, forearm and elbow conditions are not the same condition for which claimant previously had been compensated. Under current law, when a claim concerns a condition that has not previously been accepted, that claim must be analyzed either as a new injury or under the "major contributing cause" standard set forth in ORS 656.005(7)(a). Here, because the conditions for which compensation is sought are different from the previous compensable condition, the Board was correct in concluding that *Miville* did not apply.[3]

The "major contributing cause" standard is codified in ORS 656.005(7)(a), and provides, in part:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

Occupational diseases are treated as injuries for purposes of ORS chapter 656. ORS 656.804. ORS 656.273(1) deals with claims for aggravation of conditions previously deemed compensable, and provides, in part:

> "After the last award of 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 **<148 Or App 306/307>** established by medical evidence of an actual worsening of the compensable condition supported by objective findings."

**148 Or App 307>** The Board concluded that, because claimant's current conditions are not the same as the previously accepted condition, to establish compensability she is required to show that the "worsened condition resulting from the original injury" is a consequential condition and that the original condition is " the major contributing cause of the consequential condition." ORS 656.005(7)(a)(A). *See, e.g., Weyerhaeuser Co. v. Pitzer*, 123 Or App 1, 858 P2d 886 (1993) (applying ORS 656.005(7)(a)(A) to occupational disease claim).

Claimant argues that her 1994 condition is not a "consequential" condition, and thus was not subject to the major contributing cause standard. Claimant relies on this court's decision in *Albany General Hospital v. Gasperino*, 113 Or App 411, 833 P2d 1292 (1992), to support her contention that her 1994 condition is a "direct" rather than a "consequential" result of her 1989 tendinitis. In *Gasperino*, the

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[3] Moreover, although at the time *Miville* was decided, "material contributing cause" was the test for both initial accidental injury claims and aggravation claims concerning accidental injuries, occupational disease claims were analyzed under a "major contributing cause" standard rather than a "material contributing cause" standard. *See, e.g., Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983) (applying major contributing cause test to occupational disease claim); *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 501, 812 P2d 844, *rev den* 312 Or 150 (1991) (standard of proof for proving all types of occupational disease claims is major contributing cause standard).

claimant fell at work and injured her back, wrists and shoulders. The employer accepted the claim. In the next few months, the claimant experienced numbness in her arms and hands, and was diagnosed with thoracic outlet syndrome (TOS). The employer denied the claimant's claim for TOS, and argued that the claimant had not established that the TOS was a compensable "consequential condition" under ORS 656.005(7)(a)(A), the "major contributing cause" standard. This court agreed with the claimant that her TOS was not a "consequential" condition, because the "medical evidence indicated that claimant's TOS was a condition that arose directly, although belatedly, from the [accidental injury]." 113 Or App at 414. Thus, claimant is correct that, if her 1994 condition arose directly from her 1989 condition, the 1994 condition would not be treated as "consequential" for purposes of ORS 656.005(7)(a)(A).

However, as the Board noted, claimant's fibrosistis and lateral epicondylitis developed approximately three years after her wrist tendinitis claim had been closed. Moreover, uncontradicted evidence in the record indicates that claimant's wrist and elbow pain are causally related to her work in North Dakota. Claimant's argument that her 1994 **<148 Or App 307/308>** condition was directly caused by her 1989 condition is not well taken, given the evidence in the record that her 1994 condition is related, at least to some degree, to an intervening cause, *i.e.*, her work in North Dakota. Thus, the Board did not err in analyzing claimant's current condition as a "consequential condition." ORS 656.005(7)(a)(A).

The Board found that there was insufficient evidence in the record to establish that the 1989 condition was the major contributing cause of the 1994 condition. We agree. The only medical evidence concerning causation came from claimant's treating physician in North Dakota, who indicated that he believed that claimant's 1994 condition was "related" to her 1989 condition, and also that claimant's condition had "been made worse by her ongoing work activities." That evidence is insufficient to establish that the 1989 condition was the major contributing cause of the consequential condition that claimant experienced in 1994.

Finally, claimant argues that the Board erred in determining that her 1994 condition was not the same as her 1989 condition. We review the Board's finding to determine if it is supported by substantial evidence in the record. ORS 656.298(6); ORS 183.482. Claimant argues that her 1994 condition is the same condition that the employer had previously accepted. Claimant relies on this court's decision in *Boise Cascade v. Borgerding*, 143 Or App 3 71, 923 P2d 1308 (1996). That case does not assist claimant. In that case, the employer had accepted the claimant's claim for an allergy condition caused by wood dust at work. *Id.* at 373. Subsequently, another physician concluded that the claimant had been misdiagnosed and that the allergy condition was not caused by wood dust. *Id.* The employer then denied the claim. This court concluded that the denial was not permissible because the employer was attempting to deny the same condition that it previously had accepted. In reaching that conclusion, this court relied on the fact that the " 'symptoms which were accepted are the same symptoms which are now denied.' " *Id.* at 374 (quoting ALJ order). In the present case, by comparison, there is no evidence of a misdiagnosis of claimant's 1989 condition, and it is undisputed that her 1994 symptoms are not the same symptoms that accompanied the 1989 condition. While both the 1989 condition and the 1994 condition **<148 Or App 308/309>** involved wrist pain, the 1994 condition concerned claimant's forearms and elbows. Not only are the symptoms different, but the diagnoses are different. Substantial evidence in the record supports the Board's finding that claimant's 1994 condition was not the same as her 1989 condition.

The Board correctly concluded that claimant failed to establish that her 1989 wrist tendinitis is the major contributing cause of her 1994 fibrositis and lateral epicondylitis, ORS 656.005(7)(a)(A), and thus properly concluded that claimant had not established that her aggravation claim is compensable. ORS 656.273.

Affirmed.

Cite as 148 Or App 328 (1997) June 11, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Ramiro and Margarita **RANGEL**, Co-Personal Representatives for the Estate of Everado Rangel-Jasso, Deceased, *Appellants*,
v.
**DENTON PLASTICS, INC.**, an Oregon corporation, Dennis Denton, John Criswell Dickson,
*Respondents*.
(C9402-00949; CA A85718)

On remand from the Oregon Supreme Court, *Rangel v. Denton Plastics, Inc.*, 324 Or 77, 920 P2d 1098 (1996).

Appeal from Circuit Court, Multnomah County.

George M. Joseph, Senior Judge.

Submitted on remand December 23, 1996.

Kevin L. Cathcart and Clayton H. Morrison for appellants.

Scott P. Monfills, Jeffrey S. Love, W. Iain E. Levie and Lane Powell Spears Lubersky for respondents.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

EDMONDS, J.

Affirmed.

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**148 Or App 330>** Plaintiffs are the parents of Everado Rangel-Jasso and the personal representatives of his estate. Everado was killed at the age of 17 when a forklift that he was operating in his employment with Denton Plastics, Inc., (Denton) overturned. Plaintiffs assert several claims against Denton and two of its officers arising from Everado's death. The court granted summary judgment to defendants on the ground that the Workers' Compensation Act (the Act) provides plaintiffs' sole remedy. ORCP 47. We originally affirmed without opinion. *Rangel v. Denton Plastics, Inc.*, 135 Or App 385, 898 P2d 817 (1995). The Supreme Court vacated our decision and remanded for reconsideration in light of *Kilminster v. Day Management Corp.*, 323 Or 618, 929 P2d 474 (1996). On reconsideration, we again affirm.

Plaintiffs' complaint alleges five claims, including three claims based on the Oregon Racketeer Influenced and Corrupt Organization Act (ORICO), a claim entitled "Deliberate Intention to Injure," and a claim entitled "Violation of Child Labor Law In Absence of Good Faith." In their motion for summary judgment, defendants did not contest that plaintiffs could prove the factual allegations in their complaint. Rather, they submitted evidence that Denton Plastics had complied with the requirements of the Act and that plaintiffs have received the benefits to which they are entitled. In response, plaintiffs did not challenge the evidence of Denton's compliance with the Act or of the payment of workers' compensation benefits. Rather, they contended that Act did not provide their only remedy and that their claims were based on exceptions to the exclusivity provisions of the Act.

ORS 656.018(1)(a) provides that the liability of every employer who complies with the Act is "exclusive and in place of all other liability." ORS 656.156(2) creates an exception to ORS 656.018. It provides, in part:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker * * * may take under this chapter, and also have cause for action against the employer, as **<148 Or App 330/331>** if such statutes had not been passed, for damages over the amount payable under [the Workers' Compensation Act]."

Plaintiffs argue, in part, that their claim for "Deliberate Intention to Injure" falls within the exception created by ORS 656.156(2). They rely on allegations that defendants directed decedent and others to operate hazardous equipment without providing safety training and instructions on how to operate the equipment "in a language they could understand." They also allege that their decedent's work-related death

"23.

"* * * was caused by the deliberate intention of defendants to injure in one or more of the following particulars:

"* * * * *

"(c) In intentionally removing, overriding, bypassing or failing to purchase, repair or replace safety equipment and other mechanisms for the forklift on which [decedent] was killed and for other hazardous equipment used by their employees.

*"The specific nature of the acts evidencing defendants deliberate intention to injure plaintiffs' decedent are described with more particularity in a citation* issued to Denton Plastics, Inc. on or about March 12, 1992, by the State of Oregon Occupational, and Safety and Health Administration Division (OROSHA), which is attached as Exhibit 1." (Emphasis supplied.)

Regarding the *removal* of safety equipment from fork lifts, exhibit 1 says, in part,

"5. * * *

"(a) All employees were not properly trained and supervised, as evidenced by:

"* * * * *

*"(6) Although seat belts were provided on the forklifts, management did not enforce their use.*

"* * * * *

"8. * * *

**148 Or App 332>** "(a) Operators of forklifts were not required to use the seat belts installed on the forklifts." (Emphasis supplied.)

For purposes of summary judgment, defendants admit the above allegations but argue that those facts do not give rise to a reasonable inference of a deliberate intention to injure. Thus, the initial issue is whether such an inference can be drawn from the above evidence. There are three cases that are instructive on the issue. In *Lusk v. Monaco Homes, Inc.*, 97 Or App 182, 775 P2d 891 (1989), we held that such an inference could be drawn from the defendant's failure to provide a respirator in a paint booth, knowing that the paint was highly toxic, that the plaintiff's resulting injury was continuing, that the paint manufacturer had warned against such a practice and that the cost of the equipment to protect the worker was not prohibitive. We said:

"A specific intent to produce injury is not the only permissible inference to be drawn from defendant's apparent obstinacy, but it is one that a jury should be permitted to consider." *Id.* at 189.

The second case is *Kilminster v. Day Management Corp.*, 323 Or 618, 929 P2d 474 (1996). In that case, the plaintiff's decedent fell from a tower after the employer had deliberately not supplied him with safety equipment. The court interpreted the phrase "deliberate intent to injure" in ORS 656.156(2) to mean that the worker must prove that the employer "acted as it did because it wished to injure or kill decedent." *Id.* at 633. The court, in agreeing that the plaintiff's complaint stated sufficient facts to raise a reasonable inference that the employer had acted on a wish to injure the worker, reasoned:

"Plaintiff alleges that [employer] knew that decedent or someone who did the same work as decedent would be injured from a fall from the tower; that [employer] decided to forego safety procedures, knowing that, by so doing, serious injury or death would result; and that [employer] told decedent to climb the tower or lose his job." *Id.* at 632. (Emphasis in original.)

Finally, in *Davis v. United States Employers Council, Inc.*, 147 Or App 164, 934 P2d 1142, *rev den* 325 Or 368 (1997), we applied the "wish to injure" description of the test **<148 Or App 332/333>** under ORS 656.156(2) to a case in which the plaintiff alleged that he had been regularly exposed to excessive levels of paint fumes that had injured him. *Id.* at 174-79. The defendant knew that the conditions in the work place were hazardous and that its employees were being injured. Nonetheless, it directed the plaintiff to continue to work in that environment. The trial court granted the employer's motion for involuntary dismissal based on an acknowledgment by the plaintiff that the employer had acted, at worst, out of a motivation to save money, not from an affirmative desire to injure the plaintiff or his coworkers. We affirmed, stating:

> "Given plaintiff's laudable candor, the application of the 'wish to injure' formulation in this case is clear. Plaintiff acknowledges that he cannot prove that defendant refused to undertake safety measures because it wished to injure him. Consequently, the trial court correctly determined that plaintiff's action was barred by ORS 656.018." *Id.* at 179.

This case comes before us on summary judgment under ORCP 47 in contrast to the pleading issues in *Lusk* and *Kilminster.* The test under the rule is whether plaintiffs have produced sufficient evidence of a deliberate intention to injure to raise a genuine issue of material fact. The nonexistence of a material fact occurs when no objectively reasonable juror could return a verdict for the adverse party on the matter that is the subject of the summary judgment motion. Plaintiffs have alleged specific safety violations, which are described in particularity in OR-OSHA's citation appended to the complaint. Thus, we look to the citation to determine whether or not plaintiffs have raised a genuine issue of material fact.

The evidence from the citation must satisfy the specific standard of a deliberate intent to injure as required by ORS 656.156(2). Thus, to preclude summary judgment under the statute, plaintiffs must offer evidence that defendants acted as they did because they wished to injure the decedent. Acts or omissions of gross negligence, carelessness, recklessness or conscious indifference to injury do not meet the requisites of a deliberate intention to injure. *Kilminster,* 323 Or at 633. The citation complains of the failure to provide safety training, to provide instructions in a language other than **<148 Or App 333/334>** English and to require fork lift operators to use their seatbelts. When the evidence is taken as a whole, those are not facts that give rise to a reasonable inference that defendants wished to injure the decedent. Unlike in *Lusk* and in *Kilminster,* where it was *alleged* that the defendants directed the activity knowing that injury was occurring or was certain to occur without the safety equipment, the above onussions, without the benefit of additional facts, are evidence only of negligence or recklessness. A reasonable trier of fact could not infer on this record that defendants' omissions were designed to injure decedent. Accordingly, the trial court did not err when it granted summary judgment on plaintiffs' deliberate intent to injure claim under ORS 656.156(2).

Plaintiffs also assign error to the trial court's grant of summary judgment on their claims for injury arising from alleged violations ORICO. ORS 166.715 *et seq.* The complaint alleges three claims for relief under ORICO: (1) defendants recklessly endangered the decedent by directing him to operate the forklift without safety training and non-English instructions and by not requiring him to wear a seat belt (all in violation of ORS 163.195); (2) defendants falsified employment records in violation of ORS 165.080(1); and (3) defendants obstructed governmental administration in violation of ORS 162.235.[1] Plaintiffs posit that these violations give rise to viable claims even though the decedent's injury occurred in the course of his employment.

In *Kilminster,* the court held that ORS 656.018 bars claims made under ORICO unless there is evidence that the racketeering activity arises from the deliberate intention of the employer to produce injury or death. 323 Or at 633-37. Although plaintiffs allege the bare conclusion that defendants deliberately intended to injure decedent, there is no evidence from which such an inference can reasonably be drawn in the light of the information in the citation. The trial court did not err in granting summary judgment on plaintiffs' ORICO claims.

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[1] ORS 163.195 makes it unlawful to engage in conduct that creates a substantial risk of serious physical injury to another person. ORS 165.080(1) makes it unlawful to falsify records with the intent to defraud, and ORS 162.235 makes it unlawful to obstruct or hinder the administration of law by intimidation, force, physical or economic interference.

**148 Or App 335>** Finally, plaintiffs allege under ORS 656.132 that defendants employed decedent in violation of state and federal child labor statutes and regulations without a good faith belief that he was over the age of 18. In the same claim, they allege that defendants were negligent in several respects. Plaintiffs assert that defendants' bad faith violation of the statute deprives them of the protection of the exclusive remedies provision in ORS 656.018 and that they can elect to sue defendants for their negligence.

Plaintiffs' arguments are those that were rejected in *Manke, Adm'x v. Nehalem Logging Co.*, 211 Or 211, 222-23, 315 P2d 539 (1957). In that case, the plaintiffs alleged that the decedent was 17 years of age and that the defendants permitted the decedent to work without any permit or certificate of any kind. *Id.* at 216. The court analyzed whether the Act was the plaintiffs' sole remedy. At that time, ORS 656.132 provided, in part:

> "(1) A minor working at an age legally permitted under the laws of this state is considered sui juris for the purpose of [the Act]. * * *
>
> "(2) If an employer subject to [the Act] in good faith employed a minor under the age permitted by law, believing him to be of lawful age, and the minor sustains an injury or suffers death in such employment, the minor is conclusively presumed to have accepted the provisions of [the Act]. * * *
>
> "(3) If the employer holds no such certificate and the commissioner finds that the employer did not employ such minor in good faith, the minor is entitled to the benefits of [the Act], but the employer shall pay to the Industrial Accident Fund by way of penalty a sum equal to 25 percent of the amount paid out or set apart under such statutes on account of the injury or death of such minor, but such penalty shall not exceed $500."[2]

The plaintiffs argued that the statute provided an independent cause of action for minors who had been employed in bad faith in violation of the statute. The court rejected the plaintiffs' argument and determined that, because the legislature had repealed legislation[3] that had **<148 Or App 335/336>** specifically excluded minors from the Act, it had "clearly expressed the intent that all minors should be covered under the [A]ct." *Id.* at 219.

We do not perceive any reason why the *Manke* court's interpretation is not controlling, and we are bound by it. According to the Supreme Court, the statute is intended to provide only a civil penalty against a noncomplying employer. Thus, a minor, "whether lawfully or unlawfully employed," is entitled to the benefits of the Act, and "those benefits are exclusive." *Clevidence v. Portland School District #1*, 125 Or App 608, 611, 866 P2d 492, *rev den* 318 Or 478 (1994). Consequently, the trial court properly granted summary judgment on plaintiffs' claim based on the violation of child labor laws.

Affirmed.

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[2] ORS 656.132 is substantively the same today.

[3] *Compare* Or Laws 1913, ch 112, § 11 *with* Or Laws 1927, ch 312, § 1.

Cite as 148 Or App 384 (1997) June 11, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Betty S. Tee, Claimant.
Betty S. **TEE**, *Petitioner,*
v.
**ALBERTSON'S, INC.**, *Respondent.*
(88-11538; CA A91626)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 17, 1996.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison.
Thomas M. Christ argued the cause for respondent. With him on the brief was Mitchell, Lang & Smith.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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**148 Or App 386>** At issue in this workers' compensation case is whether claimant is incapable of regularly performing work at a "gainful" and suitable occupation and, thus, is permanently and totally disabled. ORS 656.206(1)(a) defines a "gainful" occupation as "one that pays wages equal to or greater than the state mandated hourly minimum wage." Claimant is capable of working at a part-time telemarketing job, which pays--on an hourly basis--more than the state mandated minimum wage. She argues that she nevertheless is not capable of "gainful" employment, because, after taking into account the expenses associated with her employment in the telemarketing business, the "net gain" to her is next to nothing. The Board held that ORS 656.206(1)(a) does not incorporate such a "net gain" analysis and that, instead, it defines "gainful" employment solely by reference to the hourly minimum wage. On that basis, the Board concluded that claimant is not permanently and totally disabled. We agree with the Board's reading of ORS 656.206(1)(a) and affirm.

This case has an unfortunately long history, which must be stated at least in brief to frame properly the issues before us. Claimant worked for employer as a meat wrapper. In 1984, she injured her back. Claimant filed a claim and contended that she was entitled to permanent total disability. Employer insisted that she was entitled to permanent partial disability only. At the time, ORS 656.206(1)(a) provided that a worker is entitled to permanent total disability only if he or she is incapable of "regularly performing work at a gainful and suitable occupation." The statute, however, did not define what is meant by "gainful" occupation. In 1988, an administrative law judge (ALJ) found that claimant was not capable of gainful employment and therefore was entitled to permanent total disability. The Board reversed, finding that claimant was employable as a telemarketer or a hotel/motel inspector on a part-time basis at or above the minimum wage. The Board awarded claimant 75 percent permanent partial disability.

**148 Or App 387>** This court affirmed, *Tee v. Albertsons, Inc.*, 107 Or App 638, 813 P2d 574 (1991), but the Supreme Court modified our decision and remanded for reconsideration. *Tee v. Albertsons, Inc.*, 314 Or 633, 842 P2d 374 (1992). According to the Supreme Court, whether employment is "gainful" within the meaning of ORS 656.206(1)(a) depends on the extent to which it provides "profitable remuneration." *Tee*, 314 Or at 643. Resorting to the *Random House Dictionary*, the majority concluded that " [t]he plain and ordinary meaning of 'gainful' is 'profitable, lucrative: *gainful employment.*'" *Id.* (emphasis in original). Having said that, the majority then noted that "[t]he Board did not have the benefit of this opinion in deciding whether claimant's part-time employment was for profitable remuneration." *Id.* Accordingly, it remanded the case to the Board for a determination whether claimant is capable of work that constitutes "profitable remuneration." *Id.*

Justice Graber dissented. She contended that the construction of the statutory term "gainful" employment was even simpler than the majority found it to be. According to Justice Graber, "gainful" employment "is simply an occupation for which the worker receives a lawful wage." *Id.* at 644. Whether the worker's expenses associated with that employment produce a "profit" for the worker, she concluded, "matters not." *Id.*

The Board remanded the case to the ALJ. The parties then stipulated that the hotel/motel inspector job was no longer available, but that employment in telemarketing remained available at a wage that exceeded the minimum wage. The parties also stipulated that, at that time, the state minimum wage was $3.35 per hour. The ALJ found that claimant would have a number of expenses associated with employment in the telemarketing field. The ALJ then concluded that, taking into account all the relevant expenses, claimant's "net gain" from her part-time employment in telemarketing would be 60 cents per hour and that such remuneration is not "profitable."

The Board affirmed by order dated May 25, 1995. Shortly after the Board issued its order, however, the 1995 **<148 Or App 387/388>** Legislative Assembly amended ORS 656.206(1), so that the statute now explicitly defines "gainful" employment:

> "As used in this section, a gainful occupation is one that pays wages equal to or greater than the state mandated hourly minimum wage."

ORS 656.206(1)(a). The amendments took effect June 7, 1995, and the legislature expressly provided that they apply to cases pending at that time. Or Laws 1995, ch 332, § 66(1). Employer timely moved for reconsideration in the light of the newly enacted amendment. The Board allowed reconsideration and reversed its former order, holding that, under the current definition, a "gainful" occupation is "an occupation that pays at or above the minimum wage rate" and nothing more. It is from that order on reconsideration that claimant now seeks review.

Claimant argues that the Board erred in interpreting the term "gainful," as used in ORS 656.206(1), to mean only paid at the minimum wage. Claimant acknowledges that the 1995 Legislative Assembly amended the statute to include a definition of the word in such terms, but she insists that the definition was intended to describe only one criterion of "gainful" employment:

> "[T]he amended statute provides that the minimum rate *qualifies* as a *potential* 'gainful occupation.' But the amended statute is silent about, among other things, the threshold number of hours separating permanent total from permanent partial disability.
>
> "* * * * *
>
> "The legislature could have specified, but did not specify, what that threshold is, and there is also no indication that the legislature intended to overrule the Board's 'net gain' analysis."

(Emphasis in original.) In support of her construction of the statute, claimant relies on what she characterizes as its "plain" meaning and a portion of the legislative history that includes a statement of one of the sponsors of the amendment to the effect that it would be unreasonable to conclude that a person would have to spend more than she earned to get a job. Employer responds that the statute's meaning--that **<148 Or App 388/389>** "gainful" employment "is" employment that pays the minimum wage--is plain on its face and that we need pursue the matter no further than that.

When we construe the language of a statute,

> "we are to effectuate the intentions of the legislature, 'if possible.' ORS 174.020. To ascertain the intentions of the legislature, we examine the text, its context and, if necessary, the legislative history. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610-12, 859 P2d 1143 (1993). In all events, however, we are constrained by the reasonable construction of the language that the legislature actually enacted. We are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted. ORS 174.010; *Fernandez v. Board of Parole,* 137 Or App 247, 252, 904 P2d 1071 (1995)."

*Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 553, 915 P2d 1053, *rev den* 324 Or 305 (1996). ORS 656.206(1)(a) defines "permanent total disability" as:

> "[T]he loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a gainful occupation is one that pays wages equal to or greater than the state mandated hourly minimum wage. As used in this section, a suitable occupation is one that the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation."

ORS 656.206(3) further provides that, to obtain permanent total disability benefits, the worker must prove his or her "permanent total disability status" and must establish "that the worker is willing to seek regular gainful employment" and that the worker has made reasonable efforts to obtain such employment.

At the outset, we note that, from the text of the statute, it is readily apparent that the extent to which a worker suffers permanent total disability depends on several factors, including whether the worker is incapable of "regularly performing" work that is "gainful" and "suitable." In this case, **<148 Or App 389/390>** there is no dispute that telemarketing work is "suitable" for claimant, and, likewise, there appears to be no argument that she is incapable of "regularly performing" that work. The sole dispute is whether telemarketing work is "gainful" within the meaning of ORS 656.206(1)(a).

We conclude that the statute speaks unambiguously to the point. It states that a "gainful" occupation *is* one that "pays wages equal to or greater than the state mandated hourly minimum wage." It does not say that a "gainful" occupation merely *includes* one that pays at least the minimum wage or that it *is, at a minimum,* one that pays at least the minimum wage. By its terms, it declares what a "gainful" occupation is. To be sure, as a matter of formal, predicate logic, it does not necessarily follow that, because the statute says that "gainful" is paid at least the minimum wage, the same word also cannot mean other things as well (*e.g.*, "gainful" also *is* an English word and is seven letters long). But a statutory term is not ambiguous merely because it is capable of such logical manipulation. There must be some evidence contained in the language of the statute that gives rise to a reasonable conclusion that the legislature may have intended more than one meaning. *See, e.g., State v. Cooper,* 319 Or 162, 167, 874 P2d 822 (1994) (statutory language is ambiguous when capable of two interpretations and "either interpretation is reasonable"); *Koitzsch v. Liberty Northwest Ins. Corp.,* 125 Or App 666, 669, 866 P2d 514 (1994) (a statute is ambiguous if "it is capable of more than one reasonable interpretation"). In this case, neither the text, nor the context, nor any applicable textual canon of construction, suggests that the legislature in this case meant anything other than that "gainful" is paid at or above the minimum wage.

Even assuming, for the sake of argument, that ORS 656.206(1)(a) plausibly could be read as claimant suggests, the legislative history removes any doubt that the legislature intended, plainly and simply, to adopt the view of the statute expressed by Justice Graber in her dissent in *Tee,* namely that "gainful" means paid at or above the minimum wage, nothing more.

The amendments to ORS 656.206(1)(a) at issue were introduced in 1995 as part of Senate Bill 369, a sweeping collection of amendments to the workers' compensation statutes **<148 Or App 390/391>** of this state. As originally introduced, section 14 of SB 369 provided that ORS 656.206(1)(a) be amended by adding the following language:

> "As used in this section, a gainful occupation is one that is either full-time or part-time and pays wages equal to or greater than the state mandated hourly minimum wage."

In introducing the bill to the Senate Committee on Labor and Government Operations, Representative Mannix, one of the bill's sponsors explained:

> "In ORS 656.206, we adopt a definition of 'gainful occupation.' The existing law states that a worker is permanently and totally disabled if unable * * * to regularly perform work at a gainful and suitable occupation. In a recent case, the Supreme Court had difficulty defining a 'gainful occupation' and sent the case back for further proceedings. This amendment adopts the definition which is currently in the Oregon Administrative Rules. In that sense, it won't make a difference in terms of claims administration, but it puts it into the statute."

Tape recording, Senate Committee on Labor and Government Operations, January 30, 1995, Tape 16, Side A at 140. As Mannix noted, existing rules--not mentioned by the Supreme Court in its opinion in *Tee*--defined "gainful occupation" as

> "occupations that are either full-time or part-time in duration and pay wages equivalent to, or greater than, the state and federal mandated minimum hourly wage."

OAR 436-30-055(1)(c) (1995). Questions arose in Committee about the extent to which a part-time worker who was paid the minimum wage would be "gainfully" employed under the proposed amendments, and the proponents of the amendments simply dropped the reference to full-time and part-time work. Jerry Keene, one of the authors of the amendments, explained that such questions more properly were considered in the context of determining whether an occupation is "regular" and "suitable" and had nothing to do with whether the occupation is "gainful":

> "[There's] already a whole set of case law about when part time is regular and sufficient enough to constitute a return **<148 Or App 391/392>** to regular work. And so that language [the reference to full-time and part-time work] was just taken out to leave it to those cases. Although [the amendment] still defines 'gainful employment' as one that pays the state minimum wage. But that's not the only factor--its not the--that's not the only factor that decides whether or not you get permanent total disability.
>
> "* * * * *
>
> "You have to be regularly performing work, and it has to be at a suitable occupation. And those are areas where there's a whole line of cases. The difficulty was, well, what is 'gainful' in that context. And this is on an hourly basis, minimum wage is--at least minimum wage is gainful. Permanent total disability is when a worker is permanently and totally disabled from regularly performing suitable and gainful employment and has made--and is willing to take such work if it were available and has made reasonable efforts to try. That's it in a nutshell. And this just goes out in one word: 'gainful.' And it says that it's gainful if it pays at least minimum wage."

Tape recording, Senate Committee on Labor and Government Operations, February 17, 1995, Tape 47, Side B at 108. The Committee Staff Summary similarly explains the effect of the change to section 14:

> "ORIGINAL MEASURE EFFECT: ORS 656.206 **Adopts definition of 'gainful occupation' used in evaluating permanent total disability.** Existing law states that a worker is permanently and totally disabled if unable to regularly perform work at a gainful and suitable occupation. In a recent case the Oregon Supreme Court had difficulty defining a gainful occupation and remanded the case for further hearings to determine the meaning of the term. This amendment adopts the definition which is currently in [the] Oregon Administrative Rules, stating that a gainful occupation is one that pays at least minimum wage.
>
> "AMENDMENT EFFECT: Permanent total disability benefits. Eliminates reference to part-time or full-time employment, leaves to existing caselaw to determine."

Testimony, Senate Committee on Labor and Government Operations, SB 369, February 17, 1995, Ex F (boldface and underscoring in original). *See Davis v. O'Brien*, 320 Or 729, **<148 Or App 392/393>** 743, 891 P2d 1307 (1995) (committee staff summary, presented as committee exhibit, treated as legislative history). In that form, the Committee approved section 14 as part of SB 369 and sent the amendments to the Senate Floor.

On the floor, Senator Leonard, an opponent of the amendments, complained that the effect of the amendment to ORS 656.206(1) would be to "cut off" disability benefits if a worker is capable of earning the minimum wage. Tape recording, Senate Floor Session, February 24, 1995, Tape 28, Side B at 209. Senator Derfler, Chair of the Senate Committee on Labor and Government Operations and a sponsor of the bill, explained that "that is not true." Referring to the recent decision in *Tee*, Derfler explained that the effect of the amendment would be

> "telling the courts, because they've asked or referred back to the lower court, 'what is a wage that must be earned to be productive?' We're just establishing that level."

Tape recording, Senate Floor Session, February 24, 1995, Tape 31, Side A at 030. Derfler explained that the amendment did not change existing case law as to other considerations regarding entitlement to permanent total disability benefits. Tape recording, Senate Floor Session, February 24, 1995, Tape 31, Side A at 279. The bill then passed out of the Senate.

In hearings before the House Committee on Labor, Representative Mannix explained the effects of section 14 in the following terms:

> "The issue that then arises is a definition of 'what is a gainful occupation?' [The bill] says: 'As used in this section, a gainful occupation is one that pays wages equal to or greater than the state mandated wage.' There has previously been no definition of what is 'gainful.' You need to understand, however, that we're talking about being permanently incapacitated from regularly performing work at a gainful and suitable occupation. In other words, there are several parameters to permanent total disability. This addresses a definition as to only one element. What is 'gainful,' in terms of an occupation or employment? And this says, if it's minimum wage, that's gainful."

**148 Or App 394>** Tape recording, House Committee on Labor, March 3, 1995, Tape 41, Side A at 051. At that point, Representative Brown asked Mannix how the enactment of section 14 would affect the claimant in *Tee*. After listening to Brown summarize the facts of the case, Mannix responded:

> "Now, from what you just described, it would seem to me to be unreasonable to say to somebody, 'you have to spend more than you're going to earn in order to get a job."'

That is the testimony on which claimant now relies. Mannix did not end his answer there, however; he went on to add:

> "I don't know what the rest of the facts of the case may be, but one issue came to me: What is--in terms of the hourly rate of pay--what is 'gainful.' That's one issue, and minimum wage is established by the legislature as being the proper standard of, you know, the minimum someone should be paid for their endeavors. But there are other factors in this statute that we don't touch. What is 'regular employment?' There's a lot of case law on that, and that has been a subject [of] discussion. What is 'suitable employment?' There's a lot of case law on that, too. * * * So, in any given case, the fact finder has to pull all of those things together."

Tape recording, House Committee on Labor, March 3, 1995, Tape 41, Side A at 120-66. The Committee approved SB 369 without further amendment to section 14, although a minority report was prepared, which eliminated the definition of "gainful" employment.

On the floor, Mannix again explained the purpose of the new definition:

> "The definition of 'gainful employment' in permanent total disability. That definition is taken out by the minority report. Why does that matter? Because we have a court decision that now says, well, this must mean 'profitable remuneration.' Another lawyer's hook. How much litigation are we going to see about profitable remuneration? That's just as bad as 'gainful employment.' The rules have defined 'gainful employment' all along, for years, and they've been great. And all we do in the majority report is we use the same definition that had been in the rules for years. So the majority report doesn't change the way things are, but it locks them in."

**148 Or App 395>** Tape recording, House Floor Session, April 4, 1995, Tape 70, Side B at 105. The House approved the majority report.

We draw several conclusions from the legislative history pertaining to the issue before us. First, there is no suggestion that the legislature intended to perpetuate--as claimant suggests--the sort of "net gain" analysis that the Board developed as a method of determining whether employment is "profitable." To the contrary, it is clear that the new definition of "gainful"' occupation was enacted in direct response to the Supreme Court's decision in *Tee*, to avoid what was perceived to be an unworkable construction of the statute. Second, the legislature intended to substitute for the court's "profitable remuneration" definition the one that already was contained in OAR 436-30-055 (1995), which defined "gainful" simply as work at or above the minimum wage. Finally, legislative history makes abundantly clear that the legislature understood that enacting the amended definition of "gainful" employment did not mean that anyone capable of earning a minimum wage automatically would be precluded from obtaining permanent total disability benefits. The point was emphasized again and

again that the extent to which a given job is "gainful" is only one of the pertinent statutory considerations in determining entitlement to such benefits and that the amendment to the definition of that one term was not intended to affect the law regarding the others. Thus, for example, a claimant capable of working at a minimum-wage job still might be entitled to permanent total disability, because that minimum-wage job is not suitable. *See, e.g., SAIF v. Terry,* 126 Or App 558, 561, 869 P2d 876 (1994) (even if the claimant's current employment is "gainful," permanent total disability benefits still are required because that employment is not "suitable").

In this case, it is agreed that telemarketing is "regular" and "suitable" within the meaning of ORS 656.206(1)(a). The only issue is whether that employment, which pays in excess of the state minimum wage, is "gainful" within the meaning of the same statute. We conclude that it is and that the Board therefore correctly determined that claimant is not entitled to permanent total disability.

**148 Or App 396>** Claimant's other assignments of error require no discussion.

Affirmed.

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IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Harry L. Lyda, Claimant.
**STATE FARM INSURANCE COMPANY** and Harry Lyda Realty, *Petitioners,*
v.
Harry L. **LYDA**, *Respondent.*
(95-13520; CA A94571)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 3, 1997.

Chess Trethewy argued the cause for petitioners. With him on the brief was Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.

David W. Hittle argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander, McCann & Smith.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LEESON, J.

Affirmed.

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**148 Or App 426>** Insurer seeks review of an order of the Workers' Compensation Board (Board) holding that, pursuant to *former* OAR 436-60-025(5)(j), the Director of the Department of Consumer and Business Services (director) correctly calculated the rate of claimant's temporary total disability (TTD) based on his assumed annual wage of $18,000.[1] Insurer contends that tbe rule impermissibly deviates from the requirement of ORS 656.210(2)(c) that TTD benefits be based on the wage at the time of injury. We review to determine if the Board's interpretation of an inexact term is consistent with the statute, *England v. Thunderbird,* 315 Or 633, 638, 848 P2d 100 (1993), and affirm.

The facts are not in dispute. Claimant, a real estate broker, is president and sole shareholder of employer, Harry Lyda Realty. At the time of employer's incorporation in 1976, claimant elected workers' compensation insurance for himself as a subject worker. ORS 656.128. Each year, he paid an annual premium based on his estimated annual income, a figure that claimant provided when he applied for coverage. From July 25, 1981, to July 25, 1983, that figure was $18,155. Insurer used $18,000 as claimant's "assumed wage" and calculated claimant's annual premium based on that figure.

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[1] *Former* OAR 436-60-025(5)(j) subsequently has been renumbered and amended by the director. OAR 436-060-0025(5)(k) (1996) now provides:

> "For workers who are sole proprietors, partners, officers of corporations, or a limited liability company member including managers, insurers shall use the assumed wage on which the employer's premium is based." WCD Admin. Order 96-053.

On March 10, 1983, claimant suffered a compensable, nondisabling injury. Pursuant to *former* OAR 436-60-025(5)(j), the Department of Consumer and Business Services (DCBS) ordered that claimant's TTD rate be calculated on the basis of the assumed wage of $18,000. However, a subsequent audit revealed that, at least for tax purposes, claimant had received no wage income from employer from July 25, 1982, to July 25, 1983. In December 1983, claimant declared that his total wage income from employer during the 1983 fiscal tax year was $6,000. In 1994, insurer notified **<148 Or App 426/427>** claimant that it was reducing his TTD benefits because it was going to begin calculating the rate on an annual wage of $6,000, rather than the $18,000 assumed wage.[2] Claimant disputed the reduction, and the dispute was referred to DCBS. On November 29, 1995, DCBS issued a Proposed and Final Order On Weekly Wage For Computing Temporary Disability Rate that required insurer to calculate claimant's TTD based on his assumed wage of $18,000. Insurer requested a hearing, contending that *former* OAR 436-60-025(5)(j) impermissibly deviates from the statutory requirement that TTD benefits be based on the wage at the time of injury. The administrative law judge concluded that the rule was consistent with the statute, and the Board affirmed.

ORS 656.210(2) provides, in pertinent part:

"(b) For the purpose of this section:

"(A) The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury.

"* * * * *

"(c) * * * For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage."

Based on the authority delegated in ORS 656.210(2)(c), the director promulgated former OAR 436-60-025(5)(j), which provided:

"For workers who are sole proprietors, partners or officers of corporations *insurers shall use the assumed wage on which the employer's premium is based.*" (Emphasis supplied.)

Insurer's first assignment of error is that *former* OAR 436-60-025(5)(j) "fails to fulfill legislative intent" and exceeds the statutory parameters of ORS 656.210(2)(c). According to insurer, in promulgating the rule, the director **<148 Or App 427/428>** inappropriately incorporated language from ORS 656.128(1). That statute provides:

"Any person who is a sole proprietor may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a classification and *an assumed monthly wage* at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter."

(Emphasis supplied.) Insurer further contends that our analysis in *Hadley v. Cody Hindman Logging,* 144 Or App 157, 925 P2d 158 (1996), is instructive in analyzing the director's error in promulgating *former* OAR 436-60-025(5)(j).

Claimant responds that ORS 656.210(2)(c) delegates broad authority to the director to prescribe the "method" for approximating the wage amount at the time of injury for those workers who are not employed regularly. Claimant argues that the director's rule is within the range of discretion allowed by the general policy of ORS 656.210(2)(c).

We need not consider insurer's argument that the director relied on ORS 656.128(1) in promulgating *former* OAR 436-60-025(5)(j), because that argument was not made below. Before the Board, insurer argued that the rule is an "unenforceable extension" of ORS 656.210. Insurer's argument

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[2] The record does not explain why a dispute over temporary total disability payments is occurring 11 years after claimant's injury.

regarding ORS 656.128(1) related only to claimant's failure to provide corroborative evidence of his wage at the time of injury, which is the subject of the second assignment of error. Arguments not raised in an administrative forum will not be considered on judicial review unless they concern errors apparent on the face of the record. *Kessler v. Board of Parole,* 145 Or App 584, 590, 931 P2d 801 (1997). We therefore turn to insurer's argument that former OAR 436-60-025(5)(j) is inconsistent with our holding in *Hadley.*

*Hadley* involved interpretation of the phrase "extended gaps" in *former* OAR 436-60-025(5)(a),[3] which also **<148 Or App 428/429>** was adopted pursuant to ORS 656.210(2)(c). We reversed the Board's holding that defined "extended gaps" as a change in the employment relationship. We held that the Board's interpretation impermissibly added a requirement to OAR 436-60-025(5)(a). *Hadley,* 144 Or App at 162. We also held that the phrase "wage * * * at the time of injury" in ORS 656.210(2)(b)(A) is an inexact term, and that the director's calculation of claimant's wage at the time of injury more closely approximated legislative intent for workers with gaps in employment. *Hadley,* 144 Or App at 161.

Insurer's contention that *Hadley* mandates that the director calculate TTD benefits using actual wages at the time of injury for all workers is based on a misreading of that case. Insurer is correct that ORS 656.210(2)(b)(A) requires the director to fashion a rule to determine wages at the time of injury. In *Hadley,* however, the *amount* of the worker's wage could be determined with certainty. The question in *Hadley* was the determination of the *time period* within which to average those wages. The director's calculation, which used amounts closest to the time of injury for workers with gaps in employment, was the nearest approximation of legislative intent behind the phrase "wages * * * at the time of injury." In this case, by contrast, the amount of claimant's wage is difficult to ascertain. The director fashioned former OAR 436-60-025(5)(j) to approximate the wage at the time of injury for the class of workers identified in ORS 656.210(2)(c): those who are not regularly employed or whose remuneration is not based solely on daily or weekly wages.

In examining the requirements of the rule at issue in *Hadley,* we held that 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." *Hadley,* 144 Or App at 160. The method prescribed in *former* OAR 436-60025(5)(j) is within the director's authority as a method of approximating the wage at time of injury for the category of workers described in ORS 656.210(2)(c).

Furthermore, if insurer's reading of *Hadley* were correct, ORS 656.210(2)(c) would be without effect. According to insurer, Hadley requires the director to determine *all* **<148 Or App 429/430>** workers' wages based on the actual wage at the time of injury. ORS 656.210(2)(c) unambiguously rejects that approach. It provides that for workers who are not "regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages," the director is authorized to "prescribe methods for establishing the worker's weekly wage." *Hadley* should not be read to eviscerate ORS 656.210(2)(c). *See* ORS 174.010 (judges may not omit from a statute language that the legislature has inserted).

Insurer also assigns error to the Board's failure to require corroborative evidence that claimant's income at the time of injury was $18,000 per year, claimant's reported assumed wage. In *SAIF v. Marshall,* 130 Or App 507, 882 P2d 1115, *rev den,* 320 Or 492 (1994), we held that ORS 656.128(3) requires a sole proprietor to present corroborative evidence that the worker's injury is work related. In this case, it is not disputed that claimant's injury is work related: Consequently, insurer's reliance on *Marshall* is misplaced.

We reject without discussion insurer's argument that an employer who is also an injured worker may set his assumed wage without accountability.

Affirmed.

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[3] *Former* OAR 436-60-025(5)(a) 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 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."

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