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VOLUME 49

(Pages 1-446)

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.

JANUARY-MARCH 1997

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In the Matter of the Compensation of
NEAL S. ANDERSON, Claimant
WCB Case No. 96-04011
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of his left inguinal hernia injury claim. With his briefs, claimant submits a medical report and chart notes that were not admitted at hearing. We treat this submission as a motion to remand for the taking on 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.

Remand

Claimant has included with his briefs a medical opinion and chart notes which were not offered or admitted into evidence at the hearing. Since our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. See Judy A. Britton, supra.

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

Here, claimant does not contend that the proffered medical evidence was unobtainable with due diligence at the time of his July 23, 1996 hearing, but rather asserts that he was "poorly represented" by his attorney at hearing. Inadequate representation, by itself, is insufficient to merit remand, however. See Lori Church, 46 Van Natta 1590 (1994); Diane E. Sullivan, 43 Van Natta 2791, 2792 (1991). Furthermore, the Workers' Compensation Board is not the proper forum for litigating the adequacy of claimant's representation. Because claimant has not shown that the evidence was not obtainable with due diligence at the time of the hearing or that the evidence is reasonably likely to affect the outcome of the case, we deny the request for remand.

Compensability

The ALJ determined that claimant failed to prove that his lifting activity at work on December 21, 1995 was the major contributing cause of his left inguinal hernia. On review, claimant contends that the major contributing cause of his condition was not any preexisting condition or congenital defect, but his work activity as a sawyer, i.e., the lifting and carrying heavy loads of lumber.

Claimant has the burden of proving the compensability of his condition. ORS 656.266. As the ALJ noted, under ORS 656.005(7)(a)(B), if an otherwise compensable injury combines with a preexisting condition to cause or prolong disability or the need for treatment, the "combined condition" is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment of the combined condition. Because of the possible combination of causes of claimant's left inguinal hernia, the determination of the major cause is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279, 282 (1993) Where, as here, the medical evidence is divided, 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).

Two doctors offered medical opinions in this case; claimant's treating doctor, Dr. Olson, and Dr. Blumberg, who reviewed claimant's medical records at the insurer's request. Dr. Blumberg opined that claimant had a congenital predisposition to developing an inguinal hernia and, although claimant's work activity may have made the hernia symptomatic, it did not did not cause the condition. (Ex. 13). Dr. Olson agreed that claimant had a preexisting predisposing congential condition, but reported that the work injury combined with the preexisting condition to cause claimant's condition. Dr. Olson concluded, however, that "it is difficult to state" whether claimant's condition resulted primarily from

his preexisting congenital predisposition or the lifting incident on December 21, 1995. Dr. Olson opined that the lifting incident made claimant's condition symptomatic, but did not discuss how the incident could have caused claimant's combined condition. See Dietz v. Ramuda, 130 Or App 387 (1994) (determining major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). On this record, we agree with the ALJ that claimant failed to establish medical causation by a preponderance of the evidence.

ORDER

The ALJ's order dated August 5, 1996 is affirmed.

In the Matter of the Compensation of
SHAMYIA M. FORD, Claimant
WCB Case No. 96-03624
ORDER ON REVIEW
Mitchell, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

Claimant, a bookbinder, filed a workers' compensation claim for her left wrist that SAIF accepted as "volar flexor tendonitis, left wrist and mild carpal tunnel syndrome, left side." After claim closure in September 1995, claimant retained legal counsel, who, on January 11, 1996, requested SAIF to amend its acceptance to include "bilateral cumulative trauma disorder and overuse syndrome of the wrists." (Ex. 22A).

In response, SAIF's claims adjuster wrote claimant's counsel on January 23, 1996 (Ex. 23), directing him to claimant's attending physician's (Dr. Browning's) August 2, 1995 chart note which stated that "site tour does not substantiate diagnosis of recurrent cumulative trauma disorder." (Ex. 17, emphasis in original). The claims adjuster asked whether claimant continued to claim bilateral cumulative trauma disorder and overuse syndrome and, if so, to notify her in writing. (Ex. 23).

On January 26, 1996, claimant's counsel again requested modification of SAIF's acceptance to include the cumulative trauma disorder and overuse syndrome, However, claimant's counsel requested that an additional condition be included in the acceptance: right wrist tendonitis. (Ex. 24-2). SAIF took no action with respect to the January 26, 1996 request. Claimant filed a request for hearing on April 12, 1996, raising "partial denial after a claim acceptance" and "penalty" as issues.

On April 26, 1996, SAIF responded to the hearing request by asserting that "No partial denial has issued." (Ex. 24A). Claimant amended her pleadings on June 4, 1996 to include "improper acceptance pursuant to ORS 656.262" as an issue. SAIF did not respond to the amendment.

A hearing was scheduled on July 10, 1996. The day before the scheduled hearing (July 9, 1996), SAIF amended its acceptance to include "right wrist tendonitis." (Ex. 27).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought an attorney fee pursuant to ORS 656.386(1) for her counsel's efforts in obtaining acceptance of the right wrist tendonitis condition. The ALJ declined claimant's request for an assessed fee. The ALJ reasoned that neither SAIF's January 23, 1996 letter nor its pleadings could be construed as a denial because they did not constitute a refusal to pay compensation on the "express ground" that the condition for which compensation was claimed was not compensable or otherwise did

not give rise to an entitlement to compensation. The ALJ further reasoned that, even though claimant's counsel was instrumental in obtaining compensation, an express denial could not be found when SAIF's conduct was viewed as a whole.

On review, claimant contends that SAIF's January 23, 1996 letter directing claimant's counsel's attention to Dr. Browning's chart note satisfied the requirement of a "denied claim" within the meaning of ORS 656.386(1). For the following reasons, we agree.

Under ORS 656.386(1), a claimant's attorney is entitled to an attorney fee in cases involving "denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined under the statute as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation." We held in Michael J. Galbraith, 48 Van Natta 351 (1996), that there was no "denied claim" under ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable. However, in Guillermo Rivera, 47 Van Natta 1723, 1725 (1995), we held that where a carrier questions the causal relationship between a claimed condition and the claimant's employment, there is a "denied claim" within the meaning of ORS 656.386(1).[1]

In this case, as in Michael J. Galbraith, supra, there is no contention that any benefits for the accepted conditions have been unpaid. Here, however, in response to claimant's request for an amended acceptance, SAIF directed claimant's counsel to a chart note that stated that the diagnosis of the claimed condition could not be substantiated.[2] Although SAIF argues that Dr. Browning's chart note merely questions the diagnosis rather than the causal relationship between the cumulative trauma disorder and claimant's employment, we do not find this argument persuasive.

A "denied claim" is a claim for compensation which the carrier refuses to pay on the "express ground" that the injury or condition is not compensable or otherwise does not give rise to an entitlement to compensation. SAIF specifically referred in its January 23, 1996 letter to a chart note that questioned the existence of the claimed condition. Moreover, SAIF's letter stated that, if claimant still wished to make a claim, she would have to again notify SAIF in writing. Given the contents of SAIF's January 23, 1996 letter, and its refusal to amend its acceptance until after a hearing request had been filed, we find that SAIF's conduct constituted a refusal to pay compensation on the "express ground" that the claimed condition is not compensable or otherwise does not give rise to an entitlement to compensation.[3]

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[1] We acknowledge that we disavowed, in Shannon E. Jenkins, 48 Van Natta 1482 (1996), that portion of our decision in Rivera that held that a hearing request could constitute a worker's "communication in writing" under ORS 656.262(6)(d). We did not, however, disavow our conclusions with respect to ORS 656.386(1).

[2] We recognize that the condition referred to in Dr. Browning's chart note (cumulative trauma disorder) is different from the condition (right wrist tendonitis) that SAIF ultimately accepted and for the acceptance of which claimant has requested an assessed fee. However, Dr. Uphoff, a physician who examined claimant prior to Dr. Browning, explained that claimant suffers from an overuse injury syndrome that had been referred to as "cumulative trauma disorder." (Ex. 26). According to Dr. Uphoff, claimant's tendonitis was a "manifestation" of the overuse or cumulative trauma disorder. (Ex. 26-3). Based on our review of Dr. Uphoff's medical opinion as a whole, we find that the diagnoses of "cumulative trauma disorder," overuse syndrome and right wrist tendonitis are interchangeable and refer to essentially the same disorder. Cf. Leslie C. Muto, 46 Van Natta 1685 (1994), aff'd mem 133 Or App 770 (1995) (no "de facto" denial when the claimant's condition was the same as that accepted by the carrier even though different medical terminology used to describe the condition).

[3] SAIF cites Donald P. James, 48 Van Natta 563, 566 (1996), in which we cited a definition of "express" which stated that, as an adjective, the term meant "firmly and explicitly stated." SAIF asserts that its January 23, 1996 letter does not constitute an "express" refusal to pay compensation under that definition. We disagree with SAIF's narrow construction of its letter. When a carrier refers to a chart note that questions the existence of the claimed condition and asks whether the claimant still intends to make a claim for compensation, it is denying that there is a compensable condition. It follows that the carrier is "firmly and explicitly" refusing to pay compensation. Under these circumstances, we find that SAIF's January 23, 1996 letter was a refusal to pay compensation in this case on the "express ground" that the condition claimed was not compensable or otherwise did not give rise to an entitlement to compensation.

Accordingly, claimant's attorney is entitled to an assessed fee for services in obtaining rescission of SAIF'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 fee for claimant's attorney's pre-hearing services is $750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 30, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which declined to award an attorney fee pursuant to ORS 656.386(1) is reversed. Claimant's counsel is awarded an attorney fee of $750 for services rendered in obtaining rescission of SAIF's "de facto" denial, payable by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GREGORY M. HARTNELL, Claimant
WCB Case No. 95-10503
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that upheld Red Lion/AIG's denial of responsibility for his right hand and shoulder condition. On review, the issue is responsibility.

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

The ALJ found claimant not credible based on his demeanor while testifying. The ALJ further found that the physicians' opinions based on claimant's history were unpersuasive. Relying instead on the opinion of an examining physician, the ALJ upheld the employer's responsibility denial.

In his reply brief, claimant makes reference to a different ALJ's credibility finding in an order which was issued in a separate proceeding against a different employer. Claimant seeks inclusion of the order into the record. Because it is based on a different record, we are not persuaded that the order referred to by claimant is relevant to claimant's credibility in this matter. Accordingly, we decline to remand or take administrative notice of the order in the separate proceeding.

After our review, we find no reason not to defer to the ALJ's demeanor-based credibility finding in this matter. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

ORDER

The ALJ's order dated May 21, 1996 is affirmed.

In the Matter of the Compensation of
STEVE H. SALAZAR, Claimant
WCB Case Nos. 95-08169 & 95-08140
ORDER DENYING RECONSIDERATION
Jon C. Correll, Claimant Attorney
Lundeen, et al, Defense Attorneys
Garrett, Hamann, et al, Defense Attorneys

On November 29, 1996, the Board issued an order which affirmed that portion of an Administrative Law Judge's (ALJ's) order that found Liberty Northwest Insurance Corporation responsible for claimant's current right knee condition and modified the ALJ's attorney fee award. Submitting a December 30, 1996 letter disputing the Board's responsibility decision, Liberty seeks reconsideration of the Board's November 29, 1996 order. Inasmuch as the November 29, 1996 order has become final, we are without authority to alter the 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 has 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 the Board's November 29, 1996 order was December 29, 1996, a Sunday. Therefore, the final day that the Board retained authority to modify its November 29, 1996 order was Monday, December 30, 1996. See Anita L. Clifton, 43 Van Natta 1921 (1991). Liberty's request for reconsideration was mailed to the Board on December 30, 1996, within the 30-day appeal period. Nevertheless, by the time the reconsideration request was received by the Board (January 3, 1996) and brought to our attention, the 30-day period of ORS 656.295(8) had expired.

Inasmuch as the Board's November 29, 1996 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, we are without authority to alter the Board's 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 the order.

Accordingly, Liberty's request for reconsideration 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
REYNA SANTOS, Claimant
WCB Case Nos. 96-09113 & 96-01003
ORDER OF DISMISSAL (REMANDING)
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Steven T. Maher, Defense Attorney

The Board has received Giesy, Greer & Gunn's request for review of Administrative Law Judge (ALJ) Davis' November 25, 1996 Opinion and Order. We have reviewed the request on our own motion to determine whether we have jurisdiction to consider Giesy's request. Because we conclude that the ALJ's order is not a final order, we dismiss the request for review and remand to the ALJ for publication of a final order which is mailed to all parties to this proceeding.

FINDINGS OF FACT

Claimant requested hearings concerning denials of her low back condition issued by Giesy, Greer & Gunn and Liberty Northwest Insurance Corporation. The hearing requests were consolidated for hearing.

On November 25, 1996, ALJ Davis issued an Opinion and Order that: (1) set aside Giesy's denial; (2) upheld Liberty's denial; and (3) awarded claimant penalties and attorney fees to be paid by Giesy. The ALJ's order provided that copies of the order were mailed to claimant, her attorney, Giesy, Giesy's principal (the employer), and their attorney. The order did not provide that copies were mailed to Liberty, its insured, and/or their attorney.

On December 6, 1996, Giesy requested Board review of the ALJ's order.

CONCLUSIONS OF LAW

An ALJ's order shall be mailed to all parties in interest. ORS 656.289(3). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(21). If an ALJ's order is not mailed to all parties, the order is not final and is not subject to Board review. Richard F. Taylor, 40 Van Natta 384 (1988); Martin N. Manning, 40 Van Natta 374 (1988); see Taylor v. Liberty Northwest Insurance Corporation, 107 Or App 107, 110 (1991); Berliner v. Weyerhaeuser Co., 90 Or App 450 (1988), 92 Or App 264 (1988).

Here, the ALJ's order does not provide that a copy of the order was mailed to either Liberty or its insured. Since both of these entities were parties to the proceeding before the ALJ, the order is not final and is not subject to our review. ORS 656.289(2), (3); Richard F. Taylor, supra; Martin N. Manning, supra; Berliner v. Weyerhaeuser Co., supra. Inasmuch as the ALJ's order is not final, Giesy's request for Board review is premature.

Accordingly, Giesy's request for Board review is dismissed. This matter is returned to ALJ Davis for the issuance of a republished and final order bearing a new date of actual mailing with copies mailed to all parties to the proceeding, as well as their respective representatives.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRED D. FEARRIEN, Deceased, Claimant
WCB Case Nos. 96-04446, 96-04445 & 96-01827
ORDER OF DISMISSAL
Kellington, et al, Claimant Attorneys
deSchweinitz, et al, Defense Attorneys

Claimant, as beneficiary of the deceased worker, has requested review of Administrative Law Judge (ALJ) Mongrain's order that affirmed the Director's determinations that the deceased worker was not a subject worker of the alleged employers at the time of his injury which resulted in his death. We have reviewed this matter to determine whether we have authority to review claimant's appeal. Inasmuch as appellate jurisdiction does not rest with this forum, we dismiss claimant's request for Board review.

FINDINGS OF FACT

Claimant, the beneficiary of the deceased worker, filed a notice of a workers' compensation injury claim (which resulted in the worker's death) with the Director of the Department of Consumer and Business Services (Director). By letters dated January 25, 1996 and April 16, 1996, the Director's designee informed claimant that his notice of injury with the alleged employers would not be processed under ORS 656.054 because the decedent was not a subject worker of those alleged employers at the time of the injury/death.

Claimant filed timely requests for hearing from the Director's determinations, and the matter was litigated before ALJ Mongrain. The only issue before ALJ Mongrain was subjectivity, i.e., whether any of the three alleged employers was a subject employer and claimant a subject worker of the alleged employer at the time of the injury/death.

By Opinion and Order dated December 2, 1996, ALJ Mongrain affirmed the Director's nonsubjectivity determinations. ALJ Mongrain's order included a notice of appeal rights to the Workers' Compensation Board. See ORS 656.289(3).

On December 12, 1996, the Board received claimant's request for review of ALJ Mongrain's order. On December 16, 1996, the ALJ issued an Order of Abatement withdrawing the December 2, 1996 order for further consideration.

CONCLUSIONS OF LAW AND OPINION

In Lankford v. Copeland, 141 Or App 138 (1996), the court determined that review of an ALJ order affirming the Director's determination that the claimant was not a subject worker was not a matter concerning a claim within the meaning of ORS 656.704(3). Thus, the court concluded that review of the ALJ's order rested with the court under ORS 183.482. Reasoning that the ALJ's inclusion of an incorrect notice of appeal rights to the Board affected a substantial right of claimant, the court remanded to the Board for dismissal of the request for review and remand to the Director for issuance of a corrected order with the proper notice of appeal rights.

Here, claimant requested review of an ALJ's order affirming the Director's nonsubjectivity determinations. Consistent with the Lankford rationale, we lack appellate review authority.

As a general rule, where the ALJ has issued an order containing incorrect notice of appeal rights, we have remanded to the Director for issuance of a corrected order. See Cindy Lankford, 48 Van Natta 1870 (1996); Vollina Draper, on recon 48 Van Natta 1862 (1996). However, in contrast to this case, the ALJ's orders in those cases had not been withdrawn. Thus, in light of the ALJ's abatement order, authority to issue a corrected order containing the proper notice of appeal remains with the ALJ.

Accordingly, claimant's request for Board review is dismissed. This matter shall be returned to ALJ Mongrain for further action.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRDA B. ROBERTSON, Claimant
WCB Case No. 96-03686
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's right knee, cervical and low back injury claim; (2) assessed a penalty for the insurer's allegedly unreasonable denial; and (3) awarded an attorney fee of $3,000. On review, the issues are compensability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's analysis and conclusion that claimant's injury arose out of and in the course of her employment, with the following change. In the fourth paragraph on page 3, we delete the fifth sentence.

Penalty

The ALJ found that the insurer failed to provide an adequate legal reason for denying the claim. In addition, the ALJ found that the employer did not conduct any investigation "in support of the other reasons identified at hearing" in support of the denial. The ALJ also noted that the insurer did not request a medical examination regarding a contribution from claimant's alleged preexisting ankle condition.

The insurer asserts that the ALJ erred by assessing a penalty, arguing that it had a legitimate doubt about compensability because claimant had not, before hearing, given any history of a work connection with the injury. The insurer contends that it was only at hearing that claimant mentioned the grains of concrete on the surface of the employer's parking lot.

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 April 12, 1996, the insurer denied the claim because claimant's injury and need for treatment did not arise out of and during the course of her employment. (Ex. 3). The insurer noted that its file showed that claimant was "off the clock" at the time of the alleged injury. (Id.)

Claimant's November 3, 1995 accident report indicated that claimant went to the parking lot to move her car, and was running back to the building when her "right ankle gave way" and she fell on the concrete. (Ex. 1a). Claimant's "827" form, "801" form and first medical report reflect the same history (claimant going to the parking lot to move her car, and running to return to work when her right ankle "gave way"). (Exs. 1b, 1d, 2). The employer's November 14, 1995 "accident investigation report" also reflects this history. (Ex. 1f). Thus, at the time the insurer issued its denial, it had information that indicated claimant's fall was the result of her running back to the building after going to the lot to move her car, and arguably, did not arise out of her employment. Under these circumstances, we conclude

that, in April 1996, and continuing through the date of the hearing, the insurer had a legitimate doubt as to its liability.[1] Consequently, the insurer's refusal to pay such benefits was not unreasonable. We therefore reverse the ALJ's penalty assessment.

Attorney Fee

The insurer argues that the attorney fee award of $3,000 was excessive because this was a nondisabling case with minimal benefits.

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

Based on the application of the previously enumerated factors, we agree with the ALJ that a reasonable fee for claimant's attorney's services at hearing regarding the compensability issue is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the 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 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 request for fees and the insurer's objections thereto), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty and attorney fee issues. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated August 15, 1996 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, payable by the insurer.

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[1] We recognize nevertheless, that, generally, an injury to an employee on the employer's premise during a lunch break occurs "in the course of" employment. Liberty Northwest Ins. Corp. v. Johnson, 142 Or App 21, 25 (1996).

In the Matter of the Compensation of
DAVID L. LEE, Claimant
WCB Case No. 95-08006
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

The self-insured employer requests reconsideration of our December 6, 1996 Order on Review that set aside its denial of claimants's right knee injury claim. Contending that we erroneously analyzed the medical evidence, the employer seeks reconsideration of our decision.

In order to further consider this matter, we withdraw our December 6, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
TREVOR E. SHAW, Claimant
WCB Case No. 95-01654
THIRD ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer requested reconsideration of our July 30, 1996 order, as reconsidered on August 27 and October 24, 1996, that directed the insurer to pay claimant temporary disability benefits for the period from June 4, 1993 to January 17, 1994, and a 25 percent penalty based on those amounts of compensation.

In order to consider the insurer's motion, we withdrew our prior orders on November 21, 1996. Claimant has submitted a response in opposition to the insurer's motion. We now proceed with our reconsideration.

SUMMARY OF FACTS

We briefly summarize the relevant facts. Claimant compensably injured his low back on April 30, 1993. On June 4, 1993, the insurer stopped temporary disability payments. In a November 4, 1993 order, ALJ Menashe held that the insurer had no statutory authority to terminate temporary disability payments until June 20, 1993; he ordered payment of temporary disability benefits through that date, and assessed a penalty for the insurer's unilateral termination of temporary disability benefits. The insurer requested Board review and, pending its appeal, did not pay the benefits awarded by the ALJ's order.

By Order on Review dated September 8, 1994, the Board affirmed ALJ Menashe's finding that the insurer had no statutory authority to terminate temporary disability payments after June 4, 1993. In addition, the Board concluded that the insurer had no statutory authority to terminate temporary disability payments on June 20, 1993 and, therefore, ordered payment of additional temporary disability from June 20, 1993 until such benefits could be lawfully terminated. The Board also assessed a 25 percent penalty based on the additional amounts of compensation made payable by its order. The insurer appealed the Board's September 8, 1994 order, but withdrew its petition for judicial review in January 1995. The insurer paid no temporary disability compensation or penalties pursuant to the Board's final order.

In the interim, the insurer had issued a January 17, 1994 Notice of Closure, declaring claimant medically stationary on January 7, 1994 and awarding substantive temporary disability benefits through June 6, 1993. An Order on Reconsideration dated August 24, 1994 affirmed the medically stationary date, but modified the closure notice to award temporary disability benefits through June 20, 1993. The parties appealed the reconsideration order.

By order dated December 15, 1994, ALJ Menashe modified the reconsideration order to find claimant became medically stationary on June 7, 1993, and award temporary disability benefits to that date. Claimant requested Board review.

By Order on Review dated July 19, 1995, the Board modified the ALJ's order to affirm the reconsideration order's finding that claimant became medically stationary on January 7, 1994, but affirmed the ALJ's award of temporary disability through June 6, 1993. In addition, the Board rejected claimant's contention that the insurer unreasonably terminated temporary disability payments on June 6, 1993, reasoning that the termination of "procedural" temporary disability was authorized when claimant was released to return to regular work on June 7, 1993. Claimant appealed the Board's July 19, 1995 order, and review of that case is currently pending before the Court of Appeals.

When the insurer did not pay the compensation and penalties awarded under the Board's September 8, 1994 final order, claimant brought this enforcement proceeding. The present ALJ declined to order the insurer to pay temporary disability or penalties pursuant to the September 8, 1994 final order, reasoning that the insurer had properly stayed payment of temporary disability benefits under ALJ Menashe's November 4, 1993 order pending its appeal to the Board. Then, because the January 17,

1994 closure notice and August 24, 1994 reconsideration order had established claimant's substantive entitlement to temporary disability by the time the September 8, 1994 order became final, the ALJ reasoned that claimant had no entitlement to additional temporary disability pursuant to Lebanon Plywood v. Seiber, 113 Or App 651 (1992) (Board cannot order a procedural overpayment of temporary disability to which a claimant is not substantively entitled).

CONCLUSIONS OF LAW AND OPINION

In our Second Order on Reconsideration dated October 24, 1996, we relied on the court's opinion in Jeld-Wen, Inc. v. Bartz, 142 Or App 433 (1996), to conclude that, by virtue of the Board's September 8, 1994 final order, the insurer is required to pay temporary disability benefits from June 4, 1993 to the January 17, 1994 date of closure, and the 25 percent penalty based on those additional amounts of compensation. In so concluding, we distinguished the court's decision in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), reasoning that we were not ordering an overpayment of "procedural" temporary disability benefits because claimant's substantive entitlement to those benefits was established by the September 8, 1994 final order.

In its motion for reconsideration, the insurer first requests that we review this case en banc. In the exercise of our de novo review, we select for en banc review those cases which raise issues of first impression that would have a widespread impact on the workers' compensation system or cases requiring disavowal of prior Board case law. Andrew D. Kirkpatrick, 48 Van Natta 1789, 1790 n 1 (1996) (order denying reconsideration). This "significant case review" standard is applied to all cases before the Board. Because we do not find that this case presents issues of sufficient novelty or legal significance to warrant en banc review, the insurer's request is denied.

On the merits, the insurer contends that our Second Order on Reconsideration conflicts with the "law of the case" established by our July 19, 1995 order in WCB Case No. 94-10424, which is currently before the Court of Appeals. In the July 19, 1995 order, we denied claimant's request for a penalty for the insurer's allegedly unreasonable termination of "procedural" temporary disability payments on June 6, 1993. In denying the penalty request, we concluded that, although our September 8, 1994 final order directed the insurer to pay temporary disability benefits from June 5, 1993 until such benefits could be terminated by law, claimant was not entitled to temporary disability payments beyond June 6, 1993. We reasoned as follows:

> "Our [September 8, 1994 final] order directed the insurer to pay temporary disability from June 5, 1993 until such benefits could be properly terminated. Claimant had been released to return to regular work on June 7, 1993, thereby terminating the insurer's obligation to provide further temporary disability benefits. In addition, the record contains no verification from the attending physician of an inability to work after June 7, 1993, which would trigger an obligation to pay procedural temporary disability. Thus, procedurally, as well as substantively, claimant's entitlement to temporary disability ended on June 6, 1993." Trevor E. Shaw, 47 Van Natta 1384, 1385 n 3 (1995) (Emphases supplied; citations omitted).

Thus, based on the finding that claimant was released for regular work on June 7, 1993, we held that the insurer was not obligated to pay "procedural" temporary disability benefits after June 6, 1993. Although our July 19, 1995 order is on appeal to the court and is not final, we have held that, for purposes of administrative efficiency, we shall give precedential effect to our prior non-final litigation orders. Elmer F. Knauss, 47 Van Natta 826, 827, recon 47 Van Natta 949, recon 47 Van Natta 1064 (1995); Michael S. Barlow, 46 Van Natta 1627 (1994). Our reasoning is that an alternative approach, (i.e., giving no effect to the prior non-final litigation order or deferring a decision pending appeal of the prior order), would encourage further and potentially unnecessary litigation or result in inconsistent rulings and additional delays in the resolution of disputes. See id.

Giving our July 19, 1995 order precedential effect, we conclude that claimant was not procedurally entitled to temporary disability payments after June 6, 1993 as a result of our September 8, 1994 final order. This case is distinguishable from Jeld-Wen, Inc. v. Bartz, supra. Like Bartz, there is a final Board order in this case which ordered the carrier to pay "procedural" temporary disability from a certain date until payments could be legally terminated. Unlike Bartz, however, there was a subsequent

Board order in this case which determined that "procedural" temporary disability was legally terminated as of a certain date. Thus, in this case, the termination date for "procedural" temporary disability payments is certain, i.e., June 6, 1993. We therefore decline to order payment of "procedural" temporary disability beyond June 6, 1993. See Elmer F. Knauss, supra; Michael S. Barlow, supra. We also decline to assess a penalty for the insurer's termination of benefits as of that date.

Given our resolution of this dispute, we do not need to address the insurer's remaining arguments.

Accordingly, on reconsideration, as modified herein, we republish our July 30, 1996 order, as reconsidered on August 27 and October 24, 1996. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA J. JENNINGS, Deceased, Claimant
WCB Case No. TP-96007
THIRD PARTY DISTRIBUTION ORDER
Burt, Swanson, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Geraldine Stephens, the personal representative for the deceased worker's estate (hereafter, claimant) has petitioned the Board for the allowance of an extraordinary attorney fee for her counsel's services rendered in connection with a third party judgment involving medical negligence. Specifically, claimant seeks approval of a fee equal to 40 percent of the $280,000 recovery. The SAIF Corporation, as the paying agency, does not oppose the petition. We find that extraordinary circumstances exist to justify the requested fee.

FINDINGS OF FACT

Claimant engaged legal counsel to bring a wrongful death action against a hospital and two physicians involved in claimant's care. This May 1988 action arose from the deceased worker's May 1986 respiratory arrest while receiving treatment for a compensable condition.

Investigation of the claim and preparation for trial involved obtaining, organizing and indexing hundreds of pages of medical records. In addition, over a dozen separate depositions were taken. Some of the depositions had to be taken multiple times due to difficulties in obtaining answers to some questions. This necessitated multiple "motions to compel" requiring briefing and oral argument before the court. Additionally, extensive motion practice was necessitated to compel the hospital to produce pertinent "lost" medical records and the initial autopsy report.

As the result of the difficulty in obtaining discovery through the usual voluntary methods and the defendants' principal defense that, notwithstanding an improperly placed breathing tube, the cause of death was the decedent's underlying chicken pox, it was necessary for claimant's counsel to spend an extraordinary amount of time consulting with experts in the fields of infectious disease, pulmonary medicine, emergency medicine, internal medicine, and emergency room medicine.

The matter was proceeding to a February 8, 1990 trial when the court granted summary judgment to the hospital for an alleged failure to give a timely tort claim notice to the public body that operated the hospital. Claimant's counsel appealed that matter to the Court of Appeals, which reversed the trial court and remanded for trial. Stephens v. Bohlman, 107 Or App 533 (1991). Thereafter, the defendant hospital filed a petition for review with the Supreme Court, which granted review and affirmed the Court of Appeals' decision. Stephens v. Bohlman, 314 Or 344 (1992).

After remand for trial, the claim against one physician was dismissed. In addition, immediately prior to the trial, a settlement was reached with the hospital for payment of $90,000. The case proceeded to trial against the remaining physician. The case was tried before a jury from January 3, 1994, until January 14, 1994. Due to the extended period between the time the case was initially ready to proceed to trial and the actual trial date, the record required additional trial preparation. This included refreshing prior experts, obtaining new experts, revisions of the materials, and preparation of depositions for trial. The trial involved direct and cross-examination of over 25 witnesses, in addition to jury selection and, given the complexity of the case, extensive briefing of the court through trial memorandum.

The trial then resulted in a verdict against the physician in the sum of $250,000, which was appealed to the Court of Appeals. Claimant's counsel's response to this appeal required reviewing over 3,500 pages of transcript, preparing briefs, and engaging in oral argument. The Court of Appeals affirmed the judgment of the trial court. Stephens v. Bohlman, 138 Or App 381 (1996). The defendant filed a motion for reconsideration, which required response from claimant's counsel. The court denied reconsideration. The defendant then filed a petition for review before the Supreme Court, which initially denied review but, upon reconsideration, later granted review. Before briefs on the merits were filed with the Supreme Court, the case was settled for a payment of $280,000, representing the judgment amount, plus interest.

Claimant and her counsel entered into a contingent fee agreement providing for attorney fees of 33 1/3 percent of the gross monies received if the case is settled without trial and 40 percent the case is tried to verdict or if it is necessary to commence the "appeal" stage. The case twice proceeded to appeal. Thus, pursuant to the contingent fee agreement, claimant agrees to a fee of 40 percent of the gross monies received. SAIF does not oppose claimant's counsel's request for an extraordinary attorney fee of 40 percent.

CONCLUSIONS OF LAW AND OPINION

The Board's advisory schedule concerning attorney fees in third party cases is set forth in OAR 438-015-0095. The rule provides as follows: "[u]nless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 to 656.595 is authorized."

We have authorized extraordinary attorney fees in the past. See Gerald G. Sampson, 42 Van Natta 1098 (1990) (a 40 percent share of a $275,000 settlement was allowed where the case involved a complex legal issue which initially resulted in a summary judgment against claimant, and settlement was reached only after successful appeal to the Ninth Circuit Court of Appeals, certification of a legal question to the Oregon Supreme Court, and withdrawal of the certification question following a favorable Court of Appeals decision; in addition, the paying agent did not object to the fee); John P. Christensen, 38 Van Natta 613 (1986) (claimant's counsel was awarded 50 percent of proceeds where the case had been litigated over a 10-year period, including two appearances before the Oregon Supreme Court and the paying agency did not object); John Galanopoulos, 35 Van Natta 548 (1983) (an extraordinary fee of 40 percent was allowed where claimant's attorney expended nearly three full months in trial preparation for a five day trial and achieved an extremely favorable result); Leonard F. Kisor, 35 Van Natta 282 (1983) (a 40 percent share of the proceeds was allowed where the third party litigation involved a complex asbestosis issue and the paying agency did not object to the fee).

We find the circumstances of the present case very similar to those in cases where we have authorized extraordinary attorney fees. Specifically, here, the issues in this medical negligence case were complex, requiring extensive case preparation involving many expert witnesses, and ultimately resulting in a trial that lasted almost two weeks. In addition, extensive motion practice and court memorandum were required due to discovery violations and the complexity of the issue. Furthermore, the litigation extended over a period of almost ten years and involved several appeals, which resulted in two appearances before the Court of Appeals and one before the Oregon Supreme Court. Moreover, claimant's counsel achieved a favorable result. In addition, claimant and her counsel agree to an attorney fee of 40 percent, as represented by the retainer agreement. Finally, SAIF does not object to claimant's counsel's request of a fee of 40 percent of the proceeds. Gerald G. Sampson, supra; John P. Christensen, supra; John Galanopoulos, supra; Leonard F. Kisor, supra.

Under these circumstances, we are persuaded that claimant's counsel is entitled to an attorney fee in excess of one-third of the third party settlement. Accordingly, for the reasons expressed herein, we find that this case constitutes extraordinary circumstances justifying the allowance of an extraordinary attorney fee. Commensurate with the request from claimant's counsel and the agreement between claimant and her counsel, we further hold that the extraordinary attorney fee shall equal 40 percent of the $280,000 settlement proceeds. Consequently, claimant's counsel is directed to retain the aforementioned extraordinary attorney fee from the settlement proceeds.

IT IS SO ORDERED.

January 8, 1997 Cite as 49 Van Natta 14 (1997)

In the Matter of the Compensation of
RAYMOND LEWELLYN, Claimant
WCB Case No. 95-10569
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Odell's order that set aside its denial of claimant's current cervical condition. On review, the issue is compensability.

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

The employer asserts that claimant is not credible regarding the mechanism of his injury, and argues that the ALJ's demeanor-based credibility finding should be overturned. Specifically, the employer contends that claimant's testimony that the April 1993 injury involved a fall is not credible. The insurer asserts that the medical reports contemporaneous with claimant's injury did not report a fall.

The medical reports contemporaneous with claimant's fall indicate generally that claimant was injured while opening a rail car. These reports do not mention whether claimant fell. Claimant reported in later medical reports and testified at hearing that he fell when the rail car door he was pulling on opened suddenly.

The ALJ concluded that claimant's testimony at hearing did not necessarily conflict with the brief descriptions of the injury given by claimant contemporaneous with the injury. On this basis, the ALJ found claimant's testimony that the injury involved a fall to be reliable.

Although not statutorily required, the Board generally defers to an ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Here, the ALJ's credibility finding was based on the observation of claimant's demeanor. In addition, the descriptions contemporaneous with the injury are generally brief and lacking in detail. Under these circumstances, we do not find a sufficient basis on which to conclude that claimant's testimony regarding how the injury occurred is false or unreliable. Thus, because the ALJ's finding was based on claimant's demeanor and because we find insufficient basis on which to set aside the finding, we defer to the ALJ's credibility determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990).

The employer next argues that Dr. Miller's opinion is unpersuasive because it is based on an incorrect history that claimant's symptoms of cervical myelopathy began contemporaneous with claimant's work accident. The employer argues that claimant testified that his symptoms did not arise until six months after the accident. On this basis, the employer argues that Dr. Miller's causation opinion is entitled to no weight.

In reaching his opinion regarding causation, Dr. Miller clearly found it significant that claimant did not have myelopathy symptoms before the 1993 injury. Dr. Miller testified that myelopathy develops over time and noted that at the time Dr. Herring evaluated claimant soon after the injury, claimant did not show signs of myelopathy. (Ex. 22-14). Given Dr. Miller's statement, it is not surprising that

claimant's myelopathy symptoms did not develop immediately. Under such circumstances, we are not persuaded that Dr. Miller based his opinion on an incorrect history that claimant's myelopathy symptoms began immediately with the injury. Rather, Dr. Miller's statement indicates that he believed that myelopathy symptoms can develop over time after the injury.[1]

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

ORDER

The ALJ's order dated May 31, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

[1] The employer also argues that Dr. Miller lacked a history of a 1957 injury. There is no indication in the record that the remote 1957 injury is responsible for claimant's current cervical problems. Thus, we do not find Dr. Miller's opinion unpersuasive on this basis.

In the Matter of the Compensation of
VINCENT S. ROBERTS, Claimant
WCB Case No. 96-02917
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that affirmed an Order on Reconsideration that awarded no scheduled permanent disability for loss of use or function of claimant's left foot. Contending that claimant improperly raises ORS 656.262(7)(b) for the first time on review, the insurer moves to strike that portion of claimant's appellant's brief. On review, the issues are the insurer's motion to strike and extent of scheduled permanent disability.

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

The insurer moves to strike that portion of claimant's appellant's brief which it asserts raises an issue not raised at hearing. Specifically, the insurer asks us to strike the portion of claimant's brief which argues that the insurer improperly closed claimant's claim because it failed to issue a denial under ORS 656.262(7)(b).

We consider the parties' appellate briefs to the extent that they address issues on review based on the record developed at hearing. Douglas B. Robbins, 45 Van Natta 2289 (1993). In this case, the parties agreed at hearing that the sole issue is the extent of claimant's scheduled permanent disability. (Tr. 2). Accordingly, we are not inclined to consider claimant's brief to the extent that its arguments depart from that issue.[1] See Ronald D. Robinson, 44 Van Natta 1232 (1992).

[1] Assuming (without deciding) that claimant's argument under ORS 656.262(7)(b) is raisable and the insurer's failure to deny the claim under that statute precludes it from contending that the major contributing cause of claimant's left ankle impairment is something other than the 1993 injury, the result would be the same because claimant has not established entitlement to scheduled permanent disability under this claim. See discussion of merits, ante, including note 3; see also Robin W. Spivey, 48 Van Natta 2363 (1996) (Before ORS 656.262(7)(b) applies, a condition must have been accepted under ORS 656.005(7) as a combined condition).

On the merits, we adopt the ALJ's reasoning and conclusion (that claimant failed to establish entitlement to permanent impairment due to the December 1993 compensable injury) with the following modification.

We consider only the opinions of Dr. Palmer, treating physician, and Dr. Witczak, medical arbiter, in evaluating claimant's permanent impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Insurance Corp., 125 Or App 666, 670 (1994) (With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability); Dennis E. Connor, 43 Van Natta 2799 (1992)

Only Dr. Witczak made impairment findings and we agree with the ALJ that Dr. Witczak's opinion regarding claimant's permanent impairment is persuasive. However, that does not aid claimant's cause.

Dr. Witczak found the following ranges of motion in the right and left ankles:

Plantar flexion, right-40 degrees; left-32 degrees;
Dorsiflexion, right-10 degrees; left-10 degrees;
Eversion, right-20 degrees; left 10 degrees;
Inversion, right 30 degrees; left 10 degrees. (Ex. 47-3).

Applying former OAR 436-35-190 according to the method set out in former OAR 436-35-007(16) results in the following: Plantar Flexion- 4.3%; Dorsiflexion-0; Eversion-2%; Inversion-4%. The total range of motion is 10.3%, which is rounded to 10 percent. Former OAR 436-35-190(10) and former OAR 436-35-007(10). We thus conclude that claimant's left ankle impairment would be rated at 10 percent.[2] However, claimant was previously awarded 11 percent permanent disability for loss of use or function of his left ankle under a 1990 injury claim. (See Ex. 16). Thus, because claimant has not established loss of use or function of his left ankle beyond that for which he has previously been compensated, we agree with the ALJ that claimant is currently not entitled to a scheduled permanent disability award.[3] See ORS 656.222; former OAR 436-35-007(3).

ORDER

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

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[2] We acknowledge claimant's contention that he is entitled to ratings for ligament instability and a chronic condition of his left ankle. However, because Dr. Witczak expressly stated that claimant's chronic condition arose "outside" the 1993 strain injury, we conclude that claimant is not presently entitled to a rating for that condition under this claim. (Ex. 47-4). In addition, because Dr. Witczak did not identify the injured ligament, claimant's ligament instability is not ratable under the standards. See former OAR 436-35-200(2).

[3] We need not determine whether claimant would be subject to the major contributing cause standard of proof in establishing the injury-related nature of his left ankle impairment because, even if he is not, the result would be the same.

In the Matter of the Compensation of
THOMAS J. KOLLEN, Claimant
WCB Case No. 96-03549
ORDER OF ABATEMENT
Flaxel & Nylander, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our December 13, 1996 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order 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 contends that we incorrectly interpreted former OAR 436-60-025(5)(a).

In order to consider this matter, we withdraw our December 13, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
LILLIE L. RODRIGUEZ, Claimant
WCB Case No. 95-13146
ORDER OF DISMISSAL
Malagon, et al, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

On December 31, 1996, the Board acknowledged the self-insured employer's "Request for Reconsideration and Stay of Appeal Period Pending Reconsideration" as a request for review of Administrative Law Judge (ALJ) Nichols' December 16, 1996 order. We have reviewed this request on our own motion to determine if we have jurisdiction to consider this matter. Because the record does not establish that the employer has requested Board review of the ALJ's order, we dismiss.

FINDINGS OF FACT

On December 16, 1996, ALJ Nichols issued an Opinion and Order that: (1) affirmed an Order on Reconsideration which awarded 12 percent scheduled permanent disability for loss of use or function of the right forearm; (2) awarded additional temporary disability; and (3) declined to assess penalties or attorney fees for allegedly unreasonable claim processing.

On December 30, 1996, the Board received a December 27, 1996 letter from the employer's counsel. Addressed to the ALJ, the letter was entitled "Request for Reconsideration and Stay of Appeal Period Pending Reconsideration."

On December 31, 1996, the Board mailed its computer-generated letter to all parties acknowledging its receipt of a request for "Board review."

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988). However, where a party expressly requests reconsideration of an ALJ's order, even though a request for Board review has been "acknowledged," the request for review must be dismissed. See Patricia L. Duerr, 41 Van Natta 2167, on recon 41 Van Natta 2341 (1989).

Here, the employer directed its request to the ALJ and expressly sought reconsideration of the ALJ's December 16, 1996 order. Under such circumstances, we conclude that the intention expressed in the employer's December 27, 1996 request is both clear and unmistakable, i.e., that the employer was asking the ALJ to reconsider her December 16, 1996 Opinion and Order.

Because the employer requested reconsideration of the ALJ's order, rather than Board review of that order, we lack jurisdiction to review this case. Consequently, we dismiss the "request for Board review," and rescind our December 31, 1996 acknowledgment letter. See Patricia L. Duerr, supra. Finally, we return the file to ALJ Nichols for review of the employer's request for reconsideration of the ALJ's December 16, 1996 order.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSE M. RUBIO, Claimant
WCB Case Nos. 96-01714 & 95-11542
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that affirmed an Order on Reconsideration that found claimant's left shoulder claim was prematurely closed. Claimant cross-requests review of that portion of the ALJ's order that denied an attorney fee pursuant to ORS 656.386(1) for a "de facto" denial of his left shoulder impingement syndrome. On review, the issues are premature closure and attorney fees.

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

The ALJ concluded that claimant was not entitled to an assessed fee under ORS 656.386(1) for the insurer's acceptance of a "de facto" denial of a left shoulder impingement syndrome because there was no "denied claim."

Claimant argues that a "denied claim" was established because the insurer denied the relief claimant was requesting. We disagree.

We agree with the ALJ that there was no evidence that, before it accepted claimant's left shoulder impingement syndrome, the insurer refused to pay compensation on the express ground that the condition was not compensable or did not give rise to an entitlement to compensation. Consequently, there was no "denied claim" pursuant to ORS 656.386(1). See Jason O. Rogers, 48 Van Natta 2361 (1996); Michael J. Galbraith, 48 Van Natta 351 (1996).[1]

The ALJ also concluded that, based on Dr. Gambee's opinion, the claim was prematurely closed. The ALJ rejected the insurer's contention that, because Dr. Gambee was not a member of the managed care organization (MCO), he could not be claimant's attending physician and, therefore, could not offer an opinion regarding claimant's medically stationary status.

The insurer argues that the ALJ erred by relying on Dr. Gambee's opinion. The insurer also contends that, in MCO situations, claimant's medically stationary status must be declared by an MCO-approved physician. We disagree.

In deciding whether a claimant is medically stationary, we have previously relied on the opinions of non-MCO physicians when the record indicates that the physicians' opinions are well-reasoned and based on medical evidence. See Orben Baldwin, 48 Van Natta 1877 (1996); Marsha Brown, 47 Van Natta 1465 (1995). We agree with the ALJ's reasoning and conclusion that, based on Dr. Gambee's opinion, claimant's compensable condition was not medically stationary. We therefore affirm the Order on Reconsideration.

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

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[1] Board Chair Hall notes that, although he is bound by the doctrine of stare decisis, he refers the parties to his dissenting opinions in Jason O. Rogers, supra, and Michael J. Galbraith, supra.

ORDER

The ALJ's order dated May 29, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
RAY A. SCHAFFER, Claimant
WCB Case No. 95-09045
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its denial of claimant's occupational disease claim of chronic infectious paranasal sinusitis; and (2) awarded an attorney fee of $5,500. Claimant cross-requests review, arguing that the insurer has filed a frivolous appeal. On review, the issues are compensability, attorney fees and sanctions.

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

Claimant argues that the insurer has filed a frivolous appeal. Claimant asserts that the insurer has "appealed without substantial evidence." We disagree.

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 Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996).

Here, the insurer's request for review is not frivolous. Dr. Montanaro's opinion supports the insurer's argument that claimant's condition is not compensable. Although we are not persuaded by the insurer's argument, we find that the insurer's request for review is supported by substantial evidence and raised arguments that were sufficiently developed so as to create a reasonable prospect of prevailing. Consequently, we deny claimant's request for sanctions on review.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services related to the sanctions issue.

ORDER

The ALJ's order dated May 29, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
CECELIA A. TALBERT, Claimant
WCB Case No. 96-02825
ORDER ON REVIEW
Walker & Potter, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's occupational disease claim for left carpal tunnel syndrome. SAIF also moves to remand the case to the ALJ for admission of additional evidence. On review, the issues are remand and compensability. We deny the motion to remand and reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the last paragraph. We also provide the following supplementation.

After the record closed, SAIF moved to reopen the record for admission of another report from Dr. Ochoa, a neurologist who examined claimant on behalf of SAIF. This additional report contradicted claimant's testimony at hearing that she took some Tylenol before Dr. Ochoa's examination. The ALJ denied the motion.

CONCLUSIONS OF LAW AND OPINION

Finding Dr. Ochoa's report unpersuasive, the ALJ concluded that claimant proved a compensable occupational disease for her left carpal tunnel syndrome. SAIF first argues that we should remand the case to the ALJ for admission of Dr. Ochoa's post-hearing report. SAIF also asserts that claimant did not carry her burden of proving a compensable occupational disease claim.

Claimant is a claim analyst for an insurance company and enters data into a computer with a keyboard. In December 1995, claimant began treating with Dr. Peters, M.D., who diagnosed left carpal tunnel syndrome. (Ex. 23). Dr. Peters referred claimant to Dr. Rosenbaum, neurologist, for nerve conduction studies "to help delineate whether it is carpal tunnel or histrionic behavior." (Ex. 24).

Dr. Rosenbaum reported that claimant "has symptoms and electrical findings of a mild left carpal tunnel syndrome" and, based on a description of claimant's work, "it sounds as though [employment conditions] are the major contributing cause of her carpal tunnel syndrome." (Ex. 28-2).

In January 1996, Dr. Ochoa examined claimant, finding that, although some of claimant's symptoms were compatible with a mild carpal tunnel syndrome, other symptoms demonstrated a marked conversion-somatization disorder. (Ex. 31-24, 25). Dr. Ochoa reported that the major contributing cause of claimant's condition was the conversion-somatization disorder. (Id. at 26). Dr. Ochoa, in part, based his opinion on diagnostic placebo testing, which he reported showed that claimant "is a strong placebo responder with injection of saline significantly reducing her spontaneous pain." (Ex. 30-2). Dr. Ochoa found that a second injection of a "local agent" showed that both claimant's "weakness and sensory loss are of a non-organic origin because they were easily reversed by [the] injection * * * which would not be expected to repair damaged motor or sensory nerve fibers." (Id.)

Both Dr. Rosenbaum and Dr. Peters indicated concurrence with Dr. Ochoa's report. (Exs. 34, 36).

The only medical evidence supporting a causal relationship between claimant's carpal tunnel syndrome and her employment conditions is from Dr. Rosenbaum. Dr. Rosenbaum, however, subsequently indicated concurrence with Dr. Ochoa's report which found that the major contributing cause of claimant's condition was a marked conversion-somatization disorder. Based on this concurrence, we find that Dr. Rosenbaum changed his initial opinion. Finally, because Dr. Peters also indicated concurrence with Dr. Ochoa's report, we find no medical opinion that carries claimant's burden to prove that employment conditions were the major contributing cause of her left carpal tunnel syndrome. Consequently, claimant failed to prove compensability. ORS 656.802.

Finally, because we find that the current record does not prove compensability, it is unnecessary to remand the case to the ALJ for admission of Dr. Ochoa's supplemental report. Specifically, because admission of the report would not change the outcome, we find no compelling reason to remand. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). Consequently, we deny SAIF's motion.

ORDER

The ALJ's order dated June 28, 1996 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

Board Chair Hall specially concurring.

I write separate to expressly voice my agreement with the ALJ concerning the unpersuasiveness of Dr. Ochoa's report. His diagnosis of a marked conversion-somatization disorder is contradicted by the nerve conduction studies. Because Dr. Rosenbaum and Dr. Peters concurred with Dr. Ochoa's report, however, there is an absence of medical evidence proving compensability.

In the Matter of the Compensation of
CHRIS G. CLAUSEN, Claimant
Own Motion No. 95-0517M
OWN MOTION ORDER
Terry & Wren, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer initially submitted claimant's request for temporary disability compensation for his compensable cervical strain injury. Claimant's aggravation rights on that claim expired on April 5, 1989.

On October 27, 1995, the insurer denied the compensability of claimant's current C5-6 herniated disc condition. Claimant requested a hearing. (WCB Case No. 95-11626). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated May 24, 1996, Administrative Law Judge (ALJ) McKean approved the insurer's denial. Claimant requested Board review of ALJ McKean's order, and, in an order issued on December 24, 1996, the Board affirmed ALJ McKean's order.[1]

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.

Here, the current condition and ensuing surgery for which claimant requests own motion relief, remain in denied status. As a result, we are not authorized to grant claimant's request for own motion relief. See Id.

Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

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[1] Claimant also requests review of the insurer's January 31, 1996 Notice of Closure in this claim. In its January 31, 1996 claim closure, the insurer awarded no temporary disability compensation, but noted that "Own Motion claim denied by carrier 10-27-95" and declared claimant medically stationary as of December 2, 1995. However, by this order, we are denying authorization of the reopening of claimant's 1982 injury claim for the payment of temporary disability compensation because he has not established that his current C5-6 disc condition is compensably related to his accepted condition. Therefore, because we have authorized no temporary disability compensation (and no time loss was paid by the insurer), the request for review of the Notice of Closure of claimant's 1982 injury claim with the insurer, is moot. ORS 656.278; OAR 438-012-0055; 438-012-0060.

In the Matter of the Compensation of
SANDRA E. POST, Claimant
WCB Case No. 95-07198
SECOND ORDER OF DISMISSAL
Susak, Dean & Powell, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Claimant has requested reconsideration of our December 13, 1996 Order of Dismissal, which dismissed her request for review as untimely filed. Specifically, claimant contends that she mailed her request for review to the Board, by certified mail, within 30 days of the ALJ's order.

Having received claimant's motion, the self-insured employer's response, and claimant's reply, we proceed with our reconsideration. For the reasons set forth herein and in our prior order of dismissal, we adhere to our determination that claimant's request for review was untimely and the ALJ's October 28, 1996 order has become final by operation of law.

In our previous order, we held that claimant's request for review was untimely because it was not mailed to the Board within 30 days after the ALJ's October 28, 1996 order.[1] We explained that ORS 656.289(3) and 656.295(2) require that the request for review be mailed or actual notice received within the statutory period. See Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). We further explained that where, as here, the request for review is actually received by the Board after the 30th day, we presume that the mailing was untimely unless the party establishes that the mailing was timely. See OAR 438-005-0046(1)(b).

On reconsideration, claimant asserts that the mailing was timely for purposes of OAR 438-005-0046(1)(b) even though the request for review "mailed" by certified mail on November 14, 1996 did not have a complete address.[2] We disagree. We conclude that the Board's rules require evidence of proper mailing by the date of filing.

First, the "presumption" of mailing set forth in OAR 438-005-0046(1)(b) is based on "the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing." Here, claimant has enclosed a copy of the envelope which initially held her request for Board review. That envelope carried a United States Postal Service postmark date of November 14, 1996. Yet, the record shows that the receipt for certified mail which accompanied this initial request for Board review was not date stamped by the United States Postal Service. (See Ex. A-1). Therefore, we cannot presume that the request was actually mailed on that date.[3]

Second, on this record, claimant has not otherwise established that the mailing was timely. Although claimant has shown that she deposited the request for review in the mail within 30 days of the ALJ's order, she acknowledges that this request was misaddressed and returned as undeliverable. Because the request was incorrectly addressed, claimant had to take further action, i.e., correct the address and remail the request to the Board, on December 2, 1996. Since the request for review was not properly mailed to the Board until December 2, 1996, we cannot find that claimant's request for review was mailed to the Board within 30 days of the ALJ's October 28, 1996 order.

In an analogous situation, we have held that a request for hearing timely sent to the wrong address (the address of employer's claims processor rather than the Board) was not timely "filed" because filing of a request for hearing is accomplished at the Board. Keith C. Brown, 46 Van Natta 2350

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[1] The Board received claimant's request for review on December 4, 1996. The request was dated November 13, 1996, but was contained in an envelope indicating it had been mailed by certified mail on December 2, 1996.

[2] The envelope containing claimant's request for review was addressed to the Board at a street address, but neglected to include a city and state. The envelope was eventually returned, as undeliverable, to claimant's counsel on December 2, 1996.

[3] The second receipt for certified mail was date stamped by the United States Postal Service on December 2, 1996, more than 30 days after the ALJ's order.

(1994). We have also held that a party's failure to properly address a request for hearing to the Board does not constitute "good cause" for the late filing of a request for hearing. See Juli E. Allgire, 48 Van Natta 205 (1996).

Consequently, based on the foregoing reasoning, we adhere to our previous determination that we lack jurisdiction to review the ALJ's order, and dismiss claimant's request for Board review. See ORS 656.289(3); 656.295(2).

Accordingly, we withdraw our December 13, 1996 order. On reconsideration, as supplemented herein, we republish our December 13, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

January 9, 1997 Cite as 49 Van Natta 23 (1997)

In the Matter of the Compensation of
VIRGIL A. RAY, Claimant
WCB Case No. C7-00015
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Stanley Fields, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

On January 3, 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 workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The summary sheet of the proposed CDA indicates that claimant is making only a partial release of temporary disability benefits. However, page 3, paragraph 12, of the CDA provides:

> "Pursuant to ORS 656.236, in consideration of the payment of $5,000.00 by the insurer/employer, claimant releases all rights to all workers' compensation benefits allowed by law, including temporary disability, permanent disability, vocational rehabilitation, aggravation rights to reopen claim, attorney fees, penalties and survivor's benefits potentially arising out of this claim, except for medical services, regardless of the condition(s) stated in this agreement. The insurer/employer's obligation to provide these benefits is also released." (Emphasis added).

In addition, page 4, paragraph 20 of the proposed CDA provides: "The parties agree that the temporary disability issue as set forth in the 11/25/96 Opinion and Order by Administrative Law Judge Kirk Spangler shall be reserved."

The summary page and page 4, paragraph 20 of the CDA provide for only a partial release of temporary disability, whereas page 3, paragraph 12 of the CDA appears to release all of claimant's rights to temporary disability. Based on the summary page and the specific paragraph on page 4, we interpret the CDA as providing for the following release of claimant's rights to temporary disability. With the exception of the temporary disability at issue in the November 25, 1996 ALJ's order, all other temporary disability benefits are released.

Finally, on page 5, the proposed CDA provides: "The parties agree that [the insurer] shall reimburse claimant as appropriate for mileage expenses to and from treatment by Dr. Robert G. Hoellrich. Claimant will withdraw this issue from the Director."

Claimant may not release his rights to medical services. ORS 656.236(1)(a). Reimbursement for mileage expenses concerning medical treatment for a compensable claim are considered medical services.

See Thurman M. Mitchell, 47 Van Natta 1971 (1995). Thus, had the paragraph purported to release claimant's rights to such benefits, it would have been contrary to ORS 656.236(1)(a). However, because this paragraph does not attempt to limit claimant's rights to medical services arising from the compensable injury, it does not render the agreement unreasonable as a matter of law. In other words, the paragraph merely reiterated the rights to medical services that claimant continues to retain.

As interpreted herein, the parties' CDA is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, as clarified herein, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

January 9, 1997 Cite as 49 Van Natta 24 (1997)

In the Matter of the Compensation of
THOMAS M. SAVELICH, Claimant
WCB Case No. 95-09940
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On September 11, 1996, the Board withdrew its August 14, 1996 Order on Review that had affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the insurer's denials of claimant's occupational disease/aggravation claim for a low back condition; and (2) declined to reopen the record to admit a medical report. This action was taken in response to claimant's announcement that the parties were negotiating a settlement of their dispute.

The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve their dispute. Pursuant to the settlement, claimant agrees that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The parties further stipulate that claimant's hearing request "shall be dismissed with prejudice as to all issues raised or raisable."

We have approved the parties' settlement, thereby fully and finally resolving this dispute. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
JESSIE J. HAYNES, Claimant
WCB Case No. 96-01131
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that dismissed his request for hearing from an Order Denying Request for Reconsideration. On review, the issue is jurisdiction.

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

Claimant's claim was closed by a Determination Order issued July 25, 1995. Claimant requested reconsideration on January 17, 1996. The Department of Consumer and Business Services (Department) issued an Order Denying Request for Reconsideration, finding that the reconsideration request was untimely. The Department's order included a notice stating that, if a party disagreed with the order, that party "may request a hearing before the Director as provided by ORS 656.704(2), the Administrative Procedures Act (ORS Chapter 183) and [former] OAR 436-30-008(6)" within 30 days from the mailing date of the order. (Emphasis added). Claimant nevertheless filed a request for hearing with the Hearings Division of the Workers' Compensation Board challenging the Department's order, and did not request a contested case hearing with the Director.

The ALJ found that the Hearings Division lacked jurisdiction to review the Department's order denying reconsideration. On review, claimant asserts that, pursuant to OAR 436-030-0008(2)(b),[1] the ALJ was authorized to consider claimant's argument that a Determination Order was invalid because it was improperly mailed. We disagree.

Subsequent to the ALJ's order, in James W. Jordan, 48 Van Natta 2602 (1996), we specifically held that the Board and the Hearings Division lacked jurisdiction to review a Department order denying reconsideration, and that a party's recourse from such an order was to request a contested case hearing before the Director.[2] See also OAR 436-30-0008(3).[3] We also noted in Jordan that a Department order denying reconsideration does not place a worker's right to receive compensation directly in issue and is therefore not a "matter concerning a claim" over which the Board or Hearings Division has jurisdiction.

Consequently, in light of James W. Jordan, supra and OAR 436-030-0008(3), we affirm the ALJ's order.

ORDER

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

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[1] This rule provides: "A party may request a hearing before the Hearings Division of the Worker's Compensation Board on any other action taken pursuant to these rules where a worker's right to compensation or the amount thereof is directly in issue in accordance with the provisions of ORS Chapter 656."

[2] Although bound by principles of stare decisis, Chair Hall directs the parties to his dissent in James W. Jordan, supra, in which he concludes that all Department orders issued in response to a request for reconsideration, including an order denying reconsideration, should be subject to the Board's review authority. In this regard, Chair Hall also indicated that he would find OAR 436-030-0008(3) invalid as inconsistent with ORS 656.268, 656.263 and 656.704.

[3] This rule specifically provides that "orders denying reconsideration" qualify for review before the Director as a contested case.

In the Matter of the Compensation of
NEIL A. LAUFER, Claimant
WCB Case No. 95-04934
ORDER ON REVIEW
Pozzi, Wilson, 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) Crumme's order that granted claimant permanent total disability (PTD) benefits. On review, the issue is entitlement to PTD. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following exceptions. We do not adopt the ALJ's findings 19, 21-23 and 25.

CONCLUSIONS OF LAW AND OPINION

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

Evidence

At hearing, the ALJ admitted medical, vocational and lay evidence that was not previously submitted at the reconsideration proceeding before the Department of Consumer and Business Services (Department). However, as amended in 1995, 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."

Amended ORS 656.283(7) retroactively applies to this case. See Dean J. Evans, 48 Van Natta 1092, recon 48 Van Natta 1196 (1996); Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996). Inasmuch as the ALJ received "post-reconsideration" medical, vocational and lay evidence, we proceed to consider the effect of the statutory exclusion in this case.

In Joe R. Ray, supra, the claimant requested a hearing concerning an Order on Reconsideration, asserting entitlement to additional permanent partial disability (PPD) benefits. At hearing, the claimant testified regarding the extent of his permanent disability. Based on that testimony, the ALJ increased his PPD award. On Board review, we reduced the ALJ's PPD award. We found that the clear language and context of amended ORS 656.283(7), as well as its legislative history, supported the conclusion that evidence not submitted at reconsideration, and not made a part of the reconsideration record, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. 48 Van Natta at 329. Thus, we concluded that the claimant's testimony at hearing was inadmissible.

Because amended ORS 656.283(7) pertains to "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration," our holding in Ray applies to proceedings involving the reconsideration procedure required by ORS 656.268. That is, when a party objects to a Notice of Closure or Determination Order, that party must first request reconsideration from the Department. ORS 656.268(4)(e), (5)(b). An evidentiary record is then developed by the Department on reconsideration. Based upon the reconsideration record, the Department issues its Order on Reconsideration. The record of any subsequent hearing concerning the reconsideration order is limited to the reconsideration record that was developed by the Department. Amended ORS 656.283(7); Dean J. Evans, supra; Joe R. Ray, supra. See also Precision Castparts Corp. v. Plummer, 140 Or App 227, 231 (1996).

Although the substantive issue in Ray was whether claimant had established her entitlement to PPD benefits, we have also applied the statutory exclusion in amended ORS 656.283(7) where the substantive issue was entitlement to PTD benefits. Virginia McClearen, 48 Van Natta 2536 (1996) (Chair

Hall specially concurring). In this case, the ALJ cited our decision in Betty S. Tee, 47 Van Natta 2396 (1995), for the proposition that the 1995 amendments to ORS 656.283(7) do not apply retroactively to those matters in which the reconsideration proceeding occurred prior to the effective date of the amendments. O&O, p 6, n 4. The ALJ misconstrued our holding in Tee.

In Betty S. Tee, supra, we held that because the Determination Order issued in 1988, long before implementation of the mandatory reconsideration procedure in 1990, retroactive application of the 1995 amendments to ORS 656.283(7) would produce an absurd and unjust result and would clearly be inconsistent with the purposes and policies of the workers' compensation law. 47 Van Natta at 2400 n 5. In this case, however, the Determination Order issued in 1994, when the reconsideration procedure was mandatory. Thus, Tee is distinguishable from, and not controlling in, this case.

Among the "post-reconsideration" evidence admitted by the ALJ, however, are the written reports and testimonies of private vocational consultants, Larry Pauciello and Richard Ross. In Virginia McClearen, supra, 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."

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 those vocational reports that were submitted at reconsideration before the Department. Once those 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. If so, the vocational reports are admissible at hearing. 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.

Here, the parties did not indicate at hearing what vocational reports were submitted at reconsideration; therefore, we review the record as a whole to identify those reports. We begin with the "Explanatory Notes" written by the Department's Appellate Reviewer at the reconsideration proceeding. Those notes state, in part:

> "The worker's attorney provided a copy of Dr. Bert's 1/05/94 letter, and a copy of a 1/20/95 questionnaire completed by Dr. Bert on 1/30/95 with the request. These documents are accepted into the record as clarifying information pursuant to OAR 436-30-125(1)(g)(h). The insurer provided no additional documents for this proceeding. The record consists of the claim file at the time of claim closure." (Ex. 48-3, emphasis in original).

The notes indicate that the reconsideration record consisted of the "claim file at the time of claim closure," as supplemented by claimant's request for reconsideration, Dr. Bert's January 5, 1994 letter, and a questionnaire completed by Dr. Bert on January 30, 1995. Therefore, we conclude that the

reconsideration record consisted of the following documents: (1) documents dated prior to the November 14, 1994 claim closure by Determination Order; (2) the November 14, 1994 Determination Order, as corrected on December 14 and December 23, 1994; (3) claimant's request for reconsideration; (4) Dr. Bert's January 5, 1994 letter; and (5) the questionnaire completed by Dr. Bert on January 30, 1995. Those documents were admitted at hearing as exhibits 1, 3-19, 21-34, 37, 38, 40, 48, A-E, 2A-2J, 2L-2Q, 5A-5C, 6A, 7A-7C, 10A-10D, 16A, 19A, 19B, 24A and 28A. Because the remaining exhibits admitted into evidence at hearing were not submitted at reconsideration, we conclude the ALJ abused his discretion in admitting those exhibits. Accordingly, those exhibits (not listed above) are excluded from the hearing record pursuant to amended ORS 656.283(7).

Among the exhibits that were submitted at reconsideration, and therefore properly admitted at hearing, are reports regarding claimant's employability from vocational consultants, Mr. Ross and Mr. Pauciello. Both consultants were cross-examined at hearing; therefore, their testimonies at hearing were admissible pursuant to ORS 656.287(1) and our holding in Virginia McClearen, supra. All other testimonies, (by claimant, Carol Laufer and Lonnie Looney), were not admissible pursuant to ORS 656.283(7) and are therefore excluded from the hearing record.[1] In excluding "post-reconsideration" evidence from the hearing record (with the exception of Mr. Ross' and Mr. Pauciello's testimonies), we note that amended ORS 656.283(7) was in effect on the date of the hearing in this case (September 14, 1995). Therefore, the ALJ's admission of such evidence was erroneous. See Precision Castparts v. Plummer, supra; Dean J. Evans, supra. We now proceed to the merits of the PTD issue in this case.

Permanent Total Disability

On the merits, we adopt the ALJ's conclusion that claimant has carried the burden of proving his entitlement to PTD benefits under the "odd-lot" doctrine. Specifically, we adopt the ALJ's finding that claimant's physical limitations due to the compensable injury, together with his age, education, training and work experience, permanently incapacitate him from regularly performing work at a gainful and suitable occupation in a hypothetically normal labor market. We also adopt the ALJ's finding that claimant has proven a willingness to seek gainful and suitable employment but for the compensable injury.

In adopting the ALJ's conclusions and findings, we agree with his opinion that the vocational opinion of Mr. Ross was more persuasive than that of Mr. Pauciello. We are mindful that the ALJ's opinion in this regard was based in part on "post-reconsideration" medical and lay evidence which we have excluded from the record pursuant to amended ORS 656.283(7). However, even without the "post-reconsideration" medical and lay evidence, we agree with the ALJ's conclusion that Mr. Ross' opinion is most consistent with the medical opinion of Dr. Bert, claimant's treating physician. In particular, Dr. Bert opined that, as a result of the compensable injury, claimant cannot perform part-time, sedentary employment on a regular, sustained basis. (Ex. 40-5; see also Exs. 7A, 10A, 14).

Mr. Ross felt that the biggest obstacle to claimant's return to any type of employment, including sedentary work, was his inability to perform any activity on a regular and sustained basis. (Tr. 50). He explained that dependability, persistence and pace are fundamental to continued employment in unskilled, entry-level jobs in a competitive labor market. (Id.) He reviewed the job analyses prepared by Mr. Pauciello, (i.e., automatic film developer, security guard, maintenance service dispatcher, and information clerk/referral aide), and concluded claimant could not perform those jobs on a regular and sustained basis, even on a part-time schedule. (Tr. 52-61, 65).

Mr. Pauciello, on the other hand, did not address claimant's ability to remain employed on a regular and sustained basis. He focused, instead, on the aforementioned job analyses he prepared. However, there is no admissible medical evidence that claimant has the physical capacity to regularly perform any of those jobs on even a part-time basis. On the contrary, as we discussed above, Dr. Bert's opinion was that claimant could not perform part-time, sedentary work on a regular and sustained basis. Because Mr. Pauciello's opinion is inconsistent with the medical opinion of Dr. Bert, we discount Mr. Pauciello's opinion and rely, instead, on the well-reasoned opinion of Mr. Ross.

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[1] Although neither party raised an objection to the admissibility of "post-reconsideration" evidence, amended ORS 656.283(7) clearly indicates that evidence on an issue regarding a Determination Order that was not submitted at the reconsideration proceeding is not admissible at hearing. Thus, we have addressed the applicability of amended ORS 656.283(7) to this case. See Gary C. Fischer, 46 Van Natta 60, recon 46 Van Natta 221 (1994).

Finally, we agree with the ALJ's opinion that claimant's cooperation in his vocational retraining program demonstrated his willingness to obtain suitable employment.[2] Accordingly, claimant has established her entitlement to PTD benefits.[3]

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 concerning the PTD issue is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 13, 1996 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,500, payable by SAIF.

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[2] Although the vocational goal of cost estimator was selected for claimant's vocational retraining, he has not completed the training necessary to obtain employment as a cost estimator. Therefore, that potential job may not be considered in our PTD determination. See Gettman v. SAIF, 289 Or 609, 614 (1980) (PTD determination must be based on conditions in existence at the time of determination, not on the potential for retraining).

[3] Because we find that claimant is PTD on the merits, we do not need to address claimant's contention that application of amended ORS 656.283(7) to this case is a violation of his constitutional rights under Article I, section 10 of the Oregon Constitution and the Fourteenth Amendment of the U.S. Constitution.

In the Matter of the Compensation of
YNNET C. MONTANEZ, Claimant
WCB Case No. 95-13010
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's head injury claim. On review, the issues are course and scope of employment and compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding the insurer's contention that claimant should have produced a witness that could have clarified whether she was an active participant in a fight at work.

The ALJ set aside the insurer's denial of claimant's injuries alleged to have resulted from a fight between claimant, a production baker, and a coworker (Gentry). In so doing, the ALJ determined that claimant was not an active participant in the fight and that she did not have an opportunity to withdraw from the fight until the fight was over. See ORS 656.005(7)(b)(A).[1]

Neither party produced Gentry as a witness. The insurer instead relied primarily on the testimony of another coworker (Nace) and claimant's supervisor (Dunbar). Nace testified that he viewed the entire fight, that both claimant and Gentry were playfully throwing pieces of dough at each other,

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

and that claimant struck Gentry near the eye with a piece of dough, which precipitated the altercation. (Trs. 80-83). Nace also testified that claimant hit and pushed Gentry, in what appeared to be an equal struggle. (Trs. 83, 87). According to Nace, there was no obstacle that prevented claimant from leaving the scene. (Tr. 94).

Dunbar arrived after the fight had started, but testified that both claimant and Gentry were equally participating in the fight. (Tr. 113). Dunbar also stated that claimant hit her head on a bakery rack as Dunbar tried to restrain claimant (Tr. 118), and, further, that claimant tried to break free from Dunbar's grasp to head in the general direction of Gentry, who was being restrained by Nace. (Tr. 116).

Claimant offered a very different version of events. She denied throwing any dough at Gentry and testified that she was struck in the abdomen by a piece of dough thrown by Gentry. (Tr. 15). This caused claimant concern because she was pregnant at the time. Claimant testified that she told Gentry to leave her alone, which prompted Gentry to attack her. Id. Claimant maintained she merely attempted to defend herself while Gentry kicked and punched her in the arms, chest and face and caused her to bang her head several times on a metal cookie rack by the floor. (Trs. 16, 17, 48). Claimant insisted that her attempts to free herself from Dunbar's grasp were not part of an attempt to continue fighting with Gentry; rather, claimant testified that she was trying to leave the scene. (Tr. 167-8).

Claimant eventually was accompanied to the employer's office by Dunbar. Claimant later filed a report with the police. The employer terminated Gentry from employment and suspended claimant a week from work. The employer's human resources manager (Christian) testified that the employer's investigation concluded that Gentry had initiated the fight, but that claimant and Gentry were equally involved. (Trs. 148, 151).

Faced with conflicting evidence regarding the circumstances of the altercation between claimant and Gentry, the ALJ reasoned that Gentry would have been the insurer's strongest evidence that claimant initiated the fight and was an active participant who failed to withdraw from the fight at the first opportunity. Citing Roberts v. SAIF, 18 Or App 590, 592 (1974), the ALJ concluded that the testimony of the employer's witnesses, particularly Nace, should be viewed with distrust. The ALJ then concluded that, based on the testimony presented, claimant was not an active participant in the fight (although she did defend herself) and that she did not have an opportunity to withdraw until the fight was over.

The insurer contends that claimant, as the party with the burden to establish a compensable claim, should have produced Gentry as a witness to establish that she was not an active participant in the fight. The insurer asserts that claimant's failure to do so should be held against her.

We need not address the insurer's contention because, even if the failure to call Gentry as a witness were construed against claimant, the preponderance of the evidence in the record would still support the ALJ's finding that claimant was not an "active participant" in the altercation at work. In other words, for the reasons expressed by the ALJ (except for his viewing of the insurer's witnesses with distrust), we agree with the ALJ's conclusion that ORS 656.005(7)(b)(A) does not exclude claimant's injuries from being compensable.

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

ORDER

The ALJ's order dated June 13, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
MAC A. PAYNE, Claimant
WCB Case No. 96-02510
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to admit Exhibits 27, 28 and 29, medical arbiter reports that were not considered by the Department on reconsideration; and (2) affirmed an Order on Reconsideration awarding no permanent disability for a low back injury. On review, the issues are evidence and extent of unscheduled permanent disability. We admit the excluded evidence and affirm.

FINDINGS OF FACT

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

Claimant compensably injured his low back at work in May 1994. The SAIF Corporation formally accepted a disabling lumbar strain on July 15, 1994. Claimant became medically stationary on June 19, 1995, and the claim was closed by a November 21, 1995 Determination Order which awarded temporary disability only.

Claimant timely requested reconsideration and a panel of medical arbiters was appointed. At claimant's request, the medical arbiters' examinations were postponed and rescheduled. On February 16, 1996, the Department issued an Order on Reconsideration affirming the Determination Order in all respects.[1] Thereafter, claimant was examined by three medical arbiters, each of whom submitted a report. Exs. 27, 28, 29.

CONCLUSIONS OF LAW AND OPINION

Evidence

Based on the 1995 amendments to ORS 656.283(7), which limits the evidence admissible in an "extent" hearing to that which was "submitted at the reconsideration required by ORS 656.268,"[2] the ALJ declined to admit Exhibits 27, 28 and 29 because these reports were not included in the record used by the Department on reconsideration. On review, claimant asserts that these medical arbiter reports are admissible at hearing pursuant to ORS 656.268(6)(e). We agree.

ORS 656.268(6)(e) provides: "Any medical arbiter report may be received as evidence at a hearing *even if the report is not prepared in time for use in the reconsideration proceeding.*" (Emphasis added). Consistent with this section, we have held that a medical arbiter report solicited by the Department but not received until after the issuance of the Order on Reconsideration was admissible at hearing, notwithstanding the evidentiary limitation set forth in amended ORS 656.283(7). Larry A. Thorpe, 48 Van Natta 2608 (1996).

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[1] The "Explanatory Notes" accompanying the Order on Reconsideration specifically note that: (1) claimant was unable to attend the medical arbiter examinations scheduled for February 1 and 2, 1996; (2) the examinations were rescheduled for March 14 and 15, 1996; and (3) due to the statutory time constraints, the Department was required to complete its reconsideration before claimant's rescheduled examinations. (Ex. 26-4). The appellate reviewer also noted that reconsideration was based on the record existing at the time of closure, but "should this Order on Reconsideration be appealed, any medical arbiter report will be available for use at hearing." Id.

[2] The ALJ also cited to Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996), and Joe R. Ray, 48 Van Natta 325 (1996), both of which construe this amendment to ORS 656.283(7).

In Thorpe, we discussed the legislative purpose behind ORS 656.268(6)(e) and ORS 656.283(7), and concluded that to the extent the latter provision could be construed to preclude the admission of a medical arbiter report simply because that report was not prepared in time to be used on reconsideration, the two statutes were inconsistent. Applying well-established rules of statutory construction, we further found that insofar as the two statutes could not be harmonized, the specific exception for medical arbiter reports set forth in ORS 656.268(6)(e)[3] controlled over the general evidentiary prohibition of ORS 656.283(7). Larry A. Thorpe, supra; see also ORS 174.020 (particular provision is paramount to a general provision).

Accordingly, in this case, as in Thorpe, we conclude that the medical arbiter reports should have been admitted at hearing even though they were not prepared in time to be used on reconsideration. Because the medical arbiters were appointed by the Department and were directed to prepare a report on behalf of the Appellate Review Unit (rather than as a witness for claimant or the carrier), Exhibits 27, 28 and 29 come within the exception set forth in ORS 656.268(6)(e). Because we find these reports admissible, we consider them on review.[4] See also Terry L. Maltbia, 48 Van Natta 1836 (1996).

Extent of Unscheduled Permanent Disability

Claimant has the burden of proving the extent of any permanent disability resulting from his compensable injury. ORS 656.266. Since claimant failed to attend a closing examination by his attending physician,[5] the only evidence concerning claimant's injury related impairment comes from the findings of the medical arbiters. See OAR 436-035-0007(13) (on reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of the evidence establishes a different level of impairment). The medical arbiters were Drs. Driggs, Mackenzie and Tuen.

Dr. Driggs examined claimant on March 14, 1996. He measured claimant's spinal range of motion, and found 56 degrees maximum true lumbar flexion, 20 degrees maximum true lumbar extension, 28 degrees maximum right lateral flexion and 25 degrees maximum left lateral flexion. In summarizing these findings, Dr. Driggs concluded that his examination showed "little or no objective findings which would cause [claimant] to be limited in the use of his spinal area." Dr. Driggs also noted that the positive findings were "minimal." (Ex. 27-7).

Dr. Mackenzie examined claimant the following day. He measured claimant's spinal range of motion, and concluded that claimant "failed to establish valid range of motion in flexion/extension of the lumbar spine, and failed two of the six Waddell tests provided." Dr. Mackenzie reported that there were no objective findings of impairment and that claimant's motivation was questionable. (Ex. 28-6).

Dr. Tuen also examined claimant on March 15, 1995. Like Dr. Mackenzie, Dr. Tuen indicated that claimant's lumbar range of motion measurements failed to meet the straight leg raising (SLR) validity check. (Ex. 29-7). Unlike the other two arbiters, however, Dr. Tuen concluded that claimant has a "partially impaired ability to repetitively use the lower back area" as a result of his lumbar strain and chronic low back pain. (Ex. 29-5).

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[3] As we noted in Larry A. Thorpe, this exception is limited to medical arbiter reports which were requested but not completed before the statutory time limit for reconsideration, and "supplemental" or "clarifying" reports when such reports are requested by the Department or when the arbiter's initial report was expressly incomplete. See Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73, 78 n 5 (1996) (construing former ORS 656.268(6)(a)); see also Constance I. Gassner, 48 Van Natta 2596 (1996); Jason O. Olson, 47 Van Natta 2192 (1995).

[4] In his brief, claimant requests that the matter be remanded for reconsideration and admission of evidence. Because the Board is in as good a position as the ALJ to determine the extent of claimant's unscheduled permanent disability on the record (including Exhibits 27, 28 and 29, which were retained in the hearing file as offers of proof), we deny the request for remand.

[5] With the exception of a medical arbiter, only the attending physician at the time of closure may make findings concerning a worker's impairment. ORS 656.245(2)(b)(B).

As noted above, these three medical arbiter examinations were conducted separately, but within the same two day period. Because each arbiter's report sets forth a complete, well-reasoned evaluation of claimant's injury-related impairment, we give each report equal weight. Although we presume Dr. Driggs' lumbar flexion and extension measurements were valid,[6] his findings are inconsistent with Dr. Mackenzie's conclusion that claimant had no objective findings of impairment. In addition, Dr. Tuen's lumbar flexion findings are given a value of zero because they failed to meet the validity criterion. See OAR 436-035-0007(27). Thus, weighing the three arbiter reports equally, we conclude that claimant has not proven a loss of lumbar motion by a preponderance of the evidence. Further, although Dr. Tuen indicated that claimant had an impaired ability to repetitively use his low back, neither Dr. Driggs nor Mackenzie found a permanent chronic condition impairment.[7] Consequently, we conclude that claimant has failed to prove any ratable impairment as a result of his compensable injury.

Because there is no persuasive evidence of permanent impairment, we agree with the ALJ that the Order on Reconsideration should be affirmed.

ORDER

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

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[6] See Linda K. Fister, 48 Van Natta 1550 (1996) (where medical arbiter did not identify invalid measurements, Board has no basis for independently finding the measurements invalid).

[7] Dr. Driggs noted that because of claimant's prolonged history of low back pain, "repetitive bending and lifting are probably contraindicated until a full Work Hardening Program has been carried out." (Ex. 27-7). Thus, although Dr. Driggs also found a limitation on repetitive use, he apparently did not consider it to be permanent.

In the Matter of the Compensation of
JOHN A. VARGO, Claimant
WCB Case Nos. 95-12980 & 95-12979
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

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

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

Claimant injured his back at work on April 5, 1995. He sought treatment and filed a claim the next day. The claim was received by the employer on April 11, 1995 and by the employer's insurer on April 19, 1995. Although the insurer's internal record, the "activity log comments" sheet, reflects that the April 5, 1995 injury claim was accepted as a nondisabling low back strain on May 30, 1995, the insurer did not send a Notice of Acceptance to claimant at that time.

In late August 1995, claimant's symptoms worsened and he again sought treatment. On September 15, 1995, the insurer issued a denial of claimant's "current low back condition." Among other things, the denial letter specifically alleged that claimant's current low back condition and need for treatment were unrelated to claimant's "accepted non-disabling injury of April 5, 1995." (Ex. 40).

At hearing, the ALJ upheld the insurer's September 15, 1995 denial, finding that the major contributing cause of claimant's need for treatment in August 1995 was his preexisting spondylosis and spondylolisthesis condition rather than his April 1995 compensable back strain. Just prior to the hearing, on June 20, 1996, the insurer sent claimant a Notice of Acceptance of his April 5, 1995 low back strain.

Claimant does not contest the ALJ's determination that claimant's current condition is not compensable. Rather, the only issue claimant raises on review is his attorney's entitlement to an attorney fee under ORS 656.386(1) for prevailing over the insurer's alleged denial of his April 5, 1995 low back strain. Claimant argues that since he did not receive proper notice of the insurer's acceptance of his low back strain, the insurer's September 13, 1995 partial denial constituted an express denial of all his low back conditions. We disagree.

ORS 656.386(1) allows for an attorney fee in cases involving a "denied claim" where the attorney is instrumental in obtaining a rescission of the denial prior to the ALJ's decision. The statute further defines a "denied claim" as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

Contrary to claimant's contention, claimant's April 1995 low back strain was not expressly denied. There has been no express denial of this condition nor any refusal to pay compensation arising out of the April 5, 1995 injury. Therefore, although the insurer's processing of the back strain claim did not comply with the provisions of ORS 656.262(6)(b), claimant has not established entitlement to an attorney fee under ORS 656.386(1). See Michael Galbraith, 48 Van Natta 351 (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); David Gonzalez, 48 Van Natta 376 (1996).

ORDER

The ALJ's order dated June 22, 1996 is affirmed.

In the Matter of the Compensation of
BILL T. WIMBERLY, Claimant
WCB Case Nos. 95-13817, 95-09920 & 95-09919
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Steven Maher, Defense Attorney
Employers Defense Counsel, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Giesy, Greer and Gunn, (Giesy) Inc. requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denials of claimant's recurrent hernia condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) denials of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that Giesy, the carrier responsible for claimant's compensable 1990 hernia injury, failed to sustain its burden of proving that claimant sustained a new compensable hernia injury in March 1995, while Liberty was on the risk. See ORS 656.308. The ALJ reasoned that the medical evidence did not establish that claimant's work activity in the Spring of 1995 was the major contributing cause of claimant's recurrent umbilical hernia. We disagree.

On review, Giesy contends that the medical evidence from Dr. Yeo, claimant's attending physician, and Dr. Braun, who conducted a review of the medical records, establishes that a new compensable injury occurred in 1995, for which Liberty is responsible. For the following reasons, we agree with Giesy's contentions.

In determining the responsibility issue, the ALJ applied ORS 656.308(1). That statute provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section."

The parties do not dispute the ALJ's finding that claimant's current hernia condition is the "same condition" as involved in the compensable 1990 hernia claim, for which Giesy is responsible. Inasmuch as we agree that claimant's current condition is the "same condition" as Giesy previously accepted, ORS 656.308 is applicable in determining responsibility. See Smurfit Newsprint v. DeRosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

Under ORS 656.308(1) and SAIF v. Drews, 318 Or 1 (1993) (legislature intended the "major contributing cause" standard of former ORS 656.005(7)(a)(B) to apply to the shifting of responsibility among employers under former ORS 656.308(1)), in order to establish a "new compensable injury" and shift responsibility to Liberty, Giesy must prove that the alleged March 1995 injury was the major contributing cause of claimant's disability and need for treatment. See SAIF v. Britton, 145 Or App 288 (1996); Rito N. Nunez, 48 Van Natta 786 (1996); Keith Thomas, 48 Van Natta 510, 511 (amended ORS 656.308(1) codified the court's holding in SAIF v. Drews, supra). We agree with Giesy that it satisfied its burden of proof.

Claimant, a millwright, underwent surgical repair in November 1990 for his compensable umbilical hernia for which Giesy was responsible. (Ex. 5). Claimant sustained no temporary or permanent disability. In the Spring of 1995, claimant experienced a recurrence of hernia symptoms after carrying a 60 pound box of tools up a flight of stairs and twisting to set the tools down. (Tr. 22). Claimant continued to work, but his abdominal complaints worsened, prompting him to seek treatment from Dr. Sarazano on April 25, 1995. Dr. Sarazano referred claimant to Dr. Yeo, who diagnosed "recurrent umbilical hernia." (Ex. 13). Claimant underwent surgical repair in August 1995. (Ex. 21).

Dr. Yeo subsequently agreed that, when he first examined claimant, he took a history of a discrete onset of pain resulting from an incident on March 15, 1995 and a history of two or three subsequent weeks of heavy lifting. (Ex. 35-1). Dr. Yeo then agreed that claimant's work activities in March and April 1995 were the major contributing cause of a pathological worsening of his recurrent umbilical hernia and of his need for treatment. (Ex. 35-2). Dr. Yeo was later deposed.

At that deposition, Dr. Yeo testified that he was claimant's attending physician for the hernia condition. (Ex. 37-6). Dr. Yeo then testified that claimant's hernia reoccurred either because the initial repair was faulty or because the stress and strain of subsequent work activity exceeded the strength of the repair. (Ex. 37-5). Dr. Yeo stated that he "assumed" the first surgical repair in 1990 was done correctly. (Ex. 37-9). Although he opined that the recurrent hernia would not have occurred in the absence of the initial hernia, Dr. Yeo concluded that, to a degree of medical probability, the continuing stresses of claimant's work activity in 1995 caused the second hernia. (Ex. 37-12).

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 this case, we find no persuasive reasons not to defer to the opinion of Dr. Yeo, claimant's attending physician. We find his opinion to be well-reasoned and based on an accurate history.[1] Accordingly, we find that Dr. Yeo's opinion satisfies Giesy's burden of proving that claimant sustained a new compensable injury in March 1995 for which Liberty is responsible.[2]

ORDER

The ALJ's order dated July 11, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld Liberty's denial of responsibility for claimant's hernia condition and set aside Giesy's denial of the same condition is reversed. Liberty's denials are set aside and the claim is remanded to Liberty for processing according to law. Giesy's denials are reinstated and upheld. Liberty, rather than Giesy, is responsible for the ALJ's attorney fee award to be paid to claimant's counsel. The remainder of the ALJ's order is affirmed.

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[1] We accept as reliable claimant's testimony regarding the specific incident of injury on or about March 15, 1995, as well as his testimony that his work was primarily heavy. (Trs. 19, 22). Although Liberty contends that claimant gave inconsistent histories concerning the onset of his hernia symptoms in 1995 and notes claimant's testimony that some of his work was medium and light, we are persuaded based on our de novo review of the record that the majority of claimant's work was "heavy" and that claimant's testimony regarding the specific incident concerning the 60 pound tool box is accurate.

[2] We note that Dr. Yeo's opinion is supported by that of Dr. Braun, who conducted a review of the medical record. Dr. Braun concluded that claimant's work activity in 1995 was the major contributing cause of claimant's hernia condition. (Ex. 31). Although a panel of examining physicians (Drs. Watson and Hunt) concluded that the original lesion in 1990 was the major contributing cause of claimant's 1995 recurrent hernia, we find that opinion unpersuasive given that the panel had no medical records to review. (Ex. 29). Somers v. SAIF, supra.

In the Matter of the Compensation of
TERRY L. STARNES, Claimant
WCB Case No. 94-03035
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's psychiatric condition. In his brief, claimant challenges those portions of the ALJ's order that declined to award temporary disability or assess a penalty for allegedly unreasonable claim processing. On review, the issues are compensability, temporary disability, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

In 1987, claimant received inpatient treatment for marijuana abuse and chronic alcoholism. (Ex. 3). On February 15, 1989, claimant injured his low back while working. SAIF accepted a claim for low back strain. From August 1989 through February 1991, claimant received psychological counseling.

In March 1990, a Determination Order issued awarding only temporary disability. (Ex. 22). A subsequent stipulation awarded 7 percent unscheduled permanent disability. (Ex. 24). In September 1991, SAIF denied claimant's psychiatric condition on the basis that it was not related to the compensable back strain. (Exs. 34, 35).

On August 17, 1995, an ALJ approved a Disputed Claim Settlement (DCS) stating that the "employer and SAIF Corporation contend that claimant's psychiatric condition and need for treatment, including substance abuse, pre-existed his February 15, 1989 injury, and the February 15, 1989 injury did not bear a causal relationship to any of [claimant's] mental disorder diagnosis." (Ex. 41-2). The DCS further provided:

"Claimant understands that if the [ALJ] approves this agreement, SAIF Corporation's denial, as supplemented by the contentions of employer/SAIF Corporation stated in this agreement, shall remain in full force and effect. Claimant shall have no further entitlement to compensation or any other legal right related to the denied treatment or conditions." (Id. at 3).

In November 1993, claimant began treating with Dr. Carter, psychiatrist.

In August 1994, an ALJ upheld SAIF's July 1993 denial of claimant's aggravation claim for his low back injury. We adopted and affirmed the order. The Court of Appeals then remanded the case for reconsideration of Senate Bill 369. In May 1996, we issued an Order on Remand that continued to conclude that claimant did not prove a compensable aggravation claim. Terry L. Starnes, 48 Van Natta 1002 (1996).

On September 12, 1995, SAIF issued a denial of claimant's "psychological condition" on the basis that it was not related to the compensable condition and it was the same condition that was subject to the August 1992 DCS. (Ex. 106).

CONCLUSIONS OF LAW AND OPINION

The ALJ first found that claimant's current psychological condition was the same condition that was resolved by the DCS. The ALJ further found, however, that treatment of the psychological condition was integral and necessary to treat the compensable condition. Relying on SAIF v. Roam, 109 Or App 169 (1991), the ALJ concluded that the "1992 DCS is not a bar to further psychological treatment as required to treat his compensable condition." Consequently, the ALJ set aside SAIF's denial to the extent of medical treatment for the psychological condition "insofar as such treatment is necessary in conjunction with diagnosis and treatment of claimant's accepted low back condition."

Claimant contends that his psychological condition is not the same that was subject to the 1992 DCS. According to claimant, as a result of his increased back pain in 1993 (for which claimant litigated a claim for aggravation), claimant's psychological condition "decompensated" and he developed a major depression.

We agree with the ALJ that the medical evidence shows that claimant's current psychological condition is not different from the condition that was resolved by the DCS. Dr. Heck, psychiatrist, evaluated claimant on behalf of SAIF and provided an extensive report. Dr. Heck diagnosed claimant with somatoform pain disorder and a mixed personality disorder, finding that both conditions were present before the 1989 injury. (Ex. 104-18). Dr. Heck relied on claimant's history of "developing physical symptoms when under stress," and claimant's "extremely chaotic and dysfunctional family system" which included "severe physical and sexual abuse[.]" (Id.) Dr. Heck found further evidence of a preexisting personality disorder with claimant's pattern of "antagonistic relationships with authority"; his "chronic marital dysfunction which has resulted in numerous separations and several extramarital affairs"; his "longstanding conflicts with his daughter"; and "preexisting drug and alcohol dependencies." (Id. at 20-21). Finally, Dr. Heck indicated that neither claimant's somatoform pain disorder nor personality disorder worsened since August 1992. (Id. at 22).

Dr. Holland, psychiatrist, performed a record review at SAIF's request. Dr. Holland previously examined claimant in May 1991 and noted his diagnoses at that time were somatoform pain disorder, alcohol dependence (currently inactive), and cannabis dependence (currently inactive). (Ex. 105-3). After reviewing records generated subsequent to the examination, Dr. Holland found no reason to change the diagnoses. (Id. at 8). Specifically, Dr. Holland found that claimant "continues to demonstrate evidence of severe and significant psychopathology which undoubtedly had it's [sic] genesis and major causation in the significantly disturbed relationships operative in his family of origin." (Id. at 9). According to Dr. Holland, a similar psychological condition "was present and required treatment prior to the 1989 industrial injury" and he found "no evidence that his condition has worsened since August of 1992[.]" (Id.) (Emphasis in original.)

Claimant relies on the opinion of his treating psychiatrist, Dr. Carter. After reviewing the reports of Drs. Heck and Holland, Dr. Carter stated that, when he initially saw claimant, he diagnosed depressive and anxiety disorders. (Ex. 107-1). According to Dr. Carter, claimant was "being impacted by a mixture of psychological stressors, both work and family oriented" and that the "work issue related stressors were contributing the major load to his emotional distress at the time[.]" (Id. at 2). Dr. Carter

conceded that claimant's "symptoms of depression are in part dependent upon his personality disorder for his particular way of reacting to illnesses" and that "lifelong chronic depression and anxiety was [sic] caused by parental neglect and emotional and physical abuse[.]" (Id. at 4) (Emphasis in original). Dr. Carter further stated that

> "the personality disorder, the chronic depression and anxiety, in themselves, have not been incapacitating until a physical injury did occur and work-related stressors in terms of adverse interactions with his supervisors increased in frequency and intensity in relation to changes in his performance and differences in his perception of injury and the supervisors['] perception of injury. At the same time marital distress increased. The temporal relationship of these events to [claimant's] accepted back injury and sequela, is, I believe, significant, and is the basis for my perception that occupational stressors * * * increased anxiety, increased experience of pain, confusion in diagnosis, and confusion in everyone's mind as to what was going on with [claimant]." (Id. at 5).

Dr. Heck, Dr. Holland, and Dr. Carter all essentially agree that claimant's psychological condition preexisted even the 1989 injury. Drs. Heck and Holland also indicated that claimant's condition was no different from his condition at the time of the August 1992 DCS. We find no support in Dr. Carter's opinion for claimant's theory that his psychological condition is different because it "decompensated" at the time of his physical "aggravation." Although Dr. Carter found that claimant's preexisting psychological condition had worsened, because he pointed to the industrial injury as the major cause, we find that he dates the worsening as of the 1989 low back injury. Consequently, we find that Dr. Carter's opinion provides no evidence that the psychological condition is different than it was in August 1992.

According to the DCS, claimant gave up "further entitlement to compensation or any other legal right related to the denied treatment or conditions." The DCS indicated that the "denied condition" was a "psychiatric condition." Because the medical evidence shows that claimant's current psychological condition is the same that was diagnosed and treated in August 1992, it is the same condition that was settled by the DCS. Consequently, claimant is barred from now litigating the compensability of the psychological condition. E.g., Wasson v. Evanite Fiber Corp., 117 Or App 246, 248 (1992) (the claimant barred from litigating worsened depression condition because it was the same condition that was denied in a DCS).

We now address the ALJ's application of SAIF v. Roam, supra. In Roam, the court held that the claimant was entitled to medical treatment for a psychiatric condition that was the subject of a DCS providing that such condition was not compensable. 109 Or App at 171. In reaching this conclusion, the court relied on evidence that treatment of the noncompensable psychiatric treatment was necessary as a prelude to treatment of a compensable elbow condition. Id. Furthermore, the court cited to Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987), which also involved the compensability of medical services for a separate preexisting condition that was necessary to treat as a prelude to successful treatment of the compensable condition.

Medical evidence in this case, however, shows that claimant's preexisting noncompensable psychological condition is the major cause of claimant's physical symptoms and need for treatment. (Exs. 104-18, 105-10). Dr. Carter also reported that claimant's psychological condition affects his physical condition by playing an important role in the onset, severity and continuation of the physical pain. (Exs. 90-6, 107-3, 107-4). Finally, Dr. Karasek, claimant's treating neurosurgeon, indicated that claimant's psychological condition was involved with his physical symptoms. (Ex. 79).

Based on such evidence, we find that claimant's compensable condition combined with his psychological condition. In other words, treatment of claimant's psychological condition in effect also is directed at the physical condition since psychological factors contribute to claimant's physical symptoms. Thus, unlike Roam and Van Blokland, medical services for the psychological condition is more than merely a necessary prelude to treating the compensable injury. Consequently, because the medical evidence shows that claimant's preexisting psychological condition combined with his compensable injury, we conclude that the appropriate statute for determining compensability is ORS 656.005(7)(a)(B).[1]

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[1] Consequently, we need not address the effect, if any, of ORS 656.225(3) on the holdings in SAIF v. Roam, supra, and Van Blokland v. Oregon Health Sciences University, supra.

As previously discussed, Dr. Heck and Dr. Holland both found that the psychological condition is the major contributing cause of claimant's physical condition. Dr. Carter also referred to the psychological condition as having an "important role" in the onset and continuation of claimant's symptoms. Thus, we conclude that the psychological condition is the major contributing cause of claimant's resultant condition. As discussed above, the 1992 DCS bars claimant from litigating the compensability of his psychological condition. Inasmuch as the psychological condition cannot be found compensable, and it is the major contributing cause of claimant's combined condition, we conclude that claimant cannot satisfy his burden of proof under ORS 656.005(7)(a)(B).

In view of this conclusion, we need not address SAIF's argument that claimant should not be allowed on review to raise the issue of medical services for the psychological condition. Furthermore, claimant is not entitled to interim compensation or penalties.

ORDER

The ALJ's order dated January 29, 1996, as amended February 15, 1996, is reversed in part and affirmed in part. The SAIF Corporation's denial of claimant's psychological condition is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
FE D. DELARIARTE, Claimant
WCB Case No. 95-11827
ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Claimant requests reconsideration of our December 18, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denial of claimant's neck and right shoulder conditions. The order also found that ORS 656.262(7)(b) did not apply because SAIF did not accept a "combined condition." Claimant also asserts that, in light of this conclusion, "this is not a 'combined condition' case," and the Board erred in applying ORS 656.005(7)(a)(B) to determine compensability. Finally, claimant contends that, consequently, she need only prove a material contributing cause and the medical record carries her burden of proof.

Claimant misconstrues the Board's discussion and conclusion concerning ORS 656.262(7)(b). That statute concerns the carrier's procedural obligation to issue a denial of the current condition if the accepted condition no longer is the major contributing cause of the combined or consequential condition. Robin Spivey, 48 Van Natta 2363 (1996). Its application depends on whether the carrier accepted a combined or consequential condition, either voluntarily or by litigation order. Id. at 2365 n 4.

Thus, determining the application of ORS 656.262(7)(b) does not depend on whether the current condition actually is a combined or consequential condition; it is only important whether the carrier accepted a combined or consequential condition. Compensability, on the other hand, is decided pursuant to the Board's determination of the applicable provision, based on its review of the medical evidence. E.g., Hewlett-Packard Company v. Renalds, 132 Or App 288 (1995). Consequently, application of ORS 656.262(7)(b) involves a different analysis and evidence than deciding compensability.

As the Board explained in the Order on Review, SAIF here did not accept a combined condition. Thus, ORS 656.262(7)(b) does not apply. Because the medical evidence, however, shows that a preexisting condition combined with the accepted conditions, ORS 656.005(7)(a)(B) applies to determine compensability. For the reasons stated by the ALJ, the Board continues to conclude that claimant did not carry her burden of proof under this statute and, thus, did not prove compensability.

Accordingly, we withdraw the Board's December 18, 1996 order. On reconsideration, as supplemented herein, the Board's December 18, 1996 order is republished.[1] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[1] Chair Hall's concurrence with this decision should not necessarily be interpreted as his agreement with the Board's initial decision. Rather, his signature denotes his agreement that, based on the prior decision from two Board members (one of whom is no longer with the Board), this reconsideration order is the appropriate response. See John A. Hoffmeister, 47 Van Natta 1688, on recon 47 Van Natta 1891 (1994), aff'd mem Hoffmeister v. City of Salem, 134 Or App 414 (1995).

In the Matter of the Compensation of
PEGGY J. BAKER, Claimant
WCB Case No. 96-02781
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that assessed a penalty for SAIF's allegedly unreasonable resistance to the payment of temporary disability compensation. On review, the issue is penalties.

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

In awarding claimant temporary disability from the date of her termination, the ALJ determined that claimant's termination was due, in large part, to her compensable right elbow condition. The ALJ further found that in declining to pay temporary disability compensation to claimant, SAIF relied on a administrative rule no longer in effect and improperly determined that full time modified work would have been available to claimant had she not been terminated. Because SAIF's factual determination was inconsistent with the evidence that claimant was terminated for reasons related to her compensable injury, the ALJ concluded that SAIF's conduct was unreasonable.

On review, SAIF asserts that it had a legitimate doubt as to its liability because it understood from the employer that claimant was terminated for reasons unrelated to her claim. We disagree.

Here, the record supports the ALJ's determination that claimant was terminated at least in part because of her inability to perform her regular work activity due to her compensable injury (see, e.g., Exs. 8A-2, 10A, 10B), and that she was not terminated because of a violation of work rules or other disciplinary reasons. Although the employer may not have accurately reported the reasons for claimant's termination to its insurer, SAIF is legally imputed with the employer's knowledge and unreasonable conduct. See Nix v. SAIF, 80 Or App 656, 660 (1986).

Consequently, where, as here, the employer provides incorrect information to the carrier which leads to a resistance to the payment of compensation, that resistance is unreasonable and claimant is entitled to penalties under ORS 656.262(11). See Anfilofieff v. SAIF, 52 Or App 127 (1981) (claimant entitled to penalties for an unreasonable denial where the employer's misconduct and misinformation contributed to the carrier's denial); see also Debora L. Doppelmayr, 48 Van Natta 1831 (1996) (same).

Inasmuch as penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for her counsel's services on Board review. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

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

In the Matter of the Compensation of
DAVID L. HANSON, Claimant
WCB Case Nos. 95-11977 & 95-11976
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Roberts, 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) Davis' order that set aside its denial of claimant's injury claim for a left ankle condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the employer's denial of claimant's injury claim for a right shoulder condition. On review, the issues are compensability of the left ankle and right shoulder conditions. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Left Ankle

The ALJ found that claimant carried his burden of proving that his July 1995 work injury was a material contributing cause of claimant's disability and need for treatment for a left ankle strain. See ORS 656.005(7)(a).

The employer argues claimant has not carried his burden, because the injury is not established by medical evidence supported by objective findings and, even if it is, the medical evidence supporting the claim is not persuasive. We agree with the latter argument.

To prove a compensable injury, claimant must (at least) establish that the claimed work incident was a material contributing cause of his disability or need for medical treatment for his left ankle. See id.[1]

Considering claimant's prior history of left ankle injuries, we find that the causation issue is essentially a medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

In this case, the medical evidence regarding causation is provided by Dr. Breen, who treated claimant primarily for his right shoulder condition, and Dr. Graham, who began treating claimant's left ankle condition on September 6, 1995. The ALJ found the doctors' opinions that claimant suffered a July 1995 left ankle strain injury to be persuasive in part because Dr. Graham provided the most thorough evaluation of claimant's condition and Dr. Breen appeared to endorse his reasoning. We disagree.

Dr. Graham did not examine claimant until September 6, 1995, six weeks after the claimed injury. Thus, he was not in a particularly good position to evaluate causation. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298, 302 (1995) ("A treating physician's opinion [] is less persuasive when the physician did not examine claimant immediately after the injury.") (citation omitted). This conclusion is further supported by Dr. Graham's acknowledgment that the reported strain had resolved by the time he examined claimant.

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[1] The employer argues that claimant should be subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B). We need not decide this issue, or whether the claim is supported by objective findings, because we find herein that claimant has not carried his burden under the "material cause" standard of proof under ORS 656.005(7)(a).

Finally, although Dr. Graham noted that claimant had suffered a previous left ankle injury, he was under the impression that claimant had only one such injury and that he had no left ankle problems for 25 years. (Ex. 39-2). This history is inconsistent with evidence indicating that claimant had left ankle problems in 1977, 1981, and March 1995. (See Exs. 21-26). Under these circumstances, we cannot say that Dr. Graham's conclusions are based on an accurate and complete history.

Consequently, we find Dr. Graham's opinion unpersuasive and we decline to rely on it. Accordingly, finding no persuasive medical evidence[2] supporting claimant's left ankle injury claim, we conclude that the employer's denial must be reinstated.

Right Shoulder

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

ORDER

The ALJ's order dated May 22, 1996 is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's claim for a left ankle lateral sprain injury is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

[2] To the extent that Dr. Breen's opinion may be read to support the claim, we agree with the ALJ that it depends on adopting Dr. Graham's reasoning regarding claimant's left ankle condition. (See Ex. 73-16-18). Under these circumstances, we find Dr. Breen's opinion unpersuasive. In addition, to the extent that initial examining physicians' diagnoses might otherwise support the claim, we find these diagnoses unpersuasive because they apparently issued without knowledge of claimant's history of prior left ankle injuries.

January 15, 1997 Cite as 49 Van Natta 42 (1997)

In the Matter of the Compensation of
DORIS A. BAILEY, Claimant
WCB Case No. 95-04385
ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
Cobb & Woodworth, Defense Attorneys

Claimant requests reconsideration of the Board's December 17, 1996 order that reversed those portions of an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's denial of claimant's medical services claim for her current cervical, thoracic and low back conditions; and (2) awarded an insurer-paid attorney fee. Noting that the Board affirmed that portion of the ALJ's order which found that the scope of the insurer's initial claim acceptance extended to a cervical and thoracic (dorsal) strain (in addition to a lumbar strain), claimant contends that she is entitled to an insurer-paid attorney fee for prevailing on this issue at hearing and defending that portion of the ALJ's order on review.

In order to further consider the parties' positions, we withdraw the Board's December 17, 1996 order. After completion of our reconsideration, we shall issue our decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS P. PANICH, Claimant
WCB Case No. 96-01958
ORDER ON REVIEW
Martin Alvey, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial, on behalf of Walsh Construction, for claimant's bilateral carpal tunnel syndrome. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with one correction: We delete the word "air" from the third sentence of the last paragraph on page 1. We summarize the pertinent facts as follows:

Claimant worked for Walsh Construction as a carpenter's apprentice for approximately six weeks in October and November 1995. He was terminated on November 17, 1995 for "poor performance." Claimant then worked on a temporary basis through Contractor Temporary Labor Pool for the last two weeks of November and through December 1995.

On November 30, 1995, claimant sought treatment for numbness in the fourth finger of his right hand. Dr. Tremaine diagnosed probable carpal tunnel syndrome (CTS). Claimant was referred to Dr. Aversano, who examined him on December 11, 1995. Dr. Aversano diagnosed bilateral CTS and recommended surgery. Nerve conduction studies showed bilateral slowing of the median nerve.

Claimant alleged that he experienced the onset of hand numbness while performing his work activities at Walsh Construction the day of his termination. He completed an 801 form on December 14, 1995. SAIF denied the compensability of claimant's CTS on February 1, 1996. On March 12, 1996, SAIF amended its denial to include responsibility.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, regardless of the compensability of claimant's CTS, SAIF was not responsible for the condition because claimant did not seek medical treatment or become disabled until after his employment terminated with SAIF's insured. In addition, the ALJ found that claimant's subsequent employment activities, including leveling sand and cutting, laying and wiring rebar, sweeping floors and picking up garbage, were of the type that could contribute to his CTS condition.

On review, claimant argues that SAIF is precluded from denying responsibility because its denial was untimely.[1] Claimant further contends that the ALJ erred in applying the "last injurious exposure" rule because Dr. Aversano specifically related claimant's condition to his work with Walsh Construction and because he did not raise responsibility as an issue at hearing. SAIF responds that claimant waived any challenge to the timeliness of its responsibility denial because he did not raise the issue at hearing. SAIF further contends that the ALJ properly applied the last injurious exposure rule to find that it was not responsible for claimant's condition. We agree with SAIF.

At hearing, claimant agreed with the ALJ's framing of the issues ("compensability and responsibility") and did not specifically contest the timeliness of SAIF's responsibility denial. (Tr. 2). In fact, claimant did not raise the timeliness issue until after the ALJ issued the Opinion and Order. We have consistently held that we will not consider issues on review that were not raised in the hearing. See, e.g., Robert D. Lawrence, 47 Van Natta 1619 (1995) (Board will not consider an issue raised for the first time during closing argument); Leslie Thomas, 44 Van Natta 200 (1992) (same). See also Donald A. Hacker, 37 Van Natta 706 (1985) (fundamental fairness dictates that parties have a reasonable

[1] SAIF issued the amended responsibility denial 91 days after claimant reported the injury to the employer.

opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy). Because claimant agreed with the ALJ's framing of the issues and did not challenge the timing of SAIF's responsibility denial at hearing, we do not entertain the timeliness issue on review.

The "last injurious exposure" rule provides that when a worker proves an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the condition. Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239 (1982). If the claimant receives treatment for the condition before experiencing time loss due to the condition, the date the claimant first sought treatment for the compensable condition is determinative for the purpose of assigning initial responsibility. See Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, as the ALJ found, both Dr. Aversano and Dr. Ushman related claimant's CTS to his work activities "as a carpenter." Dr. Aversano reported that claimant's work as a carpenter required "repetitive use and trauma to his hand, wrist and forearms." (Ex. 15). Dr. Ushman understood that being a carpenter involved "heavy lifting, hammering and carrying and is a job associated with heavy use of the upper extremities." (Ex. 18). Claimant's testimony establishes that he performed hand intensive, repetitive carpenter-type duties while working for Walsh Construction and while working through the Contractor Temporary Labor Pool after he left Walsh Construction.[2] (Tr. 6-7, 12-17). Therefore, the ALJ properly applied the last injurious exposure rule to determine responsibility.[3]

As the ALJ found, claimant did not seek treatment or miss time from work due to his CTS until after he left Walsh Construction. Because claimant's subsequent work activities through the Contractor Temporary Labor Pool were also of the type that could cause claimant's condition, SAIF is not responsible under the last injurious exposure rule. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, mod 73 Or App 223, rev den 299 Or 203 (1985) (responsibility does not shift back to the prior carrier unless the prior work activity was the sole cause or it was impossible for the later employment to have caused the claimant's condition).

ORDER

The ALJ's order dated May 23, 1996, as reconsidered June 26, 1996, is affirmed.

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[2] Contrary to claimant's contention, the record does not establish that claimant's CTS was actually caused by his specific duties at Walsh Construction. Although Dr. Aversano referred to claimant's work activities "as a carpenter with Walsh Construction," it is not evident that Dr. Aversano knew that claimant also performed hand-intensive, repetitive wrist activities while working through the temporary labor pool in the weeks before he sought treatment on November 30, 1995. Therefore, we are not persuaded by Dr. Aversano's specific mention of Walsh Construction. See Miller v. Granite Construction Co., 28 Or App 473 (1977) (causation opinion based on unreliable and inaccurate history is unpersuasive).

[3] Although claimant elected to proceed on the theory that his CTS was actually caused by his work activities at Walsh Construction, SAIF raised responsibility as an issue at hearing. (See Tr. 2). Therefore, SAIF was entitled to invoke the rule as a defense. Cf. Manual Garibay, 48 Van Natta 1476 (1996) (Board declined to decide case on the basis of the last injurious exposure rule where the claimant sought to prove his occupational disease claim against one employer and the responsibility issue was not raised, cited or referenced at any time during the hearing).

In the Matter of the Compensation of
MATHEW S. WILKINSON, Claimant
WCB Case Nos. 96-03839 & 96-02848
ORDER ON REVIEW
Lavis, 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) Otto's order that upheld the SAIF Corporation's denials of claimant's left knee injury claim issued on behalf of Quality Home Contracting and Pierce Professional Temporary Services (Pierce). In its brief, SAIF challenges that portion of the ALJ's order that found that Pierce was a subject employer under ORS 656.850 and argues that the medical evidence does not prove compensability. On review, the issues are subjectivity and compensability.

We adopt and affirm that portion of the ALJ's order finding that claimant's injury did not arise out of, or occur in the course of, his employment, with the following correction and supplementation.

In discussing this issue, the ALJ stated that claimant testified at hearing "that he was injured while unloading roofing materials from a pickup truck at Roam Furniture Store." Based on the hearing transcript, we find that claimant testified that, the day after he worked at the furniture store, he and John Owen performed a chimney stucco job. (Tr. 19). According to claimant, after this job, he and Mr. Owen went to Karl Muller's residence; Mr. Muller was their employer. (Id.) Claimant stated that a pickup truck which had been used at both the furniture store and the chimney stucco jobs contained tools and spilled tar; Mr. Muller told them to clean the pickup truck. (Id. at 27). Claimant testified that he was injured while helping to clean the pickup truck. (Id. at 22).

For the reasons stated by the ALJ, we agree that claimant's testimony is not credible. Rather, based on the evidence cited by the ALJ, we adopt and affirm that portion of the ALJ's order finding that claimant was injured while walking to Mr. Muller's house to receive a draw from his paycheck and that he did not perform any work on that day. Consequently, we agree with the ALJ that claimant's injury did not arise out of, or occur in the course of, employment.

Because claimant did not prove a compensable injury, we need not address nor adopt the ALJ's conclusion that Pierce qualified as a "worker leasing company" under ORS 656.850. Likewise, it is unnecessary to consider SAIF's assertion that the medical evidence is insufficient to prove a causal relationship between the event at Mr. Muller's residence and the left knee condition.

ORDER

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

In the Matter of the Compensation of
EVERETT E. PROCTOR, Claimant
WCB Case Nos. 94-06030 & 94-06029
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Liberty Northwest Insurance Corporation, on behalf of Eagle-Picher Minerals Inc., requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its responsibility denial of claimant's aggravation claim for his current low back and left leg condition; and (2) upheld the SAIF Corporation's responsibility denial, on behalf of A Kleene Sweep Chimney Service, of claimant's aggravation claim for the same condition. Claimant cross-requests review of that portion of the order that declined to award an assessed attorney fee for work at all levels of appeal pursuant to ORS 656.388(1) and 656.386(1). On review, the issues are responsibility and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we address the procedural posture of this case. Claimant has an accepted 1989 low back injury claim with SAIF and an accepted 1991 low back injury claim with Liberty. Both claims have been closed. In 1994, claimant sought treatment for a worsened low back condition and filed aggravation claims with each insurer. SAIF and Liberty each denied aggravation and responsibility for the claim. Claimant requested a hearing.

The ALJ issued a January 31, 1995 Opinion and Order which set aside SAIF's aggravation denial and upheld its responsibility denial. The same order set aside Liberty's aggravation and responsibility denials. A March 4, 1996 Order on Review vacated the Opinion and Order in its entirety and remanded the case to the ALJ for further proceedings to determine whether claimant's condition had "actually worsened" under amended ORS 656.273.

By agreement of the parties, a new hearing was not convened, nor were additional exhibits offered into evidence. After unrecorded closing arguments, the ALJ issued a June 24, 1996 Opinion and Order on Remand, concluding that claimant's low back condition had "actually worsened," thus establishing a compensable aggravation. The parties do not challenge this issue on review. The ALJ did not revisit the responsibility issue; however, SAIF's responsibility denial was upheld and Liberty's responsibility denial was set aside.

On review, Liberty and claimant argue that SAIF should be found responsible for claimant's current low back claim. Consequently, pursuant to our de novo review authority, we proceed to address the responsibility issue.

Responsibility

We recap the relevant facts. In 1989, claimant compensably injured his low back at SAIF's insured. SAIF accepted a low back strain and herniated disc for which claimant received surgery. The claim was closed and claimant was awarded 16 percent unscheduled permanent disability. In 1991, while working at Liberty's insured, claimant injured his low back while lifting. Claimant filed an aggravation claim against SAIF and a "new injury" claim against Liberty. Pursuant to a March 10, 1992 Stipulation, as amended March 25, 1992, the parties agreed, inter alia, that SAIF's aggravation and responsibility denials were upheld and that Liberty accepted claimant's August 21, 1991 back strain, but not claimant's lumbar disk or worsened disk condition. (Exs. 25, 26). In 1994, claimant experienced low back and bilateral leg symptoms, worse on the left.

On review, Liberty asserts that: (1) SAIF is precluded from attempting to shift responsibility for claimant's disc condition to Liberty, as responsibility for claimant's disc condition was settled by the 1992 Stipulation; and (2) ORS 656.308(1) is applicable.

The correct interpretation of an unambiguous agreement[1] is a question of law, based on the terms of the agreement as a whole. Pollock v. Tri-Met, Inc., 144 Or App 431 (1996). To construe an agreement is to render all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. Id.

Here, we conclude that the parties intended to establish that claimant sustained a "new compensable injury," namely, a low back strain. Thus, by virtue of the stipulation, the parties agreed that Liberty would remain responsible for future compensable medical services and disability relating to the compensable condition unless claimant sustained a new compensable injury involving the same condition. See ORS 656.308(1). We conclude that the parties also agreed that Liberty would not be responsible for claimant's herniated disc or worsened herniated disc condition, which was part of SAIF's accepted claim. However, contrary to Liberty's contention, responsibility for claimant's current condition has not necessarily been decided by the stipulation. Rather, we must first determine whether claimant's "current condition" is the same condition as either his 1989 condition or his 1991 condition.

Liberty contends that ORS 656.308(1) applies in this case because claimant's further disability or need for treatment involves the same disc condition that was processed as part of SAIF's 1989 claim, and for which SAIF remained responsible subsequent to the 1992 Stipulation, in which the parties agreed that Liberty accepted claimant's 1991 low back strain, but not a herniated disc or worsened disc condition.

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."

When benefits are sought for "further compensable medical services and disability subsequent to a new injury," ORS 656.308 applies only if claimant's current condition is materially related to a compensable injury and involves a condition that has previously been processed as a part of a compensable claim. Responsibility is then assigned to the insurer with the most recent accepted claim for that condition. Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993); Armand J. DeRosset, 45 Van Natta 1058 (1993). Neither insurer disputes the compensability of claimant's current condition/aggravation claim on review. Consequently, the issue is whether claimant's "current condition" involves the "same condition" as that previously accepted by SAIF in 1989 or by Liberty Northwest in 1992.

In 1989, when claimant was employed by SAIF's insured, he filed an injury claim for "strain of lower back." (Ex. 4). SAIF accepted the claim. (Ex. 6). Claimant experienced low back and radicular pain in the left leg. He was subsequently diagnosed with a herniated disc at L5-6[2] on the left and amputation of the left L6 nerve root sheath, for which he received a microsurgical lumbar diskectomy. (Exs. 7, 8). Claimant received 14 percent unscheduled permanent disability for that condition. (Exs. 13, 14A).

On August 21, 1991, claimant sought treatment for low back pain after a lifting incident at Liberty Northwest's insured. Claimant was diagnosed with chronic low back pain secondary to the 1989 injury. (Exs. 14, 17, 19-3, 22-7). SAIF denied aggravation and responsibility. Pursuant to the March 10,

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[1] None of the parties maintains that the settlement agreement is ambiguous.

[2] X-rays revealed that claimant has six true lumbar vertebrae. (Ex. 7). At the time of the 1989 injury and surgery, Dr. Newby identified the location of claimant's herniated disc as L5-6; subsequent examiners also referred to it as L5-S1. (Exs. 5, 8).

1992 stipulation, as amended March 25, 1992, the parties agreed, inter alia, that SAIF's denials were upheld and that Liberty accepted the August 21, 1991 low back strain, but did not accept claimant's lumbar disc or worsened disc condition. (Exs. 25, 26).

Claimant sought further treatment in 1994 for low back and left leg pain with left foot numbness after climbing in and out of his pickup truck. (Ex. 31, 31A, 31B). Dr. French, claimant's attending physician, reported that, subsequent to the 1991 strain injury, claimant had experienced some residual discomfort but a good functional outcome. Dr. French diagnosed radiculitis (nerve root irritation) of the L5 or S1 nerve root corresponding to the same level as the 1989 disc and surgery, which, he opined, was probably caused by a herniation or reherniation of a disc. (Ex. 48A). Accordingly, as diagnosed by Dr. French, claimant's 1994 radiculitis condition resulted from the 1989 disc and surgery, which is the same condition as his 1989 low back claim. Thus, because we conclude that claimant's 1994 radiculitis involved the same condition as his 1989 injury, ORS 656.308(1) is applicable. Accordingly, SAIF remains responsible for claimant's medical services and disability.

Moreover, even if ORS 656.308(1) was not applicable in this case, the medical evidence supports the conclusion that claimant's 1989 injury with SAIF's insured was the major contributing cause of claimant's current condition and need for treatment. Five doctors rendered opinions on causation: Drs. Olson, Stanford, Strum, Brooks and French.

Drs. Olson and Stanford, who examined claimant for Liberty, diagnosed claimant's low back condition as "residuals of back surgery with more probable than not, myofascial pain syndrome with aggravation." They initially appeared to attribute claimant's condition to both the 1989 and 1991 low back injuries, although the mechanism of the relationship is far from clear in their April 19, 1994 report. Upon subsequent questioning by Liberty, the doctors clarified their opinion to assert that the 1991 injury was not involved in claimant's current acute muscle spasm. They relied on the emergency room report that indicated that claimant had been free of pain since 1992. (See Ex. 43). Dr. Stanford provided further clarification, stating that one would expect the 1991 back strain to resolve within a few months, and any subsequent difficulty was more likely than not related to the 1989 injury and surgery. (Ex. 47). Dr. Stanford also indicated that claimant had experienced degenerative lumbar disc disease since 1989 in relation to his prior surgery, and opined that claimant's degenerative arthritic changes as a result of his surgery and the spinal stenosis that resulted from the arthritic changes were the cause of the current worsening. (Id.) Dr. French, claimant's attending physician, concurred in this opinion. (Ex. 48).

Drs. Strum and Brooks, who examined claimant for SAIF, diagnosed claimant's current conditions as chronic lumbosacral pain and status post discectomy with perhaps early degenerative disc disease. They found no objective findings during their May 12, 1994 examination and concluded that there was no objective evidence of any pathological worsening of claimant's 1989 injury. (Ex. 45). Although they had a complete medical history, the doctors did not offer an opinion in regard to the effect of claimant's 1991 injury on his current low back condition. (Ex. 45).

Dr. French diagnosed claimant's condition as "Radiculopathy, status post decompression with subsequent lumbar strain." (Ex. 48A, 49). In response to a letter from SAIF, Dr. French agreed with Drs. Strum and Brooks' report (with one exception not relevant here). (Ex. 50). Subsequently, during a deposition, Dr. French revised that opinion, stating that he thought that claimant's current low back condition, an irritated nerve root corresponding to the same level as the previous surgery, was related to the 1989 herniated disc; however, because claimant reported residual back symptoms after the 1991 injury, he opined that the 1991 injury continued to play a minor role in causing claimant's current condition, explaining that the nerve root involvement resulted from a herniated disc, a chemical irritation of the nerve root, or tension on the nerve root. Finally, Dr. French indicated that, although the 1991 injury contributed to claimant's current condition, the major cause was claimant's 1989 herniated disc and subsequent surgery. (Exs. 52-8, -20, -29, -31, -32, -42, -44).

Of the five doctors, Drs. French, Olson and Stanford opined that the major contributing cause of claimant's current low back condition was the 1989 injury; their only disagreement was the degree to which the 1991 injury contributed to the current condition. We find these opinions to be more persuasive than those of Drs. Strum and Brooks, who, at most, considered the magnitude of the worsened 1989 injury without offering an opinion on causation. Somers v. SAIF, 77 Or App 259, 263 (1986) (we give the most weight to opinions that are both well-reasoned and based on complete

information). Consequently, taken together, the medical reports by Drs. French, Olson and Stanford establish that the major contributing cause of claimant's current low back condition was his 1989 low back injury, herniated disc and subsequent surgery. Accordingly, SAIF is responsible for claimant's current low back condition.[3]

Attorney Fees

ORS 656.388(1) and ORS 656.386(1) authorize a separate attorney fee at each level of adjudication when a claimant prevails finally over a denied claim. Consequently, claimant is entitled to an attorney fee for services regarding the compensability/aggravation issue at hearing, on Board review, and before the Hearings Division on remand, to be paid by SAIF. 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 counsel's services before the Hearings Division (including remand) and on Board review (twice) is $5,500, payable by SAIF, the responsible insurer. This award is in lieu of all prior awards. In reaching this conclusion, we have particularly considered the time devoted to the compensability/aggravation issue (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated June 24, 1996 is reversed in part, modified in part, and affirmed in part. That portion of the SAIF Corporation's denial denying responsibility is set aside and the claim is remanded to SAIF for processing in accordance with law. Liberty Northwest Insurance Corporation's compensability/aggravation and responsibility denials are reinstated and upheld. In lieu of all prior attorney fee awards, for claimant's counsel's services before the Hearings Division and on Board review, claimant's attorney is awarded $5,500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

[3] Where actual causation with respect to a specific identifiable employer is proven, it is not necessary to rely on judicially created rules of assignment pertaining to successive or concurrent employments. See Eva R. Billings, 45 Van Natta 2142 (1993). Thus, because we have concluded that claimant has established actual causation, it is not necessary for us to rely on the last injury rule under Industrial Indemnity v. Kearns, 70 Or App 583 (1984). Moreover, because we have concluded that SAIF is the responsible employer, we need not address Liberty's argument that SAIF is precluded from attempting to shift responsibility for its accepted disc condition to Liberty.

In the Matter of the Compensation of
ANTHONY J. TELESMANICH, Claimant
WCB Case No. 95-10751
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) denied claimant's request to defer the hearing to await an evaluation by the Department of those conditions accepted by the SAIF Corporation after issuance of the Order on Reconsideration (a right knee and right elbow contusion, right shoulder strain and lumbar strain); (2) declined to award an assessed attorney fee under ORS 656.386(1) based on SAIF's "post-reconsideration" acceptances; and (3) affirmed the Order on Reconsideration awarding 3 percent (4.5 degrees) unscheduled permanent disability for a right hip condition and 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. In its respondent's brief, SAIF contests that portion of the ALJ's order that directed it to pay claimant's scheduled permanent disability award at a rate of $347.51 per degree. Claimant also moves for waiver of the Board's rules for acceptance of his untimely filed brief. On review, the issues are claimant's procedural motion, the ALJ's deferral ruling, extent of permanent scheduled disability, and rate of permanent disability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second sentence of the second paragraph on page 3. We briefly summarize the pertinent facts as follows:

Claimant was compensably injured on July 26, 1993, when an automatic gate malfunctioned. SAIF accepted claimant's claim for abrasions of the right hand and left shin on September 30, 1993. In November 1993, claimant wrote to SAIF making a claim for injury to his right elbow, right hip, right knee and low back, right carpal tunnel syndrome and post-concussion headache. On January 28, 1994, SAIF accepted claimant's right carpal tunnel syndrome and meralgia paresthetica, secondary to an injury of the lateral femoral cutaneous nerve in the right hip.

Claimant was declared medically stationary as of December 19, 1994. His treating doctor opined that claimant did not sustain any permanent impairment as a result of the July 26, 1993 incident. The claim was closed by Determination Order issued January 31, 1995, which awarded no permanent disability.

Claimant requested reconsideration and a medical arbiter was appointed. On September 1, 1995, claimant was examined by Dr. Gancher, who found decreased right hip motion, decreased right wrist motion and a chronic condition limiting repetitive use of the right forearm. Dr. Gancher also reported that claimant exhibited 4/5 strength in the fingers of his right hand due to referred pain in the dorsal region.

A September 15, 1995 Order on Reconsideration awarded claimant 3 percent unscheduled permanent disability for the right hip and 7 percent scheduled permanent disability for loss of use or function of the right forearm. Shortly thereafter, claimant requested a hearing alleging the "de facto" denial of certain conditions arising from the July 26, 1993 incident, including injuries to his right knee, right elbow, right shoulder and low back. SAIF accepted these particular injuries on December 12, 1995.

CONCLUSIONS OF LAW AND OPINION

Motion for Waiver of Rules

Claimant moves for waiver of the Board rules, acknowledging that his appellant's brief was untimely filed due to a clerical error. SAIF does not object to claimant's motion. In light of SAIF's position, we grant claimant's motion for waiver of the Board rules. See Juan M. Delgado, 48 Van Natta 1198 (1996). Consequently, we consider claimant's appellant's brief on review.

Deferral Ruling

The ALJ declined to defer the hearing concerning the extent of permanent disability. On review, claimant argues that the ALJ should have deferred the hearing and remanded the claim to the Department for evaluation of the conditions accepted by SAIF subsequent to the Order on Reconsideration. Claimant does not contend that he is not medically stationary or that his claim was prematurely closed, but only that all of his compensable conditions should be rated together by the Department.

We affirm the ALJ's decision not to defer the hearing based on Rodney V. Boqua, 48 Van Natta 357 (1996). There, the employer accepted the claimant's cervical condition six days after an extent hearing (concerning other, previously accepted injuries) and eight months after the claim had been closed. In affirming the ALJ's decision not to reopen the record to determine whether the claimant's injury claim had been prematurely closed, we held that the employer's "post-hearing" acceptance of the cervical condition did not automatically mean that the claim was prematurely closed. Rather, we reasoned that pursuant to its "post-hearing" acceptance, the employer was required to process the cervical claim as required by law, including payment of any compensation to which the claimant would be entitled as a result of the newly accepted condition.

Although the issues were different, the practical effect of our Boqua decision was to allow the Hearings Division to review the Order on Reconsideration and evaluate the conditions rated therein, while directing the carrier to process the later accepted condition as required by law. To the extent the claimant in Boqua objected to the carrier's processing and/or rating of the later accepted condition, he

was able to request reconsideration and a hearing at the appropriate time.[1] Consequently, in this case, we see no reason to defer evaluation of claimant's previously accepted right hand, right hip and right carpal tunnel syndrome conditions.

We do not adopt that portion of the ALJ's order which found no evidence of impairment resulting from the later accepted conditions. As of the date of hearing, these later accepted conditions had not been processed and/or rated by SAIF and had not been subject to reconsideration by the Department. Under such circumstances, the ALJ's finding was premature. Instead, such an impairment determination must await SAIF's processing and closure of the claim for these later accepted conditions. Following that closure and determination, to the extent claimant objects to SAIF's or the Department's rating of these later accepted conditions, he may then request reconsideration and a hearing at the appropriate time.

Extent of Scheduled Permanent Disability

The ALJ affirmed the Order on Reconsideration's award of 7 percent scheduled permanent disability for loss of function of the forearm. This award consisted of 2 percent for lost wrist range of motion (OAR 436-35-080(1)) (WCD Admin. Order 6-1992) and 5 percent for a chronic condition (OAR 436-35-010(6)).

On review, claimant renews his contention that he is entitled to an additional 9 percent for loss of muscle strength in the right hand. Loss of strength is rated when the cause is a peripheral nerve injury. OAR 436-35-110(8) (WCD Admin. Rules 6-1992). As the ALJ found, there is no evidence indicating claimant's right hand strength loss was caused by a peripheral nerve injury or loss of muscle. Rather, the medical arbiter specifically related the strength loss in claimant's index and long fingers to "referred pain" in the dorsal region of claimant's right hand. (Ex. 26-3). On this record, we agree with the ALJ that claimant is not entitled to additional scheduled permanent disability. See Opal L. Whelchel, 47 Van Natta 2417 (1995) (loss of strength due to pain and giveway weakness not ratable under OAR 436-35-110(8)).

Rate of Permanent Disability

The ALJ found that, because claimant's claim existed at the time of the effective date of Senate Bill 369, the amendments to ORS 656.214(2) were applicable and claimant's scheduled disability award should be paid at the rate of $347.51 per degree. On review, SAIF contends that the ALJ erred in applying amended ORS 656.214(2). Specifically, SAIF argues that because claimant's injury occurred between January 1, 1992 and December 31, 1995, the rate of permanent disability is governed by Section 18(1) of SB 369 (amending Section 2, chapter 745, Oregon Laws 1991) rather than ORS 656.214(2). We agree.

Section 18 provides, in pertinent part, as follows:

> "(1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214(2), for injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995, the worker shall receive an amount equal to 71 percent of the average weekly wage times the number of degrees stated against the disability as provided in ORS 656.214 (2) to (4)."
>
> "* * * * *
>
> "(3) Benefits referred to in this section shall be paid in the basis of the benefit amount in effect on the date of the injury."

Subsequent to the ALJ's order, in Sharon L. Hand, 48 Van Natta 1798 (1996), we held that, in light of the "notwithstanding" clause at the beginning of Section 18(1), the legislature intended that Section 18(1)

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[1] Indeed, in a later proceeding, we evaluated the extent of permanent disability arising out of the claimant's subsequently accepted cervical condition and determined that a preponderance of the evidence failed to establish any cervical impairment due to the claimant's compensable injury. See Rodney V. Boqua, 48 Van Natta 2213 (1996).

and not ORS 656.214(2) govern the rate of permanent partial disability for injuries occurring between January 1, 1992 and December 31, 1995. Cf. Randy L. Dare, 48 Van Natta 1230 (1996) (holding that amended ORS 656.214 applies retroactively to injuries occurring *prior to* January 1, 1992).

In this case, claimant was injured on July 26, 1993. The law in effect at that time provided that scheduled permanent disability awards shall be paid at the rate of $331.41 per degree. Based on SB 369, section 18 and Sharon L. Hand, supra, we reverse that part of the ALJ's order directing that claimant's scheduled permanent disability award be paid at the rate of $347.51 and reinstate the dollar amount awarded by the Order on Reconsideration.

Attorney Fees

We adopt and affirm the ALJ's decision not to award an insurer-paid attorney fee under ORS 656.386(1). See Shannon E. Jenkins, 48 Van Natta 1482 (1996) (hearing request does not constitute communication in writing under ORS 656.262(6)(d)); see also Jerome M. Baldock, 48 Van Natta 355 (1996) (no attorney fee authorized under ORS 656.386(1) where carrier did not "refuse to pay" compensation).

ORDER

The ALJ's order dated June 5, 1996 is affirmed in part and reversed in part. Those portions of the order directing SAIF to pay claimant's scheduled permanent disability award at the rate of $347.51 per degree and awarding an "out-of-compensation" attorney fee are reversed, and the dollar amount awarded by the Order on Reconsideration is affirmed. That part of the order rating claimant's impairment for the later accepted conditions is also reversed. SAIF is directed to process the claim for the "post-closure" accepted conditions according to law. The remainder of the order is affirmed.

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

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order which upheld the insurer's denial of his current low back condition. On review, the issues are the procedural validity of the insurer's denial and compensability. We affirm.

FINDINGS OF FACT

Claimant, a produce manager for the insured, experienced an onset of low back pain with radiation into the left leg while lifting watermelons. Dr. Tilley initially diagnosed a mid-back strain. (Ex. 3). Claimant then came under the care of Dr. Brust, who diagnosed a lumbar strain. (Ex. 8). Claimant was then referred to a neurosurgeon, Dr. Kim, for an evaluation of whether claimant had a herniated disc. Dr. Kim also diagnosed a low back strain. (Ex. 13-3).

After an examining physician, Dr. Kirschner, opined on August 9, 1995 that it was unlikely that claimant's current need for treatment was related to the July 3, 1995 incident, the insurer denied the compensability of claimant's low back claim on August 18, 1995. (Ex. 23). Dr. Brust concurred with Dr. Kirschner's report on August 21, 1995 and noted that claimant had severe chronic anxiety reaction status. (Ex. 25).

On October 12, 1995, the employer 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, 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.

CONCLUSIONS OF LAW AND OPINION

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.

The ALJ cited three reasons for upholding the procedural validity of the insurer's current conditions denial. First, the ALJ reasoned that, because the denial was issued before acceptance of the lumbar strain condition, it was not intended to circumvent the claim closure process. Second, the ALJ found that the parties had "waived" all procedural defects in the current condition denial by reason of the stipulation. Finally, the ALJ reasoned that a current condition denial of a separate and distinct condition was legally permissible during the pendency of an "open" claim.

On review, claimant contends that the insurer's "pre-closure" current condition denial is invalid because it was not based on a "combined condition." See ORS 656.262(7)(b); ORS 656.268(1)(a). Further, claimant asserts that, even if procedurally valid, the insurer's denial was improper because his current low back condition is compensable on the merits. Claimant also argues that he did not "waive" his right to challenge procedural defects with respect to the current condition denial and that, if he did, the insurer, in turn waived its rights to raise claimant's "waiver" as an affirmative defense. We need not address claimant's "waiver" arguments, because, even if claimant is not precluded from contesting the procedural validity of the insurer's denial, we would still find that the insurer's denial was a proper "pre-closure" denial of claimant's current low back condition, both procedurally and substantively.

The ALJ determined that there was no "combined condition" consisting of claimant's low back condition and an alleged preexisting psychological condition. The parties do not challenge that finding. Moreover, the insurer's "current condition" denial was not based on a "combined condition." Therefore, we conclude that neither ORS 656.262(7)(b) and ORS 656.268(1)(a) are applicable.

In Elizabeth B. Berntsen, 48 Van Natta 1219 (1996), we held that a "pre-closure" denial of a current condition was invalid when the condition was neither a "combined" nor a "consequential" condition. In so doing, we concluded that the rationale expressed in Roller v. Weyerhaeuser Co., 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984), remains viable despite the enactment of amended ORS 656.262(6)(c) and (7)(b) (which allow for the issuance of denials of "combined" or "consequential" conditions whenever the compensable injury ceases to be the major contributing cause of the "combined" or "consequential" condition, including before claim closure).

Prior to closure of the claimant's compensable back claim in Berntsen, the carrier issued a denial of her current back condition. Contending that the claimant's current condition constituted either a "combined" or "consequential" condition, the carrier asserted that the denial was appropriate under ORS 656.262(6)(c) and 656.262(7)(b). We disagreed with the carrier's assertion. Finding that the medical evidence failed to support either a "combined" or "consequential" condition, we determined that neither of the aforementioned statutes were applicable. Consequently, based on the rationale expressed in Roller, we held that, since the carrier's "pre-closure" denial was for the same condition that it had previously accepted, the denial was procedurally improper and invalid.

Therefore, under Berntsen, a "pre-closure" denial of a current condition is invalid in the absence of a "combined" or "consequential" condition, provided the denial is for the same condition previously accepted. While the current condition denial in this case, like that in Berntsen, was not based on a combined or consequential condition, unlike Berntsen, we do not find claimant's current low back condition to be the same condition as previously accepted.

In reaching this conclusion, we agree with the ALJ's reasoning that claimant's current low back condition is not related to his accepted low back strain and is, instead, psychologically based. Inasmuch as claimant's current condition is not related to the previously accepted low back condition, we conclude that the insurer's denial was a valid "pre-closure" current condition denial, both procedurally and substantively. See Zora A. Ransom, 46 Van Natta 1287 (1994) (upholding "pre-closure" denial not based on ORS 656.005(7)(a)(B) where the claimant's current low back strain condition was not related to the accepted low back strain).

ORDER

The ALJ's order dated June 18, 1996 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

Claimant requests review of the self-insured employer's October 20, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from September 9, 1995 through October 17, 1996. The employer declared claimant medically stationary as of October 17, 1996. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 20, 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).

The employer contends that claimant was medically stationary on October 20, 1996, when it closed his claim. The employer further contends that claimant's treating physician "has misunderstood the nature of medically stationary status and that his comments clearly indicate that [claimant] is legally medically stationary." However, we do not find persuasive evidence in the record to support the appropriateness of the employer's closure on October 20, 1996.

The record does not contain any medical evidence which indicates that claimant was medically stationary on October 20, 1996. On November 11, 1996, Dr. Johansen, claimant's treating physician, opined that:

> "I feel that placing [claimant] on Medically stationary at this time maybe be [sic] the wrong thing to do because I feel there is still problems with his foot that have not been corrected or not able to be treated."

On December 11, 1996, in response to the employer's request to "confirm that [claimant's] condition is medically stationary," Dr. Johansen opined that:

> "As far as time, materials, etc., I cannot say that [claimant's foot] may not improve. At this juncture I cannot help him anymore. He may need shoes, orthotics in the future. As fare as the above definition [of medically stationary] - I do not agree with [claimant's] being medically stationary."

Here, on two occasions, Dr. Johansen has opined that claimant "still had problems with his foot that have not been corrected." On the second occasion, Dr. Johansen was presented with the definition of medically stationary. The employer defined medically stationary as "no further material improvement would reasonable [sic] be expected from medical treatment, or the passage of time." Although Dr. Johansen also indicated that some of claimant's condition is "unrepairable," he also indicated that "[a]s far as [claimant's] prognosis[,] it is difficult to tell."

Furthermore, Dr. Johansen had not rendered any opinion regarding the status of claimant's condition, nor had he referred claimant for orthotics casting by October 20, 1996. In an October 28, 1996 prescription referral to NovaCare Orthotics and Prosthetics, Dr. Johansen prescribed custom shoes for claimant's compensable foot condition. In chart notes dated October 29, 1996 through November 29, 1996, Mr. Conyers, certified prosthetics optician, documented that claimant was being evaluated for appropriate orthotics. In a letter dated November 29, 1996, Mr. Conyers noted that:

> "Dr. Johansen is sending a second RX for an ankle foot orthosis to stabilize [claimant's] ankle. We will be contacting [claimant] to schedule a casting appointment for this brace."

On this record, we are not persuaded that the treatment prescribed by Dr. Johansen was completed on October 20, 1996, nor are we persuaded that Dr. Johansen opined that claimant was medically stationary when the employer closed his claim. ORS 656.005(17); Weiland v. SAIF, 64 Or App at 810.

Accordingly, we set aside the employer's October 20, 1996 Notice of Closure as premature. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

January 22, 1997 Cite as 49 Van Natta 55 (1997)

In the Matter of the Compensation of
CHRIS G. CLAUSEN, Claimant
WCB Case No. 95-11626
ORDER ON RECONSIDERATION
Terry & Wren, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant[1] requests reconsideration of that portion of our December 24, 1996 Order on Review that upheld the insurer's partial denial of claimant's claim for a C5-6 herniated disc condition. In our order, we affirmed and adopted Administrative Law Judge (ALJ) McKean's reasoning and conclusions regarding the compensability issue. On reconsideration, claimant alleges that neither the ALJ nor the Board were impartial in deciding the compensability issue because both forums relied on medical evidence that found that claimant had functional overlay.

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[1] Although represented at hearing and on review, claimant apparently is pro se on reconsideration. Since it does not appear that the other parties received a copy of claimant's request, copies have been included with claimant's and the insurer's attorney's copies of this order.

We withdraw our order for reconsideration. Prior to issuing our Order on Review, we independently reviewed the record and concluded that the ALJ accurately and thoroughly summarized the evidence and the law and correctly applied the law to the facts of this case. After conducting our reconsideration and reviewing claimant's arguments, we continue to find no reason to change or supplement the ALJ's reasoning and conclusions which determined that claimant's C5-6 herniated disc condition was not compensable.

Consequently, on reconsideration, we adhere to and republish our December 24, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

January 22, 1997 Cite as 49 Van Natta 56 (1997)

In the Matter of the Compensation of
LISA A. HINER, Claimant
WCB Case No. 95-11008
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge Howell's order that: (1) dismissed her request for hearing concerning the reclassification of her September 19, 1990 compensable head, shoulder, neck, and low back injury claim; (2) declined to direct the self-insured employer to process conditions found compensable, pursuant to a March 31, 1993 hearing and subsequent review, as an aggravation of her 1990 compensable injury claim; and (3) declined to assess a penalty for allegedly unreasonable claims processing. On review, the issues are claim classification, aggravation, and penalties.

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

Claimant's September 19, 1990 injury claim was accepted as nondisabling by the employer. (Ex. 5). Claimant does not assert that her claim was originally misclassified by the employer. Rather, she asserts that her condition subsequently became disabling. Because claimant asserts that her condition became disabling more than one year from the date of her original September 19, 1990 injury and subsequent to the employer's October 11, 1990 acceptance, her five-year aggravation rights run from the date of her original injury. See ORS 656.277(2); 656.273(4)(b); Liberty Northwest Ins. Corp. v. Koitzsch, 140 Or App 194, 197 (1996). Since more than five years have elapsed since her September 1990 injury, claimant's aggravation rights have expired. ORS 656.273(4)(b).

In addition, contrary to claimant's assertion, the employer had no duty to reopen claimant's claim following the 1993 litigation concerning the compensability of her neck, back fibromyalgia, thoracic outlet syndrome and psychological conditions, particularly since claimant made no claim for aggravation at that time.

ORDER

The ALJ's order dated May 6, 1996 is affirmed.

In the Matter of the Compensation of
LILLIAN L. HORNIK, Deceased, Claimant
WCB Case No. 95-07841
ORDER ON REVIEW (REMANDING)
William H. Skalak, Claimant Attorney
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that found claimant permanently and totally disabled. On review, the issue is permanent total disability. We remand.

FINDINGS OF FACT

Claimant began working for the employer in 1974. In 1991, claimant was involved in a work-related motor vehicle accident and sustained fractures to the left leg and right ankle. Claimant underwent surgery for both fractures. The insurer accepted the claim. (Ex. 1).

In February 1992, the insurer notified claimant of eligibility for vocational services. (Ex. 8). Mary Shivell was assigned to be claimant's vocational counselor.

In June 1992, claimant underwent surgery to decompress the tarsal tunnel in the right foot. (Ex. 20-2). Claimant continued to experience significant right foot symptoms.

In July 1994, claimant's attorney requested a change of vocational counselor. The insurer approved the request. Before reassignment was accomplished, claimant died of natural causes on November 25, 1994.

In February 1995, a Determination Order issued awarding to claimant's beneficiaries scheduled permanent disability of 51 percent for the right leg and 41 percent for the left leg. On May 31, 1995, an Order on Reconsideration increased the left leg award to 44 percent scheduled permanent disability and affirming the right leg award.

Claimant's husband and beneficiary requested a hearing, contending that claimant was permanently and totally disabled. The ALJ admitted the testimonies of claimant's husband; Mary Shivell; Richard Ross, a vocational evaluator and consultant who performed a record review on behalf of claimant; and claimant's former supervisor, Garth Steffan. The ALJ also admitted a report from Jeannette Tisher Jones, a vocational rehabilitation counselor who performed a record review on behalf of the insurer.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant proved permanent total disability, whether based on the record existing at the time of the Order on Reconsideration or on the entire record, which included "post-reconsideration" documents and testimony.

Subsequent to the ALJ's order, in Virginia McClearen, 48 Van Natta 2536 (1996), we addressed the effect of ORS 656.283(7) in a permanent and total disability proceeding. That statute in part provides that "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing." Based on the express terms, we found that the statutory exclusion applied to the hearing in the case.

In McClearen, because the ALJ admitted "post-reconsideration" evidence consisting of reports and testimonies from vocational consultants, we further examined whether ORS 656.287(1)[1] provided an exception to the evidentiary limitation in ORS 656.283(7). Based on the text, context, and legislative

[1] 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 for the person preparing such report shall be made available for testimony and cross-examination."

history of ORS 656.287(1), we found evidence of legislative intent to apply the statute to permanent total disability cases. Moreover, considering only the text of ORS 656.287(1), we found a grant of authority for the admission of vocational consultant's reports at hearing, provided the consultant is made available for cross-examination by the adverse party.

In McClearen, we further considered that, because such an interpretation undermined the evidentiary limitation in ORS 656.283(7), the provisions were best harmonized by interpreting ORS 656.287(1) as a grant of authority to admit at hearing vocational reports so long as: (1) the reports were previously submitted at the reconsideration proceeding; and (2) the other requirements of ORS 656.287(1) were satisfied. Finally, we decided that, if a report is admissible under this standard, the authoring consultant's testimony at hearing also is admissible if the consultant is made available for cross-examination and the adverse party exercises its right to cross-examination.

Applying McClearen to this case, we first note that the record in this case does not indicate what part of the record was submitted on reconsideration.[2] For some evidence, this absence does not prevent a finding concerning its admissibility at hearing. For instance, because the report from Jeannette Tisher Jones was prepared after the Order on Reconsideration and there is no report from Richard Ross (thus showing that no report from him could have been submitted at reconsideration), Ms. Jones' report and Mr. Ross' testimony would appear to be inadmissible. Virginia McClearen, supra.

The record does contain reports from Ms. Shivell that were prepared before reconsideration. There is nothing, however, telling us whether or not the reports were submitted on reconsideration. Lacking such evidence, we are unable to decide the admissibility of Ms. Shivell's testimony at hearing. Id.

The same is true for the medical evidence. The Order on Reconsideration solely referred to and relied on an October 12, 1994 report from examining physicians Dr. Tesar and Dr. Wilson. In requesting reconsideration, claimant's attorney submitted correspondence dated December 1993 from claimant's treating physician, Dr. Wells. Because only these documents can be found to have been included in the reconsideration record, we are unable to decide if the many additional reports admitted at hearing were submitted at reconsideration.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Here, as explained above, because there is an absence of evidence in the record showing whether or not nearly all of the documents admitted at hearing were submitted on reconsideration, we are unable to decide the propriety of their admission at hearing. We find such absence renders the record incompletely developed and thus, there is a compelling reason for remanding.[3] See Howard W. Cockeram, 48 Van Natta 1447 (1996) (Board remanded to ALJ to convene hearing and develop record in order to decide admissibility of certain evidence).

Accordingly, the ALJ's order dated March 29, 1996 is vacated. This matter is remanded to ALJ Galton for further proceedings consistent with this order. Those proceedings maybe conducted in any manner that the ALJ determines achieves substantial justice. Following those further proceedings, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[2] In this regard, we note that OAR 436-030-0155(6) allows for delivery to the Hearings Division of the original or certified copy of the record on reconsideration when a hearing is scheduled following the appeal of a reconsideration order and the parties or the ALJ requests such record. See also OAR 438-007-0018(7).

[3] We find this case distinguishable from Neil A. Laufer, 49 Van Natta 26 (1997). In Laufer, we were able to determine which exhibits admitted at hearing made up the reconsideration record because the Order on Reconsideration contained "Explanatory Notes" describing the reconsideration record. Since we were able to determine which exhibits were submitted on reconsideration and properly admitted at hearing, it was unnecessary to remand.

Here, except for referring to the October 12, 1994 report, the Order on Reconsideration did not indicate what documents were submitted on reconsideration. Because we are unable to decide which documents were included in the reconsideration record, remand is appropriate.

In the Matter of the Compensation of
BOYD K. BELDEN, Claimant
WCB Case No. 95-08382
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by the Board en banc.[1]

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Poland's order that found closure of claimant's left knee claim to be procedurally improper under ORS 656.262(7)(b). On review, the issues are the procedural validity of claim closure and, if valid, extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

Pursuant to an October 12, 1993 Opinion and Order, a combined condition was found compensable and ordered accepted. (Ex. 2A). This combined condition involved a left knee strain which resulted from a combination of claimant's preexisting left knee condition resulting from a 1986 nonwork-related injury and an October 12, 1992 work-related twisting injury.

On September 30, 1994, claimant's treating surgeon, Dr. Robert Wilson, performed a closing examination, finding claimant medically stationary with some reduced range of motion in the left knee. Based on Dr. Wilson's report, the claim was closed by a November 1, 1994 Determination Order that awarded, inter alia, 6 percent scheduled permanent disability for lost motion of the left knee. (Ex. 4). Prior to claim closure, SAIF did not issue a current condition denial pursuant to ORS 656.262(7)(b).

Claimant requested reconsideration and raised, inter alia, the issues of premature closure and impairment. Claimant disagreed with the impairment findings and requested a medical arbiter examination. Dr. N. J. Wilson, orthopedic surgeon, was appointed medical arbiter and found some reduced range of motion which he attributed to the preexisting 1986 left leg nonwork-related injury. Based on this report, the Order on Reconsideration found no permanent impairment due to the accepted condition and reduced the scheduled permanent disability award to zero. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

At hearing and on review, claimant contends that the claim closure was procedurally improper because SAIF did not issue a partial denial pursuant to ORS 656.262(7)(b)[2] prior to closure. On review, SAIF argues that claimant is precluded from making this procedural challenge to its closure because claimant did not raise that issue during the reconsideration proceeding. Claimant counters that, in his request for reconsideration, he raised the issue of premature closure, which includes any procedural challenges to the claim closure. We agree with claimant.

No hearing shall be held on any issue not raised before the Department at reconsideration, unless the issue arises out of the reconsideration order itself. ORS 656.268(8). Here, in his request for reconsideration, claimant raised the issue of premature closure, among other issues. (Ex. 4B-2). We find that the procedural propriety of a claim closure is included in the issue of "premature closure." Thus, we conclude that raising the issue of premature closure adequately raised the issue of the procedural validity of the closure and the applicability of ORS 656.262(7)(b). Accordingly, we address the merits of claimant's challenge to the procedural validity of the closure.

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[1] Board Member Moller has recused himself from participation in this review. See OAR 438-011-0023.

[2] ORS 656.262(7)(b) provides: "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

Procedural Validity of Claim Closure

The ALJ found that claim closure was procedurally improper. In reaching this conclusion, the ALJ relied on ORS 656.262(7)(b). Based on the text and context of the statute, as well as legislative history, the ALJ reasoned that, because "claimant's injury involves a combined condition, and SAIF is taking the position that the work injury is no longer the major contributing cause of the condition[,] * * * SAIF must issue a current condition denial before the claim can be closed." (Opinion and Order, page 4). Because SAIF did not issue a current condition denial prior to closing the claim, the ALJ set aside the Determination Order and Order on Reconsideration resulting from that closure and remanded the claim to SAIF for further processing consistent with the ALJ's order. While we agree with the ALJ that ORS 656.262(7)(b) applies to claimant's claim, we find that the application of this statute requires a different result, for the following reasons.

Subsequent to the ALJ's order, in Robin W. Spivey, 48 Van Natta 2363 (1996), we determined under what circumstances ORS 656.262(7)(b) applies to a claim. Relying on the text and context of ORS 656.262(7)(b), as well as legislative history, we determined that ORS 656.262(7)(b) applies only when a combined or consequential condition has been accepted, either voluntarily or by means of a litigation order. Thus, we held, "[i]n order to determine whether ORS 656.262(7)(b) applies, it is first necessary to make a factual decision regarding what condition(s) (combined or otherwise) have been accepted by the carrier." Id. at 2365 n 4; SAIF v. Tull, 113 Or App 449 (1992). In reaching this holding, we determined that the legislative intent in enacting ORS 656.262(7)(b) was to require the carrier to issue a denial of the current condition if the accepted injury no longer was the major contributing cause of the combined or consequential condition, in order for the carrier to take advantage of statutory provisions regarding combined and consequential conditions. ORS 656.005(7)(a)(A) and (B).[3] In addition, we rejected the carrier's argument that ORS 656.262(7)(b) applied only to non-medically stationary claims.

Applying this interpretation to the facts in Spivey, we determined that, there, the accepted condition was a cervical strain, without a combined or consequential component. Therefore, we reasoned that ORS 656.262(7)(b) did not apply to that case and the carrier was not obligated to issue a denial under that provision prior to closing the claim. Turning to the merits, based on the medical arbiter's opinion, we determined that only 10 percent of the claimant's loss of cervical range of motion was due to the accepted cervical strain, with the remaining 90 percent due to preexisting degenerative disc disease. Therefore, we reduced the claimant's disability award accordingly. Spivey, supra.

Here, SAIF makes several arguments that ORS 656.262(7)(b) does not apply to this claim. We address each argument separately. First, SAIF argues that the text and context of ORS 656.262(7)(b), when read in conjunction with amended ORS 656.268(1)(a),[4] indicate that ORS 656.262(7)(b) applies

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[3] ORS 656.005(7)(a) provides, in relevant part:

"A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

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

[4] Amended ORS 656.268(1)(a) provides:

"(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:

"(a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7) and the worker is not enrolled and actively engaged in training. When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated."

only to the closure of non-medically stationary claims. Therefore, SAIF argues, because claimant's claim was medically stationary at closure, ORS 656.262(7)(b) does not apply to that claim. For the reasons expressed in Spivey, we continue to reject SAIF's argument that ORS 656.262(7)(b) applies only to non-medically stationary claims.

SAIF also argues that, under the ALJ's rationale, it would be required to issue a current condition denial of a combined condition under ORS 656.005(7)(a)(B) in every combined condition case before a claim could be closed, even when the condition was medically stationary. Therefore, SAIF argues, it would be impossible to close medically stationary claims that did not support a current condition denial. SAIF's argument is without merit. Obviously, if a current condition denial is not supportable, such a denial would not be appropriate and could subject the carrier to potential penalties for an unreasonable denial under ORS 656.262(11). In that case, the cause of the disability resulting from the combined condition would necessarily be the accepted condition and, if the claimant's condition was medically stationary, the claim could be closed.

Thus, contrary to SAIF's argument, it is not impossible to close a combined condition claim without issuing a current condition denial under ORS 656.262(7)(b). However, if the carrier closes an accepted combined condition claim without first issuing a current condition denial, the carrier cannot argue that a preexisting condition is responsible (or partially responsible) for the claimant's combined condition disability. In this regard, evaluation of a worker's disability by the ALJ or the Board is made as of the date of the Order on Reconsideration. ORS 656.283(7); 656.295(5). Thus, in the absence of a "pre-closure" denial under ORS 656.005(7)(a)(B), the "combined condition" disability would be considered due to the compensable injury. ORS 656.214(5); 656.268(16).

SAIF notes that ORS 656.214(5) provides that the criteria for rating unscheduled permanent disability "shall be the permanent loss of earning capacity due to the compensable injury." Therefore, SAIF asserts that the "Department correctly rated claimant's condition based on impairment due to the accepted injury according to ORS 656.214(2)" and reduced claimant's impairment to zero. (Appellant's Brief, page 4). SAIF appears to assume that either ORS 656.262(7)(b) or ORS 656.214(5) applies in rating disability. Given this choice, SAIF further assumes that ORS 656.214(5) controls. We disagree with SAIF's assumption that it may pick and choose among the statutes that control rating disability. Instead, both of these statutes apply in rating disability in combined condition claims. Furthermore, in interpreting statutes, we must apply the interpretation that gives effect to all the applicable statutes. ORS 174.010 (providing a general rule for statutory construction that "where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all"); PGE v. Bureau of Labor and Industries, 317 Or at 611 (context of statute includes other provisions of the same statute, as well as other related statutes); Davis v. Wasco IED, 286 Or 261, 272 (1979) (different statutory sections on the same subject must be interpreted as consistent with and in harmony with each other).

Because the clear language of ORS 656.262(7)(b) requires the carrier to "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," if such a pre-closure denial of the accepted combined condition is not issued, any combined condition disability is necessarily considered "due to" the compensable injury. Under that interpretation, both ORS 656.262(7)(b) and 656.214(5) are given full effect.[5]

Furthermore, another principle of statutory construction provides that we give effect to the more specific provision. ORS 174.020. The amendment to ORS 656.262(7)(b) is a more recently enacted and more specific statute than ORS 656.214(5).[6] ORS 656.262(7)(b) specifically relates to combined conditions, whereas ORS 656.214(5) does not specify the type of condition it refers to. Therefore, if we

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[5] We note that this interpretation also gives full effect to ORS 656.268(16), which provides that "conditions that are direct medical sequelae to the original accepted condition shall be included in rating disability of the claim unless they have been specifically denied." In this regard, if "medical sequelae" conditions are not specifically denied, they are included in rating disability. In other words, absent a denial, any disability is necessarily considered "due to" the accepted condition under ORS 656.214(5).

[6] Although ORS 656.214(5) was amended in 1995 under Senate Bill 369, that amendment dealt with the value of each degree of unscheduled disability. The provision relating to the criteria for rating unscheduled disability was not amended.

found it necessary to choose between the two statutes in order to interpret ORS 656.262(7)(b), and we do not, we would find that ORS 656.262(7)(b) controls. Thus, under either interpretation of ORS 656.262(7)(b), if a pre-closure denial is not issued for an accepted combined condition under the terms of ORS 656.262(7)(b), any disability relating to the combined condition is due to the accepted injury.

SAIF also argues that ORS 656.262(7)(b) does not apply to claimant's claim because "as a threshold for application, the text of the statute expressly requires that the insurer take the position that the accepted injury is no longer the major contributing cause of the combined condition." (Appellant's Brief, page 4). SAIF further argues that it did not take this position. Id. We disagree with such reasoning. If SAIF is not contending that the major contributing cause of claimant's combined condition is no longer the accepted injury, then, as explained above, the disability resulting from that combined condition is necessarily caused, in major part, by the accepted injury. SAIF may not avoid application of ORS 656.262(7)(b) by stating that it does not contend the major contributing cause of the combined condition is no longer the accepted condition, then argue that any disability caused by the combined condition is due to the preexisting condition.

Finally, SAIF argues that, if it is not permitted to contest the cause of claimant's permanent disability without first having issued a current condition denial under ORS 656.262(7)(b), it will be "precluded at a later date from contesting the compensability of the combined condition" under Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) [Messmer II]. (Reply Brief, page 2). In Messmer II, the court held that the changes made by Senate Bill 369 to amended ORS 656.262(10) did not overturn its earlier decision in Deluxe Cabinet Works v. Messmer, 130 Or App 254 (1994), rev den 320 Or 507 (1995) [Messmer I], that a carrier is precluded from later denying compensability of a condition for which permanent disability was awarded by a determination order where the carrier failed to challenge that determination order.

Here, the only issues at hearing and on review are applicability of ORS 656.262(7)(b) and extent of scheduled permanent disability. No current condition denial has been issued; therefore, the effect of any such future current condition denial is not before us. Thus, we find premature the issue of the effect of Messmer II on any subsequently issued denial. Accordingly, we decline to address the effect of Messmer II on any subsequent denial and issue what, in effect, would be an advisory opinion. Resolution of that issue must await litigation of any current condition denial that may be issued at some future date.

Moreover, if SAIF is contending that it need not properly investigate the combined condition claim prior to claim closure but still may later argue that the combined condition disability is due to a preexisting condition, we disagree. Claims processing is the responsibility of the carrier. ORS 656.262(1). Therefore, it is the carrier's responsibility to investigate the claim prior to closure to determine whether the accepted injury remains the major contributing cause of the worker's combined condition. As discussed above, the statutory scheme provides that, if the carrier makes this determination and issues a pre-closure current condition denial pursuant to ORS 656.262(7)(b), it may take advantage of the statutory provisions regarding combined and consequential conditions. On the other hand, if the carrier fails to make this determination and fails to issue the appropriate pre-closure denial under ORS 656.262(7)(b), it may not take advantage of the statutory provisions regarding combined and consequential conditions.

In summary, we hold the following. First, ORS 656.262(7)(b) applies only when a combined or consequential condition has been accepted, either voluntarily or by means of a litigation order. Spivey, supra. Second, ORS 656.262(7)(b) applies whether or not the claimant is medically stationary. Third, claims processing is the responsibility of the carrier; therefore, the carrier must investigate the cause of any disability before claim closure. Fourth, where a combined or consequential condition has been accepted, the carrier must issue a denial under ORS 656.262(7)(b) before closing the claim in order to take advantage of the provisions of ORS 656.005(7)(a)(A) or (B) in regard to the causal relationship between any impairment and the work injury. Fifth, if the carrier does not issue such a pre-closure denial, then any combined or consequential condition disability is statutorily deemed due to the accepted condition and, having failed to issue a pre-closure denial under ORS 656.262(7)(b), the carrier may not argue otherwise.

We turn to the merits. In accordance with ORS 656.262(7)(b) and Spivey, our first inquiry in determining applicability of ORS 656.262(7)(b) is to determine whether the accepted condition is a combined condition. Whether a condition has been accepted is a question of fact. SAIF v. Tull, supra.

Here, in 1986, claimant sustained a left knee injury as a result of a noncompensable motor vehicle accident. On October 12, 1992, claimant twisted his left knee while working. (Ex. 1). SAIF initially denied claimant's left knee injury claim, and claimant requested a hearing. Following the hearing, a prior ALJ determined that claimant's work-related left knee strain injury combined with his preexisting left knee condition, with the work injury being the major contributing cause of claimant's combined condition. (Ex. 2A). The ALJ's order setting aside SAIF's denial was not appealed. On this record, we find that claimant's "combined" left knee condition was ordered accepted by a litigation order.[7] Thus, ORS 656.262(7)(b) is applicable. Spivey, supra.

SAIF did not issue a "pre-closure" denial under ORS 656.262(7)(b). Because disability is rated as of the date of the July 14, 1995 Order on Reconsideration and, in the absence of a "pre-closure" denial, the "combined condition" disability is considered due to the accepted "combined condition," we conclude that claimant's left knee impairment is compensable. ORS 656.283(7); 656.295(5); 656.214(5); 656.268(16). In other words, because SAIF failed to issue a "pre-closure" current condition denial, SAIF may not argue that claimant's left knee impairment is not due to the accepted combined condition as of the statutory "rating date," i.e., the date of the Order on Reconsideration.

Extent of Scheduled Permanent Disability

The extent of scheduled permanent disability is evaluated as of the date of the Order on Reconsideration, applying the standards effective as of the date of the Determination Order or Notice of Closure. ORS 656.283(7); 656.295(5); OAR 436-035-0003(2). Here, the claim was closed by a November 1, 1994 Determination Order. Therefore, the applicable standards are found at WCD Admin. Orders 6-1992 and 17-1992.

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. Former OAR 436-35-007(9). Here, Dr. Robert Wilson, claimant's treating physician, performed a closing examination on September 30, 1994. (Ex. 2). On June 2, 1995, Dr. N. J. Wilson, medical arbiter, examined claimant. (Ex. 5). We find the medical arbiter's evaluation more complete; therefore, we rely on that evaluation in determining claimant's scheduled permanent disability.

The medical arbiter's report identifies three possible types of impairment in claimant's left knee: (1) chronic condition; (2) chondromalacia; and (3) loss of range of motion. For the following reasons, we find that only the loss of range of motion meets the requirements of the standards.

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

Here, we find no persuasive medical evidence of a partial loss of claimant's ability to repetitively use his left knee. The medical arbiter indicated only that claimant "may have some limitations in his ability to repetitively use his left knee." (Ex. 5-3, emphasis added). This indication of a possible loss of repetitive use of the left knee does not establish a partial loss of ability to repetitively use the body part. Gormley v. SAIF, 52 Or App 1055 (1981); Donald E. Lowry, supra. Therefore, on this record, claimant has failed to establish chronic condition impairment.

The medical arbiter also indicated that chondromalacia was present in claimant's left knee. (Ex. 5-3). However, the medical arbiter's opinion is inadequate to establish the factors for an award for chondromalacia under former OAR 436-35-230(13). Pursuant to former OAR 436-35-230(13)(a), the rating for chondromalacia is determined under the chronic condition rule, if the criteria of former OAR 436-35-010(6) are met. As discussed above, the criteria of former OAR 436-35-010(6) are not met. In addition,

[7] We further note that SAIF acknowledges that it accepted claimant's "combined condition." (Appellant's Brief, page 4).

the requirements of former OAR 436-35-230(13)(b) are not met in that the medical arbiter did not identify any of the required factors listed in that rule, i.e., grade IV chondromalacia, secondary strength loss, chronic effusion, or varus or valgus deformity. To the contrary, the medical arbiter found no strength loss or swelling. (Ex. 5-2). Therefore, this record does not establish a rating for chondromalacia.

Finally, the medical arbiter measured knee ranges of motion as 140 degrees of active flexion on the right and 120 degrees on the left. (Ex. 5-2). Pursuant to former OAR 436-35-007(16), range of motion in the injured joint is compared to the contralateral joint in determining range of motion impairment, except when the contralateral joint has a history of injury or disease. No history of injury or disease in the right knee is indicated in this record. Therefore, comparing the left knee to the right knee, claimant has a loss of range of motion impairment of 7 percent,[8] for a total scheduled permanent disability award of 7 percent.

Consequently, in lieu of the ALJ's order, the Order on Reconsideration is modified. Claimant is awarded 7 percent scheduled permanent disability. Claimant's attorney is awarded 25 percent of the additional compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. OAR 438-015-0055(1).

ORDER

The ALJ's order dated April 9, 1996 is modified. In lieu of the ALJ's order, and in addition to the Order on Reconsideration's award of zero percent scheduled permanent disability, claimant is awarded 7 percent (10.5 degrees) scheduled permanent disability, which constitutes claimant's total scheduled permanent disability award to date. Claimant's attorney is awarded an out-of-compensation fee of 25 percent of the increased compensation awarded by this order, such fee is not to exceed $3,800, payable directly to claimant's counsel.

[8] This impairment is calculated as follows: 120°/140° = X/150°. X equals 129° retained flexion of the left knee, which results in 7.4 percent impairment, which is rounded to 7 percent. Former OAR 436-35-007(13) and (16), 436-35-220(1).

January 28, 1997 Cite as 49 Van Natta 64 (1997)

In the Matter of the Compensation of
GLENDA A. BARTON, Claimant
WCB Case No. 96-04031
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Moscato, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Schultz' order that: (1) set aside its "back up" denial of claimant's right hip bursitis condition; and (2) awarded a $3,000 attorney fee. On review, the issues are "back up" denial and attorney fees.

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

The ALJ awarded a $3,000 assessed attorney fee. The employer argues that the fee is excessive. We disagree.

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.

After considering the aforementioned factors and applying them to this case, we conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In particular, we have considered the complexity of the issue and the risk that claimant's attorney's efforts may have gone uncompensated. Finally, claimant is not entitled to an attorney fee on Board review, because no brief was submitted. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

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

January 28, 1997 Cite as 49 Van Natta 65 (1997)

In the Matter of the Compensation of
JAMES C. CROOK, SR., Claimant
WCB Case No. 95-07032
ORDER ON REVIEW
David Horne, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

On or about June 8, 1995, claimant filed a request for hearing that the Hearings Division received on June 12, 1995. After several postponements, a hearing was scheduled on August 1, 1996. When the hearing convened on the scheduled date, claimant's attorney, but not claimant, was present.

Claimant's attorney moved to withdraw as claimant's counsel. The ALJ granted the motion. The insurer then moved for dismissal of claimant's hearing request based on claimant's failure to appear. The ALJ granted the motion pursuant to OAR 438-006-0071. On August 12, 1996, the ALJ issued an Order of Dismissal, dismissing claimant's hearing request based on his failure to appear and to otherwise litigate his claim.

On September 11, 1996, claimant mailed a letter to the Board, stating that he did not agree with the ALJ's decision and requesting Board review.

CONCLUSIONS OF LAW AND OPINION

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

Here, the ALJ granted the insurer's motion to dismiss claimant's hearing request for failure to appear after claimant's attorney withdrew as counsel.[1] In response to the ALJ's January 30, 1996 dismissal order, claimant submitted a letter requesting review of the ALJ's order, alleging that he disagreed with the ALJ's decision. We have generally interpreted a claimant's "post-hearing" correspondence after a hearing request has been dismissed for failure to appear as a motion for postponement of the scheduled hearing. In those cases, where the ALJ did not have an opportunity to rule on the motion, we have remanded to the ALJ for consideration of the motion. See Randy L. Nott, 48 Van Natta 1 (1996); Olga G. Semeniuk, 46 Van Natta at 152.

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[1] We note that claimant's counsel did not move for a postponement or continuance prior to withdrawing as counsel. Therefore, we do not address whether the ALJ should have postponed or continued the hearing pursuant to OAR 438-006-0081.

Here, unlike the circumstances presented in Semeniuk and other cases in which we have interpreted "post-hearing" correspondence as a motion for postponement, claimant has not offered any reason for his failure to attend the scheduled hearing. Instead, claimant merely alleges that he disagrees with the ALJ's decision to dismiss his hearing request. Under these circumstances (where the claimant offers no reason for his failure to attend the scheduled hearing), we decline to remand to the ALJ for further proceedings regarding claimant's reasons for failing to attend the scheduled hearing.[2]

Therefore, having found no compelling reason to remand to the ALJ, we now proceed with a determination of whether the ALJ properly dismissed claimant's request for hearing. The ALJ found that claimant abandoned his claim because of his unjustified failure to appear at the scheduled hearing. OAR 438-006-0071(2). Based on this record, claimant has provided no reason for his failure to attend the scheduled hearing. Under such circumstances, we find that no "extraordinary circumstances" were present to justify postponement of the scheduled hearing. Accordingly, we conclude that the ALJ correctly dismissed claimant's hearing request as having been abandoned. Id.

ORDER

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

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[2] We recognize that in other cases we have determined that the "compelling reason" to remand in cases where a claimant makes a "post-hearing" request for remand is the Board's often-stated policy that the ALJ is the most appropriate adjudicator to consider a claimant's explanation for failure to appear at hearing and to determine whether "postponement" is warranted. E.g., David J. Gordon, 48 Van Natta 1450 (1996); Randy L. Nott, 48 Van Natta at 1. As we explained in Gordon and similar cases, to do otherwise could result in our making a determination of a motion for postponement on less than all the relevant facts. However, in those cases in which we have remanded, the claimant has provided at least some explanation for his or her failure to attend the scheduled hearing. In contrast, claimant, here, has provided no explanation whatsoever for his failure to attend the scheduled hearing. Claimant has merely indicated he disagreed with the ALJ's decision. Under these circumstances, we do not find a "compelling" reason to remand. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); David J. Gordon, 48 Van Natta at 1450.

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

On December 6, 1996, we issued an Order on Reconsideration that: (1) republished our October 11, 1996 order which affirmed an Administrative Law Judge's (ALJ's) order finding Wausau Insurance Company (Wausau) responsible for claimant's L4-5 disc condition; and (2) awarded claimant an insurer-paid attorney fee under ORS 656.382(2). Contending that its counsel was not "served" a copy of our Order on Reconsideration, Wausau seeks abatement and republication of that order. Inasmuch as our order has become final, we deny Wausau's request.

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).

We may republish an order if we find that we failed to mail a copy of our prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(21). An attorney is not a party. Berliner v. Weyerhaeuser Company, 92 Or App at 266; Lee R. Jones, 48 Van Natta 1286, 1287 (1996); Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989).

Here, Wausau asserts that its counsel was not timely "served" with a copy of our December 6, 1996 order. Yet, the determinative question in analyzing the finality of a Board decision is whether the order was mailed to all parties to the proceeding. Berliner v. Weyerhaeuser Company, 92 Or App at 266-67; Lee R. Jones, 48 Van Natta at 1287. An examination of this record answers that question in the affirmative.

Our December 6, 1996 order represents, and the Board's file confirms, that copies of the order were mailed to all parties, as well as to their representatives, at their listed addresses. In fact, Wausau's counsel verifies that two copies of our order were found in Wausau's claim file.[1] Finally, the Board's file does not contain copies of our order returned as undeliverable. Such circumstances persuade us, at a minimum, that copies of the Board's December 6, 1996 order were mailed to all parties to the proceeding. See Lee R. Jones, 48 Van Natta at 1287.

In conclusion, we are persuaded that a copy of our December 6, 1996 order was properly mailed to Wausau's attorney, as well as to all parties to the proceeding. Inasmuch as our 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. See ORS 656.295(8); Berliner v. Weyerhaeuser Company, 92 Or App at 267; International Paper Co. v. Wright, 80 Or App at 444; Fischer v. SAIF, 76 Or App at 656. Consequently, we lack authority to reconsider our final order.

Accordingly, Wausau's request to abate and republish our December 6, 1996 order is denied.

IT IS SO ORDERED.

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[1] Based on its recovery of two copies of our order from its claim file, as well as a conversation between its counsel and a Board secretary, Wausau asserts that its counsel's copy of our order was improperly mailed to Wausau's address. The record does not support such a conclusion. As previously noted, our order represented that copies had been mailed to Wausau and its counsel at their separately listed addresses. Moreover, the Board's file contains notations confirming that copies of our order were mailed by "bulk mail" (which means that all daily mail for that entity/individual is placed in one envelope) to Wausau and its counsel at their respective addresses. In light of such circumstances, Wausau's recovery of its counsel's copy of our order from its claim file does not cause us to conclude that Wausau's counsel's copy was incorrectly mailed to Wausau's address. In any event, because the finality of our order is dependent on the proper mailing of copies of the decision to all parties and since an attorney is not a party, any mismailing (assuming without deciding that such an error occurred) to Wausau's counsel would not invalidate the order. Berliner v. Weyerhaeuser Company, 92 Or App at 266-67; Lee R. Jones, 48 Van Natta at 1287.

In the Matter of the Compensation of
ALFREDO MARTINEZ, Claimant
WCB Case No. 96-02021
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) declined to dismiss claimant's request for hearing for lack of jurisdiction; and (2) awarded temporary disability benefits from October 16, 1995 through January 9, 1996. On review, the issues are jurisdiction and temporary disability benefits. We agree with the ALJ that the Hearings Division had authority to resolve the dispute, but we reverse the ALJ's temporary disability award.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The employer moved to dismiss claimant's request for hearing on the basis that the ALJ did not have original jurisdiction over claimant's request for temporary disability benefits because claimant's claim had been closed by a May 7, 1996 Notice of Closure. Reasoning that, where time loss benefits are terminated while a claim is in open status, claimant's procedural entitlement to temporary disability is in issue, the ALJ declined to dismiss the request for hearing. We agree with the ALJ that claimant's request for hearing should not have been dismissed, but do so based on the following reasoning.

"Procedural" temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status. See SAIF v. Taylor, 126 Or App 658 (1994). Conversely, "substantive" temporary disability benefits are payable pursuant to ORS 656.210 and 656.212 and are determined at the time of claim closure. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992). Original jurisdiction over disputes regarding procedural entitlement to temporary disability benefits rests with the Hearings Division. ORS 656.283(1). By contrast, any challenge regarding the right to substantive temporary disability benefits must first go through the reconsideration process before a party may request a hearing. ORS 656.268(4)(e) and (5).

We have previously addressed the jurisdictional issue in Patricia R. Gade, 48 Van Natta 746 (1996). In Gade, we interpreted our decision in Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992), to require three criteria be met in order to determine whether the issue concerned procedural entitlement to temporary disability benefits and to determine whether the Hearings Division had jurisdiction over the issue. First, the hearing request must have been filed before the claim was closed. Second, the request must have raised issues regarding the carrier's "pre-closure" conduct. Third, the claimant must not be seeking a greater temporary disability award than that granted by the Notice of Closure or Determination Order. 44 Van Natta at 747.

After further consideration of this matter, we conclude that our holding in Gade was in error. To begin, the determination about whether a dispute concerns procedural or substantive temporary disability benefits is not determined by the parties' conduct. Rather, it is determined by the statutory basis under which the benefits are sought. That is, if a claimant is seeking temporary disability benefits that were owing under ORS 656.268 while the claim was in open status, the dispute concerns procedural temporary disability benefits. If a claimant is seeking benefits pursuant to ORS 656.210 or 656.212, then the dispute concerns substantive entitlement to temporary disability benefits.

In addition, the fact that a claimant is seeking procedural temporary disability benefits for the same time periods covered by a Notice of Closure or Determination does not divest the Hearings Division of jurisdiction over the matter. Entitlement to temporary disability benefits, regardless of how those benefits are characterized, is clearly a "matter concerning a claim." Therefore, the Hearings Division retains jurisdiction over the dispute pursuant to ORS 656.283(1). See also SAIF v. Roles, 111 Or App 597, 601 rev den, 314 Or 391(1992)(a tribunal has subject matter jurisdiction if it has the authority to make an inquiry into the dispute).

However, under the court's decision is Lebanon Plywood v. Seiber, supra, neither the Board nor the Hearings Division may create an overpayment of temporary disability benefits and therefore lacks the authority to award procedural temporary disability, in certain situations, after a claim has been closed by Notice of Closure or Determination Order.[1]

In sum, we conclude while the Hearings Division may lack the authority to award procedural temporary disability in certain situations, that fact does not divest the Hearings Division of jurisdiction over the dispute. To the extent that Patricia R. Gade, supra, can be interpreted to the contrary, it is disavowed.

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[1] For instance, procedural temporary disability benefits that are owing pursuant to ORS 656.313 may be awarded regardless of whether or not a claimant's claim has been closed. See Anodizing, Inc. v. Heath, 129 Or App 356 (1994); Roseburg Forest Products v. McDonald, 116 Or App 448 (1992).

Temporary Disability Benefits

The ALJ found that claimant was procedurally entitled to temporary disability benefits and directed the employer to pay temporary total disability benefits from October 16, 1995 through January 9, 1996. We disagree.

Here, claimant's claim was closed by the May 7, 1996 Notice of Closure which awarded temporary disability benefits from January 4, 1995 through July 19, 1995. Thus, claimant's substantive entitlement to temporary benefits prior to the date of the Notice of Closure was determined to end on July 19, 1995. As discussed above, neither the Hearings Division nor the Board has the authority to impose a procedural overpayment by awarding temporary disability beyond that date. Lebanon Plywood v. Seiber, supra. Rather, claimant's remedy is to request reconsideration of the Notice of Closure pursuant to ORS 656.268. Accordingly, we reverse that portion of the ALJ's order which awarded temporary disability benefits from October 16, 1995 through January 9, 1996.

ORDER

The ALJ's order dated June 7, 1996 is reversed. The ALJ's temporary disability award, including the "out-of-compensation" attorney fee, is reversed.

Board Member Moller specially concurring.

I agree with the majority's conclusion that this dispute raises a "matter concerning a claim" over which the Hearings Division has jurisdiction. I further agree with the majority that neither the Hearings Division nor the Board has the authority to grant the relief claimant requests in this case. However, for the reasons set forth in my dissent in Kenneth P. Bundy, 48 Van Natta 2501 (1996), I disagree with the majority's discussion regarding the statutory basis for "procedural" and "substantive" temporary disability benefits.

January 28, 1997 Cite as 49 Van Natta 69 (1997)

In the Matter of the Compensation of
MARK TOTARO, Claimant
WCB Case No. 95-12137
ORDER ON REVIEW (REMANDING)
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

Claimant filed a request for hearing on October 31, 1995. The matter was initially set for hearing on January 30, 1996, but was postponed. After another postponement, the matter was rescheduled for hearing on October 4, 1996.

Claimant did not appear in person or through an attorney when the hearing was convened on October 4, 1996. On October 30, 1996, the ALJ issued an order dismissing claimant's hearing request pursuant to OAR 438-006-0071(2), on the ground that claimant had abandoned his request for hearing.

Thereafter, claimant requested Board review of the ALJ's order, asserting that the reasons set forth in the dismissal order were "erroneous" and that injustice would result if the ALJ's order was not reversed.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or his attorney fail to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). We have previously held that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. William E. Bent II, 48 Van Natta 1560 (1996); Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992).

Here, in response to the ALJ's October 30, 1996 dismissal order, claimant submitted a letter requesting review of the ALJ's order, alleging that the reasons for dismissing his hearing request were "erroneous," and that injustice will occur if the ALJ's order is not reversed. In light of these circumstances, we interpret claimant's correspondence as a motion for postponement of the scheduled hearing. Inasmuch as the ALJ did not have an opportunity to rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Randy L. Nott, 48 Van Natta 1 (1996); Olga G. Semeniuk, supra.

In determining that remand is appropriate, we emphasize, as we have in similar cases, that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have previously explained, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Olga G. Semeniuk, supra.[1]

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

IT IS SO ORDERED.

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

In the Matter of the Compensation of
DAVID J. WESTCOTT, Claimant
WCB Case No. 96-03720
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's medical services claim for his current right ankle condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Dr. Hess, treating physician, relied on an accurate history that claimant had been suffering right ankle instability, since the 1989 injury. By the time claimant sought treatment in 1995, this instability was increasingly accompanied by swelling and pain. (See O&O p.2).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant met his burden of proving that his 1989 compensable injury remains a material cause of his current need for right ankle treatment.

The employer argues that claimant is subject to the "major contributing cause" standard of proof because this is a claim for a consequential condition, not a claim for continuing medical services under an accepted claim. We need not resolve this "standard of proof" issue because we find the claim compensable under either standard of proof, based on the opinion of Dr. Hess, treating physician.

Claimant compensably strained his right ankle in 1989. His ankle has not felt the same since the injury. Sometimes it feels "loose," and sometimes it just doesn't "feel right." (Tr. 7, 15). By 1995, claimant's right ankle bothered him regularly, especially when he wore low topped summer shoes, rather than tightly laced work boots. Claimant has suffered no right ankle injuries other than the 1989 accepted injury.

Based on this history and clinical and radiological findings, Dr. Hess, treating physician, opined that claimant's 1989 injury directly caused claimant's current condition.[1] Dr. Hess' opinion is expressly based on an accurate history regarding claimant's continuing and increasing instability problems, his clinical presentation, the lack of other contributing causes, and a Telos radiological examination (which revealed a difference between claimant's left and right ankles). (Exs. 13, 16; see Exs. 10, 11, 11A). We find Dr. Hess' opinion persuasive, because it is well reasoned and based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986).

The only other medical evidence concerning causation is provided by Dr. Mayhall, who examined claimant at the employer's request. Dr. Mayhall relied on a history that claimant's right ankle problems began "spontaneously," with no disability of impairment after the 1989 injury healed, until 1995. (Exs. 14-1, -2). Dr. Mayhall found no evidence that the 1989 injury contributed to claimant's current right ankle problems and "no evidence that claimant had any problem from [the 1989 injury] or any ongoing problems for some 5 1/2 years. It would be unlikely for someone with ankle or subtalar instability to develop such spontaneously 5 to 6 years after an ankle sprain, which was described as completely healing without sequelae." (Ex. 14-5).

We find Dr. Mayhall's opinion unpersuasive, because it is based on an inaccurate history that claimant had no right ankle problems for 5 1/2 years following the 1989 injury. See Somers v. SAIF, supra.

Accordingly, based on Dr. Hess' opinion, we conclude that claimant has established that his compensable work injury is the major contributing cause[2] of his claim for medical services. See ORS 656.005(7)(a) & (A); ORS 656.245(1); Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (No incantation of "magic words" or statutory language is required).

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

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[1] When Dr. Hess first examined claimant on October 12, 1995, he reported claimant's history following the 1989 injury of having "had significant instability in his right ankle which results in swelling and pain. He has had minor sprains, now approximately one per week. For the last month or two, it has become enough problematic for him to seek care, which he avoids at all costs." (Ex. 10-1). (There was no evidence of swelling at the time of Dr. Hess' initial examination.) In our view, Dr. Hess' history is entirely consistent with claimant's testimony regarding his right ankle condition since 1989. (See Tr. 7, 15).

[2] In reaching this conclusion, we note that Dr. Hess considered and ruled out potential contributing causes other than claimant's work injury. See Dietz v. Ramuda, 130 Or App 397 (1994).

ORDER

The ALJ's order dated July 31, 1996 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
BRAD E. CARLSON, Claimant
WCB Case Nos. 95-07104 & 95-02028
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that upheld the SAIF Corporation's denial of his occupational disease claim for degenerative disc disease of the low back. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact from page 2 of the ALJ's order through the bottom of page 5.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. At age 15, claimant developed some lower back pain for which he was treated by a chiropractor. Claimant was treated two times a week for several weeks and then his symptoms cleared up. Years later, while working in a warehouse for a beer distributor, claimant had an episode of immediate back pain after rapidly lifting beer kegs overhead. Claimant was treated by a chiropractor for a few days. Claimant believes he probably filed a workers' compensation claim for the incident.

Thereafter, claimant had occasional sporadic discomfort with excessive lifting. Claimant remained physically active during this time and had no particular problem until late May 1991. At that time, claimant was doing paving work for the employer and was part of a two man crew. Claimant was required to lift a vibrating compactor in and out of the back of a pickup to patch pavement. Over a two or three hour period, claimant noted progressive low back pain and pain down the left lower extremity which progressed and was very debilitating the next day. Prior to this incident, claimant had not experienced any leg pain. Claimant sought treatment from Dr. Lanway, a chiropractor. After claimant did not improve, he was referred to Dr. Bernstein.

Dr. Bernstein reported that claimant had had low back pain going back at least 20 years which was non-radiating. Dr. Bernstein concluded claimant had a probable simple lumbar strain. Claimant was treated with Feldene and muscle relaxants. When claimant did not respond to treatment, he was seen by Dr. Holbert.

Dr. Holbert reported that claimant had been receiving chiropractic treatment two to three times a year for the preceding 20 years. Claimant described lumbosacral pain with some dull pain down the left leg aggravated by standing. Dr. Holbert felt claimant had four lumbar-type vertebrae with some slight posterior displacement of L5 on the sacrum and a long-standing rotoscoliosis in the lumbar spine. Dr. Holbert felt the disc spaces were well maintained. Dr. Holbert recommended an MRI of the lumbar spine.

An MRI interpreted by Dr. Shininger showed a small midline herniated disc at L5-S1 and also some degenerative changes in the disc space at L5-S1. Dr. Holbert felt that the degree of desiccation was not out of line for claimant's age. Claimant was treated with work hardening and released for work on July 22, 1991.

On November 18, 1992, claimant was injured at work while stepping out of a grader. Claimant struck his low back on a steel plate on the back of the grader blade. Claimant did not immediately file a claim or seek treatment.

On January 5, 1993, claimant experienced precipitous low back pain while flexing forward and reaching up to hang a 15 pound tool box on the bucket of a bucket truck. Claimant filed a claim for the November 18, 1992 injury and was seen by Dr. Bert on January 18, 1993. Dr. Bert's impression was of subacute and chronic disc syndrome, most likely L5-S1. An MRI was repeated and was interpreted as showing L5-S1 disc desiccation with mild central lateral disc bulging. No significant disc herniation or spinal stenosis was noted. On February 8, 1993, Dr. Bert reviewed the spectrum of treatment with claimant, including lumbar fusion. Claimant saw Dr. Kitchel for a second opinion.

Claimant was examined by Dr. Donahoo on behalf of SAIF in March 1993.

On April 14, 1993, SAIF accepted claimant's November 18, 1992 injury claim as a nondisabling "temporary exacerbation of symptoms of pre-existing degenerative disc disease at L5-S1 without worsening of the underlying pathology."

On January 16, 1995, SAIF issued a partial denial of claimant's degenerative disc disease on the basis that claimant's November 1992 compensable injury was not the major contributing cause of claimant's degenerative disc disease. On April 20, 1995, claimant filed a "new" occupational disease claim for his degenerative disc disease. SAIF denied the new occupational disease claim on June 8, 1995, on the ground that claimant's work activity was not the major contributing cause of the development of his degenerative disc disease. Claimant requested a hearing on the occupational disease denial.

The ALJ found that claimant had not established a pathological worsening of his preexisting degenerative disc condition. On this basis, the ALJ found that claimant had failed to establish compensability of the preexisting degenerative disc disease under ORS 656.802.

On review, claimant contends that we should find, based on the opinion of his attending physician, Dr. Bert, that claimant's work activities were the major contributing cause of a pathological worsening of his degenerative disc disease.

In response, SAIF argues that claimant has failed to establish a pathological worsening. Additionally, SAIF argues that, even if claimant has established a pathological worsening, he must also prove that his work exposure was the major contributing cause of the combined condition under ORS 656.802(2)(b) and Dan D. Cone, 47 Van Natta 2220 (1995).

Because this occupational disease claim is based on a worsening of claimant's preexisting degenerative disc disease, claimant must prove that his employment conditions were the major contributing cause of the combined condition and pathological worsening of his degenerative disc condition. ORS 656.802(2)(b); Dan D. Cone, supra.

Claimant argues that, since his preexisting degenerative disc disease was not a previously accepted condition, Cone is distinguishable and he need not establish that his work activities are the major contributing cause of the combined condition. We disagree with claimant's interpretation of Cone.

The Cone analysis is based on ORS 656.802(2)(b) which 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."

In Cone, a previous compensable back injury was the preexisting condition. However, the statute contains no language limiting its application to cases where the preexisting condition has been previously accepted. Based on its plain language, ORS 656.802(2)(b) applies to all occupational disease

claims which are based on the worsening of a preexisting condition and not merely those in which the preexisting condition has been accepted. Accordingly, because this occupational disease claim is based on a worsening of a preexisting condition, claimant must satisfy the requirements of ORS 656.802(2)(b) in order to establish compensability.

Three physicians addressed the cause of claimant's degenerative disc disease. Dr. Bert, orthopedist, treated claimant for his degenerative disc disease. In January 1994, Dr. Bert opined that claimant had reached a pre-injury level of discomfort and that claimant's continuing need for treatment was for the preexisting degenerative disease (as opposed to the November 1992 injury). (Ex. 22). In May 1995, Dr. Bert concurred that claimant had a preexisting degenerative disc disease and that his current disability and need for treatment was his preexisting condition rather than his work incident. (Ex. 29A). In August 1995, Dr. Bert agreed that claimant's employment activity (including the incidents in May 1991, November 1992 and January 1993) was the major contributing factor in causing his degenerative disc disease. (Ex. 30-2). On August 24, 1995, Dr. Bert agreed that claimant's degenerative disc disease was developmental and not congenital. Dr. Bert felt that claimant had some previously existing degenerative disc problems prior to his injury. He opined that the injury was a major aggravating factor, but not the sole factor in claimant's degenerative disease. He indicated that claimant's November 1992 injury exacerbated claimant's preexisting back problem and that the exacerbation had resolved and claimant's continuing symptoms were related to a preexisting degenerative disease. (Ex. 33).

At his deposition, Dr. Bert indicated that claimant's degenerative condition preexisted his work for the employer. (Ex. 34-10). Dr. Bert stated that claimant's heavy work made claimant's preexisting disc disease symptomatic and perhaps escalated worsening, but there was no objective way to quantify the worsening caused by the work activities as opposed to that caused by the preexisting degenerative disc disease. (Ex. 34-9 to 11). However, Dr. Bert gave his opinion that claimant's work activities (as opposed to the natural aging process) were the major contributing factor in the worsening of claimant's degenerative disc disease. (Ex. 34-21, 26). Although he stated he could not objectively quantify the amount of contribution from claimant's work activities, Dr. Bert explained that his opinion regarding causation was based on his experience in treating patients over the years. (Ex. 34-27). Dr. Bert also stated that claimant's symptoms of radiation of pain into his leg was an indication of worsening of the degenerative disc disease and that x-rays of claimant's spine show that there probably was increased degenerative disc disease between 1991 and 1993. (Ex. 34-25 to 26).

Dr. Kitchel is a consulting physician. He opined that any surgical treatment at the L5-S1 level would be for the underlying degenerative condition. (Ex. 28). Dr. Kitchel did not believe that claimant's work activity had led to any independent worsening of the underlying disc degeneration. (Ex. 32). Dr. Kitchel opined that claimant's work precipitated his symptoms. However, Dr. Kitchel did not believe that repetitive amounts of small trauma, such as claimant experienced, was capable of accelerating degenerative disc disease. (Ex. 35-15). In support of his opinion, Dr. Kitchel cited a study involving identical twins which indicated that disc degeneration was more related to genetics than to occupation. (Ex. 35-13).

Dr. Donahoo, who examined claimant on behalf of SAIF, also gave an opinion regarding claimant's degenerative disc disease. He opined that the preexisting condition was not the major cause and that the majority of claimant's current need for treatment was related to the three incidents at work in May 1991, November 1992 and January 1993.

We give greater weight to the opinion of the treating doctor, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to rely on Dr. Bert's opinion. Dr. Bert's opinion establishes that claimant's work activities were the major contributing cause of the combined condition (the worsened degenerative disc disease). Although he initially stated it was impossible to quantify the amount of contribution claimant's work activities had on claimant's degenerative disc disease, Dr. Bert gave his opinion based on his experience in treating patients with degenerative disc disease. Moreover, in giving his opinion regarding a pathological worsening, Dr. Bert relied on objective evidence of a worsening of the underlying degenerative disc disease. In this regard, Dr. Bert indicated that x-rays established that claimant's degenerative condition had pathologically worsened. Dr. Bert also cited claimant's radiating pain into the leg as a further indication that the underlying degenerative disease had pathologically worsened. In addition, Dr. Bert attributed the pathological worsening to claimant's work activities.

SAIF argues that Dr. Bert gave conflicting opinions regarding causation because he opined that claimant's need for treatment was no longer related to the 1992 compensable injury, but was instead now related to the degenerative disc condition. Whether claimant's treatment is related to a prior compensable injury is a different inquiry from whether claimant's condition is related to his years of work activities for an employer. Thus, Dr. Bert's opinion concerning claimant's 1992 injury is not inconsistent with his opinion regarding claimant's occupational disease claim.

Accordingly, based on this record, we conclude that claimant has established compensability of his occupational disease claim for worsened degenerative disc disease.

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 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 July 9, 1996 is reversed. SAIF's denial of claimant's occupational disease claim is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by SAIF.

January 29, 1997 Cite as 49 Van Natta 75 (1997)

In the Matter of the Compensation of
LADONNA EAGLETON, Claimant
WCB Case No. 96-03411
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, 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: (1) affirmed an Order on Reconsideration that awarded 4 percent (7.68 degrees) scheduled permanent disability for loss of use or function of the right arm; and (2) did not award scheduled permanent disability for the left arm. The insurer moves to strike portions of claimant's reply brief and attachments regarding a medical table and an anatomical photograph not admitted at the hearing. On review, the issues are motion to strike and extent of scheduled permanent disability.

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

Motion to Strike

In her reply brief, claimant argues that she is entitled to an impairment rating for bilaterally reduced ranges of motion in her wrists and thumbs, asserting that this impairment is due to the compensable bilateral carpal tunnel syndrome. In support of this argument, claimant references a table from the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition, and an anatomical photograph, apparently from the Color Atlas of Human Anatomy. In addition, claimant encloses copies of this table and photograph with her reply brief. In response, the insurer moves to strike references to these enclosures, contending that they are not appropriate matters for administrative notice. Claimant responds that the Board should take administrative notice of these enclosures. We agree with the insurer.

Although we have no authority to consider additional evidence not admitted at the hearing and not a part of the record, we may take administrative notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 656.295(5); Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); ORS 40.065. In Groshong, the court concluded that we erred in taking administrative notice of certain sections of the Dictionary of Occupational Titles. In reaching that conclusion, the court reasoned that:

" '[t]he vice of receiving these "facts" as evidence outside of the hearing is that it deprives petitioner of an opportunity to challenge them. Without presentation at hearing, petitioner has no way of showing that these facts--which carry much weight--either are not well founded or are not relevant to his case for some distinguishing reason.' " 73 Or App at 408 (quoting Rolfe v. Psychiatric Security Review Board, 53 Or App 941 (1981)).

Here, claimant attempts to rely on the enclosures she submits with her reply brief to establish a pivotal fact in her claim, i.e., whether the loss of range of motion in her wrists and thumbs is due to the compensable condition. To accept claimant's representation of these facts from a source not subject to confrontation and cross-examination would accomplish exactly what the court criticized in Groshong. Accordingly, we deny claimant's request to take administrative notice of the appended enclosures.[1] Consequently, we exclude the enclosures and do not consider them in determining whether claimant has met her burden of proving that the impairment is due to the compensable injury. ORS 656.214(2); 656.266.

Extent of Scheduled Permanent Disability

We agree with the ALJ that, given the apparently conflicting instructions[2] from the Department to the medical arbiter, it is unclear whether the medical arbiter rated only that impairment due to the compensable injury or rated all impairment for the body parts listed by the Department, including the thumbs and wrists. (Exs. 43b, 44). Furthermore, the medical arbiter fails to resolve this problem because the arbiter does not explicitly state that the bilateral wrist and thumb loss of range of motion is due to the compensable condition. In addition, the attending physician's closing report makes no mention of any thumb or wrist impairment.[3] Finally, given this record, we are unable to infer that this loss of range of motion is due to the compensable condition.

To be entitled to permanent disability compensation for her bilateral loss of range of motion in her thumbs and wrists, claimant must establish that the impairment is due to her compensable injury. ORS 656.214(2). If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that the impairment is due to the compensable injury. See Kim E. Danboise, 47 Van Natta 2163, 2164, on recon 47 Van Natta 2281, 2282 (1995).

Here, the second element of this test is met, i.e., the medical arbiter does not attribute the loss of range of motion impairment to causes other than the compensable injury. (Ex. 44). Compare Julie A. Widby, 46 Van Natta 1065 (1994) (where the medical arbiter made impairment findings but also provided comments pertaining to other causes of the claimant's impairment, the medical arbiter's findings were not persuasive evidence of impairment due to the injury). However, the first element is not met.[4] In other words, on this record, we are unable to determine whether the loss of range of motion in claimant's thumbs and wrist is consistent with the compensable bilateral carpal tunnel

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[1] In any event, even if we considered the enclosures, we would find that they fail to meet claimant's burden of proving that the loss of range of motion in her thumbs and wrists is due to the compensable bilateral carpal tunnel syndrome condition. ORS 656.214(2); ORS 656.266. In this regard, we do not have the medical expertise to translate general medical tables and anatomical photographs into medical causation of impairment when, as here, the medical records fail to make such a connection.

[2] The Department informed the medical arbiter that the accepted condition was bilateral carpal tunnel syndrome and instructed him to "[p]erform a complete examination of both wrists and describe any objective findings of permanent impairment resulting from the accepted injury including, but not limited to the following. . . ." (Ex. 43b) (Emphasis in original). The Department proceeded to specifically instruct the medical arbiter to "provide" ranges of motion for all fingers, both thumbs, and both wrists. Id.

[3] In his closing report, the attending physician indicated claimant had full range of motion of the [right] wrist and noted no impairment other than mild grip weakness in the right hand. (Ex. 39). The attending physician's failure to indicate any wrist or thumb impairment adds further support to our conclusion that claimant has failed to establish that any bilateral loss of range of motion in the wrists or thumbs measured by the medical arbiter is due to the compensable injury.

[4] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Kim E. Danboise, Member Haynes directs the parties to her dissenting opinion in that decision.

syndrome. Nothing in the record addresses this matter. Claimant contends that the compensable right carpal tunnel release surgery she underwent involved "slit[ting] open claimant's wrist." (Claimant's Reply Brief, page 1). However, the surgical report indicates that the incision was made "in the palm." (Ex. 23). In addition, only the right carpal tunnel was surgically released. Thus, the surgical report does not support an inference that the bilateral loss of wrist motion is due to the compensable condition.

ORDER

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

January 29, 1997 Cite as 49 Van Natta 77 (1997)

In the Matter of the Compensation of
DONA L. KLINGER, Claimant
WCB Case No. 96-01352
ORDER ON REVIEW
Crispin & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.[1] We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant failed to prove that her occupational disease for bilateral CTS was compensable, reasoning that she had failed to prove that her work activities, as opposed to her predisposing risk factors (body habitus, corrected vision), were the major contributing cause of her CTS condition. We affirm, but for different reasons.

In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of her bilateral CTS condition. ORS 656.802(2)(a); see also ORS 656.802(1)(a)(C). In addition, the existence of an occupational disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

Here, two doctors provided opinions regarding the cause of claimant's CTS condition: Dr. Neuberg, claimant's attending physician, and Dr. Fuller, who examined claimant for the employer. Dr. Neuberg opined both that the major contributing cause of claimant's CTS was sitting at her typewriter at work with her arms and wrists at a strange angle, and that claimant's work activities were not the major contributing cause of the development of her CTS. (Exs. 5D, 11, 11A).

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). Dr. Neuberg fails to explain the inconsistency in her opinions. Consequently, we do not find her opinion persuasive. Somers v. SAIF, 77 Or App 259 (1986) (we give little weight to opinions that are not well-reasoned and based on complete and accurate information).

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[1] In her brief, claimant also argues that Oregon's Workers' Compensation Law impermissibly discriminates against her under Title II of the Americans with Disabilities Act (ADA) and Article I, section 10 of the Oregon Constitution. Because there is no evidence that claimant raised this issue at hearing (Tr. 4), we decline to consider it for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Cynthia A. Watson, 48 Van Natta 609 (1996) (we will not consider an issue raised for the first time on appeal).

Dr. Fuller opined that claimant's work exposure was not the major contributing cause for the development of her CTS. (Ex. 6-7). Accordingly, based on this record, claimant has failed to prove that her work activities are the major contributing cause of her bilateral CTS condition.[2]

ORDER

The ALJ's order dated May 22, 1996 is affirmed.

[2] Because claimant has failed to prove the first element of her claim, we need not address whether the existence of her condition was established by medical evidence supported by objective findings.

In the Matter of the Compensation of
RANDY S. MOSER, Claimant
WCB Case Nos. 96-01655 & 95-09868
ORDER ON REVIEW
Max Rae, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside Liberty Northwest/Ryco Manufacturing's (Ryco's) denial insofar as it pertained to claimant's current low back condition; (2) upheld Ryco's denial insofar as it denied claimant's aggravation claim for the same condition; and (3) upheld Liberty Northwest/Oregon Weather Deck's (OWD) denial of claimant's "new injury" claim for the same condition. In its respondent's brief, Ryco contests the ALJ's $2,000 attorney fee award. On review, the issues are aggravation, responsibility and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's Americans with Disability Act ("ADA") and constitutional challenges and Ryco's attorney fee argument.

On review, claimant reasserts his ADA challenge to ORS 656.005(7)(a)(B) and 656.005(24).[1] Specifically, claimant argues that to the extent ORS 656.005(24) includes "predispositions" within the definition of "preexisting condition," the workers' compensation laws mandate consideration of "non-causal" factors into the causation analysis in violation of the provisions of the ADA.

First, we continue to adhere to our determination that the Board is not the proper forum for a claimant's ADA challenge to the workers' compensation statutes. See Lavena D. Rice, 48 Van Natta 2253 (1996) (citing Sandra J. Way, 45 Van Natta 876 (1993), aff'd on other grounds, Way v. Fred Meyer, Inc., 126 Or App 343 (1994)); Gary W. Benson, 48 Van Natta 1161 (1996).

Second, to the extent we had the jurisdiction to do so, we would conclude that claimant lacks standing to bring this particular ADA challenge. Despite claimant's argument, the "preexisting condition" at issue in this case does not involve a predisposition or susceptibility, but rather a previously diagnosed, chronic low back condition which is causally related to his current disability and need for treatment.[2] Therefore, claimant's argument (based on the theory that a "predisposition" is not a causal

[1] ORS 656.005(7)(a)(B) requires application of the "major contributing cause" standard where the claimant's compensable injury combines with a preexisting condition to cause or prolong disability or need for treatment. Under 656.005(24), a "preexisting condition" includes any injury or disease that contributes to or predisposes a worker to disability or need for treatment which precedes the onset of an initial claim or a claim for worsening under ORS 656.273.

[2] Claimant does not dispute the ALJ's determination that his current low back condition is a "combined condition" within the meaning of ORS 656.005(7)(a)(B), in that his preexisting chronic low back condition combined with his work activity (operating an electric grinder) on May 15, 1995 to cause or prolong his disability and need for treatment.

factor and may not properly be considered a "preexisting condition" under ORS 656.005(7)(a)(B)) is not relevant to the facts in this case. See Jim M. Greene, 47 Van Natta 2245 (1995) (rejecting the claimant's constitutional challenge to ORS 656.005(24) because the case involved a preexisting degenerative condition rather than an alleged predisposition).

Claimant also restates his constitutional challenges to the retroactive application of ORS 656.214(7).[3] In essence, claimant contends that by requiring that all permanent disability awards contemplate future waxing and waning of symptoms, the legislature has improperly usurped the ALJ's quasi-judicial function of determining what was and was not contemplated by a permanent disability award issued prior to the new law's enactment.

We reject claimant's constitutional arguments as moot. Assuming, without deciding, that claimant's prior (1990) permanent disability award did not contemplate any waxing and waning of symptoms of his compensable low back injury, claimant still cannot establish a compensable aggravation under ORS 656.273. As the court held in SAIF v. Walker, 145 Or App 294 (1996), the "actual worsening" standard of ORS 656.273(1) requires that there be direct medical evidence that the condition has worsened. Here, although claimant experienced a flare-up of symptoms, the medical evidence does not persuasively establish any pathological worsening of his chronic low back condition. (See, e.g., Exs. 95-4, 88-2).[4] Therefore, regardless of what was contemplated by his prior permanent disability award, claimant has not proven an actual worsening of his compensable condition.

Lastly, we uphold the ALJ's decision to award an assessed attorney fee under ORS 656.386(1). At hearing, Ryco challenged the compensability of claimant's "current condition" as well as the aggravation claim. (Tr. 2-3). Since claimant prevailed over the "current condition" aspect of Ryco's compensability denial, the ALJ properly awarded an attorney fee pursuant to ORS 656.386(1).[5]

ORDER

The ALJ's order dated June 13, 1996 is affirmed.

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[3] Claimant argues that retroactive application of ORS 656.214(7) violates Article III, Section 1 (the separation of powers clause) and Article I, Section 10 (the remedy for injury clause) of the Oregon Constitution as well as the Due Process Clause of the United States Constitution.

[4] Dr. Holmboe, who treated claimant in May 1995, reported that claimant's condition was not objectively worse, but that he experienced a symptomatic exacerbation due to work activity inappropriate for his low back condition. Similarly, Dr. Stewart, who became claimant's attending physician in July 1995, indicated that claimant's condition represented a mere waxing and waning of his underlying chronic condition.

[5] Claimant is not entitled to an attorney fee on review for defending the ALJ's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

In the Matter of the Compensation of
FRANK K. NICHOLAS, JR., Claimant
WCB Case No. 96-01029
ORDER ON REVIEW
Lawrence A. Castle, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the insurer's denial of his low back condition and L5-S1 herniated disc; and (2) did not award a penalty for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the second paragraph on page 2, we change the fifth and sixth sentences to read:

> "Claimant was assigned to clean up debris and throw it into the dumpster. The debris included a pile of 2x4 wood pieces, plywood panels and a six-foot railroad tie. (Tr. 14-17). Claimant estimated that the railroad tie weighed approximately 150 to 170 pounds. (Tr. 48). Claimant testified that when he got the railroad tie to the edge of the dumpster, he experienced "hot pain" in his low back. (Tr. 18)."

CONCLUSIONS OF LAW AND OPINION

Claimant is a laborer who has worked for the employer since 1993. Although claimant has experienced previous back pain and has been treated on occasion by Dr. Kadwell, he appeared in good health prior to November 21, 1995. On that day, claimant was doing heavy labor. He was assigned to clean up debris and throw it into a dumpster. The debris included a pile of 2x4 wood pieces, plywood panels and a six-foot railroad tie. (Tr. 14-17). Claimant estimated that the railroad tie weighed approximately 150 to 170 pounds. (Tr. 48). Claimant testified that when he lifted the railroad tie to the edge of the dumpster, he experienced "hot pain" in his low back. (Tr. 18). Claimant finished his shift on November 21, 1995.

Claimant's supervisor remembered the day they were loading the dumpster and he acknowledged that there was a railroad tie. (Ex. 18a-15). He testified that some of the items were "pretty heavy" and claimant had mentioned the strenuous nature of the work to him. (Id.)

The day after the November 21, 1995 incident, claimant awoke with a cramp that lasted all day. (Tr. 28). The pain continued down his leg as the days went on and his pain got worse.

Claimant's co-worker, Mr. Gray, who often rode to work with claimant, testified that claimant had commented on the clean-up project and had complained of a sharp pain from his back down into his leg. (Tr. 80-81). Gray told claimant he thought the cramp could be caused by dehydration. (Id.) Gray testified that claimant's pain got progressively worse and he had difficulty driving because of the pain down his leg. (Tr. 81). Gray said that claimant initially did not want to file a claim because he thought it was just a minor injury. (Tr. 83).

Claimant started using a back brace belt after the November 21, 1995 injury. (Tr. 50-51). He could not remember exactly when he started wearing it. Claimant's supervisor, however, testified that he noticed claimant wearing a support belt approximately one to two days after the lifting incident. (Ex. 18a-21). Claimant's coworker also testified that he remembered claimant wearing a back brace after he had complained about the pain down his leg. (Tr. 82).

Claimant saw Dr. Kadwell on December 5, 1995 and complained of left-sided sciatic pain of two to three weeks duration. (Ex. 1). Dr. Kadwell diagnosed an acute lumbosacral strain with left sciatica. Claimant hoped that "popping" his back would help, but instead his back pain got worse. (Tr. 28-29). In the past, when claimant had back pain, he had his back "popped" and the soreness would be gone within a day or two. (Tr. 29).

Claimant testified that he had trouble getting out of bed on December 12, 1995 because of back pain. (Tr. 44). Claimant did not make it to work that day. (Id.) Shortly after that, claimant testified that his supervisor offered him a workers' compensation claim form. (Id.) Claimant told his supervisor that he did not want to file a claim. (Tr. 43-44, 52-53).

Claimant returned to Dr. Kadwell on December 27, 1995. Dr. Kadwell suspected a herniated disc, which was confirmed by an MRI. (Ex. 4). Claimant filled out an "827" form on December 27, 1995 and completed an "801" form on January 16, 1996. (Exs. 3, 7). The insurer denied his claim.

The ALJ found that all the witnesses testified in a believable manner. The ALJ noted that much of claimant's testimony was corroborated, such as the lifting of the railroad tie, the heavy work for the employer and claimant's wearing a lumbar support belt shortly after November 21, 1995. Nevertheless, the ALJ concluded that claimant was not a credible witness. The ALJ reasoned that the inconsistencies with claimant's testimony and that of his supervisor and co-worker Swayze were too damaging to claimant's credibility for him to meet his burden of proof.

Claimant acknowledges that he initially refused the claim forms and said that the claim was not work-related. He explains, however, that he did not want to file a claim because he was concerned that if he did so, he would not get rehired. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

We agree with the ALJ that most of claimant's testimony was corroborated by other witnesses. The primary inconsistency between claimant's testimony and that of his supervisor was that claimant testified that he told his supervisor that his injury was due to all the heavy lifting at work. (Tr. 44, 52). On the other hand, claimant's supervisor testified that claimant did not ever tell him he had suffered any kind of injury on the job. (Ex. 18a-11). The supervisor testified that when claimant started wearing a support belt to work, he asked him about it: "I think [claimant] said that he had strained some stomach muscles or he was cramping in the stomach area." (Id.)

Both claimant and his supervisor testified that the supervisor offered claimant a workers' compensation claim form, but claimant said he did not want one. Co-worker Swayze also testified that he heard the supervisor offer claimant a form, but claimant said that it was not job-related. (Tr. 100-101). However, the testimony between claimant and the supervisor differed as to whether claimant explained why he did not want a claim form.

Claimant testified that he declined the form, saying that he wanted to be hired back. (Tr. 43-44, 52-53). Claimant explained that he did not want to file a workers' compensation claim because a lot of companies will not hire you back if you have filed a claim. (Tr. 36). Claimant wanted to be rehired by the employer and he also felt it would help the employer's insurance coverage if he did not file a claim. (Tr. 43-44, 53).

The supervisor testified:

> "[Claimant] said he didn't want [a claim form] and that he was 100 percent sure that he didn't hurt his -- Wait a minute. He was 100 percent sure that whatever was bothering him was not related to the job, that he did not hurt himself on the job." (Ex. 18a-12).

We consider the inconsistencies with claimant's testimony to be insufficient to cast doubt on the truthfulness of his testimony concerning the occurrence of a low back injury on November 21, 1995. In any event, even if claimant lacks credibility in certain matters, he can still meet his burden of proof if the remainder of the record supports his version of how he was injured. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

After our de novo review of the record, we find that, although there were inconsistencies between claimant's testimony and that of his supervisor, those inconsistencies do not detract from claimant's testimony or the evidence regarding the occurrence of his injury while lifting a railroad tie on November 21, 1995, and the fact that he began wearing a lumbar support belt shortly thereafter. Claimant adequately explained why he initially did not want to file a claim and why he originally

denied that it was work-related. Claimant hoped that it was a minor injury, but instead the pain got progressively worse. (Tr. 28- 29, 44). Claimant was concerned that he would not be hired back if he filed a workers' compensation claim and he felt it would help the employer's insurance coverage if he did not file a claim. (Tr. 36, 43-44, 53). We are persuaded that claimant injured his low back at work on November 21, 1995.

The medical evidence likewise supports claimant's testimony concerning a low back injury on November 21, 1995. Dr. Kadwell's December 5, 1995 chart note did not refer specifically to a work injury. (Ex. 1). However, Dr. Kadwell subsequently agreed with a letter from claimant's attorney that said claimant told him on December 5, 1995 that he was injured at work, but he did not want to file a workers' compensation claim because he hoped the pain would respond to manipulation. (Exs. 12, 13). Dr. Kadwell's reports are consistent with claimant's testimony that he told Dr. Kadwell on December 5, 1995 that he had an on-the-job injury, but did not want to claim it. (Tr. 28, 29). Dr. Kadwell concluded that claimant's lifting activity on November 20, 1995[1] was the cause of his herniated disc and need for treatment. (Exs. 11, 13). Although Dr. Kadwell did not expressly state that claimant's injury was the "major contributing cause" of his low back condition, 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).

Claimant argues that he is entitled to penalties. We disagree.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, claimant acknowledges that he initially refused the claim forms and originally told his supervisor that the claim was not work-related. Under those circumstances, the insurer had a legitimate doubt as to its liability for claimant's low back and herniated disc condition. Claimant is not entitled to a penalty.

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

ORDER

The ALJ's order dated July 5, 1996 is reversed in part and affirmed in part. That portion which upheld the insurer's denial is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. That portion of the ALJ's order that did not award a penalty is affirmed. For services on review, claimant's attorney is awarded $4,000, payable by the insurer.

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[1] Although claimant originally reported that the injury occurred on November 20, 1995, he testified that he was mistaken about the date of the injury, which was actually November 21, 1995. (Tr. 30-33, 46-47).

In the Matter of the Compensation of
RUSSELL D. PARKER, Claimant
WCB Case No. 96-03865
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) awarded a penalty for its allegedly unreasonable failure to pay interim compensation for the period from December 20, 1995 through January 8, 1996. On review, the issues are aggravation and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last two paragraphs, with the following supplementation.

SAIF first received notice of claimant's aggravation claim on January 8, 1996.

Dr. Rosenbaum authorized no time loss for periods after January 11, 1996.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The ALJ found that claimant established a compensable aggravation, based on the opinions of Dr. Rosenbaum, treating physician, and Drs. Farris and Bald, examining physicians.

SAIF argues that claimant failed to establish that his accepted low back condition actually worsened or that his worsening is more than a waxing and waning of symptoms contemplated by his 1994 12 percent unscheduled permanent disability award for his low back. We agree that claimant has not proven that his low back condition actually worsened.

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.

Here, Dr. Rosenbaum, claimant's long-time treating physician, opined in January 1996:

> "I am not certain whether [claimant's] increase in low back symptoms one week prior to Christmas would be classified as a waxing and waning of his symptoms or a pathological worsening. His symptoms were out of proportion to his prior waxing and waning but no objective abnormalities could be ascertained. At this juncture I would classify his symptoms to have worsened past the 12% permanent partial disability awarded at claim closure." (Ex. 35-1).

In June 1996, Dr. Rosenbaum checked boxes indicating concurrence with statements that there has been no "actual worsening" of claimant's low back condition and that claimant's symptoms (associated with bending and lifting at work since claim closure) "were within expected waxing and waning of his prior impairment." (Ex. 48-2, emphasis added). We are unable to read Dr. Rosenbaum's two opinions as consistent with one another and we find no explanation in the record for their differences. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Under such circumstances, we are unable to conclude that claimant's condition worsened since claim closure.[1] Consequently, we conclude that the aggravation claim must fail.

[1] The only other medical evidence concerning claimant's post-claim closure condition is provided by Drs. Bald and Farris, who examined claimant and opined that claimant "has undergone normal waxing and waning of symptoms consistent with his previous level of disability." (Ex. 41-5).

Penalty

The ALJ assessed a penalty for SAIF's unexplained failure to pay interim compensation for the period from December 20, 1995 through January 8, 1996. We disagree.

Claimant's entitlement to interim compensation in the form of temporary disability benefits depends on when the carrier received notice or knowledge of a medically verified inability to work in a medical report which satisfies the requirements of ORS 656.273(3).[2] See Ilene M. Herget, 47 Van Natta 2285 (1995) (Where notice of an aggravation claim was legally sufficient under ORS 656.273(3), the carrier was required to respond to it by timely paying interim compensation or issuing a denial); Richard I. Stevenson, 43 Van Natta 1883 (1991).

ORS 656.273(6) provides in relevant part:

> "A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first installment of compensation due under ORS 656.262 shall be paid no later that the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening. . . ."

In this case, SAIF received claimant's "Notice of Claim for Aggravation of Occupational Injury or Disease" form on January 8, 1996. (Ex. 30-2). The form did not indicate that time loss was authorized. The only medical reports arguably constituting medical verification of claimant's inability to work under this claim are Dr. Rosenbaum's January 3, 1996 chart note and his January 22, 1996 letter to SAIF. (Exs. 29, 35).[3] Even assuming that the January 3 chart note would otherwise be sufficient to trigger SAIF's duty to pay interim compensation, it does not aid claimant's cause because the record does not reveal when SAIF received it. (See n. 3, supra). Moreover, in the January 22, 1996 letter, Dr. Rosenbaum stated, "I am not authorizing time loss past 1/11/96." (Ex. 35-2).

Accordingly, on this record, we find no notice of an aggravation claim received by SAIF before January 8, 1996 and no authorization for time loss after January 11, 1996. See SAIF v. Christensen, 130 Or App 346 (1994) (SAIF had no procedural obligation to begin paying temporary disability absent medical verification of the claimant's inability to work).

Claimant does not dispute SAIF's contention that interim compensation was paid for the period from January 8, 1996 through January 11, 1996. Under these circumstances, claimant has not proven entitlement to any compensation which was not timely paid and we cannot say that SAIF's claim processing was unreasonable. Consequently, the ALJ's penalty assessment is reversed. See Richard I. Stevenson, 43 Van Natta at 1883.

ORDER

The ALJ's order dated July 30, 1996, as amended August 6, 1996, is reversed. The SAIF Corporation's April 2, 1996 denial is reinstated and upheld. The ALJ's penalty and attorney fee awards are reversed.

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[2] ORS 656.273(3), sets out the requirements for making an aggravation claim:

> "A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative. The claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury."

[3] On June 4, 1996, SAIF apparently received a December 26, 1996 note from Dr. Jura, former treating physician, which announced that claimant would be off work until January 3, 1996 "because of his work injury." (Ex. 28A). However, because SAIF apparently received this note after the claim was denied on April 2, 1996, the note did not trigger a duty to pay interim compensation. See Gene T. LaPraim, 41 Van Natta 956, 958 (1989) ("[I]nterim compensation (as opposed to temporary disability) is never owed on an aggravation claim for any period prior to the date upon which the employer or insurer receives notice of a medically verified inability to work.").

In the Matter of the Compensation of
ELIZABETH BERNTSEN, Claimant
WCB Case No. 95-11981
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that declined to award temporary disability after April 21, 1994.[1] In addition, claimant submits a letter and a "worker copy" of an April 11, 1994 chart note. We treat claimant's additional submissions, that were not admitted into evidence at the hearing, as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and temporary disability. We deny the motion for remand and modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant submits a September 23, 1996 letter to the Board, which she characterizes as an unsolicited letter, "not approved or disapproved by [her] attorney." In this letter, claimant provides a recitation of the facts from her perspective. In addition, claimant submits a "worker copy" of an April 11, 1994 chart note. These documents were not admitted into evidence at the hearing. Since our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. See Judy A. Britton, supra.

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

Here, claimant has offered no reasons why either document was unobtainable with due diligence at the May 3, 1996 hearing. We note that claimant testified at hearing and, therefore, had the

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[1] Attaching a copy of claimant's October 10, 1996 letter to her former attorney, the insurer asserts that claimant terminated her legal representation and did not intend to appeal the ALJ's decision. Consequently, the insurer seeks dismissal of claimant's appeal.

In the interests of clarifying her intentions, we asked for claimant's response to the insurer's assertions. Thereafter, claimant confirmed that she had dismissed her attorney. (Since it does not appear that the insurer received a copy of this December 14, 1996 submission, a copy has been included with the insurer's counsel's copy of this order.) She further noted that she, not her attorney, had appealed a September 25, 1996 Determination Order. Based on this comment, the insurer contends that claimant never authorized the request for Board review of the ALJ's June 19, 1996 order. In reply, claimant acknowledges her former attorney's appeal on her behalf, as well as her desire that the Board continue with its review.

Such circumstances do not support the insurer's contention that it was not claimant's intention to appeal the ALJ's order. Furthermore, even if claimant did not initially intend to request Board review, it is apparent that her then-attorney timely appealed on her behalf. Inasmuch as her attorney was authorized to take such an action (the request was filed in June 1996, whereas her attorney's services were terminated in October 1996) and since, following the attorney's dismissal, claimant wishes to proceed with her appeal, we retain appellate authority to proceed with our review.

opportunity to present the facts from her perspective. Furthermore, the proffered evidence will not likely affect the outcome of the case.[2] Accordingly, we deny claimant's request for remand.

In addition, to the extent that claimant's September 23, 1996 letter contains further argument, we decline to consider it. The briefing schedule closed on September 17, 1996. Claimant's reply brief was timely submitted within the briefing schedule and is considered on review. We will consider supplemental authorities, but no argument after briefing is completed. See Betty Juneau, 38 Van Natta 553, 556 (1986); Debra West, 43 Van Natta 2299 (1991). Accordingly, we have not considered claimant's September 23, 1996 letter in our review.

Temporary Disability

We adopt the ALJ's reasoning and conclusions regarding the temporary disability issue with the following modification and supplementation.

Relying on ORS 656.268(3)(d) and 656.262(4)(f),[3] the ALJ concluded that Dr. Miller, attending physician, ceased to authorize temporary disability as of April 21, 1994, the date claimant failed to return to the Legacy Clinic for a follow up appointment. While we agree that Dr. Miller ceased to authorize temporary disability, for the following reasons, we find that he took this action on May 5, 1994, rather than April 21, 1994.

On April 11, 1994, claimant sought treatment for her compensable mid-back strain condition at a Legacy Health Clinic. Claimant was treated by Dr. Miller, M.D., who took claimant off work until her follow up appointment scheduled for April 15, 1994. (Ex. 1). On April 12, 1994, Dr. Herbst, the Legacy physician on duty, approved the employer's modified work offer for a job purging application files, a light duty job.[4] (Ex. 2a). On April 14, 1994, Dr. Herbst examined claimant and confirmed that she was released to light duty. Claimant was asked to return for a follow up appointment on April 21, 1994. (Ex. 2E-1). Claimant did not return for this follow up appointment.

On May 5, 1994, Dr. Miller wrote to the employer, noting the above history, and stating that he could "only assume that [claimant] is doing well at this time as she has not sought further care with our clinic." (Ex. 2E-2). Based on this comment, we conclude that Dr. Miller "ceased" to authorize temporary disability effective May 5, 1994. See Daral T. Morrow, 48 Van Natta 497 (1996) (Board found that the date of the claimant's treating physician's letter stating that it was too difficult to authorize a release from work due to the compensable injury established the date the treating physician "ceased" to

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[2] We note that, although the "worker copy" of the April 11, 1994 chart note was not admitted at the hearing, the "insurance copy" of this document was admitted as Exhibit 1. In addition, the "insurance copy" is actually a more complete document in that the "worker copy" has a large section that is "blacked out," whereas the "insurance copy" has no "blacked out" section. In the area of the form that is "blacked out" on the "worker copy," the "insurance copy" contains a history/description of claimant's complaints. (Ex. 1).

[3] ORS 656.268(3) provides that "[t]emporary total disability benefits shall continue until whichever of the following events first occurs:

"* * * * *

"(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of this chapter."

ORS 656.262(4)(f) provides, in relevant part: "[t]emporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician."

[4] We agree with the ALJ's reasoning and conclusions that the employer was not entitled to terminate temporary disability based on claimant's failure to begin this modified job offer because the employer failed to strictly comply with the requirements to provide claimant with an accurate written description of the modified job offer. ORS 656.268(3)(c); former OAR 436-60-030(12); see Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

authorize temporary disability). Therefore, we find claimant entitled to temporary total disability benefits from April 11, 1994,[5] the date Dr. Miller took claimant off work, through May 5, 1994, the date Dr. Miller found that claimant was "doing well at this time."

Claimant argues that, pursuant to ORS 656.262(4)(c) and (d),[6] she remains entitled to temporary disability from April 11, 1994 though the present because the employer did not strictly comply with the terms of those statutes. However, we find that those statutes are not applicable to the facts of this case. In the first place, even if the employer requested from Dr. Miller verification of claimant's inability to work, and that is not clear on this record, Dr. Miller was not unable to verify claimant's inability to work. Instead, as discussed above, Dr. Miller's comments establish that he ceased authorization of temporary disability as of May 5, 1994. Therefore, we do not find ORS 656.262(4)(c) applicable to the facts of this case. In addition, based on the facts of this case, we do not find ORS 656.262(4)(d) applicable. Specifically, it is not claimant's failure to appear at the scheduled follow up appointment that is the basis for termination of her temporary disability, it is Dr. Miller's cessation of authorization of temporary disability.

Finally, claimant argues that, even if her temporary disability is terminated based on Dr. Miller's May 5, 1994 letter, she is entitled to have the temporary disability reinstated as of October 27, 1994, based on Dr. Puziss' report of that date. (Ex. 4). We disagree.

On October 27, 1994, claimant sought treatment from Dr. Puziss for complaints of pain and stiffness in the upper to lower back. (Ex. 4). On examination, Dr. Puziss noted symptoms in the thoracolumbar, upper lumbar, and lumbosacral regions. His diagnosis related to claimant's back was "dorsal lumbar muscle strain." (Ex. 4-2). He noted that claimant "is capable of part time work at her regular occupation at this time up to four hours per day, regular duties." Id.

Subsequently, the employer denied claimant's mid and low back conditions. (Ex. 5). Although the mid back condition denial was subsequently set aside, claimant did not contest the low back condition denial and that denial is final by operation of law. Elizabeth B. Berntsen, 48 Van Natta 1219, 1223 (1996). Therefore, claimant's low back condition is not part of the compensable claim. Because Dr. Puziss' October 27, 1994 report identifies both low and mid back conditions in releasing claimant to modified work, without relating the modified work restriction to the accepted mid back condition, we do not find that claimant has established that the work restriction is due to the accepted injury. ORS 656.266. Accordingly, we do not find that claimant is entitled to reinstatement of temporary disability beginning October 27, 1994. Furthermore, there is no other evidence in the record that would support any additional temporary disability.

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[5] Apparently, the employer paid temporary disability benefits from April 11, 1994 through April 13, 1994, at which time it terminated these benefits in reliance on its modified job offer. (Tr. 6). In this regard, we note that the ALJ found in the "Conclusions and Opinion" portion of his order that claimant was entitled to temporary total disability when taken off work on April 11, 1994, and awarded additional temporary total disability benefits in his order language "from April 14, 1994 through April 21, 1994." Claimant disputes only the ending date of this award, not the beginning date.

[6] ORS 656.262(4)(c) and (d) provide:

"(c) 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 claimed 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.

"(d) If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment."

Finally, since our order results in increased compensation beyond that granted by the ALJ's order, claimant's attorney is allowed an "out-of-compensation" fee equal to 25 percent of the increase, provided that the total fee granted by the ALJ's order and this order shall not exceed $3,800.[7] See ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated June 19, 1996 is modified. In addition to the ALJ's award of temporary total disability benefits from April 14, 1994 through April 21, 1994, claimant is awarded temporary total benefits from April 22, 1994 through May 5, 1994. Claimant's former attorney is awarded 25 percent of the additional compensation created by this order, payable directly by the insurer to claimant's former attorney. However, the total "out-of-compensation" attorney fee granted by the ALJ's order and this order shall not exceed $3,800.

[7] Although claimant has dismissed her attorney, she does not dispute her counsel's entitlement to a fee for services rendered in this appeal.

In the Matter of the Compensation of
GARY L. DOBBINS, Claimant
Own Motion No. 97-0036M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable claim for multiple trauma of right hand with subsequent partial amputations of the index, middle and ring fingers injury. Claimant's aggravation rights expired on November 14, 1989. SAIF recommends that we deny authorization the payment of temporary disability compensation, contending that claimant's current condition does not require surgery or inpatient hospitalization.

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 interpret surgery to be an invasive procedure undertaken for a curative purpose, which is likely to temporarily disable the worker. Fred E. Smith, 42 Van Natta 1538 (1990). Injections do not qualify as "surgeries" within the meaning of ORS 656.278(1)(a). Tamera Frolander, 45 Van Natta 968 (1993); Carol Knodel, 45 Van Natta 426 (1993). Diagnostic tests, even those that are invasive in nature, if not provided as curative treatment, do not establish that a claimant has sustained a worsening of a compensable injury as prescribed in ORS 656.278(1)(a). Kenneth C. Felton, 48 Van Natta 194 (1996); Everett G Wells, 47 Van Natta 1634 (1995); Roger D. Jobe, 41 Van Natta 1506 (1989).

Although acknowledging the compensability of claimant's treatment, SAIF contends that claimant "did not require outpatient surgery or hospitalization" for his compensable condition. We disagree.

In a January 13, 1997 operative report, Dr. Worland, claimant's treating physician, noted that he performed an excision of a large sebaceous cyst of claimant's right middle finger. The procedure was performed "in the office operating room" and entailed a "transverse incision" to excise the cyst. Dr. Worland noted that the "wound was then closed with multiple simple and vertical mattress sutures." Finally, Dr. Worland indicated on a January 13, 1997 "aggravation" form that he authorized time loss for claimant and that claimant was not to use his right hand for an indefinite period of time.

On this record, we are persuaded that claimant's compensable injury worsened to the extent that he underwent an invasive procedure which would qualify as "surgery" under ORS 656.278. See Fred E. Smith, 42 Van Natta at 1538; The incision was neither a diagnostic test nor an injection

(although claimant was administered Demerol intravenously for sedation). See Kenneth C. Felton, 48 Van Natta at 194; Tamara Frolander, 45 Van Natta at 968. Furthermore, restricted use of claimant's right hand, as prescribed by Dr. Worland, is likely to temporarily disable claimant. See Fred E. Smith, 42 Van Natta at 1538. Under such circumstances, we conclude that authorization of temporary disability compensation under claimant's compensable 1984 injury claim is appropriate.

Accordingly, we authorize the reopening of claimant's claim, requiring SAIF to provide temporary total disability compensation beginning January 13, 1997, the date claimant underwent cyst excision surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICK G. MAHLBERG, Claimant
Own Motion No. 95-0313M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Estell & Smith, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requests reconsideration of our November 7, 1996 Own Motion Order, as reconsidered on December 3, 1996, which authorized the reopening of claimant's 1984 claim for the payment of temporary disability compensation beginning September 29, 1994, the date claimant underwent surgery.

The employer previously requested that this matter be held in abeyance pending its court appeal of a Director's order approving claimant's 1994 surgery as reasonable and necessary. In our December 3, 1996 order, we declined the employer's request.

With its current request for reconsideration, the employer contends that, pursuant to a December 4, 1996 Director's "Order Granting Stay of Request," we should recognize that the employer would be "irreparably harmed" by our order requiring the payment of time loss compensation in this claim. The employer further contends that "the facts of this case fit exactly within the purposes of OAR 438-012-0050(3) [sic]," and that "the Board should wait until the issue in the other proceeding [before the court] is truly final before issuing an own motion order."

On reconsideration, we continue to adhere to our previous decisions. We base our conclusion on the following reasoning.

The employer opposed reopening of claimant's own motion claim on the ground that claimant's request for L4-S1 fusion surgery was not reasonable and necessary treatment for his accepted condition. Eventually, claimant presented the surgery issue to the Medical Review Unit (MRU) of the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services (DCBS). See amended ORS 656.245(6), 656.260, 656.327 and 656.704(3). On October 6, 1995, we postponed action on the own motion matters pending outcome of the medical services dispute.

On January 10, 1996, the MRU issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute, which found that claimant's September 29, 1994 fusion revision surgery from L4 through S1 was appropriate medical treatment for claimant's compensable injury. The employer requested Director review of that decision.

In a September 23, 1996 Proposed and Final Contested Case Hearing Order, WCD Contested Case ALJ Wehrlie affirmed the MRU's January 10, 1996 order. When no exceptions were filed within the 30-day "exception" period, the ALJ's order became a final, appealable Director's order.

On November 7, 1996, we authorized the reopening of claimant's claim to provide temporary disability compensation commencing September 29, 1994, the date of claimant's surgery. We further allowed an approved attorney fee in the amount of 25 percent of the increased compensation awarded by our order, not to exceed $1,050, payable by the employer directly to claimant's attorney.

On November 21, 1996, the employer sought reconsideration. Contending that the dispute regarding the reasonableness and necessity of claimant's surgery remained unresolved pending its court appeal of the Director's decision, the employer requested postponement of our decision. The employer further contended that, under ORS 656.278, we were without jurisdiction to award compensation in this claim until the "medical services issue is resolved."

On December 3, 1996, we denied the employer's request to postpone our review pending its court appeal. Relying on OAR 438-012-0050, we found no support for holding a case in abeyance pending judicial review. Furthermore, we concluded that, under ORS 656.278 and our rules, because claimant had exhausted his available remedy under ORS 656.327 (his appeal to the Director), the reasonableness and necessity of claimant's 1994 surgery had been determined for our purposes, and it remained within our jurisdiction to award temporary disability compensation based on the surgery.

On December 4, 1996, the Director issued an Order Granting Stay Request, which stayed the enforcement of the September 23, 1996 order. The Director took this action because the employer had sufficiently shown that: (1) it would be irreparably harmed because payment for the medical bills that were ordered to be paid would not be recoverable if the employer reimburses for them but subsequently prevails in its Petition for Review before the court; and (2) there were colorable claims of error in the Director's September 23, 1996 order.

Citing the Director's stay order, the employer sought further reconsideration. The employer contended that "the Board should recognize the same harm (which the Director purportedly recognized by his "stay" order) which comes from its order requiring payment of time loss compensation," and we "should wait until the issue in the other proceeding (before the court) is truly final before issuing an own motion order."

On December 16, 1996, we abated our prior decisions and requested that claimant respond to the employer's motion. Responses have been received from the parties, and we now proceed with our reconsideration.

ORS 656.278 provides that the Board has sole authority to award temporary disability compensation to qualified injured workers whose compensable conditions have worsened requiring surgery or inpatient hospitalization. The qualified injured worker ("claimant") is eligible to receive TTD beginning the date of actual surgery or hospitalization. ORS 656.278(1)(a).

Furthermore, OAR 438-012-0050(1) provides that:

> *The Board will act promptly upon a request for relief under the provision of ORS 656.278 and these rules unless:*
>
> *(a) The claimant has available administrative remedies under the provisions of ORS 656.273;*
>
> *(b) The claimant's condition is the subject of a contested case under ORS 656.283 to 656.298, ORS 656.307 or ORS 656.308, or an arbitration or mediation proceeding under ORS 656.307; or*
>
> *(c) The claimant's request for payment of temporary disability compensation is based on surgery or hospitalization that is the subject of a Director's medical review under ORS 656.245, 656.260 or 656.327.*

Alternatively, OAR 438-012-0050(2) provides that the Board may postpone its review of the merits of the claimant's request for relief if the available remedies set forth in section (1) of this same rule could affect the Board's authority to award compensation under the provisions of ORS 656.278.

Here, as set forth in our December 3, 1996 order, because claimant has "exhausted" his available remedies under ORS 656.327 in this claim, neither ORS 656.278 nor our rules provide for holding a case in abeyance pending judicial review. Therefore, we find no authority for postponing our review of the "merits" of this case, as the aforementioned "remedies" set forth in OAR 438-012-0050(1), have been explored and exhausted.

The employer also contends that, because the Director issued an order granting the employer a stay of enforcement for the payment of the medical treatment awarded by the Director's September 23, 1996 final order, "the Board should recognize the same harm which comes from its order requiring the payment of time loss compensation." The ALJ's September 23, 1996 order is a "final order" of the Director under ORS 183.460, which determined that the 1994 surgery was appropriate. The Director's December 4, 1996 Order Granting Stay Request did not modify the Director's determination concerning the propriety of the surgery. Rather, that order merely stayed the employer's payment of costs related to claimant's 1994 surgery, pending appeal. Thus, under ORS 656.278 and our rules, we are authorized to award temporary disability compensation for a surgery which, after the Director's medical review under ORS 656.327, has been determined to be reasonable and necessary.

We note that, under ORS 656.278, temporary disability compensation authorized by the Board is reimbursable from the Reopened Claims Reserve (RCR). ORS 656.625; SAIF v. Holstrom, 113 Or App 242 (1992). Therefore, any temporary disability paid to claimant by the employer pursuant to our order issued under ORS 656.278 will likely be eligible for reimbursement from the RCR. Under such circumstances, we are not persuaded that the employer will suffer irreparable harm in paying to claimant the reimbursable compensation which we have concluded is due. By contrast, we are persuaded that claimant could suffer irreparable harm by the withholding of temporary disability pending court appeal of the Director's order. Temporary disability is wage-replacement income that may often be necessary, particularly during a lengthy appeal, to sustain the claimant's self-sufficient economic status.

In conclusion, we have authority to authorize temporary disability compensation in this claim, beginning September 29, 1994, the date claimant underwent surgery. The decision by the Director that the surgery was reasonable and necessary stands until or unless the court decides otherwise. At that time, if the court reverses or remands the Director's decision, the employer may, as we noted in our prior order, request reconsideration of our order. In the alternative, as noted in our December 3, 1996 reconsideration order, "the aggrieved party may appeal both orders to the court, who will have the opportunity to consider both decisions which involve inter-related issues." Patrick G. Mahlberg, 48 Van Natta 2405 (1996).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 7, 1996 and December 3, 1996 orders in their entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORETA C. SHERWOOD, Claimant
WCB Case Nos. 96-01702 & 95-12804
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's partial denial of her claim for tarsal tunnel syndrome. The employer cross-requests review of those portions of the ALJ's order which: (1) affirmed an Order on Reconsideration which set aside a Notice of Closure as premature; and (2) awarded a $2,800 assessed attorney fee for claimant's counsel services concerning the employer's appeal of the Order on Reconsideration. Subsequent to the completion of the briefing schedule, claimant submitted further medical evidence and requests that the matter be remanded for the admission of that evidence. The employer has responded, objecting to such a request. On review, the issues are remand, compensability, premature closure, and attorney fees. We remand.

The ALJ upheld the self-insured employer's partial denial of claimant's claim for tarsal tunnel syndrome. Claimant has submitted further medical evidence and requested that the matter be remanded for the admission of that evidence. The proffered evidence consists of September 1996 chartnotes from Dr. Woll; a September 14, 1996 letter from Dr. Woll to Dr. Jones; a September 20, 1996 operative report from Dr. Jones; follow-up chartnotes from Dr. Jones beginning in October 1996; and a November 19, 1996 letter from Dr. Weller to claimant's counsel. The proffered evidence, all of which was generated "post-hearing," concerns claimant's September 1996 left foot tarsal tunnel release surgery.

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

Inasmuch as the proffered evidence relates to surgery on claimant's left foot, the evidence does concern disability. Moreover, since the surgery did not take place until some four months after the hearing, the evidence submitted by claimant was not obtainable, with due diligence, at the time of hearing. See Wonder Windom-Hall, 46 Van Natta 1619, 1620 (1994), rev on other grounds Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996) (Evidence derived from a "post-hearing" surgery not obtainable with due diligence). The remaining question is whether the proffered evidence is reasonably likely to affect the outcome of the case.

One of the issues presented in this case was whether claimant's tarsal tunnel condition is compensable. In determining that this condition was not compensable, the ALJ questioned whether claimant suffered from tarsal tunnel syndrome, reasoning that the opinion of Dr. Weller, who diagnosed that condition, was less persuasive than other medical opinions in the record. In addition, the ALJ concluded that Dr. Weller did not have an accurate history of the July 2, 1994 work incident. Because the ALJ's opinion is in part based on the conclusion that Dr. Weller's diagnosis of tarsal tunnel syndrome was not supported by the medical record, we conclude that the proffered evidence which concerns tarsal tunnel syndrome is reasonably likely to affect the outcome of the case, particularly since Dr. Jones' post-operative diagnosis was "tarsal tunnel syndrome." In light of this conclusion, we find a compelling reasoning to remand. See Parmer v. Plaid Pantry #54, 76 Or App 405 (1985).

Finally, because the premature closure and attorney fee issues may be affected by the decision concerning the compensability of claimant's left foot condition, we cannot proceed to address those issues. Consequently, those matters are also remanded to the ALJ to await submission of the aforementioned additional evidence regarding the compensability issue.

Under such circumstances, we conclude that the case should be remanded to ALJ Stephen Brown for further development. Accordingly, the ALJ's order is vacated and this matter is remanded to the ALJ to reopen the record for the admission of additional evidence from the parties regarding claimant's surgery and the resulting findings regarding the cause of claimant's left foot condition. The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order reconsidering all issues raised at hearing.

IT IS SO ORDERED.

January 30, 1997 Cite as 49 Van Natta 93 (1997)

In the Matter of the Compensation of
DONALD N. VATORE-BUCKOUT, Claimant
WCB Case Nos. 96-03398 & 95-13837
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that assessed a penalty for an allegedly unreasonable denial. In its respondent's brief, Mid-Century Insurance Co., on behalf of employer Dan's Subaru, requests dismissal of SAIF's request for review contending that SAIF neglected to serve a copy of the request on Mid-Century or their attorneys. In his respondent's brief, claimant seeks sanctions against SAIF for an allegedly frivolous appeal. On review, the issues are dismissal, penalties, and sanctions. We deny the motion to dismiss and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second ultimate finding of fact, and with the following supplementation:

Claimant was employed as a laborer for SAIF's insured, Metro Tire & Auto Repair. Metro required that claimant use some of his own tools, which were kept on the employer's premises. During the evening of October 30, 1995, claimant spoke on the telephone with an assistant manager of the employer and the two mutually agreed that claimant's employment was terminated. That same evening, claimant spoke with a supervisor of Dan's Subaru, and accepted an offer of employment to begin the following day, October 31, 1995.

On the morning of October 31, claimant returned to Metro to tell his supervisor he was departing for another job and to retrieve his personal tools from Metro's premises. While removing his tools, claimant experienced the sudden onset of low back pain. Claimant then drove to Dan's Subaru, where he unloaded his tools with the assistance of another Dan's Subaru employee.

Claimant's back continued to hurt and, on November 2, 1995, he sought treatment. Dr. Braddock diagnosed an acute lumbosacral strain and authorized time loss. On November 15, 1995, claimant made a claim for a low back injury with Dan's Subaru.

Dan's Subaru's insurer, Mid-Century, obtained a statement from claimant on November 20, 1995, and issued a denial on November 21, 1995. On January 25, 1996, Mid-Century issued an amended denial, denying responsibility and advising claimant that his injury may be related to his employment with Metro.

On March 22, 1996, SAIF issued a compensability and responsibility denial on Metro's behalf. On May 23, 1996, SAIF denied that claimant was a subject employee of Metro at the time of his injury.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

In its respondent's brief, Mid-Century moves to dismiss SAIF's request for review, contending that SAIF did not serve Mid-Century with a copy of its request for review or give Mid-Century actual knowledge of the appeal as required by ORS 656.295. In response, SAIF concedes it did not serve Mid-Century with a copy of the request for review, but argues that Mid-Century nevertheless had actual knowledge of the appeal within the statutory time period. We conclude Mid-Century had timely actual notice and deny the motion to dismiss.

An ALJ's order is final unless, within 30 days after a copy of the order is mailed to the parties, one of the parties requests 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 failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); a non-served party's actual notice of the appeal within the 30-day period, however, will save the appeal. See Zurich Ins.Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance v. King, 63 Or App 847 (1983). All parties to the ALJ's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley` v. Sacred Heart Hospital, 113 Or App at 237.

In this case, the ALJ's order was mailed on August 2, 1996. SAIF requested review on August 28, 1996, but did not serve a copy of the request for review on Mid-Century. On August 30, 1996, the Board mailed an Acknowledgment of Request for Review to all parties and their counsel, including Mid-Century. In order to save SAIF's appeal, we must conclude that Mid-Century received actual notice of the appeal by Tuesday, September 3, 1996.[1]

In its reply brief, SAIF represented that it received its copy of the Board's acknowledgment letter on September 3, 1996. No representation has been made that Mid-Century did not receive its copy of the notice on this same date.[2] The Board's acknowledgment letter was mailed Friday, August 30, 1996, five days before the statutory period expired.[3] Given SAIF's representation that it received the notice on Tuesday, September 3, 1996, and in the absence of evidence or a representation from Mid-Century or its counsel that it did not receive our acknowledgment letter within the statutory period, we conclude that it is more probable than not that Mid-Century did receive actual notice of SAIF's request for review within the statutory time period. See, e.g., John D. Francisco, 39 Van Natta 332 (1987) (finding it more probable than not that all parties received the acknowledgment letter within the statutory period where letter was mailed 7 days before the statutory period expired); Grover Johnson, 41 Van Natta 88 (1989) (concluding that it is more probable than not that all parties received timely actual notice of request for review where Board's acknowledgment was mailed to all parties to the hearing some 3 days before the expiration of the 30-day appeal period); Cf. Argonaut Insurance v. King, supra, (claimant's appeal not perfected where evidence established acknowledgment letter was received by the insurer more than 30 days after the referee's order was mailed). Consequently, we deny Mid-Century's motion.

Penalties

The ALJ found that SAIF did not have a reasonable doubt about claimant's subjectivity or the compensability of his injury at the time of its denials and assessed a penalty. In addition, the ALJ determined that there was no evidence to support a finding that SAIF conducted a reasonable investigation before denying the claim.

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[1] Where the 30th day after the mailing of the ALJ's order falls on a Sunday or, as in this case, federal holiday (i.e., Labor Day, September 2, 1996), the final day for perfecting the appeal is the next day in which mail is delivered. See e.g., Robert K. Warren, 47 Van Natta 84 (1995); Anita L. Clifton, 43 Van Natta 1921 (1991).

[2] Mid-Century contends that SAIF did not give it actual notice of the appeal but does not discuss when or whether it received the notice from the Board.

[3] As noted above, we recognize there was no mail delivery on Sunday, September 1 and Monday, September 2, 1996.

On review, SAIF contends it had a reasonable doubt about the compensability of claimant's low back strain because there was insufficient evidence that the injury arose in the course of his employment with SAIF's insured and because it believed he was not a subject worker at the time of his injury. In addition, SAIF contends that the record does not support the ALJ's finding that it made the decision to deny the claim without any independent investigation. After considering the record, we agree with SAIF that no penalty is warranted.

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).

Claimant alleged the injury occurred on October 31, 1995, the day after his employment with Metro had supposedly terminated. Claimant initially filed his claim against Mid-Century's insured, asserting that the injury arose in the course and scope of his new employment (which began on October 31, 1995). SAIF was advised of the claim only after Mid-Century denied responsibility and alleged that claimant's injury was related to his employment for SAIF's insured (Metro). Claimant did not report any injury the morning of October 31, 1995 nor did he report it when he returned to Metro several weeks later as a customer.

Although the ALJ was persuaded that the injury occurred on Metro's premises and that claimant was a subject worker of Metro on the day of his injury, we conclude that SAIF had a reasonable doubt regarding its liability given the circumstances of the injury[4] and the status of the subject employer law. Indeed, at the time of the denial, the legal question of whether an employee, who is injured on the employer's premises while loading up his personal effects after terminating his employment, is a subject worker was unresolved in this jurisdiction.

Consequently, unlike the ALJ, we conclude that SAIF had a legitimate doubt about its liability for claimant's low back injury. Accordingly, the ALJ's penalty assessment is reversed.

Considering our reversal of the ALJ's penalty award, it necessarily follows that SAIF's appeal is not frivolous. Therefore, sanctions under ORS 656.390 are not warranted.

ORDER

The ALJ's order dated August 2, 1996 is affirmed in part and reversed in part. That part of the order that assessed a penalty against the SAIF Corporation is reversed. The remainder of the order is affirmed.

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[4] The fact that an injury occurred on the employer's premises satisfies only one element of the course and scope test. A claimant must still prove a causal connection between the injury and employment from a medical and legal standpoint. See Andrews v. Tektronix, Inc., 323 Or 154, 161 (1996); Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994).

In the Matter of the Compensation of
EDWARD E. CRUISE, Claimant
WCB Case No. 96-03890
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and penalties or attorney fees. We affirm.

FINDINGS OF FACT

We adopt the second, third, fourth and fifth paragraphs of the ALJ's "Discussion."

CONCLUSIONS OF LAW AND OPINION

We adopt the last paragraph of the ALJ's "Discussion," with the following supplementation.

The ALJ dismissed claimant's hearing request regarding assessment of a penalty or attorney fee for the insurer's allegedly unreasonable delay in providing vocational assistance. The ALJ cited Danell L. Sweisberger, 48 Van Natta 441 (1996) (Board lacks jurisdiction to award penalties or attorney fees arising from vocational assistance matters), and Donald D. Paul, 47 Van Natta 1946 (1995) (same).

On review, claimant contends that the Hearings Division retained jurisdiction to assess a penalty or attorney fee because his substantive entitlement to vocational assistance was not resolved by a contested case hearing. See ORS 656.385(1)-(4). We disagree.

In Rick G. Lundstrom, 48 Van Natta 2252 (1996), we rejected the claimant's contention that the Director had not acquired jurisdiction over penalty issues arising under ORS 656.340 because there had not been a final contested case order by the Director. We reasoned that, under ORS 656.385(5), neither the Hearings Division nor the Board may award penalties or attorney fees in regard to matters arising under the review jurisdiction of the Director. Since the sole issue before the ALJ was penalties and attorney fees arising out of a vocational assistance dispute, and since review of the vocational assistance "matter" arose under the review jurisdiction of the Director, we determined that the Director likewise had exclusive jurisdiction over related penalties and attorney fees for such "matters."

The sole issue at hearing in this case involved the assessment of a penalty or attorney fee for the insurer's allegedly unreasonable delay in providing vocational assistance. As in Lundstrom, no contested case hearing occurred. Therefore, as we held in Lundstrom, the Director has exclusive jurisdiction over such issues.[1] See ORS 656.385(5).

ORDER

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

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[1] We acknowledge claimant's alternative request that we remand the case to the Director, "with instructions to assert jurisdiction." However, we have previously noted that ORS 656.385(5) does not require the Director to "retain" authority over vocational issues, in order to exercise jurisdiction over penalties and attorney fee issues which arise from a "matter" which was under the jurisdiction of the Director. Thus, regardless of whether the Director retains authority to reconsider the merits of the vocational "matter," the Director has the authority to consider penalties and attorney fees arising from that "matter." Anna J. Calles, 48 Van Natta 1001, 1002 (1996). Under these circumstances, it is incumbent on claimant to seek a hearing with the Director (if he wishes to do so), and remand is unnecessary.

In the Matter of the Compensation of
ANTHONY J. McKENNA, Claimant
WCB Case Nos. 95-07570, 95-02480 & 94-07262
ORDER ON REVIEW
Karl Goodwin (Saif), Defense Attorney
Bottini, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition; (2) upheld Safeco's denials of claimant's aggravation and occupational disease claims for his low back condition; (3) did not address his claim for interim compensation; (4) declined to assess Safeco and SAIF penalties for alleged discovery violations; and (5) declined to assess penalties for allegedly unreasonable and untimely denials. Safeco cross-requests review of that portion of the order that set aside its denial of claimant's claim for a current L4-5 disc condition. Claimant seeks remand, contending that the ALJ erred in: (1) allowing litigation arising out of Safeco's allegedly defective denial; and (2) declining to admit evidence submitted by claimant after the hearing. Claimant also seeks sanctions, reimbursement for costs, and moves to strike Safeco's Cross-Reply Brief. On review, the issues are claim preclusion, compensability, responsibility, aggravation, interim compensation, remand, penalties, costs, motion to strike, and sanctions. We deny claimant's motions, affirm in part, and modify in part.

FINDINGS OF FACT

Claimant was 49 years old at the time of hearing. He injured his low back in 1970 and again in either 1978, 1980, or 1984. (Exs. 11, 12, 20, 60). These injuries resolved quickly with rest, but claimant had developed low back degeneration by 1989.

On June 9, 1989 claimant suffered a low back strain while working for Safeco's insured. On June 27, 1989, claimant sought treatment and filed an injury claim. Dr. Dordevich took him off work and prescribed physical therapy. Safeco accepted the claim for a low back strain.

Dr. Dordevich released claimant to his regular work on August 14, 1989. A November 27, 1989 Determination Order closed the claim with a 9 percent unscheduled permanent partial disability award, including 4 percent impairment for claimant's L4-5 "disc derangement."

Claimant's low back problems continued. He returned to work for Safeco's insured for the period from March 19, 1990 until August 13, 1990. He worked for SAIF's insured from October 14, 1991 until July 29, 1993, and has not worked since.

Although claimant apparently sought no treatment for his low back between January 1990 and December 1991, his symptoms continued.

An October 27, 1993 internal Safeco Claims Memo indicates that claimant's accepted claim is "lumbar strn and L4-5 disc bulge." (Ex. 40C).

In March 1994, claimant experienced increased symptoms while off work.

On June 10, 1994, Safeco sent claimant a "Corrected Denial" of his current low back condition and L3-4 bulge. (Ex. 51).

On September 15, 1994, Dr. Carroll, treating physician, authored a report notifying Safeco that he was treating claimant for low back problems and indicating that claimant was disabled from working and had been since the June 9, 1989 injury. (Ex. 63).

On November 21, 1994, claimant requested reopening of his claim on an aggravation or occupational disease basis. Safeco denied claimant's aggravation claim on December 21, 1994 and denied his occupational disease claim on February 17, 1995.

Claimant filed an occupational disease claim with SAIF on February 28, 1995. SAIF disclaimed responsibility on April 25, 1995 and denied compensability on April 27, 1995.

Safeco stipulated that bills for claimant's September 28, 1993 MRI and related travel expenses (Exs. 40A & B) were not timely paid. (January 24, 1996 Tr. 32-56).

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion: L4-5 Condition

The ALJ found that Safeco accepted claimant's L4-5 disc condition by virtue of its October 27, 1993 internal memo which indicated, "Discussed accepted claim [with claimant] - lumbar strain and L4-5 disc bulge." (Ex. 40C). The ALJ further reasoned that this conclusion was reinforced by the fact that Safeco did not challenge a 1989 Determination Order award which was based on L4-5 disc impairment, citing Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).

Claimant argues that Safeco is precluded from denying his L4-5 condition because a November 27, 1989 Determination Order, (Ex. 27A, see Ex. 30A), awarded permanent disability compensation specifically for claimant's L4-5 disc impairment. We agree. See Deluxe Cabinet Works v. Messmer, supra; Roger L. Wolff, 48 Van Natta 1197 (1996).

In reaching this conclusion, we note that the 1989 evaluator's worksheet indicated that the 4 percent impairment award was for "MRI impairment Disc Derangement L4-5."[1] (Ex. 27B-1). The August 11, 1989 MRI referenced in the evaluator's worksheet revealed: "Mild central bulging at L4-5 with minimal deformity of the thecal sac. Nerve root compression is not identified." (Ex. 24).

On this evidence, we find that Safeco's denial of claimant's "current condition" must be set aside to the extent that it encompasses claimant's L4-5 disc derangement.[2] See Judy A. Tucker, 48 Van Natta 2391 (1996); Roger L. Wolff, supra.

Claimant argues that later interpretations of the 1989 MRI indicate that his L4-5 condition (at the time of the 1989 Determination Order) included desiccation and degeneration, as well as the bulging disc described in the contemporaneous reading. Claimant also argues that Safeco knew about his degenerative condition when it "accepted"[3] his L4-5 condition. Based on these contentions, claimant argues that his compensable condition is not limited to a bulging disc at L4-5. In addition, claimant argues that Safeco's current condition denial includes an impermissible "back-up" denial of the accepted L4-5 condition (based on a contention that the June 10, 1994 denial issued more than two years after "acceptance," presumably referring to the November 27, 1989 Determination Order).[4] See ORS 656.262(6)(a).

We need not address these arguments (beyond noting that claimant's L4-5 disc condition is "compensable," under Deluxe Cabinet Works v. Messmer, supra), because the current condition denial is set aside to the extent that it denied claimant's L4-5 condition. Therefore, there is no "back up" denial issue.

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[1] The worksheet also notes: "MRI Bulg disc 8/11/89 at L4-5 = 4%." (Ex. 27B-2).

[2] The ALJ set aside Safeco's denial of an L4-5 disc "protrusion." Based on the terminology used in the evaluator's worksheet and the referenced MRI, we modify the order to indicate that Safeco's denial of claimant's L4-5 disc "derangement/bulge" is set aside.

[3] Claimant argues that Safeco's internal memo indicating that claimant had been informed that his accepted condition was "Lumbar strn & L4-5 disc bulge" constituted acceptance of his L4-5 condition. (See Exs. 37D-1, 40C). We need not address this contention, because the denial is set aside on other grounds, as explained herein. Moreover, even assuming that the memo constituted an acceptance, we would not find that Safeco thereby accepted anything more than the low back strain injury (which Safeco admits accepting) and the L4-5 disc bulge. See Footnote 9, ante.

[4] We do not find that Safeco's failure to challenge the Determination Order award means that it "accepted" claimant's L4-5 condition. See Dennis L. Keller, 47 Van Natta 734, 736 (1995) (citing Messmer v. Deluxe Cabinet Works, 130 Or App 254, 258 (1994), rev den 320 Or 507 (1995) ("The result is not that SAIF has accepted claimant's degenerative disc condition; rather, it is that SAIF is barred by claim preclusion from denying that it is part of claimant's August 1980 claim.")).

Compensability: Occupational Disease Claim, L3-S1 & Injury Claim, L-3, L5-S1

Claimant has filed occupational disease claims with Safeco and SAIF (for his L3-4, L4-5, and L5-S1 conditions) and an injury claim with Safeco (for his L-3-4 and L5-S1 conditions). These claims have all been denied.[5]

Claimant bears the burden of proving that his low back condition is work-related. ORS 656.005(7)(a); ORS 656.802; see ORS 656.266.

Considering claimant's long history of back problems and the passage of time since the work injury (and occupational exposures), we find that the causation issue is essentially a medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983); Givens v. SAIF, 61 Or App 490, 494 (1983). In this case, we find such reasons.

The only evidence arguably supporting a conclusion that claimant's low back problems are work-related is provided by Dr. Carroll, current treating physician.

Dr. Carroll first examined claimant in August, 1994. (Exs. 57, 59). Dr. Carroll reported claimant's history of chronic low back pain (since the 1989 work injury), detailed his functional limitations, and opined: "Prognosis is guarded as far as any improvement. It appears to be a chronic, permanent situation." (Exs. 59, 60; see Ex. 61). Dr. Carroll examined claimant again on September 13 and November 10, 1994. (Ex. 62). On September 15, 1994, Dr. Carroll sent Safeco a report indicating that claimant was "still" disabled from working and had been disabled since June 9, 1989. (Ex. 62A, 63).

On November 1, 1994, claimant wrote to Dr. Carroll, describing his history of back problems and asking the doctor to respond to six questions. (Ex. 65-H). On November 10, 1994, Dr. Carroll responded as follows: First, he opined that claimant suffered an L4-5 disc injury before the August 11, 1989 MRI and stated "It is entirely possible the injury of June 9, 1989 caused the disc injury." (Ex. 66, emphasis added). Dr. Carroll also opined that the 1989 injury also involved lumbar muscle and ligament strain and that claimant's back pain comes from "strained ligaments and subsequent spasm of surrounding muscles." (Id.). In addition, Dr. Carroll stated that claimant's "new disc herniations at L3-4 and L5-S1 could have been from heavy lifting at work from March through August, 1990." (Id., emphasis added). Dr. Carroll further opined that claimant's back condition did not reflect an "objective worsening that is a (51%) result of the 6/09/89 injury." (Id.). Instead, Dr. Carroll stated, "I believe [claimant's] back condition from a functional perspective has progressively waxed and waned with a general overall deterioration. The objective data (MRI reports, etc) show healing, for example, resolution of the herniated discs." (Id.). Finally, Dr. Carroll responded "Yes" to the question, "Do you believe [claimant's] back condition has . . . reflected a progressive deterioration, where the major contributing cause is LESS LIKELY a combination of age and heredity, BUT MORE LIKELY the result of a series of traumatic events or occurrences that arose out of and within the course and scope of [claimant's] employment with [Safeco's insured], from January 5, 1989 to August 13, 1990??" (Id., emphasis in original).

On March 28, 1995, Dr. Carroll responded "No" (without explanation) to the following questions:

> "1. Do you believe the herniation or protrusion of the L4-5 disc, reported by Dr. Oyer and D. Launey as '. . .no change. . .' and '. . .unchanged. . .' from the 1989 Lumbar MRI exam, was a direct result of the 6-9-89 injury, in other words, do you believe, the 6-9-89 injury was the major contributing cause of herniation at L4-5?

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[5] We acknowledge claimant's contention that he did not waive his objection to Safeco's allegedly defective denial and therefore issues arising from that denial should not have been litigated. We address this contention in the section entitled "Motions."

"2. Do you believe the desiccation of the L4-5 disc reported by Dr. Oyer on 12-13-93 from the 9-28-93 exam, and desiccation of the L4-5 disc reported by Dr. Oyer on 8-16-94 is an objective worsening of the L4-5 disc condition, as a (51%) result of the original 6-9-89 injury?" (Ex. 77).

We find Dr. Carroll's opinion unpersuasive for the following reasons. First, the emphasized portions of his opinion reflect only the possibility (not probability) of a work relationship. See Gormley v. SAIF, 52 Or App 1055 (1981). Second, although Dr. Carroll opined that claimant's back condition did not reflect an objective worsening of an injury-related condition, he also stated that it did reflect a progressive deterioration of a work-related condition. Without further explanation, we find Dr. Carroll's opinion internally inconsistent. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Third, although Dr. Carroll apparently believes that claimant's current low back pain arises from the 1989 ligament and muscle strain, he does not explain how and why such a strain would cause such symptoms over five years after the injurious event. For these reasons, we find Dr. Carroll's opinion inadequately reasoned and insufficient to carry claimant's burden.[6] In addition, because Dr. Carroll did not examine claimant until years after his work injury and work exposures, we further find that he was not in a particularly good position to evaluate the potential relationship between claimant's work and his low back condition. See Givens v. SAIF, supra.

Under these circumstances, we conclude that Dr. Carroll's opinion is unpersuasive and we decline to rely on it. See Somers v. SAIF, supra. Thus, because we find no medical evidence persuasively supporting claimant's occupational disease claims or his contention that his L3-4 and L5-S1 conditions arise out of the 1989 compensable injury, we conclude that the claims must fail. Finally, because there is no evidence of a "new injury" or "new occupational disease" associated with claimant's work exposure with SAIF's insured, there is no responsibility issue.[7]

Aggravation/Interim Compensation

To establish a compensable aggravation, claimant must prove: (1) a "compensable condition"; and (2) an "actual worsening" of the compensable condition.[8] See Gloria T. Olson, 47 Van Natta 2348 (1995).

As we have explained, claimant's only "compensable" condition involves his 1989 low back strain and a disc derangement at L4-5.[9] Thus, the threshold question is whether claimant's low back strain and/or his L4-5 disc condition have worsened since the November 1989 Determination Order.

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[6] We note claimant's objection to the ALJ's admission of Exhibit 84, Dr. Carroll's concurrence with the findings and conclusions of Drs. Rich and Gambee, independent examiners. (See Exs. 82-8, 86E). Claimant argues that Exhibit 84 should be excluded because it arose out of an "independent examination" to which claimant did not submit. See OAR 436-010-0100(5)(a); 436-010-0100(1)&(4); WCD Admin. Order 94-064. We need not address claimant's contentions or his motion in this regard, because we find Dr. Carroll's opinion unpersuasive without considering Exhibit 84. We also note claimant's objections to evidence generated by Drs. Rich and Gambee and to all independent examinations after the first three. We need not address these objections, because we would reach the same result even without considering the disputed evidence, because Dr. Carroll's opinion is unpersuasive.

[7] We acknowledge claimant's contention that Safeco's responsibility disclaimer (against SAIF) was untimely under ORS 656.308(2). However, such a disclaimer is only relevant in the responsibility context and there is no responsibility issue here because the claim with SAIF is not compensable. See Joyce A. Crump, 48 Van Natta 922 (1996), aff'd mem Crump v. Safeway Stores, Inc., 145 Or App 261 (1996) (There is no ORS 656.308(2) issue unless the claim is compensable).

[8] Further, if claimant's current low back condition is a "combined condition" under ORS 656.005(7)(a)(B), claimant must prove that his compensable injury is the major contributing cause of the current condition. See Gloria T. Olson, supra. In addition, because claimant has previously been awarded permanent disability for his low back condition, he must establish that his current condition is worse than the waxing and waning of the symptoms contemplated by the previous award. ORS 656.273(8); Paul Bilecki, 48 Van Natta 97 (1996). We need not address these requirements, because we find that he has not established a worsening, as explained above.

[9] We acknowledge claimant's contention that Safeco accepted claimant's "worsened" L4-5 condition by virtue of its October 27, 1993 internal memo (because claimant had disc desiccation at the time of the memo, which he did not have previously). However, even assuming that Safeco's memo constituted an acceptance, (see n. 3, supra), we would find such an acceptance limited by its express terms to "low back strn and L4-5 disc bulge." (See Ex. 40C). See SAIF v. Tull, 113 Or App 449, 452 (1992) (Whether an acceptance occurs is a question of fact).

The medical evidence comparing claimant's current condition to his pre-claim closure condition is provided primarily by Drs. Launey, Oyer, Carroll, and Bottimer.[10]

In September 1993, Dr. Launey compared claimant's 1989 and 1993 MRIs and opined, "When compared to a prior MRI dated August 11, 1989, there has been no change in the degree of disc herniation at L4-5." (Ex. 39). On February 28, 1995, Dr. Launey interpreted the 1994 MRI and reported: "Mild degenerative disc changes seen in the lower lumbar levels. The previously described disc protrusion at L4-5 is not evident on the 8-16-94 examination. There is no evidence of spinal stenosis or nerve root effacement. No free disc fragments are identified. The examination is otherwise stable." (Ex. 73).

In December 1993, Dr. Oyer compared the 1989 and 1993 MRIs and noted diminished signal intensity at the L3-4 and L4-5 discs in the 1993 MRI, "compatible with an element of desiccation." (Ex. 43B). Dr. Oyer also found that the "small broad-based left paracentral disc protrusion impressing the thecal sac at the L4-5 level has not changed from the 1989 exam." (Id.). Dr. Oyer later noted that the August 16, 1994 MRI again revealed diminished signal intensity compatible with desiccation at L3-4 and L4-5. The small left paracentral disc herniation at L4-5 was "not readily apparent on the current exam." (Ex. 58-1 Although claimant did have a "posterior annular bulging of the L4-5 disc which results in mild impression of the anterior surface of the thecal sac," Dr. Oyer found no "clinically significant disc herniations or extruded disc fragments." (Ex. 58-1-2).

On August 15, 1994, Dr. Carroll examined claimant for the first time and recorded his "worsening" low back pain. (Ex. 57). On August 25, 1994, Dr. Carroll described claimant's low back pain as chronic and permanent. (Ex. 59-2). On September 15, 1994, Dr. Carroll filled out a form indicating that claimant had been disabled from working since the June 9, 1989 injury. (Ex. 63). On November 10, 1994, Dr. Carroll commented (as noted above), that claimant's back condition "from a functional perspective has progressively waxed and waned with a general overall deterioration. The objective data (MRI reports, etc) show healing, for example, resolution of the herniated discs." (Ex. 66). On March 28, 1995 Dr. Carroll opined that 1993 and 1994 MRI findings of L4-5 desiccation were not "an objective worsening of the L4-5 disc condition, as a (51%) result of the original 6-9-89 injury." (Ex. 77).

In May and August 1995, Dr. Bottimer opined that there was no significant difference between claimant's 1989 and 1993/1994 conditions and no significant progression of his disease. (See Exs. 80, 86).

On this record, we find that claimant has not proven an aggravation claim because there is insufficient medical evidence of an "actual worsening" of his compensable condition supported by objective findings,[11] as required by ORS 656.273(1).

Claimant's entitlement to interim compensation in the form of temporary disability benefits depends on whether the employer or insurer received notice or knowledge of a medically verified inability to work in a medical report which satisfies the requirements of ORS 656.273(3)[12] (and thus

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[10] We acknowledge claimant's reliance on proposed Exhibit 77B, an April 12, 1995 report by Dr. Thompson, as proof of his aggravation claim, as well as his contention that the ALJ improperly excluded this evidence. (See April 18, 1996 Interim Order, pp.1-2). We need not determine whether this evidence should have been admitted, because we find that it would not affect the outcome of the case. In reaching this conclusion, we particularly note Dr. Thompson's statements: "I do not see any objective indication of worsening in [claimant's] condition" and "I do not feel that there is any evidence in this man's medical record or on the MRIs to indicate a worsening of his condition. Actually, the fact that the disc protrusion that was noted on the previous MRIs has disappeared on [sic] the most recent MRI would suggest that he is actually better from an objective standpoint."

[11] Specifically, we find no persuasive medical opinion indicating that claimant's L4-5 condition has pathologically worsened. In addition, despite claimant's worsened low back symptoms, we find no evidence to support a conclusion that claimant's symptomatic worsening is greater than anticipated by his 1989 9 percent unscheduled permanent disability award. In reaching the latter conclusion, we further note that no doctor relates claimant's current low back problems to his compensable L4-5 condition.

[12] ORS 656.273(3) provides, in relevant part: "The claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury."

constitutes prima facie evidence in the form of objective findings that claimant's compensable condition has worsened). See ORS 656.273(6).[13] Ilene M. Herget, 47 Van Natta 2285 (1995).

Claimant is correct that the statutory obligation to pay interim compensation does not depend on whether the claim is ultimately determined to be compensable. See Patricia J. Sampson, 45 Van Natta 771 (1993). However, no duty to pay interim compensation arises if the insurer denies the aggravation claim within 14 days of notice of a legally sufficient aggravation claim. See Jones v. Emanuel Hospital, 280 Or 147, 151 (1977) ("ORS 656.262 gives the employer two choices: deny the claim or make interim payments.").

Thus, the pivotal question is whether Safeco received notice of claimant's aggravation claim more than 14 days before its December 21, 1994 denial. (Ex. 68).

Claimant argues that Dr. Carroll's September 15, 1994 report indicating that claimant was "still" disabled from working and (had been disabled since June 9, 1989) constituted an aggravation claim. (Ex. 62A). We disagree.

Dr. Carroll's opinion does not indicate that claimant's 1989 injury-related condition worsened since claim closure. Consequently, it does not amount to an aggravation claim sufficient to trigger a duty to pay interim compensation.[14] Because we find no evidence that Safeco (or SAIF) received notice or knowledge of medically verified inability to work resulting from a compensable worsening more than 14 days before its denial, we conclude that claimant's claim for interim compensation fails.

Motions, Penalties, and Sanctions

Remand

Claimant argues that Safeco's compensability denial, (Ex. 51), was defective because it did not specify the conditions denied.[15]

We treat claimant's objection as a motion to remand for further proceedings to cure the alleged lack of notice.

We note at the outset that amendments to the issues raised and relief requested at hearing "shall be freely allowed." OAR 438-006-0036. A party's remedy for surprise and prejudice created by a late-raised issue is a motion of continuance. OAR 438-006-0031, OAR 438-006-0036. In this case, we are unable to find that claimant requested a remedial continuance or that any such request was improperly denied by the ALJ.

Moreover, because the record is well-developed regarding the amended denial and claimant had ample opportunity to submit evidence concerning the denied conditions (see Exs. 66-6-10; 67H, 81C, 81F, 101-2, see also Exs. 73B, 76, 77, 77F, 82B, 82C, 82I, 83, 86B, 105-4), we do not find that consideration of additional evidence on remand would likely affect the outcome of the case. See

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[13] ORS 656.273(6) provides:

"A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening under subsection (1) of this section."

[14] Similarly, we find Exhibits 57, 60, and 61 insufficient to trigger a duty to pay interim compensation. In addition, because we are unable to read Dr. Carroll's November 10, 1994 opinion as internally consistent, we conclude that claimant has not established an entitlement to interim compensation. (See especially responses to questions 4&5, set out in text preceding n.6, supra, and Exs. 65H, 66).

[15] Claimant further contends that he did not waive his objection to the denial's lack of notice. See OAR 438-006-0037.

Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Consequently, it does not merit remand. See ORS 656.295(5).[16]

Claimant also argues that the ALJ erred in refusing to admit evidence submitted by claimant after the hearing. See April 18, 1996 Interim Order. We treat claimant's argument as a motion to remand for admission of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, supra. To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or at 641.

Claimant seeks admission of: Safeco records regarding disclosure of claim documents (including those indicating when and whether medical bills were paid[17]); written communications between Safeco and claimant (to establish numerous alleged discovery violations); and three December 1995 medical bills (to establish alleged untimely payment).

Having reviewed the parties' arguments, including claimant's March 13, 1995 motion to the ALJ, we cannot say that the proposed submissions were unobtainable with due diligence at the time of hearing. Moreover, because there are no "amounts then due" under this claim (other than those conceded by Safeco), the proposed exhibits would not change the result and we therefore find no compelling basis for remand. Accordingly, claimant's motion to remand for admission of evidence regarding alleged discovery violations and allegedly untimely payment of medical bills is denied.

Finally, we acknowledge claimant's motion to strike Safeco's cross-reply brief and his alternative request that we accept and consider his December 2, 1996 reply. See OAR 438-011-0020(2).

We have considered all the parties' briefs on review. However, 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).

Penalties and Costs

We adopt the ALJ's "Conclusions and Opinion" on these issues, with the following supplementation.

Claimant seeks penalties based on Safeco's allegedly unreasonable and untimely denial, allegedly unreasonable failure to pay interim compensation, allegedly unreasonable delay or refusal to pay medical bills (other than those Safeco admits were late paid), alleged discovery violations, and failure to timely process claimant's aggravation claim. Even assuming that one or more of the alleged processing infractions would otherwise support a penalty, a penalty has already been assessed on the only "amount then due" in this case and only one penalty may be assessed on a single "amount then due." See Laurie A. Bennion, 45 Van Natta 829 (1993); See Conagra, Inc. v. Jeffries, 118 Or App 373, 376 (1993). Consequently, claimant's request for additional penalties must be denied.

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[16] We acknowledge claimant's request that we review his trial motion regarding the allegedly defective denial (1/24/96 Tr. 184) in support of his request that the transcript of the September 13, 1995 pretrial conference be admitted into the record. We have reviewed claimant's arguments regarding the denial's alleged defects, including those advanced on January 24, 1996 at hearing, and the September 13, 1995 transcript is in the record. Nonetheless, we conclude that remand is not warranted, as explained above.

[17] Claimant argues that all diagnostic services between Safeco's 1989 acceptance and its June 10, 1994 denial are compensable under ORS 656.245(1)(c)(H) and that late payment of such compensation would create an "amount then due" which would support a penalty. Although claimant's legal argument is probably correct, he alleges no supporting evidence beyond that which Safeco concedes. See Opinion and Order p. 8. (See also Exs. 54C, 101-5).

Sanctions

Claimant seeks sanctions against Safeco under ORS 656.390(1), contending that its cross-request for review was frivolous and filed for the purpose of harassment. Specifically, claimant argues that Safeco was aware that it could not issue a "back up" denial more than two years after accepting claimant's L4-5 condition and therefore its continuing position that the L4-5 condition is not compensable is either frivolous or pursued to harass claimant.

ORS 656.390(1) gives the Board authority to impose an appropriate sanction against an attorney who files a frivolous request for review or one filed for purposes 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 Westfall v. Rust International, 314 Or 553 (1992) (defining "frivolous" under former ORS 656.390).

In this case, we find that Safeco's challenges to the compensability of claimant's L4-5 condition involved questions of fact which are colorable on the record. Safeco's arguments are sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Under these circumstances, we cannot say that Safeco's cross-request for review was frivolous or filed for purposes of harassment. Accordingly, claimant's request for sanctions is denied. See Donald M. Criss, 48 Van Natta 1569 (1996).

ORDER

The ALJ's order dated May 22, 1996 is modified in part and affirmed in part. That portion of the order that set aside Safeco's denial of "L4-5 protruded disc" is modified. Safeco's denial of claimant's "L4-5 disc derangement/bulge" is set aside. The remainder of the order is affirmed.

February 3, 1997 Cite as 49 Van Natta 104 (1997)

In the Matter of the Compensation of
DORIS A. BAILEY, Claimant
WCB Case No. 95-04385
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Cobb & Woodworth, Defense Attorneys

On January 15, 1997, we withdrew the Board's December 17, 1996 order that reversed those portions of an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's denial of claimant's medical services claim for her current cervical, thoracic and low back conditions; and (2) awarded an insurer-paid attorney fee. We took this action to consider claimant's motion for reconsideration. Noting that the Board had affirmed that portion of the ALJ's order which found that the scope of the insurer's initial claim acceptance extended to a cervical and thoracic (dorsal) strain (in addition to a lumbar strain), claimant contended that she was entitled to an insurer-paid attorney fee for prevailing on this issue at hearing and defending that portion of the ALJ's order on review. Having received the insurer's response and claimant's reply, we proceed with our reconsideration.

The primary issue at hearing concerned the insurer's denial of claimant's medical services claim for her current cervical, thoracic, and low back conditions. As a "threshold issue" relating to that "primary" compensability determination, the ALJ's order identified a dispute regarding what conditions had been originally accepted as a result of claimant's October 1985 compensable injury. After finding that the insurer's initial claim acceptance encompassed cervical, dorsal, and lumbar sprains, the ALJ concluded that claimant's compensable injury was the major contributing cause of her current condition and need for medical treatment. Consequently, the ALJ set aside the insurer's denial and awarded an insurer-paid attorney fee for claimant's counsel's services for clarifying the scope of claim acceptance and for prevailing against the insurer's current condition denial.

On review, the Board affirmed that portion of the ALJ's order which found that the insurer's acceptance included cervical, thoracic (dorsal), and lumbar sprains. However, reasoning that claimant's compensable injury was not the major contributing cause of claimant's current condition, the Board reversed that portion of the ALJ's order which had found claimant's current condition compensable. Reinstating the insurer's denial, the Board also reversed the ALJ's attorney fee award.

Asserting that she has prevailed at hearing and on review over the insurer's contention that its claim acceptance only extended to the low back, claimant argues that she is entitled to an insurer-paid attorney for her counsel's services at both the hearing and on Board review regarding the "scope of acceptance" issue. In support of her position, she relies on Deanna L. Ross, 48 Van Natta 118, 119 (1996), in which a claimant's attorney was granted a fee for securing the formal acceptance of additional disputed conditions.

In Ross, the claimant sought an attorney fee award under ORS 656.386(1) for securing the carrier's acknowledgment at hearing that its initial claim acceptance of a lumbosacral muscle strain extended to a lumbar root irritation. We reasoned that the carrier's amended acceptance occurred only after the scope of the insurer's partial denial of the claimant's "underlying degenerative condition and chronic sclerotic changes" was clarified at hearing to not include the root irritation and the claimant's current condition. Thus, although the carrier's denial was upheld, we granted an attorney fee under ORS 656.386(1) for the claimant's counsel's efforts in securing acceptance of the nerve root irritation condition.

Here, as in Ross, the scope of the insurer's claim acceptance has been expanded. However, unlike Ross, the insurer's denial pertained to claimant's current condition, including those conditions found to be encompassed within the insurer's initial claim acceptance. Since the "scope of acceptance" issue was encompassed within the compensability issue concerning claimant's current condition, Ross is distinguishable.

In other words, the insurer's contention that its initial claim acceptance was limited to a lumbar strain was only one of several grounds for its denial of claimant's current cervical, thoracic, and low back conditions. Although claimant overcame that particular ground, she did not finally prevail over the insurer's denial of the medical services claim in that the Board concluded that her compensable injury was not the major contributing cause of her current condition. Inasmuch as her medical services claim remains denied, she is not entitled to an attorney fee under ORS 656.386(1).[1] See David Watts, 46 Van Natta 2533 (1994), on recon 47 Van Natta 86 (1995); Anthony J. Colistro, 43 Van Natta 1835 (1991). Likewise, since the affirmed portion of the ALJ's order did not award compensation (the portion that extended the scope of the insurer's initial claim acceptance), claimant is not entitled to an attorney fee for services on Board review under ORS 656.382(2).

Accordingly, the Board's December 17, 1996 order is withdrawn. On reconsideration, as supplemented herein, the Board's December 17, 1996 order is republished.[2] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We also note that the record does not contain evidence that claimant will receive benefits as a result of our finding that the insurer's initial acceptance encompassed cervical, dorsal and lumbar sprains. See Jacquelyne M. Schulte, 48 Van Natta 1649, on recon 48 Van Natta 1873 (1996) (citing William C. Becker, 47 Van Natta 1993, 1934 (1995)) (a claimant must receive benefits in order to "prevail" under ORS 656.386(1)).

[2] Chair Hall's concurrence with this decision should not necessarily be interpreted as his agreement with the Board's initial decision. Rather, his signature denotes his agreement that, based on the prior decision from two Board members (one of whom is no longer with the Board), this reconsideration order is the appropriate response. See John A. Hoffmeister, 47 Van Natta 1688, on recon 47 Van Natta 1891 (1994), aff'd mem Hoffmeister v. City of Salem, 134 Or App 414 (1995). Chair Hall also directs the reader to his dissent in Becker.

In the Matter of the Compensation of
RUTH E. BALDWIN, Claimant
WCB Case No. 96-03343
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Schwabe, 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) Peterson's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant cross-requests review of that portion of the ALJ's order that awarded an assessed fee of $3,000 for prevailing against the denial. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant, a 47-year-old clerk, has worked full-time in the employer's water billing department for 17 years. Her duties primarily involved the operation of office equipment such as a computer, ten-key adding machine and telephone. She served customers in person and by mail and telephone. She received payments, wrote receipts, made change, endorsed checks and stamped bills "paid." She is ambidextrous and generally used both hands in her job, except that she used only her right hand to write and operate the ten-key adding machine.

In late 1995, claimant developed numbness, tingling and night pains in both hands, worse in the right. She sought treatment with her family physician, Dr. Phillips, who referred her to Dr. Dahlin, orthopedic surgeon. The undisputed diagnosis is bilateral carpal tunnel syndrome (CTS). She filed a claim for the condition, which the employer denied.

The ALJ set aside the denial. Analyzing the claim as an occupational disease, the ALJ concluded that the causation of CTS presented a complex medical question which must be resolved on the basis of expert medical evidence. The parties do not dispute those conclusions on review. The employer challenges the ALJ's conclusion that claimant carried her burden of proving medical causation, i.e., that her work activities for the employer were the major contributing cause of her bilateral CTS. The ALJ relied on the medical opinions of Drs. Phillips and Dahlin that claimant's CTS is work related. On review, the employer contends that the opinion of Dr. Button, who concluded that claimant's CTS is not work related, is most persuasive. We agree and reverse.

Citing Weiland v. SAIF, 64 Or App 810, 814 (1983), the ALJ stated that greater weight generally is given to the opinions of the treating physicians, Drs. Phillips and Dahlin, absent persuasive reasons not to do so. In this case, however, we find that the causation issue involves expert analysis, rather than expert external observation. Allie v. SAIF, 79 Or App 284, 287 (1986). The CTS diagnosis is undisputed in this case, and we are not persuaded that the opportunity to treat claimant's CTS over time gave Drs. Phillips and Dahlin any advantage in evaluating the causation of his condition. For these reasons, we do not give special credit to the conclusions of the treating physicians. See id.; Hammons v. Perini, 43 Or App 299 (1979). We give more weight, instead, to those medical opinions that are well reasoned and based upon complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

The first opinion regarding causation was provided by Dr. Button, a hand surgeon who examined claimant once at the employer's request. He opined that the CTS is idiopathic and unrelated to work activities, explaining:

> "...I would not consider this job causative. As an example, simply flipping invoices with the left hand is not anything physically demanding. Moreover, much of keying or data entry utilizing the right hand and fingers is primarily performed with what is termed the

> intrinsic muscles in the hand, which originate beyond the carpal tunnel and insert into the digits. If individuals have carpal tunnel symptomatology, it can come on with varied activities, such as driving, holding a newspaper, writing or even awakening at nighttime, which has been the case with her. The work activities may bring on symptomatology but I do not view as causative of the condition or potentially a major contributing factor relative to progression from this point on." (Ex. 7, pp. 3-4).

Dr. Dahlin, an orthopedic surgeon who began treating claimant in January 1996, gave the following opinion:

> "I believe that it is more likely than not that [claimant's] bilateral [CTS] is directly related to her work activity at the [employer] which involves office tasks classically associated with repetitive strain syndrome and [CTS]. This opinion is in line with my present understanding of the somewhat arbitrary nature of allocating certain carpal tunnel syndromes as work related and others as not." (Ex. 11).

Dr. Dahlin subsequently concurred that claimant's work activities for the employer were the major contributing cause of her bilateral CTS. (Ex. 12). Dr. Phillips, claimant's family physician, ultimately concurred with Dr. Dahlin's opinion. (Ex. 14).

In response to Dr. Dahlin's report, Dr. Button reiterated his opinion that claimant's work activities did not involve the carpal tunnels. He wrote:

> "From an anatomic standpoint, I believe one must critically assess the type of work as to what structures are involved. Oftentimes, physicians will mention repetitive motion of the wrists being a cause of [CTS]. Interestingly, the five tendons controlling wrist function do not pass within the carpal tunnel region whatsoever....In fact, in that tunnel pass the nine deep flexor tendons operating the thumb and fingers. They are utilized primarily in power grip, such as making a fist, bringing the digits into the palm as used in holding handles, etc.
>
> "In regard to a computer keyboard situation, the wrist is usually resting on a surface, such as a table or wrist support on a keyboard, and, in fact, there is little in the way of motion of the wrists.
>
> "Regarding digital function, the movements from side to side, such as tapping on the keys (which, incidentally, is light touch) is performed by what are termed the intrinsic muscles of the hand. These are large muscles which originate over the metacarpals of the hand, anatomically beyond the carpal tunnel region and then the tendon component inserts into the digits for the fine movements....
>
> "Again, if there were any type of fatigue, over-activity or an inflammatory process of these structures due to the fact they originate beyond the anatomic carpal tunnel, they would have no direct nor indirect bearing on the carpal tunnel anatomic contents nor the syndrome." (Ex. 13-2, emphasis in original).

After reviewing the aforementioned opinions, we conclude that Dr. Button's opinion is better reasoned than those of the remaining doctors. Dr. Button was the only doctor who discussed the specific job tasks performed by claimant and explained their pathophysiological impact. He explained that the primary tasks performed by claimant, i.e., keyboarding and data entry, could not have affected the carpal tunnel contents because of their anatomic placement. He indicated there is one type of activity--power gripping--which primarily involves the tendons that pass through the carpal tunnels.

By contrast, Dr. Dahlin related claimant's condition to "office tasks classically associated with repetitive strain syndrome and [CTS]." He did not describe the particular office tasks which caused claimant's CTS, nor did he rebut Dr. Button's opinion that the office tasks performed by claimant did not anatomically involve the carpal tunnel contents. In fact, Dr. Dahlin cast doubt on the persuasiveness of his own opinion when he described the relationship between CTS and occupational activities as "somewhat arbitrary." (Ex. 11). The following quotation is illustrative of Dr. Dahlin's own uncertainty regarding the etiology of CTS:

> "Though Dr. Button's reasoning for describing [claimant's CTS] as idiopathic is logical overall, the problem is that on the basis of his argument every [CTS] is idiopathic i.e. we do not know the main cause of this condition and how it develops.[1] The conclusion therefore is not helpful in terms of deciding what condition is work related or not. This is basically true but the fact is that carpal tunnel is still listed as an occupationally related condition. This necessitates for the clinician to make these decisions however, uncomfortable at the present time. The reality being that carpal tunnel pathophysiology is unknown...." (Ex. 11).

While acknowledging uncertainty about the etiology of CTS, Dr. Dahlin attempted to buttress his opinion by pointing to the fact that CTS is "listed" as an occupationally related condition. Yet, he offered no persuasive explanation as to why claimant's CTS is occupationally related. Because he based his opinion on generalities, rather than factors specific to claimant, we find his opinion is unpersuasive. See, e.g., John L. Bjerkvig, 48 Van Natta 1254 (1996); Richard H. Kellison, 48 Van Natta 53 (1996).

Finally, we reject claimant's argument that Dr. Button's opinion must be discounted because he erroneously relied on history that claimant had wrist supports while using the keyboard, (Ex. 13-2), whereas claimant testified that she first received wrist supports in April 1996, after the onset of CTS, (Tr. 14-15). While that portion of Dr. Button's history was inaccurate, there is no medical opinion to rebut Dr. Button's opinion that wrist motion does not impact carpal tunnel contents because the tendons controlling wrist function do not pass within the carpal tunnel region. Thus, Dr. Button's conclusion that claimant's CTS is idiopathic remains the most persuasive in this record. Based on Dr. Button's thorough and well-reasoned opinion, see Somers, 77 Or App at 263, we conclude claimant has not carried her burden of proving an occupational disease claim for bilateral CTS. Accordingly, we reinstate and uphold the employer's denial and do not need to address claimant's cross-request for review.

ORDER

The ALJ's order dated July 29, 1996 is reversed. The self-insured employer's denial dated March 8, 1996 is reinstated and upheld. The ALJ's assessed fee award is also reversed.

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[1] We disagree with Dr. Dahlin's premise that Dr. Button believes all CTS cases are idiopathic. As we noted above, Dr. Button indicated that some activity, such as power gripping, does impact the carpal tunnel contents.

In the Matter of the Compensation of
KENNETH L. DEVI, Claimant
WCB Case No. 93-10959
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney

Claimant has requested reconsideration of our November 26, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's current low back condition. Asserting that we erroneously declined to consider his contention that the employer was precluded from denying his low back condition, claimant sought reconsideration of our decision. On December 24, 1996, we abated our order to allow adequate time to consider claimant's argument. Having received the employer's response, we now proceed with our reconsideration.

Our initial order affirmed an ALJ's order upholding the employer's denial of claimant's current degenerative low back condition on the merits. We declined to address claimant's contention that the employer's denial was precluded (based on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996)),

because the preclusion issue was raised for the first time on review (or during closing arguments, at the earliest).[1]

On reconsideration, claimant avers by affidavit (submitted for the first time on reconsideration) that his "Messmer/claim preclusion" theory was raised prior to the hearing, during "off record" discussions.[2] Thus, apparently contending that the preclusion theory was timely raised, claimant argues that considering it would not prejudice the employer, because the relevant evidence (prior Opinion and Orders) is in the record. In addition, claimant asserts that, by refusing to address the issue because it was not raised on the record, we effectively impose heretofore unheard of formal pleading requirements on parties to workers' compensation hearings.[3] We disagree.

We note at the outset that the ALJ's review is limited to issues raised by the parties. See Jeffrey D. Ward, 45 Van Natta 1513 (1993); Michael B. Petkovich, 34 Van Natta 98 (1982).

In this case, the ALJ properly did not address a "Messmer/claim preclusion" theory, because it was not placed before him on the record.[4] (See Tr. 4-7). See Sonya G. Richardson, 48 Van Natta 1844 (1996); Nikki Burbach, 46 Van Natta 265, 268 (1994); Alden D. Muller, 43 Van Natta 1246, 1247 (1991).

The scope of our de novo review encompasses all issues considered by the ALJ. See Destael v. Nicolai, 80 Or App 723 (1986); see also OAR 438-006-0031. Our review is statutorily "based on the record submitted to [us]" by the ALJ. ORS 656.295(5); see Bailey v. SAIF, 296 Or 41 (1983); Mosley v. Sacred Heart Hosp., 113 Or App 234, 237 (1992) ("Under ORS 656.295(5) and (6), the Board has de novo review authority to decide all matters arising from the record.") (emphasis added); Knupp v. State Acc. Ins. Fund Corp., 79 Or App 273, 276-77 (1986) (" 'If the system contemplated by [former ORS 656.298(6)] -- de novo review on the record -- is to have any meaning, it is essential that there be a specific time as of which issues are to be determined. The Workmen's Compensation Law contemplates that it be the time of hearing. ORS 656.295(3) and (5).' " (quoting Mansfield v. Caplener Bros., 3 Or App 448, 452 (1970); Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Brown v. SAIF, 51 Or App 389 (1981)).

In this case, claimant offers no explanation for failing to timely raise the preclusion question on the record.[5] Under these circumstances, we decline to address it on reconsideration.

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[1] Terry Hickman, 48 Van Natta 1073, 1075 n.2 (1996) (Where compensability denial was litigated on one basis, additional basis first raised in closing argument not considered on review); Lawrence E. Millsap, 47 Van Natta 2112, 2112-13 (1995) ("We have consistently held that we will not consider an issue raised for the first time during closing argument.") (citations omitted); see also State v. Hickman, 273 Or 358, 360 (1975) ("Generally, on appeal the case, criminal or civil, should be heard on the same theory upon which it was presented in the court below.") (citations omitted).

[2] At hearing, claimant stated: "The question that is presented, ultimately, is whether or not the claimant's injury of October 5, 1978 caused or contributed to an acceleration of his degenerative disease such that it is the major cause of his current low back condition." (Tr. 6).

[3] Contending that such requirements constitute a significant departure from past practice, claimant argues that we should sit en banc to reconsider this case. However, our refusal to consider "evidence" or argument which arises off the record is not a departure from past practices. On the contrary, it is based on long-standing precedent (see cases cited herein), our statutory mandate under ORS 656.295(5) and (6), and the interests of administrative economy (see n.5, ante). Under these circumstances, we decline claimant's invitation to reconsider this case en banc.

[4] Claimant, as the proponent of the preclusion theory, bears the burden of pleading it. See Raymond A. Baker, 47 Van Natta 481, 482 (1995) ("It is incumbent on a proponent of a position to be prepared to fully develop the record at the hearing."); Roberto Rodriguez, 46 Van Natta 1722, 1724 (1994) (Where the carrier was the " 'dissatisfied party' (the proponent for changing the status quo), it had the burden not only to request a hearing, but to present evidence and arguments in support of its position."); see also Troutman v. Erlandson, 287 Or 187, 213 (1979) ("Normally, the party who asserts the [res judicata] plea would have the burden of pleading and proving the facts necessary to establish the defense.").

[5] See Wright Schuchart Harbor v. Johnson, 133 Or App 680, 685 (1995) ("[L]imitations on an appellate body's ability to address previously unasserted claims or arguments, which are generally couched in terms of 'preservation,' arise primarily from jurisprudential concerns, i.e., 'to promote an efficient administration of justice and the saving of judicial time' and fairness in the process. Shields v. Campbell, 277 Or 71, 78 559 P2d 1275 (1977).").

Accordingly, as supplemented, we adhere to and republish our November 26, 1996 order. The parties' right of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARILYN M. KEENER, Claimant
WCB Case No. 94-01739
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral upper extremity condition; and (2) awarded an assessed fee of $7,500. In its reply brief, the insurer moves to strike Appendix A and any portions of claimant's respondent's brief referring to Appendix A, contending that claimant may not provide medical evidence on review that was not part of the hearing record. In addition, in her respondent's brief, claimant seeks an order requiring the insurer to pay the costs associated with the insurer's depositions of Drs. Machado and Laubengayer. On review, the issues are motion to strike, compensability, attorney fees and costs. We grant the motion to strike and affirm on the merits.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

With her brief, claimant submitted Appendix A, a letter dated March 16, 1996 to her attorney from Dr. Laubengayer in reply to the attorney's questions regarding some medical tests, which was not offered at hearing. The insurer objects to this post-hearing "evidence" and moves to strike Appendix A and any portions of claimant's brief referring to it. We grant the insurer's motion.

Our review must be based on the record certified to us. See ORS 656.295(5). Consequently, we treat claimant's submission of evidence as a motion to remand to the ALJ for the taking of additional evidence. Judy A. Britton, 37 Van Natta 1262 (1985). We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

In this case, there is no evidence that the document submitted for the first time on review was unavailable with due diligence at the time of hearing. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome of the case. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. See ORS 656.295(5).

As stated above, our review is limited to the record certified to us. Id. Thus, because claimant's brief refers to evidence not offered and admitted at hearing (and therefore not certified to us), we grant the insurer's motion to strike those portions of claimant's brief which refer to such evidence.

Compensability

We adopt and affirm the ALJ's opinion finding claimant's occupational disease claim for a bilateral upper extremity condition compensable. We add the following supplementation.

Claimant, who had been driving a school bus for the employer since 1980, sought treatment in 1990 for elbow and wrist complaints. Dr. Gilbertson diagnosed "tennis elbow" and treated claimant with elbow and wrist splints. Claimant continued to work, and, after her symptoms spread to the interosseus area between the radius and ulna, Dr. Gilbertson injected the tendons at the elbow and wrist, with good result. (Ex. 1-1, 1-2).

Claimant had no further wrist or elbow complaints until December 1992, when she sought treatment for right arm and wrist discomfort during an extended period of driving in heavy snowfall that required a tense grip on the steering wheel. (Ex. 1-8, Tr. 23-26). Like Dr. Gilbertson, Dr. Machado found tenderness in the extensor radial aspect of the wrist and over the lateral epicondyle. He diagnosed tendinitis of the right arm, likely de Quervain syndrome, and lateral epicondylitis, for which he prescribed elbow and wrist braces. (Ex. 1-8). In April 1993, claimant sought treatment for her left wrist, top of her hand and distal forearm. Dr. Machado found tenderness over the extensor tendons of the thumb and top of the hand. He diagnosed tendinitis of the left wrist, and prescribed a splint and anti-inflammatories. (Id.). Claimant's condition improved. (Ex. 1-9).

Claimant stopped taking the anti-inflammatory medication for several months. In late June, claimant's tendinitis returned in both wrists, right greater than left. Dr. Estes (substituting for Dr. Machado) reported decreased grip strength. (Id.). Claimant failed to reinstitute her prescribed anti-inflammatory medication. On July 22, 1993, in addition to reporting claimant's increased tenderness in the right thumb, right and left lateral epicondyles, and the bicipital tendon on the right, Dr. Machado reported discoloration over the base of the right thumb and extensor tendon. (Ex. 1-10). Dr. Machado prescribed wrist and elbow splints and anti-inflammatory medication. By August 8, 1993, Dr. Machado reported that claimant's left wrist, right shoulder and elbow pain had resolved, although he found crepitance and tenderness over the left thumb tendon. He injected the tendon sheath and continued the anti-inflammatory medication. (Ex. 1-10).

On September 8, 1993, Dr. Machado reported an increase in symptoms after claimant had worked as an aide to handicapped children, which included lifting 6 to 12-year-old children into and out of wheelchairs, helping them in the bathrooms, and diapering. Dr. Machado reported tenderness in the bicipital groove bilaterally, both lateral epicondyles and extensor tendons of the thumb. His diagnoses (DeQuervain's tendinitis, lateral epicondylitis, and bicipital tendinitis) remained the same. He restarted anti-inflammatory medication and limited claimant's lifting to 10 pounds.

On October 20, 1993, Dr. Machado referred claimant to Dr. Laubengayer, orthopedist, to evaluate claimant's persistent conditions. (Ex. 1-11). On examination of claimant, Dr. Laubengayer found marked tenderness over the left lateral epicondyle and extensor tendons, as well as pain on extending the wrist against resistance and extending the elbow. He also found marked tenderness over the snuffbox area of the right wrist and radial styloid and a positive Finkelstein's test for DeQuervain's disease. His findings regarding the right elbow and left wrist were similar but less severe. (Ex. 8-1). He characterized his findings as "classic findings for lateral epicondylitis and tendinitis of both elbows and tendinitis of a DeQuervain's type in both wrists." (Ex. 7). He treated the right wrist and left elbow with injections, braces and anti-inflammatory medication. They improved, and in December 1993, he injected the left wrist. He noted that claimant continued to work as a bus driver, which he opined was the cause of claimant's continuing problems. (Ex. 8-1).

Relying on ORS 656.005(19), the insurer first contends that there are insufficient objective findings to support claimant's occupational disease claim. That statute 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 insurer contends that Dr. Machado's observation of crepitus over claimant's right thumb was the only objective finding identified by either Dr. Machado or Dr. Laubengayer. (See Ex. 24-26). We disagree. We have held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that examination findings do not constitute objective findings is irrelevant if those findings otherwise satisfy ORS 656.005(19). Scott Petty, 46 Van Natta 1051 (1994); Craig H. Ayer, 43 Van Natta 2619 (1991).

Here, in addition to Dr. Machado's finding of crepitus over claimant's right thumb (Ex. 1-10), Dr. Machado also found decreased grip strength (Ex. 1-9) and discoloration over the base of the right thumb and extensor tendon (Ex. 1-10). Moreover, Dr. Machado found tenderness localized in the lateral epicondyles and extensor tendons of both arms, which were reproduced by Dr. Laubengayer. As noted above, Dr. Laubengayer stated that these findings were "classic" findings of lateral epicondylitis and tendinitis of both elbows and DeQuervain's tendinitis in both wrists. These objective findings are, therefore, reproducible and verifiable indications of claimant's tendinitis and epicondylitis, conditions diagnosed by both Dr. Machado and Dr. Laubengayer.[1] See ORS 656.005(19); Tony D. Houck, 48 Van Natta 2443 (1996) (positive, subjective responses to Tinel's and Phalen's tests are verifiable indications of injury which are reproducible and thus constitute "objective findings"). Moreover, we agree with, and adopt, the ALJ's reasoning and conclusion that Drs. Machado's and Laubengayer's observations of claimant over a lengthy period of time entitle their opinions to greater weight than those of Drs. Nathan and Radecki. Weiland v. SAIF, 64 Or App 810 (1983).

Alternatively, the insurer asserts that, even if claimant has established the existence of an occupational disease, she failed to prove that her work conditions were the major contributing cause of her condition. Specifically, the insurer contends that Dr. Laubengayer's opinion is based on a nonexistent temporal relationship. We disagree.

As found by the ALJ, Dr. Laubengayer based his opinion on his observation of the course of claimant's condition over a period of time. (See Exs. 8-3; 15; 17; 22; 24-140; 25-13, -25, -29; 32; 33). Accordingly, because the medical evidence demonstrates a pattern of diminishment and enhancement of her condition that correlates to her exposure in the work place, and Dr. Laubengayer has opined that claimant's work is the major contributing cause of her condition, claimant has proved that her condition is compensable. ORS 656.266; Bronco Cleaners v. Velazquez, 141 Or App 295 (1996).

Attorney Fees

The ALJ awarded claimant an attorney fee of $7,500 for her counsel's services at the hearing level, based on the counsel's statement of services and consideration of the factors set out in OAR 438-015-0010(4).[2] The insurer contends that the attorney fee is excessive. Specifically, the insurer asserts that claimant should not recover attorney fees for the time her attorney expended in communicating with her attending physicians, Dr. Machado and Dr. Laubengayer; the time associated with generating their medical reports; and the time spent in attending their depositions. The insurer reasons that the doctors are expert witnesses and, under OAR 438-015-0005(6), expert witness expenses are non-reimbursible "costs" which should, therefore, be subtracted from the ALJ's attorney fee award.

OAR 438-015-0005(4) provides: "'Attorney fee' means payment for legal services performed by an attorney on behalf and at the request of a claimant under ORS Chapter 656." OAR 438-015-0005(6) provides:

> "'Costs' means money expended by an attorney for things and services reasonably necessary to pursue a matter on behalf of a party, but do not include fees paid to any attorney. Examples of costs referred to include, but are not limited to, costs of independent medical examinations, depositions, expert witness opinions, witness fees and mileage paid to execute a subpoena and costs associated with travel."

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[1] Tendinitis is inflammation of tendons and tendon-muscle attachments. De Quervain's disease is a painful tenosynovitis due to relative narrowness of the common tendon sheath of the abductor pollicis lungus and the extensor pollicis brevis. Epicondylitis is inflammation of the epicondyle or of the tissues adjoining the epicondyle of the humerus; also known as "tennis elbow." Dorland's Illustrated Medical Dictionary 455, 528, 1547 (25th ed., 1974).

[2] The insurer argues that the ALJ erred by failing to make findings regarding each of the factors under OAR 438-015-0010(4) and to adequately explain the basis for the award. The insurer's argument is not well-taken. Although all of the relevant factors must be considered in determining the appropriate amount of attorney fees to be awarded, it is not necessary to make specific findings as to each factor so long as the explanation for the award has been provided in sufficient detail to confirm that all relevant factors have been considered. See, e.g., Schoch v. Leupold & Stevens, 144 Or App 259 (1996); Roseburg Forest Products v. Owen, 129 Or App 442, rev den 320 Or 271 (1994); Leo Polehn Orchards v. Hernandez, 122 Or App 241, rev den 318 Or 97 (1993). Here, we are persuaded that the ALJ considered all of the relevant factors in awarding the fee. See O&O at 5; amended O&O at 1.

The payment of fees charged by expert witnesses for their opinion letters and their time when attending a deposition represents costs incurred by an attorney in pursuing a matter on behalf of a party. Reimbursement of those costs is not a fee payable to an attorney for legal services. See OAR 438-015-0005(4), (6); see also Candace L. Spears, 47 Van Natta 2393, 2394 (1995) (paralegal time is a cost incurred in pursuing the case on claimant's behalf; attorney time supervising paralegal research considered in evaluating a reasonable attorney fee); Tom Goodpaster, 46 Van Natta 936 (1994) (claimant's attorney's investigator's time is a cost); Jeffery P. Keimig, 41 Van Natta 1486 (1986) (charge for "word processor" time is cost). However, an attorney's preparation for, travel to and attendance at depositions and correspondence with attending physicians represent hours of legal services rendered on behalf of a party; those hours are considered in awarding a reasonable attorney fee.

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

Our review of the record reveals the following. The issue in dispute was whether claimant's bilateral arm conditions were compensable. Claimant's counsel successfully argued that they were compensable. The file contained 32 exhibits, including two depositions, one of 47 pages and one of 34 pages. The hearing lasted approximately three hours, resulting in a 65 page transcript. Claimant was the sole witness to testify and claimant's counsel presented unrecorded oral closing arguments. Based on counsel's statement of services, approximately 60 hours were devoted to the case at the hearing level.

As compared to compensability disputes normally reviewed by this forum, the issue in this claim was of a higher degree of complexity. The value of the claim and the benefit secured are of average proportions, consisting of temporary disability, medical services and, potentially, permanent disability benefits. Moreover, claimant's counsel advocated claimant's claim in the face of a vigorous defense and, finally, there was a substantial risk that claimant's counsel's efforts might go uncompensated.

After considering the above factors and applying them to this case, we conclude that the ALJ's attorney fee award should be affirmed. Specifically, we conclude that $7,500 is a reasonable assessed attorney fee for claimant's counsel's services at hearing.

Finally, in her respondent's brief, claimant cites Senters v. SAIF, 91 Or App 704 (1988), contending that she should recover all costs associated with this case, in addition to an assessed attorney fee. We disagree. Senters stands for the proposition that a party requesting a deposition, which is primarily for its benefits, is responsible for payment of the costs associated with the deposition.

Here, claimant is not requesting reimbursement for costs related to the deposition of Drs. Machado and Laubengayer.[3] Rather, claimant is requesting reimbursement for all of her attorney's costs related to pursuing this matter on her behalf. As noted above, costs incurred by an attorney are not included in amounts that the Board can authorize an opposing party to pay. Goodpaster, 46 Van Natta at 936; Keimig, 41 Van Natta at 1486. Consequently, we decline to order the insurer to pay claimant's costs.

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 issue, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the issues of attorney fees and costs. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

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[3] In fact, a review of the record, as well as claimant's counsel affidavit regarding his costs, would indicate that the insurer paid for the costs associated with the depositions of Drs. Machado and Laubengayer.

ORDER

The ALJ's order dated December 18, 1995, as amended December 19, 1995, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
DAVID A. LEE, Claimant
WCB Case No. 95-08006
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

The self-insured employer requests reconsideration of our December 6, 1996 Order on Review that: (1) set aside its denial of claimant's right knee injury claim; and (2) assessed a penalty for its unreasonable denial. The employer contends that we erred in discounting the opinion of Dr. Thompson, examining orthopedist, who attributed claimant's knee injury to preexisting ligamentous instability. On January 6, 1997, we abated our order and allowed claimant an opportunity to respond. We have received claimant's response and now proceed with our reconsideration.

We briefly summarize the undisputed facts. Claimant, a deputy sheriff, was inspecting an abandoned, stolen vehicle on the evening of June 10, 1995. Using a flashlight to look into the vehicle while sidestepping, he slipped on a curb with an uneven surface, and twisted his right knee. He sought treatment with Dr. Matteri, orthopedic surgeon, who suspected a loose body in the knee joint.

In addition to the undisputed facts, we found that at the time of claimant's inspection, it was dark outside, and the surface of the curb was wet. We implicitly found that those additional conditions contributed to claimant's slip on the curb. We reasoned that, because Dr. Thompson was not aware of those additional conditions, his opinion was unpersuasive. The employer contends that those additional conditions were not proven to have contributed to claimant's slip; it therefore argues that Dr. Thompson's opinion should not be discounted. We disagree.

At hearing, claimant gave the following description of the June 10, 1995 accident:

> "It was -- it was -- recovered a stolen motor vehicle that was abandoned in Drain, and -- on June 10, approximately 9:15 p.m., and I was checking the vehicle while going down the curb line looking into the vehicle. I had my flashlight on and it was kind of -- it was dark, I believe. And then I slipped on the curb and the curb kind of tapered off, or had a cut in it, or something, but anyway I was sidestepping and then slipped and twisted, and then it -- then I only knew it was hurting." (Tr. 10).

While claimant did not specifically testify that "it was dark outside," we infer from his testimony that darkness had at least begun to fall. We reason that if claimant required a flashlight to look into the vehicle, there was apparently insufficient light outside to illuminate the interior of the car. Moreover, our inference is supported by Dr. Matteri's June 14, 1995 chart note which states that claimant reported injuring his knee while "inspecting a car in the dark ..." (Ex. 2-12). We therefore find that claimant was inspecting the abandoned vehicle in the dark when he slipped and twisted his knee.[1] We further find that the darkness at least partially impaired claimant's vision as he was inspecting the vehicle.

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[1] The employer asks us to take official notice of the fact that sunset on June 10, 1995 was at 9:05 p.m., approximately 10 minutes before claimant suffered his injury. Based on Oregon Fish and Game Department publications which apparently allow hunting up to 30 minutes after sunset, the employer argues that there must have been a significant amount of light at the time of the injury. The employer's argument ignores the potential effect of the immediate environment on the lighting available to claimant as he was inspecting the vehicle. Claimant inspected the vehicle in Drain; there was no evidence offered concerning what obstructions, if any, were surrounding the car and possibly blocking light from the sun. Instead, we have claimant's unrebutted testimony that "it was dark." In the face of that testimony, we conclude that, even if we took official notice of the facts asserted by the employer, the employer's argument is without merit. Furthermore, for the reasons stated in this order, we conclude that, even if we had been persuaded by the employer's argument that it was not dark at the time of the accident, claimant's work conditions nevertheless put him at a substantial risk for injury.

In addition, we acknowledge that there was no evidence directly relating claimant's slip to the wet surface of the curb. However, on the 801 claim form, claimant reported that he was sidestepping on a wet curb line when his right foot slipped and his knee twisted. (Ex. 11). Again, we reasonably inferred that the wet surface of the curb was a contributing factor to the accident.

In any event, even if we assumed that the darkness or the wet surface of the curb did not actually contribute to the accident, we would still find that the accident arose out of claimant's employment as a deputy sheriff. According to claimant's unrebutted testimony, he slipped on a curb which either tapered off or had a "cut" in it. (Tr. 10). He was looking into the vehicle, not at the curb, at the time of his injury. (Id.) There is no indication that Dr. Thompson was aware of those conditions. Dr. Thompson did not know that the curb tapered off or had a cut in it; he also did not know that claimant was looking into the vehicle, not the curb, when he slipped. (Ex. 19-2). Those conditions put claimant at a substantial risk for injury. Because Dr. Thompson was not aware of those critical facts, we adhere to our conclusion that his assessment of the risk of injury associated with claimant's work activity on June 10, 1995 is wholly unpersuasive.

Claimant's counsel is entitled to an additional assessed attorney fee for time spent responding to the employer's reconsideration request. After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that an additional reasonable fee for claimant's counsel's services on reconsideration regarding the compensability issue is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our December 6, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 3, 1997 Cite as 49 Van Natta 115 (1997)

In the Matter of the Compensation of
KEITH D. OLIVER, Claimant
WCB Case Nos. 95-05995 & 95-03912
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Corporation/International Line Builders (ILB) requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) found that claimant's right shoulder and cervical injury claim was timely filed; (2) set aside ILB's denial insofar as it pertained to claimant's cervical condition; (3) upheld Liberty Northwest Insurance Corporation/Wilson Construction Company's (Wilson's) denial of claimant's injury claim for his cervical condition; and (4) awarded a $3,250 attorney fee under ORS 656.386(1), payable by ILB. Contending that claimant's respondent's brief was untimely filed, ILB moves to strike his brief. On review, the issues are motion to strike, timeliness of claim filing, compensability, responsibility, and attorney fees. We grant the motion to strike, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's factual findings, but offer the following brief summary of the pertinent facts.

ILB employed claimant as a lineman in August 1994. While participating in the installation of an underground line on August 12, 1995, claimant was struck in the upper back and right shoulder by a metal switching cabinet. Claimant indicated to co-workers that he was not injured and continued to work. No claim was filed and claimant did not seek medical treatment.

A few days later, on August 16, 1994, claimant attended a physical examination necessary to renew his commercial drivers license. The examining physician, Dr. Hancock, reported that claimant had complained of an injury to his arm, but that it was not causing severe or undue distress. (Ex. 30). Claimant was prescribed some medication for his right arm discomfort. Id.

Claimant continued to work for ILB until being laid off in October 1994. Claimant's right shoulder and arm complaints moderated, but did not completely disappear, before he was hired by Wilson in December 1994. (Tr. 89).

On December 21, 1994, claimant was carrying 200 pounds of wire over his left shoulder, as well as some work implements over his right shoulder, when he slipped and fell forward down a hill. (Tr. 91). Claimant landed hard on his right arm and hand. As a result, his right arm symptoms became more severe, but he was able to continue to work until he "jerked" his right arm in a company pick-up truck two days later. (Tr. 95).

Claimant then sought treatment at an emergency room for right upper extremity pain, diagnosed as an acute right shoulder sprain. (Ex. 3-2). Unable to work, claimant filed a claim against Wilson, which eventually denied both responsibility and compensability. On March 7, 1995, claimant filed a claim against ILB for the alleged August 12, 1994 injury. ILB denied responsibility and also asserted that the claim was untimely filed. Claimant requested a hearing from the denials.

On May 4, 1995, Dr. Purtzer, a neurosurgeon, evaluated claimant on referral from Dr. Renaud, claimant's attending physician. Dr. Purtzer diagnosed cervical radiculopathy at C6-7. (Ex. 23-2). Claimant eventually underwent cervical surgery, performed by Dr. Purtzer, in October 1995. (Ex. 37A).

CONCLUSIONS OF LAW AND OPINION

The ALJ first determined that claimant's claim against ILB for his alleged August 1994 injury was timely, finding that, under former ORS 656.265(4)(a), the employer had knowledge of the incident.[1] The ALJ then concluded that the medical evidence established that claimant injured two separate body parts: the right shoulder and cervical spine. Finding the medical evidence established that these conditions were compensable, the ALJ then assigned responsibility for the right shoulder condition to Wilson and responsibility for the cervical condition to ILB. The ALJ reasoned that, while there was a new incident of injury in December 1994, that incident only resulted in a compensable injury to the right shoulder, not the cervical spine.

On review, ILB contends that claimant did not timely file his claim because the employer had insufficient knowledge of the August 1994 incident. ILB further asserts that it was prejudiced by the delayed filing of the injury claim. Former ORS 656.265(4)(a). On the merits, ILB argues that the ALJ incorrectly assigned it responsibility for claimant's cervical condition, contending that Wilson should be responsible for the condition under the last injurious exposure rule (LIER) or on the basis that the December 1994 injury actually caused the cervical condition. ILB also contends that the ALJ incorrectly assessed an attorney fee under ORS 656.386(1) because it did not deny compensability of claimant's cervical condition. In its reply brief, ILB moves to strike claimant's respondent's brief on the ground that it was untimely submitted.

For the following reasons, we grant ILB's motion to strike claimant's brief. Moreover, we find that we need not address ILB's timeliness argument because, even if claimant's cervical injury claim was timely filed against ILB, Wilson is responsible for the cervical condition. Given this conclusion, we further hold that ILB is not responsible for an attorney fee under ORS 656.386(1).

Motion to Strike

ILB's appellant's brief was filed on October 7, 1996. Therefore, claimant had until October 28, 1996 to file his respondent's brief. OAR 438-011-0020(2). Pursuant to OAR 438-005-0046, filing of a brief may be accomplished by first class mail with postage pre-paid. An attorney's certificate indicating that a brief was deposited in the mail on the stated date is proof of mailing. Id.

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[1] Senate Bill 369 amended former ORS 656.265. However, the amended statute applies only to injuries occurring on or after June 7, 1995, the effective date of the Act. Or Laws 1995, ch 332, §§ 66(2), 69. As to injuries occurring before June 7, 1995, pre-Senate Bill 369 law applies. See Melvin L. Gordon, 48 Van Natta 1275 (1996).

Here, the certificate of service from claimant's attorney indicates that the respondent's brief was not filed until November 5, 1996. Since claimant's respondent's brief was filed after October 28, 1996, we conclude that the brief was untimely filed. We, therefore, have not considered claimant's respondent's brief on review.

Responsibility

Because there was no accepted cervical claim, the ALJ purported to apply the "last injury rule" in determining responsibility for claimant's cervical condition. See Donald M. Hughes, 46 Van Natta 2281 (1994). Finding that claimant first sought treatment for his cervical condition from Dr. Hancock in August 1994 (while ILB was on the risk), the ALJ assigned initial responsibility for the claim to ILB. See Timm v. Maley, 125 Or App 396, 401 (1993). The ALJ then reasoned that, to shift responsibility forward to Wilson, ILB had to show that claimant sustained a "new compensable injury." See ORS 656.308. The ALJ found that ILB failed to sustain its burden of proof. Thus, the ALJ concluded that responsibility for claimant's cervical condition remained with ILB.

In reaching this conclusion, the ALJ analyzed the medical opinion of Dr. Purtzer, who concluded that the August 1994 injury was the major contributing cause of claimant's cervical condition, and of Dr. Rosenbaum, who opined that the December 1994 injury was the major cause of claimant's cervical condition. The ALJ determined that Dr. Purtzer's opinion was more persuasive, in part, because he had observed claimant's condition during surgery and because Dr. Rosenbaum only examined claimant one time.

Here, there is no prior accepted claim for a cervical condition. Since a determination must be made regarding the assignment of initial responsibility for that condition, ORS 656.308(1) is not applicable. SAIF v. Yokum, 132 Or App 18 (1994) (ORS 656.308(1) does not apply to initial claim determinations); Eva R. Billings, 45 Van Natta 2142 (1993). Instead, we generally resort to the judicially created rules governing the initial assignment of responsibility in successive employment cases, e.g., the last injury rule (for injury claims) and the last injurious exposure rule (for occupational disease claims). See John J. Saint, 46 Van Natta 2224 (1994). Where, however, actual causation is proved with respect to a specific employment, we need not resort to those rules. See Eva R. Billings, 45 Van Natta 2142 (1993); see also Runft v. SAIF, 303 Or 493, 502 (1987). Rather, we will assign responsibility to the carrier with respect to whom actual causation has been established. Eva R. Billings, 45 Van Natta 2142 (1993). In this case, we conclude that actual causation has been established with respect to the December 1994 injury while claimant was employed by Wilson.

The ALJ relied on Dr. Purtzer's opinion in determining that ILB was responsible for claimant's cervical condition because of his position as attending physician. However, Dr. Purtzer testified in his deposition that he had only examined claimant two times. (Tr. 34-26). Therefore, even assuming that Dr. Purtzer was an "attending physician," his testimony does not establish that he had a significant advantage over Dr. Rosenbaum in his ability to observe claimant's condition over time. See Weiland v. SAIF, 64 Or App 810, 814 (1983) (greater weight given to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time). Moreover, as ILB correctly observes, Dr. Purtzer's opinion is not more persuasive because he performed claimant's cervical surgery. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Dr. Purtzer's last opinion on the causation issue (his deposition) was rendered on September 25, 1995, before he performed claimant's surgery on October 10, 1995.

There are also persuasive reasons to discount Dr. Purtzer's opinion. On September 19, 1995, Dr. Purtzer concurred with Dr. Rosenbaum's September 1, 1995 report, in which Dr. Rosenbaum concluded that claimant's cervical condition was related to the December 1994 injury. (Ex. 31-4). Dr. Purtzer never explained at his deposition the inconsistency between that concurrence and his opinion given elsewhere that the August 1994 injury was the major contributing factor in claimant's cervical condition. See Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Moreover, Dr. Purtzer admitted at his deposition that he did not have a good understanding of the circumstances of the two injuries claimant sustained. (Ex. 34-8). Dr. Purtzer assumed that in August 1994 claimant was struck by a 300 pound object, yet testimony at the hearing indicated that the cabinet that struck claimant could have weighed as little as 75 pounds. (Tr. 23). Although claimant's

counsel attempted to give Dr. Purtzer a detailed history of the onset of claimant's symptoms, Dr. Purtzer never provided an explanation for his "unchanged" opinion that the August 1994 injury was the major contributing cause of claimant's cervical injury. (Ex. 34-25). See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory opinion). Because Dr. Purtzer's opinion is insufficiently explained, based on a questionable history, and contradictory, we find that it is entitled to little weight. See Somers v. SAIF, 77 Or App 259 (1986) (most weight given to medical opinions that are well-reasoned and based on complete information).

In contrast to Dr. Purtzer, Dr. Rosenbaum has consistently opined that the December 1994 injury is the major factor in claimant's cervical condition. (Exs. 31, 37). In his initial report, Dr. Rosenbaum explained that, although claimant had symptoms after the August 1994 incident, he suffered a dramatic worsening in December 1994 which required medical attention. (Ex. 31-4). Dr. Rosenbaum specifically noted that claimant did not seek medical attention (apart from the medication he received from Dr. Hancock) after the August 1994 incident. Id. Dr. Rosenbaum concluded that, based on this history, claimant's cervical radiculopathy was related to the December 1994 injury.

In a follow-up report, Dr. Rosenbaum emphasized that, while claimant may have had the onset of cervical radiculopathy after the August 1994 incident, his symptoms after that incident may not have been the result of nerve root compression. (Ex. 37). Dr. Rosenbaum again noted the lack of medical attention prior to the December 1994 incident, as well as the fact that claimant was able to perform his regular work after the August 1994 incident. In light of the significant difficulties claimant experienced after the December 1994 injury that required medical care, Dr. Rosenbaum reiterated his conclusion that the December 1994 event was the major contributing cause of claimant's cervical condition and need for treatment. Id.

We conclude that Dr. Rosenbaum's opinion is based on an accurate history and on a thorough and complete analysis of the facts of this claim. Thus, we find Dr. Rosenbaum's opinion to be the most persuasive. We note that Dr. Rosenbaum's opinion is supported by the opinions of Drs. Gancher and Staver, examining physicians who also concluded that it was more likely than not that the December 1994 incident was the major contributing cause of claimant's cervical condition. (Ex. 9). Dr. Gancher reiterated his opinion on March 3, 1995. (Ex. 16).

In summary, the most persuasive medical evidence establishes that the December 1994 incident actually caused claimant's cervical condition. Thus, we find that Wilson, not ILB, is responsible for that condition. We, accordingly, reverse the ALJ's determination of responsibility for the cervical condition.

Attorney Fee

ILB contends that the ALJ incorrectly assessed an attorney fee pursuant to ORS 656.386(1) because it denied only responsibility, not compensability. However, ILB asserted that claimant's injury claim was time-barred. Therefore, we conclude that compensability was an issue with respect to ILB. Nevertheless, because Wilson, not ILB, is responsible for claimant's cervical condition, the ALJ erred in assessing an attorney fee against ILB pursuant to ORS 656.386(1). See Western Pacific Construction v. Bacon, 82 Or App 135 (1986) (Where multiple carriers, including the carrier ultimately found responsible, denied both compensability and responsibility, the carrier responsible for the claim was liable for the attorney fee at hearing under former ORS 656.386(1)); Gene R. Harrison, 48 Van Natta 2383 (1996); Charles R. Morgan, 48 Van Natta 841, on recon, 48 Van Natta 960 (1996). Therefore, we reverse the ALJ's attorney fee award under ORS 656.386(1) with respect to ILB. Finally, since we have rejected claimant's brief as untimely, claimant's counsel is not entitled to an attorney fee for services on review.

ORDER

The ALJ's order dated June 13, 1996, as reconsidered on July 30, 1996, is reversed in part and affirmed in part. That portion of the ALJ's order which set aside ILB's denial of claimant's cervical condition and upheld Wilson's denial of the same condition is reversed. ILB's denial is reinstated and upheld. Wilson's denial is set aside and the cervical claim is remanded to Wilson for processing in accordance with law. That portion of the ALJ's order that assessed a fee pursuant to ORS 656.386(1) against ILB is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
EDWARD C. STEELE, Claimant
WCB Case Nos. 96-02279 & 89-10606
ORDER ON REVIEW
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Garaventa's order that dismissed his requests for hearing. On review, the issue is the propriety of the dismissal order.

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

The ALJ dismissed claimant's hearing request on the ground that all matters raised by the requests for hearing had been resolved by two claim disposition agreements (CDAs) approved by the Board on October 10, 1996.

Claimant requested Board review of the ALJ's dismissal order and sought reconsideration of the CDAs approved on October 10, 1996. On November 15, 1996, the Board denied claimant's request for reconsideration of the CDAs. Edward C. Steele, 48 Van Natta 2292 (1996) (Board denied reconsideration because request for reconsideration of CDAs was untimely and Board's order approving CDAs had become final and was subject to no further review).

Turning to claimant's appeal of the ALJ's order, we make the following findings. Claimant's hearing requests (in WCB case numbers 96-02279 and 89-10606) raised issues of premature closure and extent of permanent disability. In the CDAs, which were approved by the Board on October 10, 1996, claimant, who was represented by an attorney, specifically released his rights to all workers' compensation benefits in WCB Case Nos. 96-02279 and 89-10606, including temporary and permanent disability benefits. In exchange for his release of benefits in WCB Case No. 96-02279, claimant received $106,000, less a $7,000 attorney fee. In WCB Case No. 89-02279, claimant received $1,120, less a $120 attorney fee. The CDAs specifically extinguished claimant's rights to the workers' compensation benefits that were raised by the hearing requests before the ALJ. Under such circumstances, because the CDAs extinguished claimant's rights to the benefits which were the subject of the hearing request, the ALJ's dismissal of the hearing request was appropriate. See Brian A. Haskie, 47 Van Natta 2171 (1995); Russell C. Terry, 47 Van Natta 304 (1995).

The Board approved the CDAs in final orders pursuant to ORS 656.236. Such orders would not issue if the Board found the agreements unreasonable as a matter of law, or based on an intentional misrepresentation, or if either of the parties had requested disapproval within 30 days of submission of the CDA to the Board. ORS 656.236(1)(a)(A),(B) and (C). Because we approved the CDA, we conclude there was no evidence of impropriety regarding the terms of the CDA. Once we issued our order approving the CDA, the agreement became final. Our order approving the CDA is not subject to review. ORS 656.236(2). Accordingly, as stated in our CDA order denying reconsideration, we are without authority to further address the CDA.[1]

ORDER

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

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[1] Claimant has asked us to answer a number of questions regarding the processing of his claim and its closure. These questions pertain to advice and decisions involving the Department, the ALJ, SAIF's counsel and claimant's former attorney. However, by entering into the CDAs, which are now final, claimant released his rights to the benefits at issue in the hearing requests. Since claimant is no longer entitled to such benefits, it would have been inappropriate for the ALJ, as well as this Board, to comment on the substantive questions raised in claimant's request for review. In other words, we are statutorily precluded from addressing such questions. The only action which claimant could have taken that would have allowed the ALJ and the Board to address claimant's questions would have been his refusal to settle his claim. However, since his claim was settled, pursuant to the executed and approved CDAs, those questions likewise are no longer subject to our review and response.

In the Matter of the Compensation of
SCOTT B. ALLEY, Claimant
WCB Case No. 96-03732
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that upheld the insurer's denial of claimant's aggravation claim for L4-5 disc bulge, herniation, and nerve impingement conditions. Asserting that one of his attending physician's reports contains a clerical error, claimant seeks to supplement the record. On review, the issues are claimant's procedural motion and compensability. We deny claimant's motion and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a sacral fracture as a result of a November 1994 work injury. He seeks to prove compensability of a low back disc bulge, herniation and nerve impingement. The ALJ found no persuasive evidence establishing causation between claimant's conditions and the work injury and concluded that claimant did not carry his burden of proof.

We agree that the medical record is insufficient to prove compensability. Examining physicians Dr. Reimer, neurologist, and Dr. Gripekoven, orthopedic surgeon, found no relationship between the compensable injury and the low back conditions. (Ex. 33). Dr. Reichle, claimant's former treating physician, concurred. (Ex. 34).

Dr. Woods, claimant's present treating physician, "strongly disagreed" with the panel's report. Dr. Platt, claimant's treating chiropractor, first indicated that he also did not concur with the panel's report. (Ex. 36). In a subsequent report to claimant's attorney, Dr. Platt stated that "I do concur with their report." (Ex. 39-1). Dr. Platt then stated that, "based upon reasonable medical probability[, claimant] sustained an injury to his lumbar spine disc at level L4-5." (Id.) Dr. Platt based this opinion on the MRI showing a disc bulge and protrusion, symptoms noted by Dr. Reichle, and Dr. Woods' examination.

Claimant seeks to "supplement" the record to correct Dr. Platt's statement from "I do concur with their report" to "I do not concur with their report." Inasmuch as our review is limited to that evidence developed at hearing, we treat claimant's request as a motion to remand for the taking of additional evidence. See ORS 656.295(5). We find such action to be unnecessary. The record already contains evidence that Dr. Platt initially did not concur with the panel's report and his subsequent letter to claimant's attorney shows that, despite stating that he did "concur" with a report rejecting a work connection, he also supported a causal relationship between claimant's low back condition and the November 1994 work accident. Under such circumstances, we find that the existing record suggests that Dr. Platt's subsequent letter contains a "scrivener's error;" i.e., we interpret Dr. Platt as supporting a connection between claimant's work accident and his low back condition. Thus, remand is not warranted.

When there is a dispute between medical experts, we rely on those opinions that are well-reasoned and based on an accurate and complete history. Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Reichle, because he first treated claimant following the work accident, was in the best position to evaluate whether the accident caused claimant's low back conditions. For this reason, we are more persuaded by Dr. Reichle's concurrence with the panel's report than Dr. Woods' disagreement, which was accompanied by no reasoning or explanation, and the opinion of Dr. Platt, claimant's current treating chiropractor.

Consequently, we conclude that, lacking persuasive medical evidence of a causal relationship between his low back condition and the November 1994 work accident, claimant failed to carry his burden in proving compensability.

ORDER

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

In the Matter of the Compensation of
BARBARA A. MITCHELL, Claimant
WCB Case Nos. 96-01385 & 96-01384
ORDER ON REVIEW (REMANDING)
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

Claimant filed a request for hearing on February 6, 1996. The matter was initially set for hearing on April 17, 1996, but was postponed. On May 9, 1996, claimant's attorney resigned as her counsel. The matter was rescheduled for hearing on September 18, 1996.

Claimant did not appear in person or through an attorney when the hearing was convened. On September 30, 1996, the ALJ issued an Order dismissing claimant's hearing request pursuant to OAR 438-006-0071(2), on the ground that claimant had abandoned her request for hearing.

Thereafter, claimant requested Board review of the ALJ's order. Requesting another hearing, claimant stated that she had written the wrong date for the hearing on her calendar and that she did not wish to abandon her claim.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or her attorney fail to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). We have previously held that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. William E. Bent II, 48 Van Natta 1560 (1996); Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992).

Here, in response to the ALJ's September 30, 1996 dismissal order, claimant submitted a letter requesting review of the ALJ's order, alleging that she did not attend the scheduled hearing because she had incorrectly recorded the date of the scheduled hearing. In light of these circumstances, we interpret claimant's correspondence as a motion for postponement of the scheduled hearing. See Mark Totaro, 49 Van Natta 69 (1997) (remand appropriate to consider motion to postpone when the claimant contended that ALJ's order was "erroneous" and that "injustice would result" if order not reversed); Compare James C. Crook, Sr., 49 Van Natta 65 (1997) (no compelling reason to remand when the claimant offered no explanation for failing to appear at hearing). Inasmuch as the ALJ did not have an opportunity to rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Randy L. Nott, 48 Van Natta 1 (1996); Olga G. Semeniuk, 46 Van Natta at 152.[1]

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[1] The SAIF Corporation argues that there is no justifiable reason for a postponement. We need not address SAIF's argument because it will have the opportunity to present its objections to the request for postponement to the ALJ on remand.

In determining that remand is appropriate, we emphasize, as we have in similar cases, that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have previously explained, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Olga G. Semeniuk, 46 Van Natta at 152.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ARCHIEL F. SANFORD, Claimant
WCB Case Nos. 93-10958, 93-10147 & 93-06783
ORDER ON REMAND
Black, Chapman, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Sanford v. Balteau Standard, 140 Or App 177 (1996). The court has reversed our prior order which affirmed the Administrative Law Judge's (ALJ's) order finding the SAIF Corporation responsible for claimant's low back condition. Archiel F. Sanford, 46 Van Natta 1736 (1994). The court has remanded for clarification of our decision.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's finding that "[claimant's] back condition due to the 1990 injury is lumbosacral strain, superimposed on degenerative and mechanical changes due to the 1985 surgery." Instead, we find that claimant's accepted back condition as a result of the 1990 and 1991 accepted claims with Scott Wetzel was a lumbar strain.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that responsibility for claimant's back condition remained with SAIF under claimant's accepted 1984 claim. Claimant requested Board review of the ALJ's order.

On Board review, claimant argued that his 1991 accepted back claim with Scott Wetzel involved the same condition as the 1984 SAIF injury. On that basis, claimant asserted that responsibility had shifted under ORS 656.308(1) from SAIF to Scott Wetzel.

We concluded that the medical evidence did not establish that claimant's accepted temporary lumbar strain in 1991 with Scott Wetzel, which resolved without permanent impairment, was related to his prior 1984 compensable injury with SAIF which resulted in L5 disc surgery, degenerative changes of the spine and joint pain and synovitis. We also reasoned that no medical evidence related claimant's current condition to the 1991 injury and that the persuasive medical evidence did not establish that claimant sustained a new compensable injury in 1993 (while Fireman's Fund insured the employer). Accordingly, we held that claimant's low back condition remained the responsibility of SAIF. Archiel F. Sanford, 46 Van Natta at 1736.

On review of our order, the court noted that neither claimant nor SAIF asserted that claimant suffered a new injury in 1993 when Fireman's Fund insured the employer. Instead, claimant and SAIF had argued that claimant's 1990 and 1991 treatments, which were accepted by Scott Wetzel on behalf of the employer, involved the same condition as the 1984 and 1985 treatments, which were accepted by SAIF. On the basis of that reasoning, claimant and SAIF asserted that, under ORS 656.308(1), responsibility for claimant's back condition shifted to Scott Wetzel (as the claims processor for the employer).

The court identified the critical issue as whether Scott Wetzel's acceptance, on behalf of the employer, involved the same condition as that accepted by SAIF in 1984 and 1985. The court indicated that if the condition accepted by Scott Wetzel involved the same condition as that accepted by SAIF, Scott Wetzel was responsible for claimant's current back condition. Conversely, the court reasoned that, if the condition accepted by Scott Wetzel on behalf of the employer did not involve the same condition as that accepted by SAIF, then SAIF remained responsible for claimant's current (1993) need for treatment.

The court noted that we adopted the ALJ's finding that "[claimant's] back condition due to the 1990 injury is lumbosacral strain, superimposed on degenerative and mechanical changes due to the 1985 surgery." The court stated that the above finding was potentially inconsistent with our later conclusion that: "the medical evidence fails to establish that claimant's temporary lumbar strain in 1991 which resolved without permanent impairment, is related to his prior 1984 injury which resulted in L5 disc surgery, degenerative changes of the spine and joint pain and synovitis." Because it could not determine whether our findings and conclusion were consistent, the court reversed and remanded for clarification.

After conducting our reconsideration, we find that the 1990 and 1991 conditions accepted by Scott Wetzel, on behalf of the employer, were lumbar strains. (Exs. 93; 98). The 1984/1985 accepted SAIF claim, by contrast, involved L5 disc surgery, degenerative changes of the spine and joint pain and synovitis. In reaching this conclusion, we note that Scott Wetzel's acceptance expressly referred to a "strain," rather than mentioning claimant's underlying degenerative back condition related to the 1984 SAIF injury. Furthermore, our conclusion is supported by our interpretation of the opinions offered by Dr. Lichtenstein, claimant's treating physician.

In referring to claimant's 1990 and 1991 injuries, Dr. Lichtenstein used the phrase "lumbar strain superimposed on [claimant's] pre-existing condition." Yet, Dr. Lichtenstein also had concluded that claimant suffered no residuals from either injury and that claimant's condition had returned to his "pre-1990 baseline." (Ex. 110b-1). Taken as a whole, we consider Dr. Lichtenstein's opinion to be supportive of a conclusion that claimant's 1990 and 1991 lumbar strains did not involve the same condition as his preexisting 1984 and 1985 low back degenerative conditions.[1]

Accordingly, we find that claimant's current (1993) need for medical treatment is related to his low back degenerative condition, which is the same condition accepted by SAIF, but not the same condition accepted by Scott Wetzel. Under such circumstances, SAIF remains responsible for claimant's medical services claim.

On reconsideration, as supplemented and clarified herein, we republish our August 31, 1994 Order on Review that affirmed the ALJ's December 29, 1993 order.

IT IS SO ORDERED.

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[1] In reaching its decision to return this case for further consideration, the court expressed concerns regarding the meaning of the term "superimpose." Referring to its definition in Webster's Third New International Dictionary (unabridged 1971), at 2294, the court reasoned that "superimpose" may mean to become interrelated with something else or to overlap something without integration. In response to the court's inquiry, we believe that the definition of "superimposed" will necessarily require case by case definition because it is a medical term (versus a legal / statutory term, such as "objective findings" under ORS 656.005(19) for example). In other words, any particular definition of "superimposed" will necessarily derive from the medical expert's utilization of the term in the context of the specific medical evidence in a given case. Here, based on the context of Dr. Lichtenstein's opinion, we interpret the treating physician's use of the term "superimposed" to mean that the 1984 and 1985 degenerative condition overlapped, but did not integrate with the 1990 and 1991 strains. Consequently, we find that claimant's 1990 and 1991 strains did not involve the same condition as the 1984 and 1985 degenerative condition.

Board Chair Hall specially concurring.

The court stated that the "critical issue" in this case is whether Scott Wetzel's acceptance, on behalf of the employer, of claimant's claims for "lumbar strain" did, in fact, involve the same condition as that accepted by SAIF in 1984 and 1985. The court's opinion focuses on what condition was accepted by the carriers rather than what conditions actually existed medically as a result of the 1984-85 and 1990-91 injuries. Our analysis on remand has followed the court's instruction and framing of the issue.

ORS 656.308(1) refers to whether the claimant sustains a new compensable injury "involving" the same condition. The term "involving" is not statutorily defined. In interpreting the court's decision herein, the question remains whether the court intended to equate "involving" with what was technically "accepted." We have, here on remand, interpreted the court to define "involving" as "acceptance." I specially concur because of the lingering doubt I have regarding the court's focus on the "acceptance," rather than the actual medical condition (when these two are potentially different).

February 6, 1997 Cite as 49 Van Natta 124 (1997)

In the Matter of the Compensation of
BOBBI K. AMATO, Claimant
WCB Case No. 96-04527
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Schultz' order that: (1) affirmed an Order on Reconsideration that awarded claimant 9 percent (28.8 degrees) unscheduled permanent disability for a cervical/dorsal injury; and (2) awarded claimant's counsel an insurer-paid attorney fee under ORS 656.382(2). On review, the issues are extent of unscheduled permanent disability and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained an injury at work on May 4, 1995, which was accepted by the insurer as "cervical/dorsal strain." Dr. Farris, an examining physician, found lost ranges of cervical motion. Dr. Farris attributed 50 percent of claimant's lost range of motion to her compensable injury and 50 percent to her preexisting degenerative disc disease. Claimant's attending physician concurred with Dr. Farris' reports.

The claim was closed by a February 7, 1996 Determination Order which awarded claimant 5 percent unscheduled permanent disability. Although the total lost range of motion based on Dr. Farris' findings (as concurred with by claimant's attending physician) equaled 9 percent, the award was reduced to 5 percent because of claimant's preexisting degenerative condition. Claimant requested reconsideration of the Determination Order. An April 22, 1996 Order on Reconsideration awarded claimant 9 percent unscheduled permanent disability for lost range of motion without any reduction for claimant's preexisting degenerative condition.

The ALJ found that claimant's compensable injury had combined with her preexisting degenerative disc disease. See ORS 656.005(7)(a)(B). Because the insurer had not issued a denial pursuant to ORS 656.262(7)(b)[1] prior to closing the claim, the ALJ found that the insurer was precluded from arguing that any of claimant's impairment was not "due to" the compensable injury. We disagree with the ALJ's conclusion.

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[1] ORS 656.262(7)(b) provides: "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

Subsequent to the ALJ's order, in Robin W. Spivey, 48 Van Natta 2363 (1996), we held that ORS 656.262(7)(b) was inapplicable unless a condition had been accepted under ORS 656.005(7) as a "combined condition."

Here, the insurer accepted "cervical/dorsal strain." Claimant did not request the insurer to accept, nor did the insurer voluntarily accept, a combination of cervical/dorsal strain and degenerative disc disease. Thus, ORS 656.262(7)(b) does not apply to this claim. Fe D. Delariarte, 48 Van Natta 2485 (1996), on recon 49 Van Natta 39 (1997); Robin W. Spivey, supra.

Turning to the merits (i.e., the extent of permanent disability due to claimant's accepted cervical/dorsal strain), the parties agree that if the insurer prevails on its "combined condition" argument, claimant's unscheduled permanent disability award should not be reduced below the 5 percent awarded by the Determination Order since the insurer did not seek reconsideration of that award. Accordingly, we modify the Order on Reconsideration to reinstate the 5 percent unscheduled permanent disability award.

Inasmuch as claimant's compensation has been reduced on review, she is not entitled to an attorney fee pursuant to ORS 656.382(2). Consequently, we reverse the ALJ's award of an assessed attorney fee.

ORDER

The ALJ's order dated August 22, 1996 is modified in part and reversed in part. The Order on Reconsideration is modified to affirm the Determination Order award of 5 percent (16 degrees) unscheduled permanent disability. The ALJ's award of an attorney fee is reversed.

In the Matter of the Compensation of
CRAIG L. HIATT, Claimant
WCB Case No. 92-14383
SECOND ORDER ON REMAND
Donald E. Beer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Hiatt v. Halton Company, 143 Or App 579 (1996). The court has reversed our prior order, Craig L. Hiatt, 47 Van Natta 2287 (1995), which had upheld the self-insured employer's denial of claimant's left hearing loss condition. Citing Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), the court has remanded for reconsideration.

In reaching our prior decision, we applied ORS 656.262(10) to conclude that the employer's payment of a prior unappealed permanent disability award for a noncompensable left hearing loss condition under the accepted left ear otitis media claim did not preclude the employer from later denying the left hearing loss condition. Craig L. Hiatt, 47 Van Natta at 2287. Relying on its holding in Messmer, the court has reversed and remanded for reconsideration.

In Messmer, the court concluded that, since ORS 656.262(10) did not address the consequences of a carrier's failure to appeal a permanent disability award, its holding in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) continued to be controlling. Inasmuch as the court's first decision in Messmer controls, it follows that the employer's failure to appeal claimant's permanent disability award for the left hearing loss condition precludes it from now contesting the compensability of the condition.

Consequently, on reconsideration of our prior decisions, we affirm those portions of the Administrative Law Judge's order dated February 25, 1993 which set aside the employer's denial and awarded a $3,000 employer-paid attorney fee.

Next, we address claimant's entitlement to an employer-paid attorney fee for services rendered before the Board (on our initial review and on remand following the court's initial remand decision) and before the court (on appeal of our Order on Review and our first Order on Remand).[1]

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); Mark L. Hadley, 47 Van Natta 725 (1995). Here, since claimant did not finally prevail until issuance of this Order on Remand, statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum. Id. However, pursuant to its May 9, 1995 order allowing attorney fees and its June 12, 1995 appellate judgment, the court has already granted a $3,756 carrier-paid attorney fee for services rendered before the Board on review and the court prior to its initial remand decision.

Inasmuch as neither party challenges the statutory basis for such an award, we shall likewise not examine that question. Mark L. Hadley, 47 Van Natta at 726. In any event, after considering the factors set forth in OAR 438-015-0010(4), we find that such an award represents a reasonable attorney fee for claimant's counsel's services before the Board on review of the ALJ's order and the court on review of our initial order. Likewise, based on a review of the aforementioned factors, we find that the ALJ's $3,000 attorney fee award is a reasonable attorney fee for claimant's counsel's services at hearing.

Finally, we turn to a determination of a reasonable attorney fee for claimant's counsel's services on remand before the Board and before the Court of Appeals on review of our first remand order. 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 remand before the Board and on court review of that remand decision is $3,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated. This award is in addition to the previous $3,000 and $3,756 awards, resulting in a total award for services rendered before all prior forums of $9,756, to be paid by the employer.

IT IS SO ORDERED.

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[1] Other than submitting a statement of services and providing argument in support of an attorney fee award, claimant's counsel has not provided additional legal services regarding the compensability issue during this remand proceeding.

In the Matter of the Compensation of
THOMAS J. KOLLEN, Claimant
WCB Case No. 96-03549
ORDER ON RECONSIDERATION
Flaxel & Nylander, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

On January 10, 1997, we abated our December 13, 1996 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order 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. We took this action to consider the SAIF Corporation's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

Claimant, a carpenter, began working for the employer on October 2, 1995, at a wage of $10 per hour. (Tr. 3). He worked until November 27, 1995, when he was laid off due to a lack of work. Claimant returned to work for the employer on January 2, 1996 at the same wage. He injured his right leg on January 3, 1996 and SAIF accepted a disabling claim for a right lower leg contusion and torn anterior horn of the lateral meniscus of the right knee. (Ex. 4).

On February 22, 1996, SAIF informed claimant that his time loss rate had been recalculated and notified him of an overpayment of $96.52. (Ex. 4a). Claimant appealed to the Director. On April 5, 1996, the Director issued a "Proposed and Final Order on Weekly Wage for Computing Temporary Disability Rate," affirming SAIF's recalculation. Claimant requested a hearing.

In our prior order, we found that claimant was employed less than 52 weeks before he was injured. Although claimant was laid off from November 27, 1995 to January 2, 1996, there was no change in the amount or method of the wage earning agreement during his employment. We applied former OAR 436-60-025(5)(a) (WCD Admin. Order 94-055),[1] which provides that, for workers employed less than 52 weeks, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Since claimant was employed less than 52 weeks, we concluded that SAIF was to calculate his temporary total disability benefits by using claimant's actual weeks of employment. We determined that SAIF incorrectly recalculated claimant's temporary total disability benefits.

On reconsideration, SAIF contends that we incorrectly interpreted former OAR 436-60-025(5)(a). SAIF argues that the phrase "actual weeks of employment" in former OAR 436-60-025(5)(a) is 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 asserts 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.

Even if we assume that SAIF is correct that the phrase "actual weeks of employment" in former OAR 436-60-025(5)(a) can 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 has no

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[1] Former OAR 436-60-025(5)(a) provides, in part:

"The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *

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

application in this case. According to SAIF, claimant was "employed" from October 2, 1995 through January 3, 1996. SAIF argues that claimant continued to be "employed" during the layoff period from November 27, 1995 through January 2, 1996. We disagree.

The ALJ found, and we agree, 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).

Although the employer testified that he told claimant that he was going to bring him back to work on a commercial job (Tr. 26), the employer did not explain whether he told that to claimant at the time he was laid off. The employer was not asked whether or not he told claimant to look for other work. Based on claimant's testimony, we conclude that, at the time claimant was laid off, he was told by the employer that he should take another job if he could find one.

Although SAIF argues that claimant continued to be "employed" during the layoff period from November 27, 1995 through January 2, 1996, SAIF does not explain why, if claimant was a "worker" who was continuously employed, he performed no work for the employer and received no wages. Rather, claimant indicated he was receiving unemployment benefits after he was laid off on November 27, 1995. Moreover, claimant was told by the employer that he should look for another job.

ORS 656.210(2)(b)(A) provides that temporary disability benefits of a worker who incurs an injury are based on the "wage" of the "worker" at the time of injury. See also former OAR 436-60-025(1) (the rate of compensation shall be based on the wage of the worker at the time of injury). ORS 656.210(1) provides that when the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66 -2/3 percent of "wages." Former OAR 436-60-025(5) 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." (Emphasis added).

A "worker" is defined, in part, as "any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer[.]" ORS 656.005(30). 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[.]" The definition of "wages" does not include unemployment benefits. David D. Plueard, 47 Van Natta 1364 (1995) (unemployment benefits were not included in time loss calculation).

Since claimant was not receiving any wages between November 27, 1995 and January 2, 1996 and was told to seek other employment, we previously concluded that he was not a "worker" employed by the employer during that period. On reconsideration, we adhere to our conclusion that SAIF incorrectly recalculated claimant's temporary total disability benefits.[2] The time period between November 27, 1995 and January 2, 1996 should not be included in determining claimant's average weekly wage.

Claimant's attorney is entitled to an attorney fee for services on reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted

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[2] SAIF points out that the Director has since amended OAR 436-60-025(5) (WCD Admin. Order No. 96-070), effective November 27, 1996. However, claimant's rate of temporary disability compensation is based on his wage at the time of injury. Since claimant was injured on January 3, 1996, the former rules apply. Former OAR 436-060-025(1). We do not address the validity or interpretation of the new rules.

to the issue (as represented by the claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved. This award is in addition to claimant's previous attorney fee awards.

On reconsideration, as supplemented herein, we adhere to and republish our December 13, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GERMAN C. RONQUILLO, Claimant
WCB Case No. 95-12708
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) declined to grant claimant's requests to remand his nasal and left thumb claims to the Director for the adoption of temporary rules regarding his permanent impairment; and (2) affirmed an Order on Reconsideration that did not award unscheduled permanent disability for claimant's nasal injury. In its respondent's brief, the self-insured employer contests that portion of the ALJ's order which remanded claimant's left thumb claim to the Director insofar as the claim pertained to a loss of extension in the MP joint and objects to the inclusion in claimant's appellant's brief of pages from the AMA Guides to the Evaluation of Permanent Impairment. On review, the issues are the employer's motion to strike, remand, and extent of permanent disability (unscheduled and scheduled). We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction, exception, and supplementation. Claimant's claim was closed by a March 10, 1995 Notice of Closure, not a Determination Order.

We do not adopt the ALJ's third ultimate finding of fact.

Claimant had sustained a previous facial injury, which involved multiple fractures. These fractures were demonstrated on films taken on June 29, 1993, before the February 28, 1994 compensable injury which resulted in a fractured nose, bruised right ribs, and left thumb sprain. (Ex. 32A-1).

Claimant requested reconsideration of the March 10, 1995 Notice of Closure and appointment of a medical arbiter panel. Drs. Becker and Ballard, orthopedic surgeons, and Dr. Stoner, otolaryngologist, were appointed to the medical arbiter panel. (Exs. 32, 32A). Dr. Stoner separately examined claimant regarding the fractured nose and issued a separate report regarding that condition. (Exs. 32-4, 32A).

The November 17, 1995 Order on Reconsideration (OOR) specifically found that the Director's disability standards "address all impairments in this claim." (Ex. 33-4).

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

In his briefs on review, claimant argues that he is entitled to an impairment rating for his nasal condition. Specifically, claimant contends that, following the surgery to correct his fractured nose, he was left with a slight nasal deformity which entitles him to an impairment rating. In support of this contention, with his opening brief, claimant attached copies of a couple of pages that are apparently copied from the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides). Claimant highlighted the portion of a table dealing with "Facial Disfigurement and Impairments" which states that

"[n]asal distortion in physical appearance" can result in "0-5" percent "[i]mpairment of the whole person." The employer objects to these attachments, arguing that the Board may not consider them both under ORS 656.283(7)[1] and because they were not admitted as evidence at hearing. Claimant responds that the Board may take administrative notice of these attachments.

Although we have authority to consider additional evidence not admitted at the hearing and not a part of the record, we may take administrative notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 656.295(5); Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); ORS 40.065. However, for the reasons that follow, we need not resolve the issue of whether these attachments are strikable under ORS 656.283(7) or whether they meet the criteria of evidence of which we may take administrative notice because, even if we considered these attachments, they would not affect the outcome of the merits of claimant's entitlement to impairment for his nasal condition.

A worker's disability is evaluated as of the date of issuance of the OOR, applying the standards in effect as of the date of claim closure. ORS 656.283(7), 656.295(5); OAR 436-035-0003(2). Claimant's claim was closed by Notice of Closure dated March 10, 1995. (Ex. 31). Therefore, the applicable standards are found at WCD Admin. Orders 6-1992 and 93-056. Impairment is determined either by the attending physician or the medical arbiter. Former OAR 436-35-007(9). On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, unless a preponderance of medical opinion establishes a different level of impairment. Id. It is claimant's burden of proving the extent of any disability resulting from the compensable injury. ORS 656.266.

Here, neither the attending physician, Dr. Allan, nor the medical arbiters, Drs. Becker, Ballard, and Stoner, opined that claimant has any impairment due to his compensable nose fracture injury. Claimant had sustained a previous facial injury, which involved multiple fractures. These fractures were demonstrated on films taken on June 29, 1993, before the February 28, 1994 compensable injury which resulted in a fractured nose, bruised right ribs, and left thumb sprain. (Ex. 32A-1). Dr. Allan surgically repaired claimant's fractured nose. (Ex. 13). In his operative report, Dr. Allan stated that, following surgical repair, "a slight residual deformity [was] noted, possibly preexisting." (Ex. 13-1). In addition, Dr. Allan noted that "[t]here was still a slight asymmetry but generally pleasing. The right nasal bones could not be moved and it is suspected were not involved in the fracture. * * * [The surgical procedure] provided good straightening of the septum and improvement of the airway." Id. In his supplemental medical report, Dr. Allan noted that claimant was medically stationary as of June 14, 1994, but did not address impairment. (Ex. 30). Thus, Dr. Allan's opinion does not support any nasal impairment resulting from the compensable injury.

Regarding the medical arbiters, two separate reports were issued, with the orthopedists, Drs. Becker and Ballard, issuing a report primarily addressing the right rib and left thumb strain injuries and the otolaryngologist, Dr. Stoner, issuing a report solely addressing the fractured nose injury. Regarding claimant's nose, Drs. Becker and Ballard noted that "there was no major deformity about the periorbital or facial bones, although with [claimant's] nose slightly to the right." (Ex. 32-3). They deferred to Dr. Stoner the "ultimate evaluation" regarding any breathing problems or other residuals as a result of claimant's fractured nose. (Ex. 32-4).

Dr. Stoner noted that claimant had sustained a previous facial injury, which involved multiple fractures as revealed by films taken about eight months before the compensable nose fracture. (Ex. 32A-1). Dr. Stoner opined that:

> "[f]rom the review of the records and the examination of [claimant], it appears most reasonable that [claimant] had a pre-existing injury and deformity, which was aggravated by the February 28, 1994 [work-related] fall. [Following surgery to correct the compensable nose fracture, claimant] continues to have residual decrease in his nasal breathing, which, based on Dr. Allan's findings, at surgery, are more likely the result of pre-existing deformity. There are no other residuals. This decrease in nasal breathing is relatively mild and I would not expect this to interfere with the worker's day to day activities." (Ex. 32A-2) (Emphasis added).

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[1] The relevant portion of ORS 656.283(7) provides: "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing. . . ."

Thus, Dr. Stoner does not relate any impairment to the compensable nasal injury. In addition, although Drs. Allan, Becker, and Ballard note a slight asymmetry regarding claimant's nose, none of these physicians opine that this slight asymmetry results in any impairment. In fact, in addition to questioning whether this "residual deformity" is related to the compensable injury, Dr. Allan notes that the result of the corrective surgery was "generally pleasing." (Ex. 13-1). Thus, there is no persuasive medical evidence to support claimant's contention that his slight nasal asymmetry results in impairment. Therefore, even if we considered the AMA Guides submitted by claimant, the record does not support a finding that claimant has meet his burden of proving any impairment related to the nasal injury.

Remand to the Director for Temporary Rules

At hearing, claimant requested remand to the Director for adoption of temporary rules to address his unscheduled impairment (relating to his nasal injury) and scheduled impairment (relating to his left thumb injury).[2] The ALJ declined to remand to the Director for temporary rules regarding unscheduled impairment, concluding that claimant had not established any impairment due to the nasal injury. For the reasons discussed above, as well as those addressed in the ALJ's order, we adopt and affirm that portion of the ALJ's reasoning and opinion. See Susan D. Wells, 46 Van Natta 1127 (1994) (no remand to the Director for temporary rules where the claimant failed to meet her burden of proving that her disability was not addressed by the standards).

On the other hand, the ALJ set aside that portion of the OOR that awarded 6 percent (9 degrees) scheduled permanent disability for loss of use or function of the left hand and remanded the extent of scheduled permanent disability issue to the Director for promulgation of a temporary rule regarding loss of extension of the left thumb at the MP joint, an impairment the ALJ found was not addressed by the standards. On review, claimant argues that the standards also do not address his radial deviation and ulnar collateral ligament laxity in the MP joint of the left thumb. Therefore, he contends, the remand to the Director should also include instructions to promulgate temporary rules for those additional left thumb impairments. The employer counters that claimant's left thumb impairment is addressed by the standards, so there should be no remand to the Director for promulgation of any temporary rules. We agree with the employer.

Under ORS 656.726(3)(f)(C), the Director shall stay further proceedings and shall adopt temporary rules when "it is found that the worker's disability is not addressed by the standards. . . ." The Board has the authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). Claimant has the burden of proving that his disability is not addressed by the standards. See ORS 656.266; Susan D. Wells, supra.

Here, claimant contends that he is entitled to additional scheduled permanent disability for loss of extension, radial deviation, and ulnar collateral ligament laxity in the MP joint of the left thumb. Claimant also argues that the Director's adoption of temporary rules in other cases involving lateral deviation of the digits and instability of the MP joint of the thumb supports his entitlement to similar awards.

The OOR makes an express finding that "[t]he Division 35 rules [the standards] address all impairments in this claim." (Ex. 33-4). Furthermore, the OOR awarded impairment for loss of IP flexion of the left thumb and awarded chronic condition impairment of the left hand regarding decreased pinching and gripping ability related to the ulnar collateral ligament laxity. (Ex. 33-3). In light of the Director's findings, we conclude that claimant has not proven that his disability is not addressed in the standards. See Robert W. Wilmot, 48 Van Natta 1525 (1996); Terry I. Hockett, 48 Van Natta 1297 (1996).

Furthermore, we are not persuaded by claimant's argument that, because other workers have been awarded impairment for lateral deviation of the digits and instability of the MP joint of the thumb, an award is appropriate in this case. Temporary rules are promulgated to address individual workers'

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[2] On review, citing ORS 656.268(8) and 656.283(7), the employer argues that claimant cannot raise the issue of remand to the Director for adoption of temporary rules regarding any thumb impairment because he did not raise that issue during the reconsideration process. We need not address the employer's argument, because we conclude that claimant has failed to establish that he has scheduled permanent disability that is not addressed by the standards.

impairment. See Wanda E. Scanlon, 47 Van Natta 1464 (1995). Consequently, because the circumstances and disabilities of all workers vary, we are unable to say that the Director's failure to promulgate a temporary rule in this situation is inconsistent with his actions in other cases. Terry J. Hockett, supra.

Accordingly, on this record, we conclude that claimant has failed to prove that the standards do not adequately address his disability. ORS 656.266; Robert W. Wilmot, supra; Terry J. Hockett, supra; Susan D. Wells, supra. Therefore, we have no authority to remand to the Director pursuant to ORS 656.726(3)(f)(C). The ALJ's remand ruling is reversed.

Extent of Unscheduled Permanent Disability

For the reasons addressed in the above section entitled "Motion to Strike," we find that claimant has failed to establish any impairment due to the compensable nasal injury. Because measurable impairment is a prerequisite to awarding unscheduled permanent disability, we conclude that claimant is not entitled to an unscheduled permanent disability award. Former OAR 436-35-320(2).

Extent of Scheduled Permanent Disability

Because the ALJ remanded the scheduled permanent disability claim to the Director for promulgation of a temporary rule regarding claimant's loss of terminal extension in the MP joint of the left thumb, he did not rate extent of scheduled permanent disability. We find that the standards address claimant's thumb impairment; therefore, we proceed to rate that impairment.

Drs. Becker and Ballard evaluated claimant's left thumb impairment and measured 76 degrees of flexion in the left IP joint, which translates to 2.4 percent impairment of the thumb, which is rounded to 2 percent. Former OAR 436-35-050(1); OAR 436-35-007(11). Their measurement of range of motion relating to the left MP joint is less clear; however, we interpret it to mean that claimant has retained flexion of 55 degrees.[3] This translates to 4.5 percent impairment of the thumb, which is rounded to 5 percent. Former OAR 436-35-050(3). These values are combined for a total motion impairment of the left thumb of 7 percent. Former 436-35-050(5). This converts to 3 percent impairment of the hand.

Finally, Drs. Becker and Ballard opined that claimant's left "thumb ulnar collateral ligament rupture with residual laxity" represented "an ongoing problem with strong pinching or gripping where opposition or stability of the thumb is required." This opinion supports a finding that claimant is unable to repetitively use his left hand due to a chronic and permanent medical condition, which entitles claimant to a 5 percent chronic condition impairment for his left hand. Former OAR 436-35-010(6). The hand impairment values are combined for a total scheduled permanent disability award of 8 percent (12 degrees). Former OAR 436-35-075(5).

Claimant's attorney is awarded an out-of-compensation fee of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. OAR 438-015-0055(1).

ORDER

The ALJ's order dated September 5, 1996 is reversed in part and affirmed in part. Those portions of the order that reversed the November 17, 1995 Order on Reconsideration's award of scheduled permanent disability and remanded the scheduled permanent disability claim to the Director for promulgation of a temporary rule are reversed. In addition to the November 17, 1995 Order on Reconsideration's award of 6 percent (9 degrees) scheduled permanent disability for loss of use or function of the left hand, claimant is awarded 2 percent (3 degrees), giving claimant a total award to date of 8 percent (12 degrees) scheduled permanent disability for loss of use or function of the left hand. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly from claimant's compensation to claimant's attorney by the self-insured employer. The remainder of the ALJ's order is affirmed.

[3] Specifically, Drs. Becker and Ballard state that "[t]humb MP joint range of motion had a measurable 5 degree radial deviation, as compared to the opposite right thumb with a 5 degree loss of terminal extension as compared to the opposite right thumb with flexion to 60 degrees for 55 degree range of motion on the left." (Ex. 32-3).

In the Matter of the Compensation of
CECELIA A. TALBERT, Claimant
WCB Case No. 96-02825
ORDER ON RECONSIDERATION
Walker & Potter, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On January 8, 1997, we reversed an Administrative Law Judge's (ALJ's) order that had set aside the SAIF Corporation's denial of claimant's occupational disease claim for left carpal tunnel syndrome. Submitting new evidence which he believes will effect our prior decision, claimant seeks reconsideration. Specifically, claimant asks that we redetermine compensability in light of a report from Dr. Thomas Rosenbaum, who saw claimant after the hearing, or remand the case to the ALJ for admission of the report.

We have no authority to consider evidence that was not admitted at hearing. Under ORS 656.295(5), however, we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the case; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

In her motion, claimant explains that she did not see Dr. Thomas Rosenbaum[1] until August 1996, subsequent to the June 1996 hearing, and thus his report was not obtainable at the time of hearing. Claimant further contends that, because Dr. Rosenbaum stated in his report that claimant's "symptoms are work related on an occupational basis," his report concerns disability and will affect the Board's decision concerning compensability.

Claimant must show that employment conditions were the major contributing cause of her left carpal tunnel syndrome in order to prove compensability. ORS 656.802(2)(a). Dr. Rosenbaum's report does not meet this standard since he indicates only that claimant's "symptoms" are work related. Dr. Rosenbaum also does not specify that the symptoms are "work related" because claimant's job was the major contributing cause of the left carpal tunnel syndrome. Thus, particularly when considered in light of the countervailing medical opinions discussed in our prior decision, we find that it is not reasonably likely that Dr. Rosenbaum's report would affect the outcome of our decision. Therefore, there is no compelling reason to remand.

Accordingly, we withdraw our January 8, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our January 8, 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] At the time of hearing, claimant was treating with Dr. Robert Rosenbaum.

In the Matter of the Compensation of
JENNIE S. DEBELLOY, Claimant
WCB Case No. 96-00913
ORDER ON REVIEW (REMANDING)
Nancy Marque (Saif), Defense Attorney

Reviewed by Board members Haynes and Biehl.

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

FINDINGS OF FACT

Claimant filed a request for hearing on January 19, 1996. The matter was initially set for hearing on April 11, 1996, but was postponed after claimant's attorney withdrew as counsel on March 5, 1996. The matter was rescheduled for hearing on September 13, 1996.

Claimant did not appear in person or through an attorney when the hearing was convened on September 13, 1996. On September 18, 1996, the ALJ issued an order dismissing claimant's hearing request pursuant to OAR 438-006-0071(2), on the ground that claimant had abandoned her request for hearing.

Thereafter, claimant requested Board review of the ALJ's order, asserting that she did not intend to abandon her claim and that she had been advised by her counsel not to attend the hearing. Claimant further stated that it was her understanding that there would be no hearing and that she was in the process of seeking new legal counsel.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or his or her attorney fail to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). It is well-settled that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. William E. Bent II, 48 Van Natta 1560 (1996); Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992).

Here, in response to the ALJ's September 18, 1996 dismissal order, claimant submitted a letter requesting review of the ALJ's order, alleging that she did not appear at the hearing on the advice of legal counsel that had since withdrawn. In light of these circumstances, we interpret claimant's correspondence as a motion for postponement of the scheduled hearing. See Mark Totaro, 49 Van Natta 69 (1997) (remand appropriate to consider "Motion to Postpone" when the claimant contended that ALJ's order was "erroneous" and that "injustice would result" if the ALJ's order was not reversed); compare James C. Crook, Sr., 49 Van Natta 65 (1997) (no compelling reason to remand when the claimant offers no explanation or argument concerning his failure to appear at hearing). Inasmuch as the ALJ did not have an opportunity to rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Randy L. Nott, 48 Van Natta 1 (1996); Olga G. Semeniuk, supra.

In determining that remand is appropriate, we emphasize, as we have in similar cases, that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have previously explained, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Olga G. Semeniuk, supra.[1]

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

Accordingly, the ALJ's September 18, 1996 order is vacated. This matter is remanded to ALJ Lipton to determine whether postponement of claimant's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT D. HANNINGTON, Claimant
WCB Case No. 95-13703
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's "de facto" denial of claimant's claim for anxiety, depression, lumbosacral disc bulges and herniations, skin and back tissue scarring, and vertebrae injury conditions. The employer cross-requests review of that portion of the order that assessed an attorney fee for claimant's counsel's services in setting aside the employer's "de facto" denial of claimant's claim for lumbosacral sprain and tongue and mouth irritation conditions. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee of $1,000 for prevailing over the employer's "de facto" denial of claimant's lumbosacral sprain and tongue and mouth irritation conditions. ORS 656.386(1). On review, the employer argues that claimant's attorney is not entitled to an assessed attorney fee under ORS 656.386(1) because claimant failed to establish he was denied any compensation with respect to these two conditions. For the following reasons, we agree with the ALJ.

ORS 656.386(1) is the statutory provision for attorney fees in cases involving "denied claims." For purposes of that statutory section, a "denied claim" is one which the carrier "refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." In deciding whether there is a "denied claim," our focus is on whether there is evidence that the carrier has refused to pay compensation because it questioned causation. E.g., Michael J. Galbraith, 48 Van Natta 351 (1996).

For instance, in Galbraith, the only evidence that arguably showed that the carrier challenged causation was its response to the claimant's request for hearing stating that "claimant is entitled to no relief." We found such evidence did not constitute proof that the carrier questioned causation and, thus, an assessed fee was not warranted. 48 Van Natta at 351-52. On the other hand, we concluded in Emily M. Bowman, 48 Van Natta 1199 (1996), that a carrier's response to a request for hearing denying that

the claimant sustained a work-related injury or occupational disease was a refusal to pay compensation on the express ground that the condition was not compensable. Hence, we found that there was a "denied claim" for purposes of awarding a fee under ORS 656.386(1).

We find Bowman directly on point. Here, as in Bowman, the employer responded to claimant's request for hearing by denying that claimant sustained a work-related injury or occupational disease. We conclude that this response is a refusal to pay compensation on the express ground that the condition was not compensable. Therefore, we find that claimant is entitled to a fee under ORS 656.386(1).

Claimant is not entitled to an attorney fee for his counsel's services in defending the attorney fee award. Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 30, 1996, as reconsidered on August 12, 1996, is affirmed.

February 10, 1997 Cite as 49 Van Natta 136 (1997)

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
Own Motion No. 94-0277M
OWN MOTION ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
SAIF Legal Department, Defense Attorney

The Board issued a Second Own Motion Order on Reconsideration on March 26, 1996, in which we dismissed claimant's request for temporary disability compensation for his compensable right leg injury because we lacked jurisdiction to consider claimant's request. We based our order, in part, on Administrative Law Judge (ALJ) Poland's February 23, 1996 Opinion and Order, which had enforced a prior ALJ's order that had remanded a claim to the Department to proceed with reconsideration under ORS 656.268. Reliance on that order led us to conclude that the Board, in its Own Motion jurisdiction, did not have authority to consider claimant's request for relief in a claim in which claimant's aggravation rights had not expired under ORS 656.273(4)(a) and (b).

However, ALJ Poland's order was appealed to the Board. In a December 31, 1996 Order on Review, the Board reversed ALJ Poland's order, concluding that the prior ALJ's order (a November 29, 1994 Opinion and Order issued by ALJ Davis) was invalid, and, thus, not "enforceable." James W. Jordan, 48 Van Natta 2602 (1996). This order was subsequently appealed to the court. Because the Board's holding affects our jurisdiction in this matter, we conclude that our March 26, 1996 Own Motion order was premature.

In extraordinary circumstances we may, on our own motion, reconsider a prior order. OAR 438-012-0065(2). Under the particular facts of this case, we find that extraordinary circumstances exist that justify reconsideration of our prior orders. Therefore, we withdraw our prior orders for the purposes of reconsideration, and implement the following evidence / briefing schedule.

SAIF opposes reopening of claimant's claim, contending that claimant was not in the work force at the time of disability. Claimant has the burden of proof on this issue. Therefore, within 14 days after the date of this order, claimant is requested to submit evidence to the Board and to the SAIF Corporation supporting his contention that he qualifies for own motion relief. SAIF is requested to file a response to claimant's opening submission within 14 days after the mailing date of claimant's response. Claimant's reply shall be due 14 days from the mailing of SAIF's response. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY L. KOCHER, Claimant
WCB Case No. 96-03155
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) admitted into evidence surveillance videotapes of claimant; and (2) affirmed an Order on Reconsideration awarding claimant 9 percent (28.8 degrees) unscheduled permanent disability for a cervical injury. On review, the issues are evidence and extent of permanent disability.

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

At hearing, the ALJ admitted into evidence two videotapes of claimant made in December 1995, following the November 3, 1995 closure of his cervical strain claim. The ALJ found that since the videotapes were submitted on reconsideration and made part of the reconsideration record, they were admissible at hearing under amended ORS 656.283(7) even though they were not considered by the appellate reviewer.[1] On review, claimant contends the ALJ erred in admitting the videotapes and considering them as evidence of his permanent disability. We disagree.

The videotapes were submitted to the Department prior to the issuance of the Order on Reconsideration and were part of the reconsideration record. There is, therefore, no statutory prohibition to their admission at hearing. Amended ORS 656.283(7); compare Tim L. Besheone, 48 Van Natta 2337 (1996) (impeachment evidence that was not submitted at reconsideration, and not made part of the reconsideration record, is statutorily inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability). In addition, we find no abuse of discretion in the ALJ's decision to admit the videotapes into evidence. The videotapes, which depict claimant actively working on a Christmas tree farm in December 1995, are relevant to claimant's permanent disability insofar as they pertain to claimant's credibility and the history on which the medical experts relied, as well as the accuracy of the medical findings.

ORDER

The ALJ's order dated August 20, 1996 is affirmed.

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[1] In determining claimant's impairment, the appellate reviewer refused to consider any evidence submitted by the parties on reconsideration that was obtained subsequent to claim closure. (See Ex. 102-4).

In the Matter of the Compensation of
CHARLES H. TOUPS, Claimant
WCB Case No. 95-09541
ORDER ON REVIEW
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Neal's order that upheld the insurer's denial of his occupational disease claims for toxic exposure, eye strain, elevated blood histamine, vascular inflammation, hemorrhoids and a cyst condition. With his brief, claimant submits a medical release form, a medical report and a letter from an attorney regarding claimant's complaints to the Oregon State Bar. We treat claimant's additional submissions, which were not admitted into evidence at the hearing, as a motion for remand. 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.

Remand

Claimant has included with his brief a medical release form, a medical report from Dr. Taylor and a letter from an attorney regarding claimant's complaints to the Oregon State Bar, which were not admitted into evidence at the hearing. Since our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. See Judy A. Britton, 37 Van Natta at 1262.

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

Here, claimant has offered no reasons why the medical release form, a medical report from Dr. Taylor and a letter from an attorney regarding claimant's complaints to the Oregon State Bar were unobtainable with due diligence at the August 14, 1996 hearing. Furthermore, the proffered evidence will not likely affect the outcome of the case. Therefore, we deny claimant's request for remand.

Compensability

On page 2, after the first paragraph of the "Opinion," we add the following paragraph:

"Due to the number of potential causes of claimant's conditions and the passage of time, the causation issue is a complex medical question which requires expert medical evidence for its resolution. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993)."

We adopt the ALJ's reasoning and conclusion regarding compensability.

ORDER

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

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

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for her 1976 compensable sprain / strain to the back, L4-5 disc herniation injury. Claimant's aggravation rights expired on March 29, 1989. On March 15, 1996, SAIF issued a denial of the compensability of claimant's current right knee medical meniscus tear condition. In addition, SAIF opposed reopening of the claim on the grounds that: (1) it is not responsible for claimant's current condition; 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. 96-02953).

In an April 4, 1996 letter, SAIF noted that claimant requested temporary disability compensation under her 1976 injury claim for two proposed surgeries: one for repair of claimant's right medial meniscus tear; and the other to fuse claimant's back. As noted above, SAIF formally denied the compensability of claimant's right medial meniscus tear condition on March 15, 1996. In its April 4, 1996 letter, SAIF contended that claimant's requested back fusion surgery "is needed due to degenerative disc disewase [sic], which SAIF denied May 16, 1980." Although SAIF's recommendation to the Board indicated that claimant's current condition was "Lumbar Disc Disease," it only issued a current denial of claimant's current right knee condition. The record does not contain a current denial of claimant's current degenerative disc disease.

On April 8, 1996, the Board consolidated the own motion matter with the hearing pending resolution of that litigation. Our order requested that, if the current requests for treatment were found to be 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.

In a December 10, 1996 Opinion and Order, ALJ Spangler set aside SAIF's March 15, 1996 denial of claimant's right knee torn medial meniscus condition, and ordered SAIF to pay to claimant's attorney an assessed fee for his services in overturning that denial at hearing. That order was not appealed, and has become final by operation of law.

In his December 10, 1996 order, the ALJ further stated that "[t]he Board has directed me to make findings and conclusions concerning the compensability of claimant's current condition, as well as whether she was in the work force at the time of her November 1995 worsening." The ALJ recommended that the Board find that claimant's current degenerative disc disease condition was not compensably related to her accepted low back injury, and that claimant was not in the work force at the time of disability.

In a January 16, 1997 letter, we requested the parties' positions with respect to the work force issue. In our letter, we noted that ALJ Spangler's order set aside SAIF's March 15, 1996 denial, and found claimant's right knee torn medial meniscus condition compensable to her 1976 injury claim with SAIF. We further noted that the ALJ recommended that claimant was not in the work force at the time of disability.

On January 31, 1997, we received SAIF's response to our request. With respect to the work force issue, SAIF contends that: (1) claimant testified at hearing that she had not worked since 1982; (2) a review of its records (claimant's claim file) did not reveal any evidence that claimant was in the work force; and (3) claimant has not provided any evidence to support her contention that she was in the work force at the time of disability. Therefore, it is SAIF's position that claimant "has withdrawn from the work force." On February 4, 1997, we received claimant's response. Claimant takes exception to

the ALJ's recommendation that she was not in the work force at the time of disability, but failed to submit any evidence or argument to support that contention.[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 March 7, 1996 letter, Dr. Sulkowsky, examining claimant at SAIF's request, recommended arthroscopic surgery of claimant's knee. Thus, we conclude that claimant's compensable condition worsened requiring surgery.[2]

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 period. Claimant has not responded to SAIF's contention with any evidence or argument, other than to allege that she was in the work force at the time of disability. Therefore, we adopt the ALJ's recommendation that claimant was not in the work force at the of her current disability.

On this record, we conclude that claimant has not carried her burden of proving she was in the work force at the time of disability. Accordingly, we deny claimant's request for temporary disability compensation for knee surgery in her 1976 injury claim with SAIF.

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

IT IS SO ORDERED.

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[1] Claimant's response to our request for positions regarding the work force issue fails to argue the merits of that issue. Claimant offers argument to ALJ Spangler's "findings" that her current low back condition and need for surgery are not related to her 1976 injury. However, claimant only "takes issue" (but offers no argument or evidence) to the ALJ's recommendation that she was not in the work force at the time of disability. Although the ALJ made a recommendation regarding claimant's current low back condition and need for surgery (the ALJ concluded that claimant's degenerative disc disease was due to a pre-existing condition rather than attributable to claimant's 1976 injury), he referred this compensability matter to the Board for determination under ORS 656.278. However, that statute does not provide that the Board, in its Own Motion authority, has 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 which occurred within the period from August 5, 1959 and December 31, 1965). Therefore, we offer no opinion on the compensability of claimant's current degenerative disc disease, or on claimant's entitlement to temporary disability compensation for a low back fusion.

[2] Because claimant's knee condition has been determined a compensable component of her 1976 injury claim (SAIF did not appeal the ALJ's December 10, 1996 order), she is eligible for temporary disability compensation beginning the date of that surgery. However, claimant must further establish that she was in the work force at the time of current right knee disability.

In the Matter of the Compensation of
BLANCA R. ARELLANO, Claimant
WCB Case No. 96-04039
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that awarded 50 percent (75 degrees) scheduled permanent disability for loss of use or function of claimant's left hand, whereas an Order on Reconsideration had awarded 44 percent (66 degrees) scheduled permanent disability. We reverse.

FINDINGS OF FACT

The employer accepted claimant's claim for a fractured left index finger with multiple lacerations. The claim was initially closed with an award of 90 percent scheduled permanent disability for loss of use or function of the left index finger.

The claim was subsequently reopened for surgical amputation of the left index finger. The Notice of Acceptance was amended to include the amputation.

On October 24, 1995, Dr. Dietrich, treating surgeon, opined that claimant was medically stationary, that she was using her hand better, and that she could return to work.

The claim was closed by a November 7, 1995 Notice of Closure which awarded 33 percent scheduled permanent disability for loss of use or function of claimant's left hand.

On February 7, 1996, Dr. McKillop performed a medical arbiter's examination.

A March 29, 1996 Order on Reconsideration increased claimant's award to 44 percent scheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant to be entitled to ratings for loss of sensation in her left middle finger and for a chronic left hand condition, based on the medical evidence. We disagree.

The extent of claimant's permanent disability is determined by an application of the "standards." Claimant became medically stationary on October 24, 1995 and a Notice of Closure issued on November 7, 1995. Accordingly, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 95-063 apply to claimant's claim. Former OAR 436-35-003(2).

Sensory Loss

The ALJ rated claimant's left middle finger sensory loss at 50 percent of the finger, based on the opinion of Dr. McKillop, medical arbiter.

Dr. McKillop noted claimant's complaint that her left hand was "hypersensitive to touch in the region of the amputation, with shock-like sensations at the amputation site. . . .She also describes a lot of reduced sensation in the left hand, especially in the middle finger and in the adjacent portions of the palm, and dorsum of the hand." (Ex. 43-3). He described claimant's sensory testing as follows:

> "The patient had a glove-like distribution of reduced sensation to touch or pinprick that involved the entire left hand from the wrist joint level down to the tips of all remaining digits. This was a non-anatomical distribution that did not fit in any way with her injury. This kind of distribution is probably an hysterical type of sensory loss, rather than an organic type of sensory loss.

> "With respect to two-point discrimination, there were certain abnormalities what were hard to evaluate. With the points spread as far as 17 mm apart, she was still doing rather poorly with respect to discrimination between two points and one point. This lack of two-point discriminatory sensation was diffuse over the entire hand, including the palm, dorsum of the hand, and all sides of the remaining digits. I am not sure that this testing represented a reliable or valid assessment of her sensory perception. It was too wide spread to relate it to her specific injuries and thus, we may again have an hysterical type of sensory response to two-point discriminatory testing." (Ex. 43-5).

Under the heading, "Diagnoses," Dr. McKillop reported, "Diffuse sensory loss, involving the entire left hand in a glove-like, non-anatomic distribution." (Ex. 43-6) In the section entitled "Comments and Recommendations," Dr. McKillop stated, "Some of the findings are somewhat non-anatomic, and some of the findings are probably not completely valid with respect to two-point discriminatory loss and strength. . . .Sensory loss, other than these two digits [i.e., the middle finger and missing index finger] does not seem to be very valid with respect to the location of the injury." (Ex. 43-6-7).

Considering Dr. McKillop's (uncontradicted) opinion that claimant's sensory loss presented as "a non-anatomical distribution that did not fit in any way with her injury" and his conclusion the distribution probably represents "an hysterical type of sensory loss rather than an organic type of sensory loss," (Ex. 43-5), we conclude that claimant has not established entitlement to a rating for injury-related sensory loss under the standards. See former OAR 436-035-0110(1) & 436-035-0007(1); Opal L. Whelchel, 47 Van Natta 2417 (1995); Beverly L. Cardin, 46 Van Natta 770 (1994); Robert Parsons, 44 Van Natta 1786 (1992) ("Subjective diminished sensation is not sufficient to entitle claimant to ratings under the applicable standards.").

Chronic Condition

To be entitled to permanent disability compensation for a scheduled chronic condition under former OAR 436-35-0010(6), claimant must establish, by a preponderance of persuasive medical evidence, that she is unable to repetitively use her left hand due to a chronic medical condition. See Weckesser v. Jet Delivery Systems, 132 Or App 325, 328 (1995). There must be medical evidence of at least a partial loss of ability to repetitively use the body part. Kim S. Anderson, 48 Van Natta 1876 (1996) (citing Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993)).

In this case, Dr. Dietrich, treating physician, opined on August 16, 1995 that claimant would be "able to use [her injured left] hand quite well once she stops being overly protective of it[.]" (Ex. 38). On October 24, 1995, Dr. Dietrich noted that claimant was medically stationary, that she was "using her hand a lot better," and that she could return to work. (Ex. 41). On February 7, 1996, Dr. McKillop, medical arbiter, opined that claimant "of course should try to use this hand as much as possible in the future. She should not be told not to use the hand. As much use as tolerated will have the effect of improving function in the future." (Ex. 43-7). We find no other medical evidence regarding claimant's use of her left hand.

Considering the medical evidence encouraging claimant to use her left hand and the absence of restrictions against such use, we conclude that claimant has not established at least a partial inability to use her left hand. Consequently, she is not entitled to a scheduled permanent disability award on this basis.

In conclusion, since we find that claimant is not entitled to a scheduled permanent disability award beyond that granted by the Order on Reconsideration, we reverse the ALJ's order and affirm the reconsideration award of 44 percent for the left hand.

ORDER

The ALJ's order dated August 29, 1996 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
SCOTT CAMPBELL, Claimant
WCB Case No. 96-04550
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order that awarded 13 percent (41.6 degrees) unscheduled permanent disability for a cervical and thoracic condition, whereas an Order on Reconsideration awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for cervical and thoracic strains. The Notice of Closure and Order on Reconsideration awarded no permanent disability. The ALJ, based on the medical arbiter's report, found that claimant proved impairment due to the compensable injury and concluded that claimant was entitled to 13 percent unscheduled permanent disability. SAIF challenges the ALJ's order, asserting that the medical evidence does not show that any impairment is due to claimant's compensable condition.

On October 31, 1995, Dr. Gaskell, claimant's treating physician, indicated that claimant was released to modified work and there was no permanent impairment. (Ex. 35). On December 1, 1995, Dr. Gaskell performed a closing examination and measured range of motion for the neck. (Ex. 39). Dr. Gaskell specifically noted that he saw "no permanent disability with this injury." (Id.)

During reconsideration before the Director, claimant underwent a medical arbiter examination with Dr. Martens, orthopedic surgeon. Dr. Martens performed a complete examination, including measurements of the cervical and thoracic range of motion. Dr. Martens also noted that the "findings are valid. In my opinion, the range of motion of the cervical and thoracic spine are within the ranges of normal for a man his age, height, and muscle development." (Ex. 46-5). Based on this comment, the Order on Reconsideration found that "the deficit in spinal range of motion measured by [Dr. Martens] does not represent a finding of impairment attributable to the current injury." (Ex. 47-4). Thus, there was no award of permanent disability.

The ALJ disagreed, finding that the "huge preponderance" of the evidence showed that the loss of range of motion was due to the compensable injury. The ALJ further found that Dr. Martens' comment was an impermissible attempt to override the standards for determining impairment.[1] The ALJ, however, found Dr. Martens' measurements reliable and, based on such findings, concluded that claimant was entitled to 13 percent unscheduled permanent disability.

Impairment is determined by a medical arbiter where one is used "except where a preponderance of medical evidence establishes a different level of impairment." OAR 436-35-007(9). "Preponderance of medical evidence" is "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 436-35-005(10); Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board relies on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

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[1] We agree with the ALJ that Dr. Martens' statement that range of motion was "normal" did not constitute an opinion concerning causation and is contrary to the legal standards. For the reasons expressed in this order, however, we conclude that Dr. Gaskell provided the more reliable opinion regarding permanent impairment.

We are more persuaded by Dr. Gaskell's opinion that no permanent impairment resulted from claimant's injury. As the treating physician, Dr. Gaskell was more familiar with claimant's condition than Dr. Martens, who saw claimant only once. Dr. Gaskell's closing examination also was thorough and complete. Consequently, we conclude that the preponderance of medical evidence shows that claimant has no permanent impairment from his compensable injury and that claimant failed to prove entitlement to permanent disability.

ORDER

The ALJ's order dated August 13, 1996 is reversed. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

February 12, 1997 Cite as 49 Van Natta 144 (1997)

In the Matter of the Compensation of
EVELYN J. HOWARD, Claimant
WCB Case No. 94-13631
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Odell's order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. Submitting documents pertaining to a post-hearing surgery, claimant seeks remand to the ALJ for the admission of additional evidence. On review, the issues are remand and aggravation. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

The ALJ upheld the insurer's aggravation denial, finding that claimant did not prove an "actual worsening." Claimant challenges this conclusion and also moves for remand to the ALJ for admission of reports concerning claimant's surgery performed after the ALJ closed the record.

Claimant's submitted evidence consists of "post-hearing" correspondence from Dr. Miller concerning his decision to obtain a discogram and then proceed with a fusion at L5-S1 and L4-5, as well as follow-up reports that, after the surgery, claimant's pain was greatly reduced. Claimant asserts that "the discogram, the subsequent surgery and results thereof are new findings and information that were not previously available with [sic] regarding the stationary status of her condition and whether curative treatment was available."

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Inasmuch as the proffered evidence relates to low back surgery, the evidence does concern disability. Moreover, since the surgery did not take place until after the hearing, the evidence submitted by claimant was not obtainable, with due diligence, at the time of hearing. See Wonder

Windom-Hall, 46 Van Natta 1619, 1620 (1994), rev on other grounds Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996) (Evidence derived from a "post-hearing" surgery not obtainable with due diligence). The remaining question is whether the proffered evidence is likely to affect the outcome of the case. Based on the following reasoning, we conclude that it would not.

The issue in this case is whether claimant has established an aggravation. An aggravation is proved by medical evidence of an "actual worsening of the compensable condition." ORS 656.273(1). After examining the text, context, and legislative history, the court has decided that an "actual worsening" was not intended to include a symptomatic worsening. SAIF v. Walker, 145 Or App 294, 305 (1996). Instead 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.

We find nothing in the submitted reports that pertains to, much less proves, an "actual worsening." That is, the documents do not provide direct medical evidence that claimant's condition has worsened.[1] At best, the documents could be interpreted as showing that claimant's symptoms have improved following surgery. As noted above, this is not sufficient to establish an aggravation. Because the documents offered by claimant, either independently or when considered in light of the existing record, do not establish that her compensable condition has "actually worsened," we find no reasonable likelihood that the submitted evidence will affect the outcome of the hearing.[2]

Consequently, lacking a compelling reason, we conclude that remand is not warranted.

Aggravation

The ALJ found that claimant had not established an aggravation. We agree.

As noted above, to establish an aggravation pursuant to ORS 656.273(1), claimant must prove that her compensable condition "actually worsened" and must do so by direct medical evidence establishing that her condition has worsened. Walker, 145 Or App at 305. An "actual worsening" cannot be inferred from increased symptoms. Id.

In May 1994, claimant first saw Dr. Miller, neurosurgeon, who diagnosed "internal disk disruption syndrome at L5-S1." (Ex. 4AA-2). Dr. Miller indicated that claimant was a "good candidate for a fusion" and proposed surgery. (Id.). Dr. Miller subsequently concurred with a report authored by the employer's attorney stating that claimant's "condition has not changed significantly since it was closed[.]" (Ex. 11A-1). The report further stated that, "unless and until [claimant] has [the proposed] surgery, her condition is going to remain the same as it has since her case was closed," including the same level of permanent disability. (Id. at 2).

In a later deposition, Dr. Miller clarified that he had intended to indicate in the report that claimant's condition had not changed significantly since she began treating with Dr. Miller; because Dr. Miller had not been claimant's physician at closure, Dr. Miller explained that he could not assess her condition from the date of closure. (Ex. 17-8). Dr. Miller further stated that, based on the records at closure, he felt claimant was "significantly worse" because she was experiencing more severe back pain

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[1] We note in particular claimant's reliance on the discogram's finding of a protruding disc at L4-5. However, the submitted evidence does not indicate whether or not the condition developed after claim closure. As early as July 1992, claimant was diagnosed with a diffuse central disk bulge at L4-5. Furthermore, Dr. Miller reported that such condition "does not seem to cause much pain," thus indicating that the L4-5 disc had a limited role in claimant's symptoms. Dr. Miller performed fusion surgery at this level in order to be on the safe side.

[2] We also find no basis for remanding based on claimant's assertion that the post-hearing evidence shows that claimant was not medically stationary and the surgery constitutes curative care. Claimant's medically stationary status would be relevant only to premature claim closure, an issue that has never been contested in this proceeding. Finally, the issue of the necessity and reasonableness of the surgery was decided in a separate proceeding before the Director.

that went into the legs. (Id. at 8-9). According to Dr. Miller, however, the worsening was symptomatic and claimant neither had "neurologic findings" nor had developed "any new [neurologic] findings." (Id. at 9). Moreover, imaging studies had not shown "any progression of the problem so it's not an objective thing, it's a subjective thing." (Id. at 10).

Dr. Karasek, neurologist, began treating claimant in October 1992 and concurred with a report written by claimant's attorney stating that claimant's "underlying condition continued to worsen since her claim was closed" and claimant's condition was not "a mere waxing and waning of symptoms." (Ex. 12-2).

Dr. Donahoo, examining orthopedic surgeon, reported that, although claimant subjectively was worse, there was no "objective evidence" of worsening. (Ex. 16-11, -13).

Finally, examining physician Dr. Fitzgerald concurred in a report authored by the employer's attorney stating that "claimant's condition does not appear to have deteriorated significantly over time." (Ex. 15-2).

We find no persuasive evidence of an actual worsening of the compensable condition. Only Dr. Karasek indicated that claimant's condition has worsened. We are more persuaded by Dr. Miller's opinion that claimant only subjectively or symptomatically worsened. Dr. Miller explained that he based his opinion on the lack of neurologic findings while Dr. Karasek provided no reasoning for his conclusion. Furthermore, according to Dr. Miller, Dr. Karasek was a "consultant," while Dr. Miller was the physician "making the surgical decisions about" claimant. (Ex. 13AA-1). Dr. Miller's characterization is borne out by the record showing that Dr. Karasek saw claimant on only two occasions following claim closure. (Ex. 4B). Thus, based on Dr. Miller's opinion, we find that claimant did not prove a compensable aggravation. ORS 656.273(1); Walker, 145 Or App at 305.

ORDER

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

February 12, 1997 Cite as 49 Van Natta 146 (1997)

In the Matter of the Compensation of
NEIL A. LAUFER, Claimant
WCB Case No. 95-04934
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our January 13, 1997 Order on Review which affirmed the Administrative Law Judge's (ALJ's) order that granted claimant permanent total disability benefits. SAIF contends that we erroneously excluded "post-reconsideration" evidence from the hearing record pursuant to amended ORS 656.283(7). SAIF argues that amended ORS 656.283(7) does not erect an absolute bar to the admission of "post-reconsideration" evidence in this case, because the parties did not object to its admission. We disagree.

Amended ORS 656.283(7) unequivocally bars the admission of evidence on a claim closure issue that was not submitted at reconsideration. In the face of that statutory bar, the ALJ was not authorized to admit "post-reconsideration" evidence on a permanent disability issue into the record after June 7, 1995, the effective date of amended ORS 656.283(7). Therefore, we properly reversed the ALJ's ruling in that regard, and it is immaterial that the parties did not register an objection.

Accordingly, our January 13, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 13, 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
ANN M. MANLEY, Claimant
WCB Case No. 95-07918
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that upheld the self-insured employer's denial of her occupational disease/injury claim for a left foot condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a customer service manager, began working for the employer in late 1992 or early 1993. Her work required her to be on her feet on concrete floors with tile overlay for eight hours a day. (Tr. 6).

On July 7, 1993, claimant sought treatment at an immediate care center, reporting left ankle pain for two months with no known trauma. (Ex. 2). In September 1993, claimant's hours increased to beyond 12 hours a day while she assisted in the preparation of the grand opening of the employer's new store. (Tr. 7). On October 6, 1993, claimant sought treatment from Dr. McKellar, who reported a history of "chronic" left ankle pain for over one year that had progressively worsened. (Ex. 1-2). Dr. McKellar referred claimant to Dr. Gargaro, who became claimant's attending physician.

During claimant's first office visit on October 19, 1993, Dr. Gargaro recorded a history of progressive left ankle pain for the "past several months." (Ex. 4). Dr. Gargaro's initial diagnosis was inflammatory left ankle arthritis. Id. Uncertain of the etiology of claimant's left ankle pain, Dr. Gargaro later performed arthroscopic surgery on the left ankle in April 1994. Claimant's pain continued, however, prompting a referral to an orthopedic foot/ankle specialist, Dr. Woll.

Dr. Woll examined claimant in March 1995 and, after an MRI scan, opined that claimant's symptoms were due to a left tarsonavicular stress fracture. (Ex. 12). Claimant, upon returning to Dr. Gargaro's care on April 3, 1995, inquired as to whether the stress fracture could be due to her long shifts in September 1993. Dr. Gargaro opined that it was within the "realm of possibility." (Ex. 10).

On April 5, 1995, claimant filed a claim for her left foot condition, alleging that it was related to standing and walking on concrete floors during the "set up" of the employer's new store on or about September 24, 1993. The employer denied the claim on June 30, 1995. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At the hearing, the employer asserted that claimant's left foot claim was untimely filed and that, on the merits, the left foot condition was not compensable. Determining that the left foot claim should be characterized as one for accidental injury, the ALJ upheld the employer's denial. The ALJ reasoned that the claim was time-barred because it was filed more than a year after the alleged injury in September 1993. Given his conclusion on the timeliness of the claim, the ALJ did not address the merits of the compensability issue.

On review, claimant contends that, regardless of whether it is classified as an injury or occupational disease, her claim was not time-barred. Moreover, claimant asserts that, on the merits, the medical evidence establishes that her employment was the major contributing cause of her left foot stress fracture. While we disagree with the ALJ's conclusion that the claim was untimely filed, we nonetheless conclude that the claim is not compensable on the merits. We reach these conclusions for the following reasons.

Timeliness of Claim Filing

For the purposes of the timeliness issue, we first determine whether the left foot claim should be characterized as an occupational disease or accidental injury. Compensable injuries refer to events, while occupational diseases refer to ongoing conditions or states of the body or mind. Mathel v. Josephine County, 319 Or 235, 241-42 (1994). In addition, an occupational disease is gradual, rather than sudden in onset. Id. at 240 (quoting James v. SAIF, 290 Or 343, 348 (1981)); See also Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984) (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset").

The onset of claimant's symptoms in this case did not correspond to a specific "event." Rather, claimant's symptoms arose gradually over the course of at least several months, perhaps longer, with claimant unable to identify a specific event that precipitated the onset of her symptoms. (Exs. 1, 4, 4A). Thus, we conclude that claimant's left foot claim more properly relates to an ongoing condition with a gradual onset rather than an event. Thus, we conclude that it is most appropriately characterized as an occupational disease. Mathel, 319 Or at 241-42.

Having categorized claimant's left foot claim, we now proceed to determine whether it was time-barred. ORS 656.807(1) provides that an occupational disease claim shall be void unless it is filed with the insurer or self-insured employer by whichever is the later of the following dates:

> "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or
>
> "(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

Here, claimant filed her claim two days after Dr. Gargaro informed her on April 3, 1995 that her condition may be related to her employment. Under these circumstances, we find that claimant timely filed her claim within a year of first discovering or being informed of her alleged occupational disease. See Bohemia Inc. v. McKillop, 112 Or App 261, 265 (1992).

Moreover, even if claimant's occupational disease claim was untimely filed, it would still not be time-barred. Occupational disease claims are to be processed in the same manner as accidental injuries. See ORS 656.807(3). As amended, ORS 656.265(4)(a) now provides that "[f]ailure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the injury and: (a) The employer had knowledge of the injury or death[.]" As amended, the statute eliminates the prejudice requirement of former ORS 656.265(4)(a). The amended statute, however, applies only to injuries occurring on or after June 7, 1995, the effective date of the Act. Or Laws 1995, ch 332, Secs. 66(2), 69. As to injuries (or diseases) occurring before June 7, 1995, pre-Senate Bill 369 law remains viable in this context. See Melvin L. Gordon, 48 Van Natta 1275 (1996).

Because claimant's occupational disease arose before the effective date of Senate Bill 369 (June 7, 1995), the claim would not be time-barred unless the employer could prove it was prejudiced by the untimely claim filing. Melvin L. Gordon, 48 Van Natta at 1275 (to establish a late filing defense to an occupational disease claim, the carrier must prove prejudice); Joanne C. Rockwell, 44 Van Natta 2290, 2292 (1992). The employer does not argue that it was prejudiced by claimant's allegedly untimely claim filing. In addition, we find that the record does not establish any prejudice to the employer. Therefore, even if claimant's occupational disease claim was untimely filed, it would still not be time-barred.

Compensability

ORS 656.802(2)(a) requires that, in order to establish a compensable occupational disease claim, the "worker must prove that employment conditions were the major contributing cause of the disease." Wanda L. Boone, 48 Van Natta 1757 (1996). Considering the insidious onset of claimant's left foot condition, the determination of the cause of claimant's condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967).

Four physicians have rendered opinions on the causation issue: Dr. Gargaro, the attending physician; Dr. Woll, the consulting specialist; and the examining physicians, Drs. Potter (orthopedic surgeon) and Melson (neurologist). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons to do otherwise.

Dr. Gargaro treated claimant for one year with limited success before referring her to Dr. Woll. (Ex. 8A). Dr. Gargaro's initial opinion on the causation issue (April 3, 1995) was that it was "possible" claimant's stress fracture was an injury-related condition. (Ex. 10). In his subsequent report (April 4, 1995), Dr. Gargaro admitted he missed the correct diagnosis of claimant's foot condition in October 1993. Dr. Gargaro opined that he "suspect[ed]" that the stress fracture was an industrial injury, but again stated that it was only "possible" that claimant's condition was caused by excessive walking at work. (Ex. 15-1).

In a somewhat more definitive report on September 6, 1995, Dr. Gargaro stated that it was "likely" claimant's foot condition was due to work activities. (Ex. 18). However, Dr. Gargaro conceded that this was "speculation." Id. Dr. Gargaro was subsequently deposed. When asked to confirm that claimant's work activities were the major contributing cause of her foot condition, Dr. Gargaro testified: "I think so." (Ex. 22-3). Dr. Gargaro later testified, however, that, given the history in Dr. McKellar's October 6, 1993 chart note that claimant's symptoms first appeared a year before, it made his causation opinion more "speculative." (Ex. 22-7). Finally, Dr. Gargaro admitted that his opinion that claimant's work caused her stress fracture was based more on "advocacy" for claimant than on medical opinion or evidence. (Ex. 22-13). Dr. Gargaro further stated "To give her the benefit of a doubt, I think that her work at [the employer] is still a significant factor here." (Ex. 22-12).

Viewing Dr. Gargaro's opinion as a whole, we find that it is too equivocal to establish to a degree of medical probability that claimant's work activities were the major contributing cause of her stress fracture. We also find the other medical evidence in the record does not satisfy claimant's burden of proof.

Dr. Gargaro referred claimant to Dr. Woll and subsequently stated that Dr. Woll's opinion "certainly could hold more weight than my own given his experience in the area." (Ex. 22-12). Dr. Woll opined both in his medical reports and in his deposition that he was unable to state that claimant's work activities caused her stress fracture. (Exs. 18a, 21-17). Dr. Woll explained that claimant's vague history of the onset of the symptoms, as well as the fact that claimant would be on her feet while off work, made him unable to identify the cause of her left foot condition. (Ex. 21-18).

Drs. Potter and Melson concluded in their report that claimant's obesity, along with standing and walking at work, caused claimant's stress fracture. (Ex. 19-8). However, this opinion was based on a history that claimant's symptoms developed while assisting in the preparation of the grand opening of the employer's store. (Ex. 19-7). This history was contradicted by the contemporaneous medical reports which indicate that claimant's symptoms preceded September 1993. (Exs. 1, 2, 4). Claimant, herself, testified that she had left ankle symptoms prior to September 1993, although at a lesser level, and that the history contained in the Potter/Melson medical report was inaccurate. (Tr. 15). Apart from having an inaccurate history, Drs. Potter and Melson also never clarified the relative contribution of the obesity or the employment activity in claimant's foot condition. See Dietz v. Ramuda, 130 Or App 397, 401 (1994).

Dr. Potter was later deposed. Dr. Potter again attributed claimant's stress fracture to employment and her obesity. Once again, however, Dr. Potter did not clarify the relative degree of contribution from either factor. (Ex. 23-20). Dr. Potter later agreed that it was impossible to determine when, where and how claimant sustained her stress fracture. (Ex. 23-23).

Based on our de novo review of both Dr. Woll's and Dr. Potter's medical opinions, we are not persuaded that, separately or cumulatively, these medical opinions satisfy claimant's burden of proving medical causation under a major contributing cause standard. Accordingly, we conclude that the ALJ properly upheld the employer's denial, based on the preceding reasoning. Therefore, we affirm.

ORDER

The ALJ's order dated August 9, 1996 is affirmed.

In the Matter of the Compensation of
ANN D. WEAVER, Claimant
WCB Case No. 96-04009
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) set aside its denial of claimant's injury claim; and (2) awarded a $3,000 attorney fee. Claimant cross-requests review of that portion of the order that declined to award penalties for an allegedly unreasonable denial and allegedly unreasonable failure to timely provide discovery. The employer objects to the amount of the attorney fee claimant has requested for her counsel's services on review. On review, the issues are whether claimant's injury arose out of and in the course and scope of her employment, penalties, 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

Course and Scope

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

We note at the outset that the ALJ found that claimant's activity at the time of injury (driving from her parents' residence), did not constitute "an increased risk." (O&O p. 3). We modify this finding to indicate that claimant's driving at the time of injury did not create "any unusual risk of injury." See Proctor v. SAIF, 123 Or App 326, 333 (1993); see also First Interstate Bank of Oregon v. Clark, 133 Or App 712, 720 (1995) ("According to Larson, the majority rule in street and highway injury cases is the 'actual risk' test, under which an injury arises out of the employment 'if in fact the employment subjected the employee to the hazards of the street, whether continuously or infrequently.'")

We agree with the ALJ that claimant was not engaged in a distinct departure from her traveling employment[1] at the time of injury, based on the following reasoning.

"In determining whether a traveling employee's injury is compensable, we consider whether the activity that resulted in the injury was reasonably related to the employee's travel status." Savin Corp. v. McBride, 134 Or App 321, 325 (1993) (citing Proctor v. SAIF, 123 Or App at 330, and Slaughter v. SAIF, 60 Or App 610, 616 (1982)); see Rolland R. Duby 45 Van Natta 2335, 2336 (1993) ("The test of a reasonable relation to the travel status is whether a claimant's presence at the place of injury had a work connection, or whether it violated employer directives or was so inconsistent with the purpose of the worker's trip, or such a deviation therefrom, as to constitute an abandonment of employment.")

"Thus, when travel is part of the employment, 'the risk of injury during activities necessitated by travel remains incident to the employment,' even though the employee may not actually be working when the injury occurs." Id. (quoting PP&L v. Jacobsen, 121 Or App 260, 263 (1993)).

In this case, considering the undisputed evidence that claimant performed work-related activities at her parents' home the evening before her injury, (see Tr. 26, 33), and the fact that she was an

[1] We note, as did the ALJ, that the parties stipulated that claimant was a traveling employee.

overnight traveling employee (who was to be reimbursed for travel expenses,[2] including lodging[3]), we do not find that claimant had abandoned her employment, or was engaged in a "distinct departure" from it when she was injured while traveling from her parents' home to her out-of-town workplace on December 13, 1995. Accordingly, we conclude, as did the ALJ, that claimant has proven that her injury arose out of and in the course and scope of her employment.[4]

Penalties and Attorney Fees

We agree with the ALJ that claimant's personal reasons for staying with her parents created a legitimate doubt (about whether she had abandoned her traveling employee status). See International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) ("An employer's refusal to pay is not unreasonable if it had a legitimate doubt about its liability.") Accordingly, we conclude that the denial was not unreasonable.

Claimant also seeks a penalty based on the employer's late and incomplete discovery. Specifically, claimant argues that the employer's failure to timely discover minutes of a business meeting and its failure to provide claimant with documents establishing ownership of the laptop computer claimant used (on the trip in question) support a penalty.

The ALJ found that the employer's explanation for not providing documentation concerning the computer (that it could not be found) was reasonable. The ALJ also found that the employer's failure to timely provide the meeting minutes did not support a penalty, because the minutes were not relevant. We disagree.

The employer's denial was expressly based on a contention that claimant's injury did not occur in the course and scope of her employment. (Ex. 17). Under these circumstances, we find that the meeting minutes were relevant to establish the business purpose of claimant's trip. Thus, they also pertain to the claim.

Failure to comply with discovery requirements (including requests for documents "pertaining to a claim") if found unreasonable, constitutes delay or refusal to pay compensation. See OAR 438-007-0015(5); see also ORS 656.262(11)(a).

Here, the employer never provided documentation regarding the computer, because it never found such documentation. The employer provided the requested meeting minutes late.[5] We do not find inability to find documents (or the inability to find them in a timely manner) to be a reasonable explanation for failing to provide timely discovery. Accordingly, we assess a penalty, based on the

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[2] Reimbursable travel expenses included airfare, auto rental, business auto mileage, meals, telephone calls, and lodging. (See Exs. a, aa, 8a, 8aa; Tr. 20-26, 29).

[3] The ALJ sustained the employer's objection to claimant's testimony regarding the amount of money claimant may have saved the employer by staying at her parents' house instead of at a hotel. (See Tr. 24-25). Claimant did not object to the ALJ's evidentiary ruling. Under these circumstances, we do not consider the testimony subject to the ruling and there is no need to strike portions of claimant's brief which allegedly refer to that testimony.

In addition, we acknowledge claimant's motion to strike portions of the employer's brief which argue that claimant "was on a departure from her business trip" when she was injured. (Claimant's brief, p. 2). However, as claimant noted, such arguments address a matter which is before the Board on review. Accordingly, claimant's motion is denied.

[4] In reaching this conclusion, we note that even if claimant's primary reason for choosing to stay with her parents (rather than in a hotel) was personal, that alone would not make her activity at the time of injury a distinct departure from her employment, because the employer granted employees broad discretion in choosing among alternative lodgings.

[5] The ALJ noted that the employer provided the meeting minutes on July 23, 1996, the date it received them from its corporate headquarters office. To the extent the employer argues that it provided the minutes when it found them, we do not find the explanation reasonable. See Jose S. Sandoval-Perez, 48 Van Natta 395, 396 (1996) (We do not limit the carrier's knowledge to information available in its local office).

employer's unreasonable discovery violations. See ORS 656.262(11)(a). That penalty will equal 10 percent of the amounts then due as of the date of hearing as a result of the ALJ's compensability decision (which we have affirmed). The penalty will be shared equally by claimant and her attorney.

The ALJ awarded a $3,000 attorney fee. The employer argues that the ALJ's attorney fee award should be reduced. We disagree.

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 whether claimant's MVA-related injury arose out of and in the course and scope of her employment. Approximately 22 exhibits were received into evidence. The hearing transcript consists of 47 pages. Three witnesses, including claimant, testified at hearing. Claimant's counsel submitted 9 pages of hearing memoranda and an affidavit attesting to 23.6 hours of service.[6]

As compared to typical compensability cases, the issue here was of average complexity. The claim's value and the benefits secured are of above average proportions, consisting of substantial medical services and, potentially, permanent disability. The hearing was relatively short. Claimant's counsel skillfully advocated claimant's claim. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)).

After consideration of the aforementioned factors, we conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In reaching this conclusion, we have particularly considered the value of the interest involved and the benefits secured, the time devoted to the "course and scope" issue (as represented by the hearing record and claimant's counsel's statement of services), the complexity of the issue, and the risk that claimant's counsel might go uncompensated.

Furthermore, after considering and applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the "course and scope" issue is $1,355, 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, claimant's counsel's statement of services, and the employer's objections), the complexity of the issue, and the value of the interest involved. No separate attorney fee is awarded for counsel's services on review related to securing the penalty. Likewise, no attorney fee is available for defending the ALJ's attorney fee award. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 20, 1996 is reversed in part and affirmed in part. That portion of the order that declined to assess a penalty is reversed. For its discovery violation, the self-insured employer is directed to pay a penalty equal to 10 percent of the amounts then due as of the date of hearing which are payable as a result of the ALJ's compensability decision (which we have affirmed). This penalty is to be paid in equal parts to claimant and claimant's attorney. The remainder of the order is affirmed. For services on review, claimant is awarded a $1,355 attorney fee, payable by the employer.

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[6] The affidavit describes counsel's time expenditures, including approximately 6 hours of legal research; 12 hours of hearing preparation; and 3 hours writing the trial memorandum.

In the Matter of the Compensation of
REBECCA C. COLE, Claimant
WCB Case No. 94-03392
ORDER DENYING MOTION TO DISMISS
Mitchell & Associates, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Claimant has requested Board review of Administrative Law Judge (ALJ) Schultz' order. Asserting that claimant's request for review refers only to the ALJ's December 20, 1996 order (rather than the ALJ's January 3, 1997 amended order), the insurer has moved to dismiss claimant's request for review. The motion is denied.

FINDINGS OF FACT

On December 20, 1996, ALJ Schultz issued an Opinion and Order which upheld the insurer's current condition/aggravation denials for claimant's current conditions, including fibromyalgia, myofascial pain syndrome, somatic dysfunction, a neck condition, somatoform pain disorder, a mid-back condition, and a right shoulder condition. The order included a notice to the parties that the parties had 30 days to request Board review.

On December 26, 1996, the insurer notified the ALJ that the order contained an apparent typographical error. Specifically, the insurer asserted that the ALJ's order neglected to include the word "no" before the word "evidence" in the phrase "there is evidence to support a worsening of claimant's condition to justify reopening the claim on an aggravation basis." To correct that error, the insurer sought an amended order.

On January 3, 1997, ALJ Schultz issued an "Amended Opinion and Order," which reprinted the December 20, 1996 order in its entirety and corrected the typographical error by adding the word "no" to the aforementioned sentence. The amended order neither withdrew, abated, nor stayed the ALJ's December 20, 1996 order. Rather, the order simply contained a notice to the parties, advising that the parties had 30 days from the mailing date of the order within which to request Board review.

On January 17, 1997, claimant requested Board review. Claimant's request stated that she sought Board review of ALJ Schultz' order "dated December 20, 1996." The request also indicated that copies of the request had been provided to the parties to the proceeding before the ALJ.

On January 22, 1997, the Board mailed letters to all parties to the proceeding acknowledging claimant's request for review.

CONCLUSIONS OF LAW

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for adjudication. Nollen v. SAIF, 23 Or App 420, 423 (1975).

The time within which to appeal an order continues to run unless the order has been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, the insurer asserts that, although claimant requested review of the ALJ's December 20, 1996 order, she failed to request review of the ALJ's January 3, 1997 amended order. Reasoning that the expired appeal rights on the January 3, 1997 order preclude claimant from now appealing the amended order, the insurer contends that claimant's request for review is defective. We disagree.

The ALJ's December 20, 1996 order was not expressly abated, stayed or withdrawn. Rather, it was expressly "amended" by the January 3, 1997 order, which, in direct response to the insurer's request, corrected the ALJ's December 20, 1996 order. In all other respects, the January 3, 1997 order was identical to the December 20, 1996 order.

Claimant's January 17, 1997 request for Board review did state that she was seeking review of the ALJ's order "dated December 20, 1996." Nevertheless, since the ALJ's "non-withdrawn" December 20, 1996 order had been expressly amended by the January 3, 1997 order, we interpret claimant's request as an appeal of the ALJ's "non-withdrawn" December 20, 1996 order, as amended by the January 3, 1997 order. See Terry L. Starnes, 48 Van Natta 790, 791 n. 1 (1996); Michael A. Ferdinand, 44 Van Natta 1167, 1168 (1992). Inasmuch as claimant's request was mailed to the Board within 30 days of the issuance of the ALJ's January 3, 1997 amended order (with copies timely provided to the other parties), we hold that we have jurisdiction to consider this matter. See ORS 656.289(3); ORS 656.295(2); Terry L. Starnes, 48 Van Natta at 791, n. 1 (1996).

Accordingly, the insurer's motion to dismiss is denied. In light of these circumstances, the briefing schedule shall be revised as follows. Claimant's appellant's brief shall be due 21 days from the date of this order.[1] The insurer's respondent's brief shall be due 21 days from the date of mailing of claimant's brief. Claimant's reply brief shall be due 14 days from the date of mailing of the insurer's respondent's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] Claimant seeks an extension of the briefing schedule in order for her new attorney to receive copies of her claim documents. Claimant does not assert that the insurer neglected to provide her former attorney with copies of these documents at the time of the hearing. In light of such circumstances, we are not authorized to mandate the "re-disclosure" of these previously disclosed documents. Nonetheless, in the interests of substantial justice, the parties are encouraged to explore alternative methods which will enable claimant's current attorney to secure copies of the relevant claim documents (be that through claimant's former counsel or through the insurer's counsel). In the event that such methods are unsuccessful, claimant may again seek an extension of the briefing schedule based on the existing circumstances at that time. In the meantime, the briefing schedule shall continue as currently implemented.

In the Matter of the Compensation of
GERALD A. STRUCKMEIER, Claimant
WCB Case Nos. 96-03997, 96-03996 & 96-00717
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
John E. Snarskis, Defense Attorney
Lundeen, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its denial of claimant's injury and/or occupational disease claim for his neck, left arm/hand, and back condition; (2) upheld Industrial Indemnity Company's (Industrial's) denial of claimant's injury and/or occupational disease claim for the same condition; and (3) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of claimant's "aggravation" claim for the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and supplementation. We do not adopt the first paragraph of the ALJ's ultimate findings of fact.

In late 1987 and early 1988, claimant treated with Dr. Tahir, M.D., for neck pain radiating into the left upper extremity. (Exs. 23, 24, 25).

In March 1995, claimant sought treatment for "left paracervical pain radiating down left arm to hand." (Exs. 28, 29). X-rays taken at that time and compared to September 24, 1987 studies showed ongoing degenerative changes at C5-6 and C3-4. (Ex. 29).

Dr. Breen, claimant's treating physician, opined that claimant had "an element of a cervical disc complicated by degenerative and osteophytic changes which I believe are the cause of [claimant's] neck pain radiating into his arm and the numbness in his hand." (Ex. 41). Dr. Breen also opined that claimant had preexisting cervical degenerative disc pathology which combined with the work-related cervical and shoulder strains, with the earlier part of his treatment due to the muscular strains and the radicular symptoms more related to the preexisting degenerative disease. (Exs. 45, 60).

There is no evidence that Dr. Soldevilla, treating surgeon, was aware of claimant's prior symptoms and treatment of neck pain with radiation into the left arm and hand. (Exs. 47, 52, 53, 56).

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant sustained both separate compensable left shoulder and cervical strains and a compensable combined condition involving claimant's preexisting cervical degenerative disc disease. On review, SAIF argues that the strains combined with claimant's preexisting condition from the outset; therefore, SAIF argues, claimant must prove that the work incident is the major contributing cause of the disability or need for treatment of the combined condition. SAIF further argues that, on this record, claimant failed to meet his burden of proving a compensable claim. We agree with SAIF on both counts.

We begin with a brief summary of the facts. In 1969, claimant began working for Blue Bell Potato Chip Company (Blue Bell). In March 1986, claimant sustained a work-related left shoulder contusion injury while Liberty was on the risk as Blue Bell's workers' compensation insurance carrier. Liberty accepted this injury as a nondisabling injury on April 1, 1986. Following conservative treatment, claimant's condition became medically stationary with no impairment. Liberty closed the claim on August 15, 1986.

In March and September 1987, claimant sought treatment for neck and shoulder pain, without report of new injury or overuse. (Exs. 17, 18, 19, 20). An October 28, 1987 MRI showed evidence of degenerative disc disease at C5-6 and C6-7, with spurring at those levels. (Ex. 21). In late 1987 and early 1988, claimant treated with Dr. Tahir, M.D., for neck pain radiating into the left upper extremity. (Exs. 23, 24, 25).

On April 18, 1988, Industrial became Blue Bell's workers' compensation insurance carrier. In November and December 1991, claimant was treated for severe muscle pain and spasm following unloading heavy machinery. (Exs. 26, 27). In March and April 1995, claimant was treated for left neck pain with pain radiating down the left arm to the hand and pain in the last two fingers of the hand. (Exs. 28, 29, 30, 31, 32, 33).

On June 9, 1995, Blue Bell shut down. On June 16, 1995, claimant began working for Rudie Wilhelm Warehouse, which was insured by SAIF. There, claimant performed heavy work as a warehouseman. On October 9, 1995, while filling an order at work, claimant lifted at least 405 five-gallon pails of roof mending liquid. By the end of the day, claimant's left arm was hurting. On October 11, 1995, claimant sought treatment from Dr. Breen, treating physician, who diagnosed shoulder and cervical strain. (Ex. 36). Claimant's symptoms of cervical pain with radiation into the left arm and hand did not improve with conservative treatment. Dr. Breen eventually referred claimant to Dr. Soldevilla, neurosurgeon, who performed an anterior cervical diskectomy with fusion at C6-7 on February 20, 1996. (Ex. 53).

Claimant filed claims with SAIF, Liberty, and Industrial regarding his neck and shoulder strains and cervical condition. All three carriers denied compensability of and responsibility for those conditions.

Relying on Valtinson v. SAIF, 56 Or App 184 (1982), claimant contends that this is an injury claim rather than an occupational disease claim because the events on October 9, 1995 that led claimant to seek medical treatment occurred during a discrete period of time. We agree. In addition, we note that there is no medical evidence in the record that would support the proposition that claimant's condition is the result of an occupational disease.

It is claimant's burden to prove the compensability of his claim by a preponderance of the evidence. ORS 656.266. When a preexisting disease or condition combines with a compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the combined condition. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993). Furthermore, the proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause. Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995).

We note that claimant acknowledges that ORS 656.005(7)(a)(B) applies to his claim because the strain injury combined with the preexisting cervical degenerative disease. However, while we agree that ORS 656.005(7)(a)(B) applies to claimant's claim, we disagree that claimant has met his burden of proof under that statute.

The record clearly shows that claimant had preexisting cervical degenerative disc disease. In late 1987 and early 1988, claimant treated with Dr. Tahir, M.D., for neck pain radiating into the left upper extremity. (Exs. 23, 24, 25). An October 28, 1987 MRI revealed degenerative disc disease at C5-6 and C6-7, with spurring at those levels. (Ex. 21). In addition, in March and April of 1995, claimant was treated for left neck pain with radiation down the left arm to the hand. (Ex. 29).

On October 11, 1995, Dr. Breen examined claimant following the October 9, 1995 work incident and continued to follow claimant's treatment. Dr. Breen noted claimant had pain in his left arm and in his cervical spine. Dr. Breen diagnosed shoulder and cervical strains and opined that, from the evidence he had at that time, it appeared to be "work-related in a major contributing factor." (Ex. 36). However, Dr. Breen also opined that claimant had "a cervical disc complicated by degenerative and osteophytic changes which [he] believe[d were] the cause of [claimant's] neck pain radiating into his arm and the numbness in his hand." (Ex. 41). In responding to a question posed by SAIF's claims adjuster

regarding the major contributing cause of claimant's cervical and left upper extremity conditions, Dr. Breen stated that he believed the earlier part of claimant's treatment was due to the muscular strain and work-related, but the radicular complaints were more related to the preexisting cervical degenerative disease. (Exs. 44, 45, 60). Finally, Dr. Breen opined that the October 9, 1995 injury and claimant's preexisting cervical degenerative disease combined "to aggravate [claimant's] degenerative situation and create the need for surgery done by Dr. Soldevilla." (Ex. 60).

Dr. Wilson, examining neurologist, examined claimant, reviewed his medical record, and concluded that the October 9, 1995 injury combined with claimant's preexisting cervical degenerative condition, with the major contributing cause of claimant's condition being the preexisting degenerative disc disease. (Ex. 54).

In determining whether ORS 656.005(7)(a)(B) applies, we must determine whether claimant's preexisting cervical condition "combined" with his October 1995 injury to cause disability or a need for medical treatment. Based on the opinions of Drs. Breen and Wilson, the only physicians to directly address the issue, we find that claimant's October 1995 injury "combined" with his preexisting cervical condition to cause a need for medical treatment. (Exs. 54, 60). We, therefore, conclude that ORS 656.005(7)(a)(B) is applicable and decide the compensability issue pursuant to that statute. Regarding compensability, only the opinions of Dr. Breen and Dr. Soldevilla can be read to support claimant's claim.[1] However, neither opinion meets claimant's burden of proof.

While Dr. Breen states that the October 1995 work injury and claimant's preexisting cervical condition combined to "aggravate his degenerative situation and create the need for surgery," he does not evaluate the relative contribution of each cause, as required by Dietz. (Ex. 60). In fact, to the extent Dr. Breen's opinion can be considered to evaluate the relative contribution of each cause, he appears to attribute the cause to claimant's cervical "degenerative and osteophytic changes." (Ex. 41). Therefore, we do not find that Dr. Breen's opinion supports claimant's claim.

Dr. Soldevilla first examined claimant in January 1996. (Ex. 47). Although he noted that claimant had an MRI that showed "some degenerative disease," he gave no opinion regarding the contribution of claimant's preexisting cervical degenerative disease. (Exs. 47, 52, 53, 56). Furthermore, there is no indication that Dr. Soldevilla was aware of claimant's past treatment for symptoms of left neck pain with radiation into the left arm and hand. In this regard, Dr. Soldevilla noted that claimant's "past medical history" was "[r]emarkable only for diabetes." (Ex. 47). Moreover, in discussing the cause of claimant's condition, Dr. Soldevilla noted that when he first examined claimant he complained of "severe pain in his left arm, with onset after an on the job accident in the Fall of 1995. Since that time he had had significant pain in his left arm which did not improve with conservative care." (Ex. 56). In addition, Dr. Soldevilla stated that:

> "I don't believe there was any pre-existing condition prior to [claimant's] employment at Blue Bell in 1968, and there were no similar complaints that I am aware of prior to October 1995. For this reason, I believe that his work related injury is the medically probable cause of his arm pain, which was subsequently relieved with surgery on February 20, 1996." Id.

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[1] Claimant argues, as the ALJ found, that Dr. Rosenbaum's opinion supports compensability. We disagree. Dr. Rosenbaum was concerned that claimant expressly denied any prior problems with his neck or left upper extremity, even after Dr. Rosenbaum reviewed with claimant the medical records which revealed those prior problems. (Ex. 50-2-3). Thereafter, Dr. Rosenbaum stated that, if claimant's history of no prior neck and left upper extremity pain was accurate, "then [claimant's] diagnosis would be a cervical radiculopathy secondary to his industrial injury of 10/9/95." (Ex. 50-4). However, Dr. Rosenbaum found claimant's history "quite inaccurate from the medical records." Id. Thus, it is clear that Dr. Rosenbaum did not opine that the cervical radiculopathy was secondary to the work injury. Dr. Rosenbaum later stated that, if claimant were entirely asymptomatic following the March 1995 cervical radiculopathy episode until the October 1995 work injury, "then the radiculopathy could be considered to have originated from [claimant's] work activity." (Ex. 50-6). However, at most, this statement supports only a possibility of a causal connection, which is insufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

Claimant argues that Dr. Soldevilla's reference to "no similar complaints" refers to a lack of any previous radiation of pain into the left thumb and index finger, which were among the symptoms that claimant reported to Dr. Soldevilla. (Exs. 47, 52). However, as quoted above, in addressing causation, Dr. Soldevilla focused on the radiation of pain into claimant's left arm, without mentioning the radiation of pain into the left thumb and index finger. Furthermore, Dr. Soldevilla based his causation opinion on his understanding that claimant had not had similar complaints prior to October 1995. However, the record clearly shows that he did have prior complaints of left neck pain with radiation into the left arm and hand. Because Dr. Soldevilla bases his opinion on an inaccurate history, we do not find it persuasive. Somers v. SAIF, 77 Or App 259 (1986) (the most weight is given to opinions that are both well-reasoned and based on complete information). In addition, like Dr. Breen, Dr. Soldevilla does not evaluate the relative contribution of the preexisting cervical degenerative condition.

No other physician supports claimant's claim. Accordingly, we find that claimant has failed to meet his burden of proving a compensable injury pursuant to ORS 656.005(7)(a)(B). Because claimant has failed to establish a compensable claim, we need not address the responsibility issue.

ORDER

The ALJ's order dated July 31, 1996 is reversed in part and affirmed in part. That part of the order that set aside the SAIF Corporation's January 3, 1996 denial of compensability of and responsibility for an industrial injury and/or occupational disease claim is reversed and SAIF's denial is upheld. The ALJ's attorney fee award is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
RUSSELL K. ANDERSON, Claimant
WCB Case No. 95-10863
ORDER ON REVIEW
Pozzi, Wilson, et al, 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) Lipton's order that upheld the self-insured employer's denial of claimant's claim for a consequential herniated C6-7 disc 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 claimant's contention that he sought chiropractic treatment for neck and upper back pain to be necessarily inconsistent with his contention that a July 9, 1995 chiropractic manipulation caused his need for treatment for a herniated C6-7 disc. (O&O p.4).

Nonetheless, we agree with the ALJ that the claim fails, because there is no persuasive medical evidence relating claimant's herniated C6-7 disc to such manipulation.[1] See ORS 656.005(7)(a)(A). Barrett Business Services v. Hames, 130 Or App 190, 193, rev den, 320 Or 492 (1994); see also Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

ORDER

The ALJ's order dated July 23, 1996 is affirmed.

[1] Dr. Grewe would likely relate the C6-7 disc to chiropractic treatment, if claimant had cervical manipulation on August 9, 1995. (See Exs. 15, 21, 25). However, because we agree with the ALJ that claimant has not established that he did have cervical manipulation on that date, to the extent that Dr. Grewe formed such an opinion, it was either speculative or based on an inaccurate history. (See Ex. 30-38-39).

In the Matter of the Compensation of
JAMES D. ORTNER, Claimant
Own Motion No. 960544M
INTERIM OWN MOTION ORDER
CONSENTING TO DESIGNATION OF PAYING AGENT (ORS 656.307)
SAIF Legal Department, Defense Attorney

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 1974 injury claim with The SAIF Corporation expired on March 24, 1981. 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 1974 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.

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.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELLIOTT ROSS, Claimant
WCB Case No. 96-02700
ORDER ON REVIEW
Estell & Smith, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the insurer's denial of claimant's injury claim. On review, the issue is whether claimant was a subject worker.

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

The ALJ concluded that the case was controlled by the principles set forth in Castle Homes, Inc. v. Whaite, 95 Or App 269, 272 (1989). We agree. In Trabosh v. Washington County, 140 Or App 159 (1996), the court held that, in determining whether a worker was an independent contractor or a subject worker, it would apply the "right to control" test. If that test proved inclusive, the court concluded that it would then move to the "nature of the work" test. The primary elements of the right to control test are: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Castle Homes, 95 Or App at 272.

Here, claimant, a vacuum cleaner salesperson, received some initial training from the distributor. However, claimant was not given customer names and his demonstrations for customers were not overseen by the distributor. Claimant did not work under a schedule arranged by the distributor, nor was he required to work for a maximum number of hours per week. Accordingly, we find minimal direct evidence of the right to, or the exercise of, control.

Claimant was paid on a commission basis. Additionally, the ALJ found that a "monthly guarantee" based on 60 demonstrations per month was, in reality, unattainable by any of the salespersons. Consequently, we conclude that the method of payment does not weigh in favor of a finding that the distributor controlled claimant's work. Moreover, although claimant argues that the advertisement he responded to suggested an hourly salary, rather than a bonus, claimant conceded at hearing that nothing in the agreement he signed indicated that he would be paid on an hourly basis. (Tr. 24).

Other than the sales items, or vacuum cleaners, there is no evidence that the distributor supplied claimant with equipment. Claimant provided his own car and paid for his gasoline and mileage. Therefore, the lack of furnishing of equipment suggests an independent contractor agreement, and lack of control on the part of the distributor.

Finally, the agreement entered into by claimant and the distributor provided that either party could terminate the relationship at any time. Such facts also suggest an independent contractor relationship.

Accordingly, we agree with the ALJ that the facts support a finding that, based on the lack of the distributor's right to control, claimant was an independent contractor, rather than a subject worker.[1] Furthermore, because we find that the right to control test is conclusive, we do not address the "nature of the work" test. Therefore, claimant's status as an independent contractor compels us to conclude that claimant is not covered under the Workers' Compensation Law.

ORDER

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

[1] We agree with the insurer that a prior Board case, Michael R. Cigler, 42 Van Natta 2732 (1990), is on point. In Cigler, the Board concluded that the claimant, a vacuum cleaner salesman, was not a subject worker. The claimant chose the time, place, and persons to whom he would demonstrate the cleaners. The claimant used his own car, purchased his own gas, and had no equipment provided by the distributor. Furthermore, the claimant earned money only if he sold a vacuum cleaner, and an offered bonus was found to be an incentive tool, rather than a salary or payment. Under the circumstances, the Board in Cigler held that the claimant was an independent contractor, and was not a subject worker.

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
State Farm, Insurance Carrier

Claimant requests review of the insurer's February 8, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from November 4, 1991 through January 30, 1995. The insurer declared claimant medically stationary as of January 30, 1995. Claimant contends that his claim was prematurely closed.

Claimant's compensable condition must be medically stationary in order for the insurer to properly close a claim which has been reopened under the Board's own motion authority for payment of temporary disability compensation. See OAR 438-12-055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the February 8, 1995 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

We begin our analysis with a brief history of claimant's current claim. In April 1981, claimant sustained compensable right knee and low back injuries. His claim was last reopened under the Board's own motion jurisdiction in November 1991 for right knee surgery. By May 1993, claimant's knee condition was medically stationary. However, the claim remained open for lumbar surgery. Specifically, in June 1993, claimant underwent a right L5-S1 microdecompression and microdiscectomy performed by Dr. Berkeley, treating neurosurgeon.

On September 1, 1994, the insurer issued a Notice of Closure closing claimant's claim. By order dated October 26, 1994, the Board set aside that Notice of Closure as premature based on the opinion of Dr. Puziss, attending physician. Specifically, Dr. Puziss recanted his earlier opinion that claimant was medically stationary and opined that claimant's marked improvement as a result of treatment with a Raney Flexion Jacket indicated that lumbosacral fusion may be a worthwhile option.

By letter dated January 30, 1995, Dr. Puziss stated that treatment with the flexion jacket had become palliative, since claimant was not able to tolerate it that much. In addition, Dr. Puziss opined that "[s]ince a spinal fusion appears not to be indicated at this time according to Dr. Waldrum, then as far as I can tell there is nothing to keep this patient from becoming medically stationary at this point." Based on this letter, the insurer issued its February 8, 1995 Notice of Closure and declared claimant medically stationary as of January 30, 1995.

By letter dated February 9, 1995, Dr. Puziss reported that he had spoken with claimant on that date and that:

> "[claimant] continues to worsen over the last two months. His pains are increasingly severe. Since [claimant's] pains in the left leg have not decreased with rest, a new MRI scan is now indicated and probably a new neurosurgical consultation with [claimant's] neurosurgeon, Edward Berkeley, M.D.. His need for Vicodin continues to increase.
>
> " * * * * *
>
> "I would have to conclude at this time, that [claimant] is not medically stationary. If his claim was recently closed, then it should be reopened since it would be considered a premature claim closure based on the above information. He is not medically stationary because he continues to worsen and requires further diagnosis and possibly treatment."

The record indicates that Dr. Puziss last examined claimant on September 13, 1994, before declaring him medically stationary on January 30, 1995. (See September 13, 1994 letter from Dr. Puziss to the insurer). Dr. Puziss next examined claimant on February 24, 1995, at which time he affirmed his February 9, 1995 report that claimant continued to slowly worsen. (See February 24, 1995 letter from Dr. Puziss to the insurer).

We find that Dr. Puziss rescinded his January 30, 1995 opinion that claimant was medically stationary. At the time Dr. Puziss rendered that opinion, he had not examined claimant for several months. After consulting with claimant, Dr. Puziss found that claimant's low back condition had worsened over the past two months, which would place the start of the worsening before Dr. Puziss declared him medically stationary. Thus, claimant's condition had "worsened" before Dr. Puziss declared him medically stationary, and Puziss was unaware of that "worsening" at the time he gave his initial opinion regarding claimant's medically stationary status. Once Dr. Puziss became aware of claimant's actual condition, he recanted his earlier opinion. Dr. Puziss provides the only opinion regarding claimant's medically stationary status.

Furthermore, although a "worsening" prior to 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. ORS 656.005(17). The day after closure, after becoming aware of claimant's actual condition, Dr. Puziss indicated that further treatment was possible. In addition, this possibility was confirmed by Dr. Berkeley's subsequent recommendation for microdecompression right L4-5 and L5-S1. (See Dr. Berkeley's examination report dated March 29, 1995). Dr. Puziss concurred with that recommendation and opined that the recommended surgery would provide claimant "significant improvement." (See letter dated April 6, 1995 from Dr. Puziss to the insurer).

Moreover, although claimant's condition continued to worsen after claim closure, and we are precluded from considering post-closure changes, we are persuaded that claimant's worsened condition at the time of claim closure prompted Dr. Puziss to consider further treatment for improvement in claimant's condition. (See February 9, 1995 letter from Dr. Puziss to the insurer).

Thus, based on Dr. Puziss' opinion read as a whole, we find that claimant was not medically stationary when his claim was closed. Therefore, we set aside the insurer's February 2, 1995 Notice of Closure and direct it to resume payment of temporary disability compensation beginning February 1, 1995. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

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

Claimant requests abatement and reconsideration of our January 21, 1997 Order on Review, which affirmed the Administrative Law Judge's (ALJ's) order which upheld the insurer's denial of his current low back condition.

In order to consider this matter, we withdraw our January 21, 1997 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARLENE L. STACY-BRYANT, Claimant
WCB Case No. 96-06642
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that dismissed her request for hearing for lack of jurisdiction. On review, the issue is the propriety of the ALJ's dismissal order.

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

The ALJ dismissed claimant's hearing request which alleged that the self-insured employer had "de facto" denied her request for cervical surgery at C5-6. The ALJ concluded that claimant had failed to satisfy the requirements for a "new medical condition" claim pursuant to ORS 656.262(7)(a) and, thus, that her hearing request, filed in the absence of a "claim," was premature. In reaching this conclusion, the ALJ reasoned that neither claimant's hearing request nor her counsel's correspondence with the employer prior to her July 18, 1996 hearing request constituted a "clear request" for formal written acceptance of a new medical condition under the statute.

On review, claimant contends that Dr. Hacker's April 8, 1996 letter recommending surgery triggered the 90-day period in ORS 656.262(7)(a) in which to accept or deny a "new medical condition" claim. Claimant further asserts that, since the employer failed to accept or deny her surgery claim within 90 days of receipt of Dr. Hacker's report, her hearing request properly conferred jurisdiction upon the Hearings Division to address the causation aspect of the medical services dispute. We disagree with claimant's contentions.

Applying amended ORS 656.262(7)(a), we held in Diane S. Hill, 48 Van Natta 2351 (1996) (a decision issued subsequent to the ALJ's order) 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 particular, we determined that a claimant must "clearly request formal written acceptance of the [new medical] condition" before a carrier is obligated to issue a written acceptance or denial. Based on the text, context, and legislative history of ORS 656.262(7)(a), we reasoned that the legislature intended to require a worker who wished to file a new medical condition claim to do so through a formal written request for acceptance of the claim before requesting a hearing. Finally, 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.

In this case, Dr. Hacker urged the employer in his April 8, 1995 report to "consider the appropriateness of the operative treatment I am recommending." (Ex. 1-3). Dr. Hacker concluded: "I feel that now, based on her failure to improve with exhaustive conservative therapies and the identification of the problem at the C5-6 level that her condition could be substantially improved with the appropriate surgery there." Id. Claimant asserts that Dr. Hacker's report satisfies the communication requirement of ORS 656.262(7)(a). We disagree.

ORS 656.262(7)(a) provides that a new medical condition claim 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." While we agree with claimant that Dr. Hacker's report, written in response to the medical report of an examining physician, is not a "claim billing," the report does not "clearly request" formal written acceptance of the underlying cervical condition. Diane S. Hill, 48 Van Natta at 2351. Instead, Dr. Hacker's report reiterates his prior recommendation that claimant undergo cervical surgery.

Therefore, even assuming that a physician can make a "new medical condition" claim on behalf of a claimant, under these circumstances where the employer has challenged the propriety of proceeding

with compensability litigation, we agree with the ALJ that claimant failed to satisfy the requirements of ORS 656.262(7)(a) for the perfection of a "new medical condition claim." Id.[1] Accordingly, we affirm the ALJ's dismissal of claimant's request for hearing.

ORDER

The ALJ's order dated September 27, 1996 is affirmed.

[1] Although required by stare decisis to follow our decisions in Hill and Jenkins, Board Chair Hall refers the reader to his dissents in those cases.

In the Matter of the Compensation of
PATRICK G. MAHLBERG, Claimant
Own Motion No. 95-0313M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Estell & Smith, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requests reconsideration of our November 7, 1996 Own Motion Order, as reconsidered on December 3, 1996 and on January 30, 1997. In our prior orders, we concluded that we have authority under ORS 656.278 to authorize temporary disability compensation in this claim, beginning September 29, 1994, the date claimant underwent surgery. On reconsideration, the employer argues that we are disregarding our own policy to await final determination of a compensability / surgery dispute prior to issuance of an Own Motion order. The employer further argues that claimant is not entitled to temporary disability compensation beginning the date of surgery in this claim because claimant "is no longer in the work force."

The employer cites Lisa A. Hiner, 48 Van Natta 1042 (1996) in its attempt to draw an analogous reference to the Board's rules which provide postponement of action on own motion matters pending exhaustion of a claimant's "administrative remedies." (See OAR 438-012-0050). As noted in our prior orders, we will postpone own motion proceedings until "administrative procedures" are completed. Consistent with the aforementioned rule and policy, in Hiner, we declined to issue an Own Motion order while a party's Board appeal of an ALJ's order was pending review. In that way, as we also previously explained, both the Board's Order on Review and the Own Motion Order can be issued in tandem, and a party may appeal both orders to the court.

Although the present case involves an order by the Director, rather than an order by the Board on review, our decision remains consistent with the express policy prescribed in OAR 438-012-0050. Specifically, we will not issue an Own Motion order while the case is proceeding through the Board's or the Director's "administrative process." OAR 438-012-0050. However, once the Director issues a final order, the next level of appeal is to the court, as is the next level of appeal for a Board order.

Finally, again as explained in our prior orders, the employer has several alternative actions it can take if it disagrees with our decision. In other words, since we have issued our order "in tandem" with the Director's order, the parties have the opportunity to appeal our order to the court, who, in all likelihood, will consolidate its review of the Director and Board orders.

Turning to the "work force" argument, we note that the employer previously conceded that claimant was in the work force at the time of disability. Under such circumstances, we decline to consider, at this late date, its new position that claimant was not in the work force at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 7, 1996 order (as reconsidered on December 3, 1996 and on January 30, 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.

In the Matter of the Compensation of
ANTHONY J. TELESMANICH, Claimant
WCB Case No. 95-10751
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of that part of our January 21, 1997 Order on Review that directed it to process conditions accepted subsequent to claim closure. Specifically, SAIF requests clarification of its obligation to process the "post-closure" accepted claims. SAIF also asserts that, to the extent the order directs it to "reopen" the claim, the order is inconsistent with our determination in Lisa A. Hiner, 49 Van Natta 56 (1997) and Julianne Cartwright, 48 Van Natta 918 (1996).

Claimant was compensably injured in July 1993. The claim was closed by Determination Order in January 1995. Claimant requested reconsideration, seeking an award of permanent disability. A September 15, 1995 Order on Reconsideration awarded 3 percent unscheduled permanent disability for a right hip condition and 7 percent scheduled permanent disability for loss of use or function of the right forearm. In addition to requesting a hearing concerning the Order on Reconsideration, claimant also requested a hearing alleging the "de facto" denial of certain conditions arising from the July 1993 incident, including injuries to the right knee, right elbow, right shoulder and low back. Prior to the hearing, SAIF accepted these particular conditions.

In our January 21, 1997 order, we declined claimant's request to defer the "extent" hearing so that the Department could evaluate those conditions accepted by SAIF subsequent to the Order on Reconsideration. Citing Rodney V. Boqua, 48 Van Natta 357 (1996), we held that the Hearings Division and Board could review the Order on Reconsideration and the conditions rated therein, but that SAIF was nevertheless required to process the later ("post-reconsideration") accepted conditions as required by law. We further noted that, to the extent claimant objected to SAIF's processing of these later accepted conditions, he could request reconsideration and a hearing at the appropriate time.

On reconsideration, SAIF asserts that our order directing it to process these later accepted condition appears contrary to Lisa A. Hiner and Julianne Cartwright, supra. We disagree. These cases address different issues and are distinguishable.

In Lisa A. Hiner, we held that the carrier had no obligation to "reopen" the claim and process compensable conditions as an aggravation pursuant to a prior ALJ's "compensability" finding because no aggravation claim had been made. In this case, we are not dealing with an aggravation issue, nor are we specifically directing SAIF to "reopen" the claim to process those conditions accepted subsequent to the Order on Reconsideration. Rather, we have simply found that SAIF has a duty to *process* these later-accepted conditions and pay any outstanding compensation. The processing of these later-accepted conditions may or may not include a reopening of the claim and an extent determination.

In Julianne Cartwright, the carrier agreed to withdraw its denial and "process" a L5-S1 disc bulge condition after the claimant's back injury claim had been closed by Determination Order. Because the claimant had not contested the Determination Order (which had become final by operation of law), we did not construe the carrier's "post-closure" agreement to "process" the claim as an obligation to "reopen" the claim and process the L5-S1 disc condition to another claim closure. Instead, we analyzed the claimant's L5-S1 disc condition as a disputed aggravation claim, and found that the claimant failed to sustain her burden of proving that her compensable condition had actually worsened. Contrary to Julianne Cartwright, the issue at this hearing did not involve a disputed aggravation claim.

At issue in this case is whether our review of claim closure and extent of permanent disability should automatically be deferred when there is a "post-closure" or "post-reconsideration" acceptance of other conditions. As in Rodney V. Boqua, we have determined that the answer is no. The claim closure and previously accepted conditions may be evaluated, and the 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. See ORS 656.262(7)(a). As noted above, 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. In the event that claimant disagrees with SAIF's processing of the claim, he may request another hearing under ORS 656.283(1).

Accordingly, our January 21, 1997 order is withdrawn. On reconsideration, as modified and clarified, we republish out January 21, 1997 order. The parties rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 20, 1997 Cite as 49 Van Natta 167 (1997)

In the Matter of the Compensation of
CHRIS G. CLAUSEN, Claimant
WCB Case No. 95-11626
SECOND ORDER ON RECONSIDERATION
Terry & Wren, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant[1] requests reconsideration of that portion of our December 24, 1996 Order on Review, as reconsidered on January 22, 1997, that upheld the insurer's partial denial of claimant's claim for a C5-6 herniated disc condition. In both our initial order and our reconsideration of that order, we adopted and affirmed Administrative Law Judge (ALJ) McKean's reasoning and conclusions regarding the compensability issue. With his current reconsideration request, claimant submits copies of multiple documents and urges us to rely on these reports to find his C5-6 herniated disc condition compensable. Some of these documents were not offered into the record at hearing. Since our review is confined to the record developed before the ALJ, we treat claimant's submission as a motion to remand for the taking of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985).

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).

As a preliminary matter we note that claimant submits copies of Exhibits 11, 15, 26, 28, and 86-4. All of these exhibits were admitted at hearing and have been included in our independent review of the record. Therefore, remand is not necessary regarding these exhibits.

Claimant also submits copies of Exhibits 7A and 19A. As addressed in our initial order, these exhibits were withdrawn by claimant at hearing.[2] On review, claimant requested that, if we found his C5-6 disc herniation condition not compensable, we remand the case to the ALJ with instructions to permit claimant to offer Exhibits 7A and 19A without granting the insurer the right to cross-examine the author, Dr. Bell. We declined claimant's request for remand, finding both that the exhibits were obtainable with due diligence at the time of hearing and that consideration of the exhibits would not change the result. On reconsideration, claimant again requests that we remand the case for admission of these exhibits. After reconsidering the matter, for the reasons stated in our initial order, we deny the motion for remand regarding Exhibits 7A and 19A.

Finally, claimant submits several documents that were not submitted into the record at hearing. These documents include various reports and chart notes from Dr. Bell, treating physician, dated June 24, 1983, February 24, 1984, September 23, 1985, December 20, 1985, June 13, 1986, June 24, 1986, and October 26, 1995. In addition, claimant submits copies of reports from Dr. Butters, M.D., and Dr. Misko, consulting neurologist. These reports are dated August 2, 1983 and October 10, 1985, respectively.

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[1] Although represented at hearing and on review, claimant apparently is pro se on reconsideration.

[2] As we noted in our initial order, Exhibit 7A consists of three pages. Although claimant ultimately withdrew Exhibit 7A, the insurer subsequently submitted page one of Exhibit 7A solely for impeachment purposes. (Tr. 41-42). The ALJ admitted page one of Exhibit 7A for that purpose. Id. That evidentiary issue was not at issue on review. With his current reconsideration, claimant submits all three pages of Exhibit 7A.

The hearing convened on April 19, 1996, with the record closing on April 24, 1996. The documents claimant seeks to have admitted on remand were generated from June 1983 to October 1995, well before the date of hearing. We find that all of these documents were obtainable with due diligence at the time of hearing. Accordingly, we deny the motion for remand.

Furthermore, even if these documents were admitted and considered, they would not change the result. The documents from Drs. Misko and Butters do not address the causation issue regarding claimant's C5-6 disc herniation condition. Regarding the documents from Dr. Bell, after reconsideration, we continue to agree with the ALJ's assessment of Dr. Bell's opinion. The documents submitted by claimant do not change that assessment. Specifically, the ALJ found that Dr. Bell's causation opinion was not persuasive because: (1) Dr. Bell relies heavily on claimant's subjective complaints and symptoms and claimant has well-documented, severe functional overlay, which makes reliance on subjective symptoms questionable; and (2) Dr. Bell infers causation from a temporal relationship. For the reasons explained by the ALJ, even if we considered the additional documents submitted by claimant on reconsideration, we are not persuaded that the 1982 injuries were a material contributing cause of claimant's current C5-6 herniated disc condition. Therefore, the additional evidence does not merit remand because it is not reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or at 646.

Consequently, we withdraw our prior orders. On reconsideration, we adhere to and republish our December 24, 1996 order, as reconsidered on January 22, 1997. 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
JON O. NORSTADT, Claimant
Own Motion No. 96-0568M
OWN MOTION ORDER
Cole, 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 lower leg, double compound fracture injury. Claimant's aggravation rights expired on February 13, 1995. SAIF opposes authorization 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.

On September 27, 1996, Dr. Thompson, claimant's treating physician, removed claimant's right ankle Asnis screw. 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. Claimant contends that he qualifies for temporary disability compensation because he continued working until his compensable condition worsened requiring surgery. 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.

In an October 10, 1996 chart note, Dr. Thompson noted that claimant was doing well following removal of the medial screw in his right ankle, and that claimant "is back to work." (Emphasis added.) In an October 23, 1996 chart note, Dr. Thompson noted that claimant "is doing his regular work." We are persuaded that claimant returned "back to work" after surgery, and, thus, was working prior to surgery in the employment to which he returned after surgery. On this record, we conclude that claimant has established that he was working at the time of disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning September 27, 1996, the date he was 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.

February 21, 1997 Cite as 49 Van Natta 169 (1997)

In the Matter of the Compensation of
KEITH D. OLIVER, Claimant
WCB Case Nos. 95-05995 & 95-03912
ORDER ON RECONSIDERATION
Myrick, Seagraves, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration/clarification of our February 3, 1997 Order on Review, in which we: (1) reversed the Administrative Law Judge's (ALJ's) order that set aside Liberty/ILB's denial of claimant's cervical condition and upheld Liberty/Wilson's denial of the same condition; and (2) reversed that portion of the ALJ's order that assessed a fee pursuant to ORS 656.386(1) against ILB. Noting that no party has challenged the total amount of the ALJ's assessed fee of $6,500 ($3250 to be paid by Liberty/ILB for claimant's cervical condition and $3250 to be paid by Liberty/Wilson for claimant's right shoulder condition), claimant specifically requests that we order Liberty/Wilson to pay the entire attorney fee award, since we have determined that it is now responsible for claimant's entire claim (both the right shoulder and cervical condition).

Although the conclusion that Liberty/Wilson is responsible for the entire attorney fee award was implicit in our order, we did not specifically order Liberty/Wilson to pay the entire attorney fee awarded by the ALJ pursuant to ORS 656.386(1). Therefore, our February 3, 1997 order is modified to hold that Liberty/Wilson is responsible for the entire amount of the ALJ's $6,500 attorney fee awarded pursuant to ORS 656.386(1).

Accordingly, we withdraw our February 3, 1997 order. On reconsideration, as supplemented/clarified herein, we adhere to and republish our February 3, 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
LOIS J. SCHOCH, Claimant
WCB Case Nos. 93-12032 & 93-08669
ORDER ON REMAND
Pozzi, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Schoch v. Leupold & Stevens, 144 Or App 259 (1996). The court has vacated the attorney fee award granted under ORS 656.386(1) in our prior order, Lois J. Schoch, 46 Van Natta 1816 (1994), and remanded for reconsideration. Specifically, the court concluded that we erred in concluding that we were precluded from applying a contingency multiplier in evaluating the factors set forth in OAR 438-015-0010(4)(g) to determine the amount of a reasonable assessed attorney fee. The court further reasoned that, because we did not explain the basis of our award in sufficient detail, it was not informed that we had, in fact, considered the factors, as required by the rule.

The court has instructed that, if the Board finds that there is a risk in a particular case that an attorney will be uncompensated, "then the Board must take that risk into account pursuant to OAR 438-015-0010(4)(g) in determining the reasonable attorney fee." Schoch, 144 Or App at 262. In light of the court's instructions, we proceed with our reconsideration.

We begin with a summary of the relevant facts.

The issues at hearing were the compensability of claimant's occupational disease claims for bilateral tendinitis and bilateral carpal tunnel syndrome (CTS) conditions, aggravation, and penalties and attorney fees for allegedly unreasonable processing of the CTS claim and for allegedly unreasonable denials. The Administrative Law Judge (ALJ) set aside the insurer's occupational disease denials, upheld its aggravation denial, and declined to assess penalties or related attorney fees.

Claimant's counsel submitted a statement of services attesting to 28 3/4 hours of attorney services at $175 per hour and 13 hours of paralegal services at $60 per hour. He requested a total fee of $9,250 for services at the hearings level.

The insurer argued that claimant's counsel's time expenditure was excessive. In addition, the insurer contended that claimant unreasonably requested approximately $3,000 in addition to the services claimed at a high hourly rate.

The ALJ awarded an assessed attorney fee of $2,100 for claimant's counsel's services in prevailing over each occupational disease denial. Claimant requested reconsideration of the attorney fee award, contending that $4,200 was inadequate. On reconsideration, the ALJ republished his Opinion and Order. Claimant requested review regarding the penalty and attorney fee issues.

On review, we adopted the ALJ's order, with supplementation. In doing so, we found that claimant was not entitled to a separate contingency multiplier, as requested by her counsel.

The court vacated our attorney fee award, concluding that we erred in stating that we were precluded from applying a contingency multiplier to determine the amount of a reasonable assessed attorney fee. The court further reasoned that, because we did not explain the basis of our award in sufficient detail, it was not informed that we had, in fact, considered the factors set forth in OAR 438-015-0010(4)(g).

On remand, 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 issues in dispute were the compensability of claimant's tendinitis and CTS conditions, aggravation, and the reasonableness of the insurer's processing and denials. Approximately 66 exhibits were received into evidence, including approximately 21 provided by claimant, at least two of which are medical reports generated by claimant's counsel. The hearing lasted three hours and the transcript consists of 91 pages. Two witnesses, including claimant, testified. At the hearing, claimant submitted 11 pages of written

argument to the ALJ. The compensability issues present factual and medical questions of a complexity similar to those generally submitted for Board consideration. The claim's value and the benefits secured are significant, because substantial medical services are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for the ALJ's resolution. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that the ALJ's $4,200 attorney fee is reasonable and appropriate in this case. In reaching this conclusion, we have particularly considered the time devoted to the occupational disease issues (as represented by the record, claimant's counsel's submission, and the insurer's objection), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.[1]

Accordingly, on reconsideration, the ALJ's July 25, 1994 order, as reconsidered August 24, 1994, is republished and affirmed, as supplemented herein.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we have not used claimant's counsel's "contingency multiplier" in a strict mathematical sense; i.e., we have not simply multiplied claimant's counsel's hourly fee by the contingency factor. Rather, in conjunction with the other relevant factors, the risk that claimant's counsel might go uncompensated for his services has been factored into our overall determination of a reasonable attorney fee for efforts devoted to the occupational disease denials. In arriving at such a determination, we have also taken into consideration counsel's unsuccessful efforts in overturning the employer's aggravation denial, as well as his unsuccessful attempts to secure penalties and attorney fees for several alleged unreasonable claim processing actions.

February 21, 1997 Cite as 49 Van Natta 171 (1997)

In the Matter of the Compensation of
ROBERT K. WARNOCK, Claimant
WCB Case No. 96-02475
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Judy L. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order which upheld the SAIF Corporation's denial of his right hip injury claim. On review, the issue is compensability.

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

In upholding SAIF's denial of claimant's right hip injury claim, the ALJ reasoned that claimant's preexisting hip condition combined with work injuries on October 26, 1995 and December 11, 1995 to cause disability and a need for medical treatment. Finding that the medical opinions from the attending physician, Dr. Mayhall, and an examining physician, Dr. Fuller, established that the preexisting condition was the major contributing cause of the disability and need for treatment, the ALJ concluded that claimant's right hip condition was not compensable under ORS 656.005(7)(a)(B).

On review, claimant contends that he sustained a compensable injury to the sciatic nerve as a result of the first incident on October 26, 1995 and that SAIF's denial should be set aside as to that condition. We disagree.

In Charles L. Grantham, 48 Van Natta 1094 (1996), the preponderance of the evidence established that the claimant's preexisting degenerative disc disease combined with a work-related lumbar strain at the outset, and that the preexisting disease was the major contributing cause of the combined condition. However, the claimant asserted that the "combined condition" analysis under former ORS 656.005(7)(a)(B) did not apply to the initial work-related lumbar strain, but applied only to his condition after the initial strain resolved. We found, however, that the court in Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590, rev den 318 Or 27 (1993), had rejected the

"two-step" analysis proposed by the claimant. Specifically, in Nazari, the court explained that former ORS 656.005(7)(a)(B) was applicable in the context of an initial injury claim, if in the initial claim the "the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition." 120 Or App at 594.

In Grantham, we determined that the Nazari analysis remained viable under amended ORS 656.005(7)(a)(B), which provides that if "an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability or need for treatment of the combined condition." Because the work injury combined with the claimant's preexisting degenerative disc disease at the outset, we concluded in Grantham that compensability of the claim was properly analyzed under amended ORS 656.005(7)(a)(B).

As we did in Grantham, we conclude in this case that ORS 656.005(7)(a)(B) is applicable. We reach this conclusion for the following reasons.

On November 2, 1995, Dr. Walker noted that claimant had injured himself when he slipped at work in October 1995. Based on claimant's report of right hip and leg pain and his examination of claimant, Dr. Walker "suspect[ed]" that claimant had stretched his sciatic nerve. (Ex. A).

Claimant eventually came under the care of Dr. Mayhall after the December 11, 1995 incident, in which claimant experienced additional right hip pain related to catching his foot on a piece of molding at work. Dr. Mayhall later confirmed that the December 11, 1995 incident "combined" with a preexisting avascular necrosis (AVN) of the right hip and that the AVN was the major contributing cause of claimant's need for treatment of a collapse of the right femoral head. (Ex. 8).

At a subsequent deposition, Dr. Mayhall was queried as to the accuracy of Dr. Walker's diagnosis of a stretching of the sciatic nerve as a result of the October 1995 incident. While acknowledging that Dr. Walker's diagnosis was "one of the reasonable explanations" of claimant's right hip pain, Dr. Mayhall reiterated his belief that claimant had the collapse of the femoral head, but that he was not sure which of the incidents caused the actual collapse. (Ex. 10-6). However, Dr. Mayhall opined that "I kind of thought it was probably the first one, but I don't know that there's any way to know." (Ex. 10-6, 7).

Dr. Fuller provided the only other opinion addressing causation. Dr. Fuller stated that claimant's injuries in October and December 1995 combined with a preexisting right hip dysplasia to cause claimant's need for treatment. (Ex. 9-6). Dr. Fuller agreed that claimant's preexisting right hip condition was the major contributing cause of claimant's right hip condition and need for treatment. (Ex. 9-6).

Based on our de novo review of the record, we conclude that the medical evidence as a whole supports a finding that a preexisting right hip condition (whether described as AVN or dysplasia) combined at the outset with claimant's October 1995 injury to cause disability and a need for treatment. Thus, we conclude that the ALJ properly applied ORS 656.005(7)(a)(B) in determining compensability. Further, because both Dr. Mayhall and Dr. Fuller identified the preexisting right hip condition as the major factor in claimant's disability and need for treatment, we further conclude that the ALJ properly upheld SAIF's denial under that statute.

Lastly, claimant argues that the "major contributing cause" standard of ORS 656.005(7)(a)(B), applied in conjunction with the exclusive remedy provision of amended ORS 656.018, effectively deprives him of a remedy for his right hip condition in violation of Article I, Section 10 of the Oregon Constitution. As we did in Jim M. Greene, 47 Van Natta 2245 (1995), we decline to consider this constitutional challenge because claimant has not demonstrated that he has been injured by operation of amended ORS 656.018. Instead, we continue to adhere to the fundamental rule that a case shall not be decided upon constitutional grounds unless absolutely necessary to determination of the issue before it. See, e.g., Jackson v. Fred Meyer, Inc., 139 Or App 222 (1996) (declining to consider Article I, Section 10 challenge to amended ORS 656.018(1)).

ORDER

The ALJ's order dated August 22, 1996 is affirmed.

In the Matter of the Compensation of
STEVEN J. ELWELL, Claimant
WCB Case Nos. 96-03848 & 96-00466
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that set aside the insurer's denial of claimant's cervical disc herniation condition. On review, the issue is compensability.

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

In September 1995, claimant worked as a framing carpenter. In October 1995, he sought treatment for right shoulder pain and, eventually, neck pain. Claimant subsequently was diagnosed with disc herniations at C5-6 and C6-7. The ALJ, applying ORS 656.005(7)(a)(B), concluded that claimant did not prove compensability. The ALJ was more persuaded by the opinions of the treating occupational health specialist Dr. Pierson and examining physician Dr. Rosenbaum, than the opinion of Dr. Wayson, the treating neurosurgeon.

On review, claimant disputes the ALJ's application of ORS 656.005(7)(a)(B),[1] asserting that the claim should be analyzed under the material contributing cause standard pursuant to ORS 656.005(7)(a) because the record shows that claimant's herniations resulted from an injurious event. We disagree. All the physicians, including Dr. Wayson, indicate that claimant's preexisting degenerative arthritis was a factor in causing his neck condition. (Exs. 32-2, 50, 52-5, 53A). Since we interpret these opinions as supporting a theory that claimant's work injury combined with the preexisting condition, ORS 656.005(7)(a)(B) is the appropriate statute for determining compensability of claimant's "combined" neck condition.

Claimant also disagrees with that portion of the ALJ's order characterizing the "combined condition" as "cervical radiculopathy." Claimant asserts that such characterization is inconsistent with the denials for cervical disc herniations. As Dr. Rosenbaum explained, cervical radiculopathy is an irritated or "pinched" nerve caused either by a bone spur or herniated disc. (Ex. 56-4). Consequently, we find little distinction between cervical radiculopathy and herniated disc since both refer to the process resulting in claimant's symptoms.

Finally, for the reasons expressed in the ALJ's order, we agree with the ALJ's assessment of the medical evidence and his conclusion that claimant failed to carry his burden under ORS 656.005(7)(a)(B).

ORDER

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

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[1] ORS 656.005(7)(a)(B) provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or 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."

In the Matter of the Compensation of
DOUGLAS D. LAGRAVE, Claimant
WCB Case No. 96-02654
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 Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for left shoulder and left elbow conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

In lieu of the ALJ's finding that claimant did not treat for, or was disabled by, his left shoulder condition prior to January 1996, we find that claimant sought treatment for pain in both shoulders in February 1995 and that he was disabled by bilateral shoulder pain in February 1995.

In lieu of the finding that claimant had an onset of left elbow pain prior to the onset of left shoulder pain, we find that the onset of left elbow pain in January 1996 was caused in major part by claimant's unconscious modified use of the painful left shoulder.

CONCLUSIONS OF LAW AND OPINION

It is undisputed that claimant's left shoulder and elbow conditions are compensably related to work exposure. The dispute is over whether SAIF is responsible for those conditions. The ALJ applied the last injurious exposure rule (LIER) and, finding that claimant first sought medical treatment for his shoulder condition while he was employed with SAIF's insured, assigned responsibility for the condition to SAIF. The ALJ also found that responsibility did not shift forward to a subsequent employer (after SAIF's insured) and that the elbow condition was a consequence of the shoulder condition. The ALJ thus concluded that SAIF is responsible for the left shoulder and elbow conditions.

On review, SAIF contends that the ALJ should not have applied LIER because the medical record establishes that claimant's employment prior to SAIF's insured was the actual cause of his left shoulder and elbow conditions. SAIF relies on the opinion of Dr. Naugle that "[claimant's] left upper extremity complaints that became apparent during his employment [prior to SAIF's insured] have never completely resolved and that his current complaints are a flare-up of his prior left shoulder condition...." (Ex. 42A). We are not persuaded, however, that Dr. Naugle believed the employment prior to SAIF's insured was the major, or primary, cause of claimant's current left upper extremity condition. At most, his opinion indicates that the prior employment was a contributing factor. That is not sufficient to prove actual causation for an occupational disease claim. See Runft v. SAIF, 303 Or 493, 501-502 (1987); Eva R. Billings, 45 Van Natta 2142 (1993).

SAIF contends, alternatively, that the ALJ misapplied LIER. Alleging that claimant first sought treatment for the shoulder condition prior to commencing employment with its insured, SAIF argues that it is not the responsible carrier. We agree and reverse.

Under LIER, if a claimant establishes that disability was caused by a disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for initial assignment of responsibility. See Bracke v. Baza'r, 293 Or 239 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to a condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributed independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). The dispositive date is the date that the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Here, the ALJ found that claimant first sought treatment for his left shoulder and elbow condition on January 29, 1996. That finding is supported by claimant's testimony at hearing that he neither sought nor received treatment for left shoulder or elbow pain prior to 1996. (Tr. 26-27). However, claimant's testimony is inconsistent with the medical record which shows that claimant first sought treatment for left shoulder pain in February 1995. Dr. DiPaolo's February 16, 1995 chart note reports that claimant "called stating that he had too much pain in his wrists and both shoulders in order to work. He had been doing a lot of overhead, heavy work and this has flared up his condition." (Ex. 15, emphasis supplied). Examination at that time revealed irritability in both shoulders and wrists. (Id.) Dr. DiPaolo diagnosed bilateral shoulder pain and bilateral carpal tunnel syndrome, and released claimant from work for one week. (Id.)

The following week, on February 23, 1995, claimant saw Dr. Weintraub who reported that both hands and shoulders were bothering claimant. (Id.) Dr. Weintraub's examination revealed mildly positive impingement signs in both shoulders. (Id.) Dr. Weintraub felt it was appropriate for Dr. DiPaolo to release claimant from work. (Id.)

In early May 1995, claimant was continuing to have bilateral shoulder pain. At that time, Dr. Weintraub diagnosed bilateral subacromial impingement syndrome and stated: "The reason [claimant] is not working now is his shoulders." (Ex. 18). By May 23, 1995, Dr. Weintraub reported that claimant was unable to work for three weeks due to bilateral shoulder bursitis. (Ex. 19).

Thus, the medical record shows that claimant sought treatment for, and was disabled by, pain in both shoulders prior to November 1995, when he began employment with SAIF's insured. We are mindful that physical therapy notes in April through June 1995 show that therapy was directed to the right shoulder only; (Ex. 16A), however, the chart notes of Drs. DiPaolo and Weintraub clearly show that claimant sought treatment for pain in both shoulders. In addition, claimant was medically released from work due to pain in both shoulders. Although the right shoulder was apparently more painful than the left, we are persuaded that the left shoulder condition resulted in treatment and disability prior to November 1995. Insofar as claimant's testimony conflicts with the medical record on this issue, we conclude that the contemporaneous medical records are the most reliable evidence of claimant's treatment history.

Claimant's left shoulder condition prior to November 1995 is essentially the same condition which prompted claimant to seek treatment with Dr. Naugle in January/February 1996. Dr. Naugle found a positive impingement sign in the left shoulder and opined that the left shoulder symptoms in 1996 were a flare-up of the prior left shoulder condition. (Exs. 37, 38, 39, 41, 42A).

Based on this record, therefore, we find that claimant first sought treatment for his left shoulder condition prior to commencing employment with SAIF's insured in November 1995. Under LIER, SAIF is not initially assigned responsibility for the left shoulder condition.[1] See Starbuck, supra; Bracke, supra. Responsibility may still be shifted forward to SAIF, however, if employment conditions with its insured contributed to the cause of, aggravated or exacerbated the underlying shoulder condition. Bracke, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992). Claimant must experience more than a mere increase in symptoms in order to shift responsibility. Bracke, supra; Timm v. Maley, 134 Or App 245, 249 (1995).

There is no persuasive medical evidence to prove that claimant's employment with SAIF's insured contributed to the cause or worsening of the underlying left shoulder condition. Dr. Naugle opined that the left upper extremity symptoms claimant experienced prior to his employment with SAIF's insured, never completely resolved, and that claimant's left shoulder complaints in 1996 were "a flare-up of his prior left shoulder condition." (Ex. 42A). Dr. Naugle's opinion is unrebutted, and he did not waver from that opinion in his deposition. (Ex. 44). Accordingly, we conclude that SAIF is not responsible for the left shoulder condition.

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[1] Claimant did not join any previous employers, aside from SAIF's insured, at this proceeding. Because SAIF timely denied responsibility for claimant's claim and advised claimant to file claims against other potentially responsible employers/insurers, (Ex. 36), SAIF may use LIER defensively to establish it is not responsible for the claim. See ORS 656.308(2); Kristin Montgomery, 47 Van Natta 961, 964 (1995).

Turning to the left elbow condition, we again rely on the unrebutted opinion of Dr. Naugle, who opined that claimant's elbow condition, diagnosed as medial epicondylitis, was "quite likely" the result of "unconscious modified use" of the left shoulder as a means to avoid pain or discomfort in the shoulder. (Ex. 42A). At his deposition, Dr. Naugle further opined that the left elbow condition was caused in major part by claimant's compensating for the left shoulder pain. (Ex. 44, pp. 29-30, 38). Based on that opinion, we conclude that the left elbow condition was a consequence of the left shoulder condition. Because SAIF is not responsible for the left shoulder condition, we conclude it is likewise not responsible for the consequential, left elbow condition.

In reaching our conclusion that SAIF is not responsible for the left elbow condition, we decline to rely on claimant's testimony at hearing that his left elbow symptoms began prior to the onset of his left shoulder pain. (See Tr. 17). His testimony in that regard is inconsistent with the contemporaneous medical record, which shows that left shoulder pain developed in early 1995, before the onset of left elbow symptoms. (Exs. 15, 18, 19, 20, 23, 24, 25). For the aforementioned reasons, we conclude SAIF is not responsible for claimant's left shoulder and elbow conditions, and its denial shall be upheld.

ORDER

The ALJ's order dated August 2, 1996 is reversed. SAIF's denial is reinstated and upheld. The ALJ's assessed fee award is also reversed.

February 24, 1997 Cite as 49 Van Natta 176 (1997)

In the Matter of the Compensation of
WILLIAM R. NIXON, Claimant
WCB Case No. 96-02840
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Baker's order which found that the SAIF Corporation had properly calculated the rate of claimant's temporary disability benefits. On review, the issue is the rate of temporary total disability benefits. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. On page 1, we change the second sentence of the third paragraph to read: "At the time of the injury, the employment agreement between claimant and Moon did not include any further scheduled jobs."

CONCLUSIONS OF LAW AND OPINION

Claimant, a concrete finisher, injured his right hand on September 12, 1995, while working on a one-day concrete job with David Moon. Claimant's wage on the date of injury was $150. On September 12, 1995, the employment agreement between claimant and Moon did not include any further scheduled jobs.

At the time of the injury, claimant was a full-time employee of an unrelated employer, Ace Concrete. Claimant testified that, after David Moon Concrete[1] went out of business in mid-July 1995, he performed two "side-jobs" for David Moon. (Tr. 14). He performed one job on July 31, 1995 for $140, which involved one day of work. (Id.) Regarding his further employment with David Moon after July 31, claimant testified:

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[1] Claimant asserts that his former employment with David Moon Concrete is irrelevant, because that employment ceased in mid-July 1995 when claimant was informed that the employer was going out of business.

"Q. Mr. Nixon, did you have any scheduled employment with Mr. Moon on -- at any point after July 31? Did you have any set employment scheduled with Mr. Moon?

"A. No.

"Q. Okay.

"A. It was when Mr. Moon called.

"Q. Okay. That's all I'm trying to get at here.

"A. All right. I knew that there was a job here and a job there, but exactly the specific date to do it, no.

"Q. Okay. And, in fact you had regular employment with another employer. Didn't you?

"A. Yes, I did.

"Q. You were working for Ace Concrete?

"A. Yes, I was.

"Q. So the only time you would've been available to do any work for Mr. Moon is if you were off - - you had a day off from Ace Concrete?

"A. A day off, or I took a day off." (Tr. 19).

Claimant testified that David Moon called him on September 11, 1995, said that he needed help on a job and asked if claimant would help him. (Tr. 4). Claimant agreed to do so and injured his hand while working for David Moon on September 12, 1995.

Citing ORS 656.210(2)(c), claimant argues that he was "regularly employed" for one day at the rate of $150 per day. Claimant asserts that, since he was available for actual employment with the employer five days a week, his average weekly wage was $750. Alternatively, claimant contends that, even if was not "regularly employed," former OAR 436-60-025(5) does not apply because his employment was not unscheduled, irregular or without earnings. We disagree with both contentions.

ORS 656.210(2)(a) provides that the "weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed." ORS 656.210(2)(c) provides:

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

Former OAR 436-60-025(1) provides that the rate of compensation shall be based on the wage of the worker at the time of injury, except in occupational disease cases. Here, claimant was injured on September 12, 1995. Thus, the rules contained in Workers' Compensation Department Order No. 94-055 apply to this claim. Former OAR 436-60-025(5) (WCD Admin. Order 94-055) provides, in part:

"The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *

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

the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker."

Claimant agreed that he did not have any employment scheduled with David Moon after July 31, 1995. (Tr. 19). Claimant testified that the next employment would be when David Moon called and there were no specific dates for his next employment with Moon. (Id.) David Moon testified that claimant had told him he would come and help if Moon called and needed his services. (Tr. 25, 30, 31). Both parties understood that the employment was sporadic and unscheduled, depending on the need of David Moon and the availability of claimant.

Under these circumstances, we conclude that, at the time of his injury, he was employed "on call" with David Moon. Since claimant was employed "on call," his employment was unscheduled, see former OAR 436-60-005(10), and his benefits must be calculated under the Director's rules. See former OAR 436-60-025(5) (the rate of compensation for workers "employed with unscheduled, irregular or no earnings" shall be computed under this rule). Claimant's wages for his regular employment with Ace Concrete, from which he would have to take time off to work on David Moon's projects, is not considered in calculating his TTD rate.[2]

As of September 12, 1995, claimant had worked for David Moon on two occasions, July 31, 1995 and September 12, 1995. On July 31, 1995, claimant was paid $140 and on September 12, 1995, he was paid $150. Thus, claimant was employed less than 52 weeks prior to the injury and the amount of the wage earning agreement had changed. Former OAR 436-60-025(5)(a) provides that "Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury." Thus, the "most recent wage earning agreement" between claimant and David Moon was for one day of work at $150. We conclude that SAIF correctly computed claimant's temporary total disability rate.

ORDER

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

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[2] Former OAR 436-60-025(c) provides, in part: "For workers employed in two jobs with two employers at time of injury insurers shall use only the wage of the job on which the worker was injured to compute the rate of compensation."

February 24, 1997 Cite as 49 Van Natta 178 (1997)

In the Matter of the Compensation of
GORDON M. RUTTER, Claimant
WCB Case No. 96-05292
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that authorized the SAIF Corporation's request for an offset based on a recalculation of claimant's rate of temporary disability benefits. On review, the issues are the rate of temporary disability benefits and offset. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 1, we change the first sentence of the first paragraph to reflect that claimant worked as a pipe layer. In the first sentence of the third full paragraph on page 2, we change the date of "March 3, 1995" to read "March 9, 1995."

CONCLUSIONS OF LAW AND OPINION

Claimant, a pipe layer, began working for the employer on October 26, 1994. He was paid $14 per hour and worked as many hours as were available. Claimant worked for the employer until November 23, 1994, when he left to take other work in Nevada. Claimant left work for the employer due to a decrease in hours occasioned by bad weather.

On February 13, 1995, claimant returned to work for the employer in the same position he had left in November 1994. Claimant's hours and wages were the same as in November 1994. On February 28, 1995, claimant cut his left index finger while working for the employer. SAIF accepted the claim for disabling purulent tenosynovitis, left index finger.

SAIF initially calculated temporary total disability benefits based on the average hours that claimant had worked and the wage that he had received for the two week period in February 1995 when he returned to work for the employer.[1] SAIF's January 8, 1996 Notice of Closure awarded claimant temporary disability benefits and 25 percent scheduled permanent disability for the left forearm. (Ex. 6). The Notice of Closure indicated that SAIF was allowed to deduct overpaid disability benefits. Claimant requested reconsideration of the Notice of Closure.

On February 5, 1996, SAIF informed claimant that it was claiming an overpayment of temporary disability benefits due to incorrect wage information. (Ex. 6A). SAIF recalculated claimant's rate of temporary disability benefits by averaging the entire time that claimant worked for the employer, which included the period between October 26, 1994 and November 23, 1994.

The ALJ concluded that SAIF had properly recalculated claimant's rate of temporary disability, reasoning that claimant's "average weekly wage" should be calculated by using the actual time worked for the employer during the previous 52 weeks. The ALJ authorized SAIF's request for an offset of $3,657.04.

Although we agree with the ALJ's conclusion, we base our decision on the following reasoning.

Claimant contends that the ALJ erred by allowing the offset, arguing that his temporary disability should be calculated pursuant to ORS 656.210(2)(c) because he was "regularly employed."

ORS 656.210(2)(a) provides that the "weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed." ORS 656.210(2)(c) provides:

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

Even if claimant was "regularly employed," as characterized in ORS 656.210(2), if he was paid on a basis other than a daily or weekly wage, benefits shall be calculated under the Director's rules, not under ORS 656.210. ORS 656.210(2)(c); Lowry v. DuLog, Inc., 99 Or App 459 (1989), rev den 310 Or 70 (1990).

The parties agreed that claimant was paid at $14 per hour and he worked as many hours as were available. The employer's director of personnel and safety and claimant both testified that claimant's hours were sporadic, depending on the weather and how much work was available. (Tr. 10-12, 20-21). Since claimant worked "varying" hours, rather than "regular" hours, he was paid on other than a daily or weekly basis and his benefits must be calculated under the Director's rules. See Lowry, 99 Or App at 462; Catherine A. Barringer, 42 Van Natta 2356 (1990).

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[1] SAIF's March 21, 1995 "1502" form referred to claimant's weekly wage as $630. (Ex. 2A). The weekly wage was apparently based on the "801" form, which showed a wage of $14 per hour, 9 hours per shift and a 5-day work week ($14 x 9 x 5 = $630). (Ex. 2).

Former OAR 436-60-025(1) provides that the rate of compensation shall be based on the wage of the worker at the time of injury, except in occupational disease cases. Here, claimant was injured on February 28, 1995 and the rules contained in Workers' Compensation Department Order No. 94-055 apply to this claim. Former OAR 436-60-025(5) (WCD Admin. Order 94-055) provides, in part:

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

Claimant asserts that he had two separate periods of employment with the employer. In its brief, SAIF agrees that claimant worked for the employer at two different times. Claimant's entire period of employment was less than 52 weeks.

In calculating temporary disability benefits, former OAR 436-60-025(5)(a) provides that for workers employed less than 52 weeks, "insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks." (Emphasis added). Here, claimant was employed by the employer from October 26, 1994 to November 23, 1994, and from February 13, 1995 until he was injured on February 28, 1995. The interim period from November 24, 1994 to February 12, 1995, when claimant was working for another employer, does not constitute "employment with the employer at injury" pursuant to former OAR 436-60-025(5)(a). Therefore, that time period is not considered for purposes of calculating claimant's temporary disability benefits. We conclude that SAIF properly calculated claimant's rate of temporary disability benefits by averaging the entire time that claimant worked for the employer, which included the period between October 26, 1994 and November 23, 1994. We agree with the ALJ that SAIF is entitled to an offset of $3,657.04.

ORDER

The ALJ's order dated September 13, 1996 is affirmed.

In the Matter of the Compensation of
JAMES M. FIRESTONE, JR., Claimant
WCB Case No. 96-04016
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that awarded temporary total disability from November 30, 1992 to February 4, 1993. On review, the issue is temporary disability.

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

The ALJ awarded claimant temporary disability from November 30, 1992 to February 4, 1993 based on his attending physician's (Dr. Sampson's) February 29, 1996 retroactive authorization of temporary disability. Citing Ivan E. Dame, 48 Van Natta 1228 (1996), the ALJ reasoned that amended ORS 656.262(4)(f), which prohibits retroactive authorization of payment of temporary disability more than 14 days prior to authorization by the attending physician, did not eliminate the distinction between procedural and substantive entitlement to temporary disability. Inasmuch as there was no dispute that claimant was totally disabled due to the compensable injury during the period in dispute, the ALJ concluded that claimant was entitled to the temporary disability sought.

On review, SAIF acknowledges the relevant contrary Board precedent, but nevertheless argues that the legislature effectively eliminated the distinction between "substantive" and "procedural" temporary disability. It requests that we "revisit" the issue and reverse the ALJ's temporary disability award. For the following reasons, we decline SAIF's request to reverse the ALJ.

Subsequent to the ALJ's order, we did, in fact, reexamine the procedural/substantive temporary disability distinction in Kenneth P. Bundy, 48 Van Natta 2501 (1996). In Bundy, we concluded that the 1995 amendments to the Workers' Compensation Law had no effect on the principle that a worker is substantively entitled to temporary disability benefits for those periods during which he is able to prove that he was unable to work as a result of his compensable injury, and that substantive entitlement to such benefits is not contingent upon contemporaneous authorization of time loss by the attending physician.

Having fully examined the issue SAIF raises in both Dame and Bundy, we decline SAIF's invitation to examine this issue another time. Accordingly, based on the rationale articulated in Dame and Bundy, we conclude that the ALJ properly awarded claimant temporary disability for the period in dispute.

Inasmuch as we have not reduced or disallowed the compensation awarded to claimant, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 26, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
SUZETTE L. LOPEZ, Claimant
WCB Case No. 96-01433
ORDER ON REVIEW
Max Rae, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the insurer'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.

Considering the passage of time between claimant's 1993 compensable strain injury and the November 1995 driving incident, 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).

The medical evidence concerning causation is provided primarily[1] by Dr. Donovan, who treated claimant after the 1993 injury, and Dr. Hoang, who examined claimant on November 10, 1995.

Dr. Hoang could not say whether claimant's current low back problems are related to her 1993 injury. (See Ex. 72).

Based on a 1996 review of claimant's chart and her past history, Dr. Donovan initially suspected that claimant's current low back problem "was a coincidental occurrence, not related to the on-the-job injury in a major way." (Ex. 70). During deposition, Dr. Donovan explained that she was reluctant to express an opinion concerning causation based on Dr. Hoang's findings, without examining claimant herself. (Exs. 71-10). Although acknowledging that claimant's 1995 incident was consistent with her prior exacerbations, and noting that claimant's recent pain had been in her lumber area, Dr. Donovan was nonetheless "a little concerned about that." (Ex. 71-11). She explained that claimant's current low back condition could be related to her 1993 condition, and that it would probably be the same condition if claimant was having the same exam findings now as she did previously. (Exs. 71-12, -17). However, Dr. Donovan's opinion as a whole indicates that she was unwilling to state that r. Hoang's examination findings were similar enough to her own findings to relate claimant's current condition to the 1993 strain injury. (See Ex. 71-12). Under these circumstances, we conclude, as did the ALJ, that claimant has not established that her current low back problems are materially related to her compensable injury.[2] See Lenox v. SAIF, 54 Or App 551, 554 (1981) (To prove medical causation, a medical opinion must be based on medical probability).

ORDER

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

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[1] Based on a review of claimant's chart, Dr. Byrkit suspected "that a causal relationship to the 1993 injury will be quite difficult to approve." (Ex. 62). He further opined that it was "certainly more likely than not that the injury may not be related to her previous back injury." (Id.)

[2] We acknowledge the insurer's motion to strike that portion of claimant's brief which includes an illustration. However, because we have determined that the claim is not compensable based on the medical opinions, we need not address the motion.

In the Matter of the Compensation of
BRADFORD SEXTON, Deceased, Claimant
WCB Case No. C700145
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On January 23, 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 (the deceased worker's surviving spouse), releases certain rights to future worker's compensation benefits for the compensable injury. We disapprove the proposed disposition.

Under the proposed disposition, the deceased worker's surviving spouse releases her rights to monthly survivor's benefits under ORS 656.204 in exchange for one dollar. Although the disposition refers to a "separate" third party settlement in an amount "well in excess of one million dollars," the carrier does not waive any portion of its third party lien within the terms of the CDA.[1]

On January 30, 1997, we wrote the parties requesting additional information to determine the value of the survivor's benefits claimant was releasing under the CDA. Specifically, we requested the amount of the surviving spouse's monthly benefit under ORS 656.204(2)(a),[2] and information regarding the surviving spouse's current marital status and whether she planned to remarry. In addition, we sought information regarding whether the deceased worker was survived by minor children, and if so, the amount of their monthly benefit and the effect, if any, the CDA would have on those benefits.

In response to our letter, the parties have indicated that the surviving spouse's monthly benefit under ORS 656.204(2)(a), as of the date of the agreement was $1,433.95 per month, that the surviving spouse has not remarried and has no current plans to remarry, and that the deceased worker was not survived by any minor children.

Although the proposed disposition alludes to a significant third party settlement arising out of the deceased worker's death, the separate third party settlement does not provide consideration for the proposed CDA. In this regard, the parties have emphasized that the third party settlement is separate from the CDA and that they have reached a separate agreement concerning the resolution of the insurer's lien. The CDA also indicates that claimant "does not want the complication of an insurer's lien which is available to the insurer under ORS 656.576, et. seq."

Thus, on its face, the CDA provides that the surviving spouse releases her rights to a $1,433.95 monthly payment, which could potentially continue for the rest of her life if she does not remarry, in exchange for a total consideration of one dollar.[3] Under the statutory scheme, even if the surviving spouse immediately remarries, she will receive a lump sum payment of 24 times the monthly benefit as final payment of the claim under ORS 656.204(3)(a).[4] Thus, even if claimant had remarried at the time of the CDA, she would still be releasing a significant benefit ($34,414.80 -- $1,433.95 multiplied by 24) in exchange for one dollar under the CDA.

Under ORS 656.236(1), a CDA shall be approved unless we find the proposed disposition unreasonable as a matter of law. Applying this standard, we find that this CDA, in which the surviving

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[1] Moreover, the CDA provides that the insurer's lien has been resolved and released pursuant to the "separate" third party settlement.

[2] ORS 656.204(2)(a) provides: "If the worker is survived by a spouse, monthly benefits shall be paid in an amount equal to 4.35 times 66- 2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs."

[3] The proposed agreement indicates that the surviving spouse is 29 years old.

[4] ORS 656.204(3)(a) provides: "Upon remarriage, a surviving spouse shall be paid 24 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payments for each child shall continue as before."

spouse releases a substantial monthly benefit (a minimum value of $34,414.80) in exchange for one dollar, is, on its face, unreasonable as a matter of law. Consequently, we decline to approve the agreement and return it to the parties.[5]

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any benefits stayed by the submission of the proposed disposition. OAR 436-060-0150(5)(k) and (7)(e).

If the parties wish to seek reconsideration in accordance with OAR 438-009-0035, we would be willing to abate this order to await consideration of a revised agreement.[6]

IT IS SO ORDERED.

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[5] In reaching this decision, we note it is not unusual for CDAs to include, as full or partial consideration, the paying agency's waiver or reduction of its lien against a specific and ascertainable third party settlement. Through such a disposition, the claimant releases her rights to past, present and future compensation in return for a greater share of his third party recovery. In the present case, however, the CDA does not include a full or partial waiver of the third party lien. Instead, the two agreements are expressly separate. Despite significant proceeds from the third party settlement, claimant retains benefits under the workers' compensation law (surviving spouse benefits). Those benefits are viable and valuable. One dollar for release of those benefits (regardless of the value of the separate third party settlement) is unreasonable as a matter of law.

[6] Based on the parties' representations, the proceeds paid out in the CDA are "available" to the insurer's "third party" lien. In that case, any CDA proceeds would be simultaneously recoverable by the insurer in satisfaction of its third party lien. Under such circumstances, had the consideration reasonably approximated the minimum value of the surviving spouse benefit available to claimant ($34,414.80), the CDA proceeds would not only apparently be "available" to the insurer's lien, but the CDA itself would likely withstand our review standard under ORS 656.236.

In the Matter of the Compensation of
ARCELIA M. VILLAGOMEZ, Claimant
WCB Case No. 96-02604
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that affirmed an Order on Reconsideration's award of 5 percent (16 degrees) unscheduled permanent disability for a lumbosacral strain injury. 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. The March 8, 1996 Order on Reconsideration determined claimant to be medically stationary on October 10, 1995. (Ex. 69-2). Neither party raised any issue regarding the medically stationary date at hearing. (Tr. 1). The sole issue at hearing was extent of unscheduled permanent disability. Id.

At hearing, the parties stipulated that, if it were found appropriate to award nonimpairment factors, those factors would be valued as follows: age (0), formal education (1), skills (4), and adaptability (4), for a total nonimpairment factor of 20. (Tr. 2, Appellant's Brief, page 2).

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Order on Reconsideration which awarded a total of 5 percent unscheduled permanent disability for chronic condition impairment. Like the Order on Reconsideration, the ALJ found that claimant had been released for her regular work and, therefore, did not factor in any value for adaptability or the other nonimpairment values for age, education, and skills. Claimant contends

that she was not released to regular work at the time of claim closure and, therefore, is entitled to a value for adaptability and the other nonimpairment values. In addition, claimant contends that she is entitled to increased impairment rating for the loss of range of motion in her lumbar spine. We modify the ALJ's order.

Claimant was found medically stationary on October 10, 1995, and her claim was closed by Determination Order on October 12, 1995. (Exs. 55, 69). The applicable standards for rating claimant's permanent disability are set forth in WCD Admin. Order 6-1992, as amended by WCD Admin. Orders 93-056, 95-060 (temp.), 95-063 (temp.), and 96-068 (temp). Former OAR 436-35-003(1) and (2); former OAR 436-035-0003(3).

Impairment

Based on the medical arbiter's report, the ALJ awarded claimant five percent chronic condition impairment. However, the ALJ declined to award any impairment based on the reduced range of motion measured by the medical arbiter because he questioned the precision and validity of those measurements. In questioning those measurements, the ALJ relied on comments made by examining physicians and claimant's former attending physician, in addition to comments made by the medical arbiter. On review, claimant argues that she is entitled to impairment ratings for both loss of range of motion and chronic condition. For the following reasons, we agree that claimant is entitled to an impairment rating for loss of range of motion; however, we find that the applicable rules do not allow an impairment rating for a chronic condition under the facts of claimant's case.

Claimant has the burden of proving the extent of any disability resulting from the compensable lumbosacral strain injury. ORS 656.266. The Director's rules provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) (hereinafter AMA Guides) and methods the Director may describe by bulletin shall be used to measure and report impairment. Former OAR 436-35-007(4). Furthermore, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(2)(b)(B); former OAR 436-35-007(8) and (9); Koitzsch v. Liberty Northwest Insurance Corporation, 125 Or App 666 (1994); but see Tektronix, Inc. v. Watson, 132 Or App 483 (1995) (impairment findings from a physician, other than the attending physician, may be used, if those findings are ratified by the attending physician). In other words, impairment findings must be made by one of the above listed medical practitioners.

Here, on October 4, 1995, Dr. Donovan, M.D., became claimant's attending physician. (Ex. 52). Prior to that time, Dr. Verzosa, M.D., served as claimant's attending physician. (Exs. 14, 18, 25, 29, 32, 39, 42, 45, 47). Although Dr. Verzosa declared claimant medically stationary on August 25, 1995,[1] and performed a closing examination at that time, claimant's claim was not closed until October 12, 1995. (Exs. 47, 55). At the time of claim closure, claimant had changed her attending physician to Dr. Donovan. However, Dr. Donovan did not express any opinion regarding any impairment due to the compensable lumbosacral strain, although she noted that claimant demonstrated marked somatic focus, severe pain behaviors, and poor effort with all movements. (Exs. 51, 67). In addition, Dr. Donovan did not ratify any other physician's opinion regarding any impairment findings. Therefore, if claimant is to establish entitlement to impairment, she must do so through the medical arbiter's opinion. For the following reasons, we find that the medical arbiter's opinion meets claimant's burden of proving compensable impairment.

Dr. James, orthopedist, served as the medical arbiter. (Ex. 68). Dr. James reviewed the medical records, including reports from Dr. Verzosa, Dr. Donovan, and Dr. Scheinberg, examining orthopedist. (Ex. 68-1, -2). Therefore, Dr. James was aware of these physicians' reports of inconsistencies on examination and symptom magnification. In addition, Dr. James noted some inconsistencies during his examination of claimant. (Ex. 68-2, -3).

On the other hand, Dr. James determined that the range of motion measurements were valid. In this regard, Dr. James stated that lumbar flexion was valid. (Ex. 68-4). In addition, he explained that, although there were inconsistencies on six attempts on the right straight leg raise test, the last three attempts were within 5 degrees. (Exs. 68-3). Moreover, Dr. James took at least three separate

[1] We note that the Order on Reconsideration found claimant medically stationary as of October 10, 1995. (Ex. 69). No issue regarding claimant's medically stationary date was raised at hearing.

measurements for each type of range of motion and he noted that these separate measurements were "within +/- 10% or 5° (whichever is greater)." (Ex. 68-7). We note that Bulletin 239 quotes a portion of the AMA Guides regarding range of motion validity testing endorsed by the Department as follows: "The examiner must take at least three consecutive measurements of mobility which must fall within ± 10% or 5 degrees (whichever is greater) of each other to be considered. The measurements may be repeated up to six times. If inconsistency persists, the measurements are invalid." (Bulletin 239 (Rev. July 24, 1992), page 5). Thus, Dr. James applied the validity testing described in the AMA Guides and Bulletin 239 in determining the validity of claimant's range of motion. (Exs. 68-3, -7).

In addition, in addressing a question from the Department regarding chronic condition impairment, Dr. James stated that claimant's "complaints and findings are largely subjective, and there are some signs of embellishment with Waddell's testing. However, there are objective valid findings of reduced lumbosacral range of motion indicating a partial loss of ability to use the spinal area repetitively." (Ex. 68-5). Finally, when asked by the Department to describe any invalid findings, Dr. James responded that claimant's "[i]nvalid findings were a positive Waddell test for rotation and compression, excessive diffuse tenderness and over-reaction." (Ex. 68-4). He did not include claimant's range of motion findings as being among the invalid findings.

Reviewing Dr. James' report as a whole, we find that, although he was aware of claimant's history of symptom magnification and some inconsistencies during his own examination of claimant, he determined that claimant's range of motion findings were valid. Finally, Dr. James found that the reduced lumbosacral range of motion findings were due to the work injury. (Exs. 68-4, -5). Therefore, we rely on those findings in determining claimant's impairment.

For her loss of lumbosacral range of motion claimant is entitled to the following impairment values: 7 percent impairment for 17 degrees retained flexion, 6.4 percent impairment for 3 degrees retained extension, 3.4 percent impairment for 8 degrees retained right flexion, and 3.2 percent impairment for 9 degrees retained left flexion. Former OAR 436-35-360(19)-(21). These values are added for a total value of 20 percent impairment due to loss of range of motion. Former OAR 436-35-360(22).

The only other impairment value that Dr. James' report might support is a chronic condition impairment. (Ex. 68-5). However, the applicable rules provide that a worker is not entitled to any chronic condition impairment where the total unscheduled impairment within a body area is otherwise equal to or in excess of 5 percent. Former OAR 436-35-320(5).[2] Here, claimant's impairment, before considering any chronic condition, is 20 percent. Therefore, claimant is not entitled to any value for chronic condition impairment. Id. Thus, claimant's total unscheduled permanent impairment is 20 percent.

Adaptability/Nonimpairment Factors

The ALJ determined that claimant could return to her regular work. Therefore, the ALJ found claimant not entitled to consideration of any nonimpairment values, including adaptability. Consequently, the ALJ limited claimant's unscheduled permanent disability award to her impairment value, which he determined was 5 percent. While we agree that claimant is entitled only to the impairment value in rating her unscheduled permanent disability, we reach this conclusion for the following reasons. In addition, we note that, as explained in the above section, we find the impairment value is 20 percent.

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[2] We have held that the Board and the Hearings Division have no authority to invalidate the 5 percent limitation in former OAR 436-35-320(5) and, alternatively, that such limitation was within the Director's statutory rule making authority under ORS 656.726(3)(f)(A). Gregory D. Schultz, 47 Van Natta 2265, corrected 47 Van Natta 2297 (1995). Here, inasmuch as claimant's lumbosacral spine is within one "body area," and because we have found claimant entitled to receive in excess of 5 percent unscheduled permanent impairment in that "body area," we find that claimant is not entitled to a separate award for a chronic condition, even if Dr. James' report could be interpreted to support such an award. On review, claimant notes that the Board's decision in Gregory D. Schultz is pending review before the Court of Appeals. However, since the court has not yet reached a decision regarding Schultz, that case remains good law, and we continue to apply it on review.

On review, the insurer argues that claimant's attending physician, Dr. Verzosa, released her to regular work and, therefore, pursuant to ORS 656.726(3)(f)(D),[3] claimant is entitled only to a value for the impairment factor. Claimant counters that: (1) Dr. Verzosa's release to regular work is not relevant because claimant was not medically stationary at the time of that release;[4] and (2) Dr. Verzosa was not claimant's attending physician at the time of claim closure. Furthermore, claimant contends that, at the time of claim closure by the October 12, 1995 Determination Order, Dr. Donovan was claimant's attending physician and she had not released claimant to regular work at that time. While we agree with claimant's contentions regarding the identity of her attending physician and her work status at the time of her medically stationary status and claim closure, the relevant statutes provide that the determinative time to evaluate a worker's disability is "as of the date of issuance of the reconsideration order pursuant to ORS 656.268." ORS 656.283(7); 656.295(5). Therefore, we must determine whether claimant was released to her regular work by her attending physician as of the date of the March 8, 1996 Order on Reconsideration in order to determine whether ORS 656.726(3)(f)(D) applies here. For the following reasons, we find that ORS 656.726(3)(f)(D) applies here and limits claimant's unscheduled permanent disability award to the impairment value.

At the time claimant became medically stationary and thereafter, Dr. Donovan was claimant's attending physician. (Ex. 52, 51, 56, 67). Prior to becoming medically stationary and after attempting to return to her regular job, claimant sought treatment at the Emergency Room for increased back pain. (Ex. 49). Subsequently, on September 29, 1995, Dr. Donovan initially examined claimant, noted claimant's marked somatic focus, and recommended a psychological evaluation. (Ex. 51). Dr. Donovan noted that claimant was "now approximately five months out from an injury that should have easily resolved within two to three months." (Ex. 51-3). Dr. Donovan also recommended an aggressive, short term physical therapy program "to see if we can get [claimant] to a point where she can go back to her job." (Ex. 51-3, 52). On October 16, 1995, Dr. Donovan released claimant to "full time - full duty" over a three week period. (Ex. 56).

On December 4, 1995, claimant again returned to the Emergency Room complaining of increased pain. (Exs. 58, 60, 62). Claimant was released to modified work and referred to Dr. Adams, M.D., apparently on the mistaken assumption that Dr. Adams was her treating physician. Id. On December 5, 1995, Dr. Adams examined claimant, noted significant pain behavior and released her to modified work. (Ex. 63). Dr. Adams also referred claimant back to Dr. Donovan. Id.

On December 13, 1995, Dr. Donovan examined claimant and noted that claimant reported that she had been "working modified duty." (Ex. 67-1). Dr. Donovan noted that claimant exhibited marked somatic focus and severe pain behavior. (Ex. 67-2). She noted that claimant was "now approximately 8 months out from an injury that really should have resolved in 2 to 3 months." (Ex. 67-2). Dr. Donovan also noted that she did not have much to offer claimant other than a psychological evaluation to assess the possibility of a somatoform pain disorder. Id. Dr. Donovan did not restrict claimant's ability to work, nor did she change her earlier October 16, 1995 release which released claimant to full time, full duty.

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[3] ORS 656.726(3)(f)(D) provides:

"Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if:

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury."

ORS 656.726(3)(f)(D) applies to claims that become medically stationary on or after June 7, 1995, the effective date of the changes to the Workers' Compensation Law enacted by the 1995 legislature in Senate Bill 369. See SB 369, Secs. 66(4), 69. Because this claim became medically stationary on October 10, 1995, ORS 656.726(3)(f)(D) applies, provided that the terms of that statute are met.

[4] The Order on Reconsideration found claimant's condition medically stationary as of October 10, 1995. (Ex. 69). Neither party challenged this medically stationary date at hearing.

On this record, we find that claimant's attending physician, Dr. Donovan, released claimant to her regular work. Furthermore, Dr. Donovan did not subsequently withdraw or limit that release. In this regard, Dr. Donovan's final opinion made no mention of any limitations on claimant's ability to do the at-injury job due to the compensable lumbosacral strain injury. Instead, that opinion focused on claimant's pain behavior and somatic focus, with Dr. Donovan noting that she did not have much to offer claimant. (Ex. 67). Thus, we find that Dr. Donovan remained of the opinion that claimant was able to perform full time, full duty. In addition, claimant offers no evidence that the at-injury job was not available or that her employment was terminated for a cause related to the injury. ORS 656.266. To the extent that claimant only returned to modified work, she failed to return to the at-injury job.[5] Consequently, on this record, we find that the provisions of ORS 656.726(3)(f)(D) are satisfied. Therefore, claimant is entitled only to the impairment factor of 20 percent in rating her unscheduled permanent disability. Thus, claimant's unscheduled permanent disability is 20 percent.

Claimant's attorney is awarded an out-of-compensation fee of 25 percent of the increased compensation created by this order, not to exceed $3,800. OAR 438-015-0055(1).

ORDER

The ALJ's order dated August 6, 1996 is modified. In lieu of the ALJ's award and in addition to the 5 percent (16 degrees) awarded by the Order on Reconsideration, claimant is awarded 15 percent (48 degrees), giving her a total award to date of 20 percent (64 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded an out-of-compensation fee of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

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[5] We note that the Emergency Room physicians and Dr. Adams, who examined claimant one time, released claimant to modified work pending examination by her attending physician. In addition, the medical arbiter placed restrictions on claimant's residual functional capacity. (Ex. 68-5). However, ORS 656.726(3)(f)(D) explicitly provides that the determinative release to work within the terms of that statute is the one provided by the attending physician, the statute does not allow for consideration of releases by non-attending physicians. Therefore, we rely on Dr. Donovan's release to work.

In the Matter of the Compensation of
CAROL D. COURTRIGHT, Claimant
WCB Case No. 95-13887
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Hoffman, 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) Michael Johnson's order that set aside its denial of claimant's current condition. On review, the issue is compensability.

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

On review, the employer challenges the ALJ's credibility finding and argues that claimant has not proven that she was injured at work. After reviewing the record, we find no reason to disturb the ALJ's credibility finding, and we adopt the ALJ's conclusions regarding "legal" causation.

Alternatively, the employer contends that claimant has not established a compensable claim, as she has no specific diagnosis and has not received medical services for a condition due to the injury. Additionally, the employer argues that there are no objective findings to support the claim. We disagree.

Claimant has received a variety of diagnoses from different doctors. At different times, claimant's condition has been diagnosed as myalgia, arthralgia and overuse syndrome. However, it is well-established that the lack of a definitive diagnosis does not per se defeat a claim; nor is it necessary that the medical experts know the exact mechanism of a disease. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Danalee R. Wilcox, 48 Van Natta 1591 (1996).

The employer also argues that, unless claimant was disabled and required medical services as a result of a work injury, she cannot establish a compensable claim. Here, as the ALJ noted, claimant has been seen in the emergency room and by various physicians for her condition. Furthermore, the ALJ found that claimant's work injury was a material contributing cause of her condition. Accordingly, when claimant sought treatment for her condition, she sought treatment for the August 22, 1995 injury. See Claude R. Bauder, 46 Van Natta 765 (1994).

Finally, the employer renews its argument that claimant does not have "objective findings" sufficient to support her claim. Dr. Lewis, however, found that claimant's "findings on exam of tenderness to palpation [were] reproducible and verifiable findings" which supported the diagnosis of overuse injury. (Ex. 20). Consequently, we find that claimant has established objective findings to support a compensable injury. ORS 656.005(19); Rosalie A. Peek, 47 Van Natta 1432 (1995) (Physician's report that the claimant had reproducible tenderness was held sufficient as an objective finding).

Accordingly, we agree with the ALJ that claimant has established the compensability of her claim. Therefore, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated October 21, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the employer.

February 26, 1997 Cite as 49 Van Natta 189 (1997)

In the Matter of the Compensation of
LUTHER P. GANN, Claimant
WCB Case Nos. 96-00938, 95-08673, 95-07738, 95-06704 & 95-04275
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
William J. Blitz, Defense Attorney
Thaddeus J. Hettle, Defense Attorney
Garrett, Hemann, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation, on behalf of United Express, Ltd. (Liberty/United), requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its denial of responsibility for claimant's bilateral carpal tunnel syndrome; and (2) upheld denials of responsibility for the same condition from the SAIF Corporation, on behalf of Gary Foglio Trucking, Inc. (SAIF/Foglio); SAIF, on behalf of J. L. Goodell Trucking, Inc. (SAIF/Goodell); SAIF, on behalf of K. T. Mitchell Trucking Company (SAIF/Mitchell); and SAIF, on behalf of M. E. Fanno Trucking (SAIF/Fanno). On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant has worked as a truck driver for several years. At hearing, the parties stipulated that claimant worked for United from December 1, 1990[1] "through and sometime into but before" January 24, 1994; Goodell from January 24, 1994 until May 16, 1994; Mitchell from January 1, 1994 until April 17, 1994; Fanno from May 1994 until November 28, 1994; and for Foglio from July 14, 1995 through September 26, 1995. (Tr. 2).

Claimant testified that he began to notice symptoms of numbness and pain in both hands in December 1992, when he was working as a long haul truck driver for United. (Tr. 14). He occasionally took aspirin for his symptoms. (Tr. 28). Claimant drove 70 hours a week while working at United, up to seven days per week. (Tr. 12, 15). He left United in January 1994 because he was tired of the long periods of time on the road. Claimant's symptoms were worse by the time he left United. (Tr. 27-28). His symptoms have not resolved. (Tr. 14).

While working for Goodell, claimant drove a log truck from the job site to a mill, with trips lasting approximately an hour and a half. (Tr. 15). Claimant had some of the same symptoms he had while working at United, but he did not have an increase in symptoms. (Tr. 16).

Claimant worked for Mitchell hauling chips when he was not working for Goodell. (Tr. 16). His trips lasted 20 to 30 minutes and he had no increase or difference in symptoms while working for Mitchell. (Id.)

In May 1994, claimant began driving a log truck for Fanno. (Tr. 17). At times his trips lasted 4 1/2 hours, with some off road and some highway driving. (Tr. 17-18). He estimated that he drove about 400 miles per day and sometimes up to 600 miles per day. (Tr. 18). Claimant had symptoms of numbness while working at Fanno and the symptoms woke him up at night. (Id.) He took over-the-counter medications to relieve the symptoms. (Id.)

In July 1995, claimant began driving a log truck for Foglio. Most of his trips lasted one hour to 90 minutes. (Tr. 20). Claimant did not have any increase of symptoms while working for Foglio. (Tr. 20, 32) His work at Foglio was not as strenuous as the work with United. (Tr. 31).

Claimant first sought medical treatment for his symptoms in December 1994. Dr. Remy diagnosed bilateral carpal tunnel syndrome (CTS) and referred claimant to a neurologist. (Exs. A, 1). He did not see a neurologist. Claimant filed a claim with United and subsequently filed claims with other carriers. Each of the carriers denied responsibility for claimant's condition and eventually SAIF/Goodell was appointed as the paying agent.

On February 24, 1995, claimant was examined by Drs. Barth and Coletti on behalf of Liberty. (Ex. 4). On June 27, 1995, Dr. Martens examined claimant on behalf of Liberty. (Ex. 13). After the hearing, the parties deposed Dr. Martens. (Ex. 20).

CONCLUSIONS OF LAW AND OPINION

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

The last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. Bracke v. Baza'r, 293 Or 239, 248-49 (1982). On the other hand, where actual causation is established with respect to a specific employer, it is not necessary to rely on judicially created rules of assignment pertaining to successive employments in determining responsibility. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Winfred L. Swonger, 48 Van Natta 280 (1996), aff'd mem 145 Or App 548 (1997).

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[1] Although the parties stipulated that claimant started working for United in December 1990, it appears that they later agreed at Dr. Martens' deposition that claimant started working for United in September 1992. (Ex. 20-12). Our decision would remain the same in either event.

The ALJ concluded that the medical evidence established that claimant's work at Liberty/United was the actual cause of the bilateral CTS. Therefore, the ALJ assigned initial responsibility to Liberty/United and concluded that responsibility did not shift to another carrier.

Liberty/United argues that claimant's work at United was not the actual cause of his CTS. Rather, Liberty/United contends that the last injurious exposure rule applies to determine responsibility and it asserts that SAIF/Fanno is responsible for claimant's condition.

Drs. Barth and Martens provided medical opinions on causation. Drs. Barth and Coletti examined claimant on February 24, 1995 on behalf of Liberty, and diagnosed mild CTS. (Ex. 4-3). They reported that claimant had been a long-haul truck driver for United for about two to three months when he noted the onset of symptoms. (Ex. 4-2). They commented that claimant's CTS "may indeed be related to his driving" and said that claimant's morbid obesity contributed to the onset of the CTS. (Ex. 4-4).

On March 14, 1995, Dr. Barth reported that claimant's carpal tunnel symptoms "arose as a result of his driving for United Express from gripping the steering wheel for extended periods of time." (Ex. 6). He concluded that claimant's driving for United was the "major (51 percent or more) contributing cause for his development of carpal tunnel symptoms." (Id.) Dr. Barth commented that since claimant's symptoms began in December 1992 while working for United, there was no basis for apportionment to other employers.

In a later report, Dr. Barth said that claimant's carpal tunnel symptoms "could have" begun or worsened while working for Fanno from May 1994 to November 1994, but it was a "medical probability" that was not the case. (Ex. 7). Dr. Barth adhered to his opinion that the major contributing cause of claimant's condition was his truck driving for United. (Id.)

We are not persuaded by Dr. Barth's reports because he did not explain his conclusion. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). Dr. Barth did not explain why claimant's employment with United was the major contributing cause of his CTS, other than to say that his symptoms began when he worked for United. Dr. Barth did not discuss the extent or type of claimant's work activities for other trucking companies. Although Dr. Barth mentioned in his first report that claimant had worked for Fanno, he merely stated that claimant had worked there from May 1994 to November 1994. (Ex. 4-3). Furthermore, although Dr. Barth's February 24, 1995 report said that claimant's morbid obesity had contributed to the onset of CTS, Dr. Barth did not discuss the relative contribution of claimant's obesity in his later opinions on causation. Because Dr. Barth's reports on causation were conclusory and unexplained, we give them little weight.

On June 27, 1995, Dr. Martens examined claimant on behalf of Liberty. Dr. Martens diagnosed mild bilateral CTS and reported that claimant had the onset of carpal tunnel symptoms while working for United starting in September 1992 and he developed the numbness and tingling within 3 months. (Ex. 13-4).

In a concurrence letter from Liberty, Dr. Martens agreed that claimant's morbid obesity was not the major contributing cause of his carpal tunnel condition and he had ruled out other off-the-job causes of claimant's condition. (Ex. 14-1). Dr. Martens agreed that the major cause of claimant's carpal tunnel condition was "the repetitive activity involved in trucking of the type claimant had both for United Express from September 1992 through January of 1994, when he drove log truck for Goodell Trucking in January of 1994, and from driving a log truck for Marvin Fanno from May to November 1994." (Ex. 14-2).

In a later "check-the-box" report from SAIF, Dr. Martens agreed that claimant's work activities as a log truck driver for Foglio "independently contributed to the cause and worsening" of claimant's bilateral CTS. (Ex. 18).

In a deposition, Dr. Martens initially agreed that "by history" the major contributing cause of claimant's CTS was the work activity for United in the fall of 1992. (Ex. 20-10). However, Dr. Martens disagreed with Dr. Barth's opinion that claimant's work with United was the major contributing cause of his CTS. (Ex. 20-14, -15, -16,-17, 18). Dr. Martens thought claimant's carpal tunnel symptoms were from driving and he said "[w]hether he drives for United Express or how many others, Foglio or Fanno or K.T. Mitchell or Goodell, that kind of activity can bring on carpal tunnel symptoms." (Ex. 20-14). He

agreed that claimant first reported symptoms when he worked for United. (Ex. 20-15). However, Dr. Martens explained that he did not think anything specific happened to claimant at United (Ex. 20-16), and his other work activities also made him symptomatic. (Ex. 20-14, -19). Thus, although Dr. Martens associated claimant's CTS with his driving activities, Dr. Martens did not believe that claimant's work activities at United were the major contributing cause of his CTS.

We conclude that the medical evidence is not sufficient to establish actual causation with respect to a specific employer. Therefore, we apply the last injurious exposure rule. The last injurious exposure rule provides that when a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke, 293 Or at 248. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant first received treatment for carpal tunnel symptoms on December 9, 1994, when he was examined by Dr. Remy. (Exs. A, 1). Claimant had worked for SAIF/Fanno from May 1994 until November 28, 1994. (Tr. 2). Under the last injurious exposure rule, the last employment providing potentially causal conditions is deemed to have caused the occupational disease. Starbuck, 296 Or at 241. Since SAIF/Fanno is the last employment that potentially caused claimant's bilateral CTS, we assign initial responsibility for that condition to SAIF/Fanno.

SAIF/Fanno can shift responsibility to a prior carrier by showing that claimant's work activity at an earlier employer was the sole cause of claimant's bilateral CTS condition, or that it was impossible for conditions while SAIF/Fanno was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). We find no such evidence in this case. Dr. Martens indicated that claimant's truck-driving activities in general contributed to his bilateral CTS condition. For the reasons discussed earlier, we are not persuaded by Dr. Barth's opinion on causation. We conclude that responsibility does not shift to an earlier carrier.

In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must have actually contributed to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245, 249 (1995); see Bracke, 293 Or at 250 ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer").

In a "check-the-box" report from SAIF, Dr. Martens answered "yes" to the following:

> "Assuming that [claimant] worked as a log truck driver for Gary Folio [sic] Trucking from mid-July, 1995, until mid-October, 1995, for approximately 430 hours, which included 10-12 hour days and throwing wrappers and binders, do you agree, to a reasonable medical probability, that such work activities independently contributed to the cause and worsening of [claimant's] bilateral carpal tunnel syndrome?" (Ex. 18).[2]

Although Dr. Martens adhered to that opinion in a deposition (Ex. 20-19), his testimony indicated that claimant had only a recurrence of symptoms at SAIF/Foglio. Dr. Martens testified that claimant's activity at SAIF/Foglio made claimant symptomatic. (Ex. 20-19). Dr. Martens said that worsened symptoms did not necessarily mean the condition was worsened. (Ex. 20-21, -22). Dr. Martens explained that, when claimant is having symptoms, something is compressing the median nerve. (Id.) However, the change is not necessarily permanent unless there is some atrophy or unless electrodiagnostic studies indicate a permanent change. (Id.) Dr. Martens testified that since claimant

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[2] Claimant testified that, when he drove a log truck, he put binders and wrappers on his loads, using his hands and wrists. (Tr. 35, 37). The wrapper is a steel cable and the binder is the device that tightens the cable. (Id.)

had no apparent change in the underlying compression of the nerve and did not have any atrophy, Dr. Martens assumed that the nerve itself had not changed between 1992 and 1995. (Ex. 20-25, -26). Although Dr. Martens agreed that claimant's subsequent employment activities caused symptoms, he could not say whether there had been an independent contribution to a pathological worsening of the condition from subsequent employment since claimant had no atrophy and there was no indication of nerve damage. (Ex. 20-33).

In sum, although Dr. Martens initially agreed that claimant's work at SAIF/Foglio independently contributed to the cause and worsening of the bilateral CTS, he later testified that he could not say whether there had been an independent contribution to a pathological worsening of the condition from subsequent employment. In light of Dr. Martens' deposition testimony, we are not persuaded that claimant's later employment conditions at SAIF/Foglio actually contributed to a worsening of claimant's bilateral CTS condition. See Lott, 115 Or App at 74. Rather, Dr. Martens' testimony indicated that claimant's work activities at SAIF/Foglio merely increased his symptoms. See Timm v. Maley, 134 Or App at 249. We find no other medical evidence to establish that claimant's later employment conditions actually contributed to the cause of, aggravated, or exacerbated his bilateral CTS condition. See Bracke, 293 Or at 250; Lott, 115 Or App at 74. Therefore, responsibility does not shift to a later carrier. We conclude that SAIF/Fanno is responsible for claimant's bilateral CTS condition.

ORDER

The ALJ's order dated August 5, 1996 is reversed in part and affirmed in part. SAIF/Fanno's responsibility denial is set aside and the claim is remanded to SAIF/Fanno for processing in accordance with law. Liberty/United's responsibility denial is reinstated and upheld. The ALJ's attorney fee award is payable by SAIF/Fanno, rather than Liberty/United. The remainder of the order is affirmed.

In the Matter of the Compensation of
HAROLD K. LAWHORN, Claimant
WCB Case No. 96-00019
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that declined to award temporary total disability benefits. On review, the issue is temporary total disability. We modify.

FINDINGS OF FACT

Claimant had a compensable psychological condition (adjustment disorder). He initially sought treatment from Dr. Mead, psychiatrist, on August 26, 1993. (Ex. 1). Dr. Mead recommended that claimant utilize his sick leave and remain away from work until September 14, 1993. (Exs. 1, 3-1, 42-1, -3).

On September 7, 1993, claimant was hospitalized for a noncompensable, life-threatening pneumococcal sepsis condition with multiple organ system failure. (Exs. 2 through 35). On January 27, 1994, Dr. Walker, claimant's attending nephrologist, released claimant from the hospital and opined that claimant would be disabled as a result of his physical condition until January 1995. (Exs. 35, 42-2).

On February 1, 1994, claimant filed a claim with the SAIF Corporation for his psychological condition. (Ex. 36). On March 1, 1994, claimant returned to Dr. Mead for treatment. (Ex. 41). On March 18, 1994, claimant was examined for SAIF by Dr. Glass, psychiatrist. (Ex. 42). On April 25, 1994, SAIF denied claimant's claim. (Ex. 44). In a June 21, 1995 Opinion and Order, as amended July 3, 1995, a prior ALJ found claimant's mental disorder compensable. (Exs. 50, 51).

On August 16, 1995, Dr. Mead declared claimant's psychological condition medically stationary and released claimant to regular work. (Ex. 53, 54). An October 31, 1995 Notice of Closure, which was affirmed by a December 21, 1995 Order on Reconsideration, awarded no temporary disability benefits. (Exs. 56, 61). On November 20, 1995, Dr. Mead indicated that claimant had been unable to work in his regular job from August 26, 1993 to August 16, 1995. (Ex. 57).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant failed to establish that he was disabled at any time due to his compensable condition before becoming medically stationary. On review, claimant contends that he had been taken off work on August 26, 1993 by Dr. Mead, his attending psychiatrist, because of his compensable psychological condition and was disabled from work due to that condition until August 16, 1995. SAIF argues that claimant was unable to work during this period due to his noncompensable physical illnesses rather than his compensable psychological condition.

Inasmuch as claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. A claimant's substantive entitlement to temporary disability benefits, which is set forth in ORS 656.210 and 656.212, is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. 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); Dorothy E. Bruce, 48 Van Natta 518 (1996).

The ALJ's conclusion was based on the premise that, although claimant had treated with Dr. Mead "at least as early as March 1994," at no time prior to November 25, 1995, did Dr. Mead give any indication that claimant's psychological condition was keeping him off work, nor did he explain his "check-the-box" opinion that claimant was unable to work due to his psychological condition during the disputed period.

On November 25, 1995, Dr. Mead indicated in a "check-the-box" opinion that claimant had been unable to work in his regular job from August 26, 1993 until August 16, 1995. (Ex. 57). Although we agree with the ALJ that Dr. Mead's opinion regarding claimant's inability to work subsequent to September 14, 1993 because of his psychological condition is not persuasive, we find that the portion of his opinion related to claimant's inability to work from August 26, 1993 to September 14, 1993 is persuasive. Castle & Cook, Inc. v. Porras, 103 Or App 65, 68 n3 (1990) (a fact finder may rely on part of a medical opinion and reject another part of the opinion as long as a subsequent finding does not flow from factors necessarily rejected by the initial finding).

Dr. Mead treated claimant for his psychological condition beginning on August 26, 1993. His chart notes for that date indicate that he recommended that claimant take sick leave due to his psychological condition. (Ex. 1). Although Dr. Mead's chart note did not expressly authorize time loss for claimant, the note documented claimant's need to be off work as a result of his psychological stress.

That claimant was off work due to his psychological condition from August 26, 1993 to September 14, 1993, is supported by the consistent histories reported in medical records at the time claimant was hospitalized and again when evaluated by Dr. Glass, psychiatrist, in addition to the findings of fact in the prior ALJ's Opinion and Order, as amended, each of which indicated that claimant was on medical leave until September 14, 1993, due to his psychological condition. (Exs. 3-1; 42-1, -3; 51-6). Consequently, we conclude that the record, taken as a whole, shows that claimant was disabled due to his compensable condition for the two week period from August 26, 1993 until September 14, 1993. Therefore, whether or not claimant was hospitalized on September 7, 1993, he was unable to work because of his psychological condition until September 14, 1993.

Conversely, we are not persuaded by that portion of Dr. Mead's opinion regarding claimant's inability to work due to his psychological condition from September 14, 1993 until August 16, 1995, as it is not supported by the contemporary record. Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of an opinion depends on the persuasiveness of the explanation or the persuasiveness of the foundation on which the opinion is based).

The medical evidence regarding claimant's physical condition shows that claimant was totally disabled due to his noncompensable sepsis condition after September 14, 1993. (Exs. 2 through 35). Moreover, on January 27, 1994, when claimant was released from the hospital by Dr. Walker, claimant's attending nephrologist, he opined that claimant would continue to be disabled as a result of his physical condition until January 1995. (Exs. 35, 42-2).

When claimant returned to Dr. Mead on March 1, 1994, Dr. Mead noted that claimant was "off work x/y via Dr. James Walker - (nephrologist)." Dr. Mead prescribed Zoloft for claimant's psychological symptoms but made no note regarding whether claimant would have been disabled from work at that time due to his psychological condition. (Ex. 41). At claimant's next appointment, on March 25, 1994, claimant reported that he had discontinued the Zoloft after taking it twice. Dr. Mead prescribed no other medication for claimant's condition. (Ex. 43). Claimant sought no further psychological treatment until October 31, 1994, seven months later.

At that time, Dr. Mead reported that claimant had been feeling emotionally well until he was fired from his job retroactive to November 1993. Nevertheless, Dr. Mead noted that claimant's affect looked "pretty good today." Dr. Mead also noted that claimant remained on physical disability, as he was still recovering from his physical condition. (Ex. 49).

Claimant next consulted Dr. Mead ten months later, on August 16, 1995. Claimant reported that he estimated himself to be 90 percent recovered in regard to his physical condition. Dr. Mead found claimant medically stationary and released him to regular work. (Exs. 53, 54).

Given the complex circumstances of this case, and in the absence of either an explanation or support in the record, we do not find Dr. Mead's opinion that claimant was disabled from work due to his psychological condition from September 14, 1993 until August 16, 1995 persuasive.

In sum, we conclude that the preponderance of the evidence in the entire record shows that claimant was disabled by his compensable psychological condition only from August 26, 1993 to September 14, 1993.

ORDER

The ALJ's order dated August 28, 1996 is modified. Claimant is awarded temporary total disability benefits from August 26, 1993 to September 14, 1993. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

February 26, 1997 Cite as 49 Van Natta 195 (1997)

In the Matter of the Compensation of
PHYLLIS G. NEASE, Claimant
WCB Case No. 96-03809
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 17 percent (54.4 degrees), as awarded by an Order on Reconsideration, to 34 percent (108.8 degrees); and (2) awarded 2 percent (3 degrees) scheduled permanent disability for loss of use or function of the left foot, whereas the Order on Reconsideration awarded no scheduled permanent disability. In her brief, claimant contends she is entitled a penalty pursuant to ORS 656.268(4)(g) due to the increase of her unscheduled permanent disability award upon reconsideration by the Department. On review, the issues are extent of scheduled and unscheduled permanent disability and penalties. We modify in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 51 at the time of hearing, compensably injured her low back on July 11, 1995 while lifting an oxygen tank at work. At that time, she was employed as a cashier and clerk for a farm supply store. Claimant experienced low back and left leg symptoms and was treated by Dr. Kho, who diagnosed a lumbar strain and degenerative facet arthropathy. (Exs. 9, 12, 15).

The employer accepted a claim for a lumbar strain on October 2, 1995. On October 9, 1995, Dr. Kho examined claimant and declared her medically stationary. Dr. Kho found reduced lumbar range of motion and permanently restricted claimant from lifting more than 20 pounds. (Ex. 20).

On November 30, 1995, Dr. Kho opined that the major contributing cause of claimant's lifting restriction was her July 1995 injury. Dr. Kho further reported that 60 percent of claimant's pain was due to her compensable injury and 40 percent was due to degenerative changes, facet arthropathy and obesity. (Ex. 21).

The employer closed the claim with a December 20, 1995 Notice of Closure, awarding temporary disability and 2 percent unscheduled permanent disability for the low back. Claimant requested reconsideration and appointment of a medical arbiter. On March 8, 1995, claimant was examined by Dr. Gritzka is the medical arbiter. Dr. Gritzka recorded his examination findings, including significantly decreased lumbar range of motion, but was of the opinion that claimant had not reached maximum medical improvement. (Ex. 26).

In response to Dr. Gritzka's report, claimant sought to postpone the reconsideration process. (Ex. 27A). The employer did not consent to deferral of reconsideration and the process proceeded. An April 12, 1996 Order on Reconsideration awarded claimant 17 percent unscheduled permanent disability, consisting of 2 percent impairment plus 15 percent for age, education and adaptability factors.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

Relying on the findings of the medical arbiter, the ALJ concluded that claimant demonstrated unscheduled permanent disability in excess of the 17 percent awarded by the Order of Reconsideration, as well as 2 percent scheduled permanent disability of the left foot due to her compensable injury. On review, the employer argues that the ALJ erred in relying on the findings of the medical arbiter over those of Dr. Kho. Specifically, the employer contends that claimant has established only 2 percent unscheduled impairment[1] and no scheduled permanent disability. The employer also asserts that the ALJ improperly awarded claimant unscheduled permanent disability for impairment caused by her noncompensable, preexisting condition.

After considering the record, we are persuaded by the claim closure examination findings of Dr. Kho. We modify claimant's award accordingly.

Claimant is only entitled to an award of permanent disability for conditions that are permanent and caused by her accepted injury and/or its accepted condition. Unrelated or noncompensable impairment findings may not be rated. Former OAR 436-35-007(1). Here, we rate only claimant's accepted lumbar sprain. There has been no claim for, nor acceptance of, her preexisting low back condition, i.e., degenerative facet arthropathy.

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

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[1] The employer does not challenge the ALJ's determination that claimant is entitled to a social-vocational/adaptability value of 20.

In this case, we find no persuasive reason not to rely on the opinion of claimant's attending physician, Dr. Kho. Dr. Kho was claimant's attending physician throughout the course of this claim. In his October 1995 claim closure examination, Dr. Kho found anterior flexion 60 degrees, posterior extension 20 degrees, tilt bilaterally 30 degrees. He found residual tenderness over the left SI joint and, significant tenderness over the iliolumbar ligament. Dr. Kho further reported 5/5 muscle strength in the lower extremities, 2/2 reflexes and intact sensation. Dr. Kho noted no inconsistencies or invalid findings in this examination (Ex. 20), although he had previously documented pain behavior with some interference. (See Exs. 12, 15, 27). Given Dr. Kho's familiarity with claimant's medical condition throughout the relevant time period, we find his assessment of claimant's permanent impairment to be complete and persuasive.

The medical arbiter, on the other hand, examined claimant on one occasion in March 1996, and found substantially more loss of lumbar motion than what Dr. Kho found five months prior. Dr. Gritzka noted, however, that he was only able to measure claimant's lumbar flexion once, due to claimant's reports of sharp pain in the left sacroiliac joint. Dr. Gritzka also believed claimant was not medically stationary and that she was in need of further physical therapy of the sacroiliac joint.[2] Given Dr. Gritzka's concern that claimant was not medically stationary at the time of her arbiter's examination, we do not consider his examination findings to be a persuasive evaluation of claimant's permanent impairment due to her accepted lumbar strain.

Accordingly, relying on Dr. Kho's assessment of claimant's injury-related impairment, we award claimant 2 percent unscheduled impairment for loss of lumbar motion. Former OAR 436-35-360. Claimant is also entitled to a value of 20 for her age, education and adaptability factors,[3] for a total unscheduled permanent disability award of 22 percent.

Moreover, contrary to the ALJ's finding, claimant is not entitled to an award of scheduled disability as there are no objective findings of loss of sensation in the left foot. See ORS 656.283(7) and 656.726(3)(f)(B) (requiring that impairment be established by medical evidence supported by objective findings). Dr. Kho found claimant's sensation "intact" when he examined her on October 9, 1995. (Ex. 20). Furthermore, although Dr. Gritzka noted a loss of sensation in the first two toes of claimant's left foot, his findings were based on a subjective rather than objective standard. (Ex. 26-3). Finally, as previously discussed, we find Dr. Gritzka's opinion unpersuasive. Therefore, claimant has not established any impairment of her left foot due to her compensable injury.

Penalty

As noted above, claimant seeks a penalty pursuant to ORS 656.268(4)(g) for the increased permanent disability awarded by the Order on Reconsideration. We decline to consider this argument because claimant has raised it for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). We find no evidence in the record that claimant asserted her entitlement to this penalty during the reconsideration proceedings or at the hearing.

ORDER

The ALJ's order dated October 7, 1996, as reconsidered October 11, 1996, is modified in part and reversed in part. In lieu of the ALJ's award and in addition to the Order on Reconsideration's award of 17 percent (54.4 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for a total unscheduled permanent disability award of 22 percent (70.4 degrees). Claimant's counsel's "out of compensation" attorney fee shall be modified accordingly. The ALJ's award of 2 percent (3 degrees) scheduled permanent disability and an "out-of-compensation" attorney fee from this award are reversed.

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[2] In response to Dr. Gritzka's report, Dr. Kho opined that claimant was medically stationary on October 9, 1995, but had worsened. (Ex. 27-2). Dr. Kho also questioned whether claimant would benefit from further physical therapy treatment because her prior trial of physical therapy had failed. (Ex. 27-1).

[3] As the ALJ found, claimant's age (+1 value for workers over forty) plus her highest SVP value (+3) entitle her to a modifier of 4, as opposed to the value of 3 given in the Order on Reconsideration. Four, multiplied by value by an adaptability value of 5 (heavy base functional capacity to light residual functional capacity), equals 20.

In the Matter of the Compensation of
DOUGLAS B. ORGAN, Claimant
WCB Case Nos. 95-08498 & 95-08107
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order which: (1) determined that it was obligated to resume payment of temporary total disability after claimant was terminated from participation in a job-skills program; and (2) awarded claimant a penalty for SAIF's allegedly unreasonable failure to resume payment of temporary total disability. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

After claimant, a carpenter for a construction company, compensably injured his low back in October 1994, he was fired in December 1994 for reasons unrelated to the compensable injury. At the time, claimant was released for modified work. SAIF began paying temporary disability.

The employer then offered, and claimant accepted, modified "employment" at the AGC Job-Skills center, beginning in January 1995. Claimant was paid his regular wages while attending the program, which offered a "self-directed, self-paced learning environment." (Ex. A). As part of this learning environment, claimant had access to a number of interactive computer-based training programs. Id. The center also provided a number of training programs in areas for which a participant could receive certification, such as Flagger Certification, Red Cross First Aid, Construction Safety and CPR training. Id. However, no goods or services were produced or rendered at the skills center. (Tr. 66). The center's supervisor testified that participants could "pretty much" do whatever they wanted while attending, although they were expected to be at the center from 7 a.m. to 3:30 p.m. (Tr. 14). The supervisor conceded that a participant could play video games all day without violating any rules of the center. (Tr. 15). He also testified that there was no agenda for claimant other than he was required to attend the program. (Tr. 34).

The employer eventually discharged claimant from this "employment" on June 2, 1995 because of tardiness and absenteeism, as well as allegedly disruptive behavior at the skills center. (Ex. 36A). SAIF did not resume payment of temporary total disability when claimant was terminated from the modified "employment." Claimant requested a hearing.

The specific issue the ALJ determined at hearing was whether claimant's participation at the job skills center was "modified employment" within the meaning of ORS 656.268(3)(c).[1] The ALJ

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[1] ORS 656.268(3) provides that temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment; or

"(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter."

determined that it was not. The ALJ reasoned that, pursuant to ORS 656.005(30)[2], claimant was not a "worker" at the skills center because he provided no services in exchange for the employer's remuneration. While acknowledging that a claimant generally would be considered at "work" if he or she was participating in an employer sponsored or paid training program, the ALJ refused to consider the skills-center program to be such a program because the training provided had nothing to do with claimant's job and was at too basic a level to be considered "training."

On review, SAIF frames the issue as whether claimant was entitled to resumption of temporary total disability after his termination from employment on June 2, 1995. SAIF argues that claimant's participation at the skills center was "modified" employment that justified its termination of temporary total disability benefits when claimant was "rehired " to enter the program and that, when claimant was later terminated from the skills center for reasons unrelated to his "employment," he would not be entitled to resumption of temporary total disability on June 2, 1995.[3] See Safeway Stores v. Owsley, 91 Or App 478 (1988).

We agree with the ALJ's reasoning that claimant's participation at the skills center was not modified "employment."[4] SAIF, however, argues that, under McKeown v. SAIF, 116 Or App 295 (1992), claimant was in the scope of his "employment" while at the skills center because "employment" encompasses more than performance of services and includes employer-sponsored training programs that may not provide an obvious immediate benefit to the employer. We disagree with SAIF's contention that McKeown is controlling.

In McKeown, the claimant, an attorney, was injured in the course of employment while on his way to continuing legal education courses (CLE); the claimant was the sole shareholder of the employer and the courses were required for him to maintain legal qualifications for employment. The court reasoned that the uncontroverted evidence was that the claimant directed himself to go to Portland to conduct business and to attend the CLE and that he was injured on his way to the CLE. Although the claimant was not paid separately for his attendance at the CLE, the court stated that it was contemplated that, as a part of his regular work and within his monthly salary, he would work outside the office and attend such programs. The fact that the injury occurred off the employer's premises was not significant according to the court, since claimant had traveled to and was in Portland as a part of his work at the employer's direction and, at the time of the injury, was on his way to a program for the employer's benefit. Accordingly, on these undisputed facts, the court held that, as a matter of law, the claimant was injured in the course of his employment and that the injury was compensable.

In contrast to McKeown, where the claimant was to participate in training that was directly related to his employment and that would directly benefit the employer, claimant, here, was participating in a training program that the employer concedes provided little, if any, benefit to the employer. (Tr. 66). Moreover, considering the general nature of the self-improvement and educational opportunities available, we find that the skills-center training was not sufficiently related to claimant's employment as a construction carpenter to fall within the parameters of McKeown. Therefore, based on the record in this particular case, we agree with the ALJ that the skills-center "training" does not

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[2] ORS 656.005(30) provides that:

" 'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant."

[3] Since claimant received his regular at-injury wage while participating at the skills center, according to SAIF, claimant's temporary partial disability rate would be zero while at the center. Therefore, claimant presumably would be entitled to temporary partial disability at the rate of zero when terminated on June 2, 1995.

[4] The ALJ used the term "work" instead of the word "employment." SAIF argues that there is a distinction between "employment," the term used in ORS 656.268(3)(c), and "work." We conclude that there is no meaningful distinction and that the ALJ's use of the word "work" is not an error.

constitute modified "employment."[5] Accordingly, we find that SAIF was obligated to resume payment of temporary total disability upon claimant's June 2, 1995 termination.

Because we have not reduced or disallowed claimant's compensation as a result of SAIF's request for review, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by 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.

Penalties

The ALJ found that SAIF's refusal to resume payment of temporary total disability after claimant's June 2, 1995 termination from the skills center was unreasonable. Thus, the ALJ assessed a 25 percent penalty pursuant to ORS 656.262(11). On review, SAIF contends that it had a reasonable belief that the skills-center program was "modified employment." We agree.

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 its liability for payment of temporary total disability upon claimant's termination from the skills center. While we have determined that claimant's participation in that program was not "modified employment," we do not find the issue to have been so clear that SAIF acted unreasonably in considering the skills center program to be modified employment. We note that claimant's counsel conceded at the hearing that the issue was in doubt. (Tr. 46). Moreover, there is evidence that the skills center program was eligible for the employer-at-injury program. (Ex. C). Under these circumstances, we reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated July 26, 1996 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a penalty is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by SAIF.

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[5] Our decision should not be construed as a determination that the AGC Job-Skills program can never qualify as "modified" employment. To the contrary, as previously noted, our decision is based on the record as developed in this particular case.

Board Member Haynes specially concurring.

I agree that, based on the record developed in this case, the AGC Job-Skills program does not qualify as "modified" employment. I write separately, however, to emphasize that our decision should not signal the death knell of this program. To the contrary, should another record establish that a similar job-skills program provides a more structured learning environment which more directly pertains to the skills and aptitudes transferable to the injured worker's employer, the result may well be different.

In the Matter of the Compensation of
CARL D. PETERSON, Claimant
WCB Case No. 96-03827
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that assessed a 25 percent penalty for its allegedly unreasonable claim processing. On review, the issue is penalties.

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

We agree with the ALJ's conclusion that, at the time of its April 1, 1996 denial, SAIF did not have a legitimate doubt as to its liability for claimant's claim for a ruptured finger tendon. At that time, SAIF had in its possession a March 26, 1996 letter from Dr. Gallagher, the orthopedic surgeon with whom claimant first sought treatment for his finger condition in January 1996. In the March 26 letter, Dr. Gallagher reported that claimant did not provide a specific history of injury to the finger. (Ex. 11). Dr. Gallagher also wrote that he did not think claimant would have developed the ruptured finger tendon in the absence of a traumatic event. (Id.) Nevertheless, Dr. Gallagher concluded: "It is my opinion that [claimant's] condition is the result of his work activities." (Id.) He added that he had referred claimant to Dr. Wilson for further treatment in February 1996 and that SAIF could perhaps get more specific information from Dr. Wilson. (Id.)

SAIF did not seek any information from Dr. Wilson, nor did it seek further clarification of Dr. Gallagher's opinion. Instead, it issued its denial letter on April 1, 1996, stating in part: "We have reviewed the information in your file and find that there is insufficient evidence that your rupture of the profundus tendon of the left fifth finger is the result of either a work-related injury or disease." (Ex. 12). Subsequently, in May 1996, Dr. Wilson advised SAIF that claimant's work activity of carrying plywood sheets was the major contributing cause of the ruptured finger tendon. (Ex. 16). SAIF promptly rescinded its denial. (Ex. 15).

Like the ALJ, we find that Dr. Gallagher was unequivocal in his ultimate opinion that claimant's condition was related to his work activity. There also was no medical opinion to the contrary. In the face of such evidence, we are not persuaded there was a legitimate doubt that SAIF was liable for the claim. Although Dr. Gallagher's reasoning was suspect (insofar as he apparently did not think the tendon rupture would have occurred without a traumatic event), it was SAIF's claims processing obligation to seek further clarification from Dr. Gallagher or Dr. Wilson or to seek new information/opinion from another medical expert. SAIF did neither and, instead, issued a denial without further investigation. We therefore agree with the ALJ's conclusion that its denial was unreasonable. Accordingly, we affirm the ALJ's 25 percent penalty assessment as an appropriate sanction for SAIF's unreasonable claim processing.

Claimant's attorney is not entitled to an assessed fee for services on review defending the ALJ's penalty assessment. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated November 21, 1996 is affirmed.

In the Matter of the Compensation of
PAUL RAUCH, Claimant
WCB Case No. 95-08843
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's claim for vasovagal syncope with fume inhalation. In his respondent's brief, claimant seeks an increase in the ALJ's attorney fee award. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant, age 68 at the time of hearing, worked part time as a custodian. On June 27, 1995, a warm summer day, claimant was on his hands and knees cleaning the floor, when he began to black out and feel short of breath. Feeling shaky, claimant stood up and left the room.

Just prior to the time claimant began cleaning up the floor, an electric baseboard heater had been installed and tested in a nearby room. When he got down on his hands and knees, claimant detected a "burning off" odor from the heater.

Claimant sought emergency treatment shortly after this episode of dizziness. He was seen by Dr. Barnhouse, who provided pure oxygen which resolved his symptoms. Dr. Barnhouse diagnosed a vasovagal syncope with fume inhalation.

Since at least 1980, claimant has regularly taken medication for high blood pressure (hypertension).

Between June 27, 1995 and July 7, 1995, claimant experienced two other episodes of dizziness and light-headedness while carrying on his normal daily activity.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant sustained a compensable injury on June 27, 1995, either by inhaling nontoxic fumes or by hard work on a hot day. On review, SAIF asserts that claimant has not affirmatively proven that his medical condition arose out of his employment. We agree with SAIF.

Claimant has the burden of proving the compensability of his medical condition.[1] ORS 656.266. Specifically, claimant must establish by medical evidence supported by objective findings that he experienced an accidental injury arising out of and in the course of his employment. ORS 656.005(7)(a); see also Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994) (claimant must show a sufficient work connection to justify compensability). Furthermore, to the extent this compensable injury combined with a preexisting condition, i.e. his hypertension and regular use of antihypertensive drugs, claimant must show that the compensable injury is the major contributing cause of his syncope condition. ORS 656.005(7)(a)(B).

Due to the various potential causes for claimant's syncope episode, the causation issue is a complex medical question, the resolution of which requires expert medical evidence.[2] See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105,

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[1] A "syncope" is a fainting spell. (Ex. 11-6). According to Dr. DeMots, "vasovagal syncope" occurs when the vagus nerve is activated by stimuli, such as a blow to the "crazy bone" (ulnar nerve) or an accumulation of gas in the intestinal tract, which sends a signal to the brain that causes a drop in blood pressure. (Exs. 9, 11-10)

[2] The medical evidence identifies such possible causes as smoke or fume inhalation, excessive heat and claimant's history of hypertension. (Exs. 3, 8, 9, 11).

109 (1985). We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons to do otherwise.

The emergency room physician, Dr. Barnhouse, opined that claimant's work exposure was the major contributing cause of a vasovagal syncope. (Ex. 8). The record demonstrates, however, that Dr. Barnhouse's opinion is based on an inaccurate history. See Miller v. Granite Construction, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and inaccurate history are not persuasive). Specifically, Dr. Barnhouse understood that, at the time of claimant's dizzy spell, he was working in front of a newly installed heater and that smoke and fumes from the heater were being blown into his face. (See Exs. 3A, 8). Yet, as claimant testified at hearing, he was actually working in a room adjacent to the room in which the heater was installed, approximately 15 to 20 feet away. (Tr. 51-53, 60). Although claimant detected an odor from the heater in the air, the heater was no longer on or being tested when claimant got down on his hands and knees to work. (Tr. 60). Claimant neither saw nor inhaled any smoke. (Tr. 59-60). Indeed, a window was open to the outside so that claimant could detect a breeze along with an odor in the air. (Tr. 53). Because Dr. Barnhouse's assumption (that claimant was working in a hot environment while inhaling toxic fumes or noxious smoke) is not supported by the evidence, his causation opinion does not carry claimant's burden of proof.

The other expert medical opinion also does not support compensability. Dr. DeMots, a cardiologist who reviewed claimant's medical records on SAIF's request, opined that claimant likely experienced an orthostatic hypotension related to his preexisting hypertension condition. Dr. DeMots initially understood that claimant experienced the syncope episode while standing up from a kneeling position.[3] (Ex. 9). Dr. DeMots explained that orthostatic hypotension is a phenomenon that occurs when a person stands up suddenly and experiences a loss of blood flow to the brain. Dr. DeMots opined that claimant was probably predisposed to orthostatic hypotension because of his age and his history of hypertension and hypertension medication. Id. In his deposition, Dr. DeMots acknowledged that if claimant was not attempting to stand when he experienced the syncope then he probably did not experience orthostatic hypotension. (Ex. 11-7). Dr. DeMots further opined, however, that even if claimant was on his hands and knees when he became dizzy, the episode was not likely work-related. (Ex. 11-10). Dr. DeMots doubted that claimant experienced a vasovagal-type syncope from respiratory stimuli, because claimant did not report any nausea, vomiting or retching along with his dizziness. (Ex. 9-2). Because claimant experienced two other episodes of dizziness following the June 27, 1995 incident without inhaling any fumes or odors, Dr. DeMots opined the syncope episode was more likely than not related to his preexisting condition. (Ex. 11-13).

Because there is no persuasive evidence that claimant inhaled toxic fumes and no persuasive medical opinion relating claimant's syncope to his work activities on June 27, 1995, claimant has not proven the compensability of his medical condition by a preponderance of the evidence. In light of our determination that claimant's condition is not compensable, we do not address claimant's contentions concerning the attorney fee issue.

ORDER

The ALJ's order dated August 30, 1996 is reversed. SAIF's July 25, 1995 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[3] At hearing, the parties disputed whether claimant began to feel faint while still on his hands and knees or when he started to stand. Claimant testified that he could not recall specifically what he was doing when he started to black out. (Tr. 57-58).

In the Matter of the Compensation of
ESTELLA M. CERVANTES, Claimant
WCB Case Nos. 96-06147, 96-06037 & 96-05535
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Roberts, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Fleetwood Homes/Matrix Companies (Fleetwood) requests review of those portions of Administrative Law Judge (ALJ) Martha Brown's order that: (1) set aside its denials of claimant's current condition/carpal tunnel syndrome; and (2) upheld the SAIF Corporation's denial for the same condition. On review, the issues are compensability and responsibility.

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

Relying on the causation opinions of Drs. McDonald and Gottschalk over the contrary opinion of Dr. Radecki, the ALJ found claimant's carpal tunnel syndrome (CTS) compensable and Fleetwood responsible for claimant's condition. On review, Fleetwood argues that claimant's CTS is a new and different condition from the right wrist overuse injury it had previously accepted and that claimant has failed to prove the compensability of her CTS. Alternatively, Fleetwood contends that if claimant's current condition is compensable, SAIF should be responsible under the last injurious exposure rule.

We agree with Fleetwood that claimant's bilateral CTS is not the same condition as the previously accepted overuse injury. We conclude, however, for the reasons set forth below, that claimant's CTS is compensable as a new occupational disease, and that Fleetwood is the responsible employer.

A new occupational disease claim for the bilateral CTS is established by proof that claimant's employment conditions at Fleetwood were the major contributing cause of the disease. ORS 656.802(2)(a). Here, both claimant's treating doctor, Dr. McDonald, and Dr. Gottschalk, who saw claimant on referral from Dr. McDonald, opined on several occasions that claimant's work activity at Fleetwood was the major contributing cause of her CTS. (Exs. 13, 17, 19, 40, 41).

Like the ALJ, we find no persuasive reason not to rely on the opinions of claimant's treating doctors. See Weiland v. SAIF, 64 Or App 810, 814 (1983) (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). Both Dr. McDonald and Dr. Gottschalk considered claimant's medical history (including other possible predisposing or contributing factors), her work activities, and the findings of the electrodiagnostic tests in concluding that claimant's condition was caused in major part by her repetitive hand work at Fleetwood.

Given our determination that claimant's work activities at Fleetwood were the major contributing cause of her current CTS condition, we need not apply the last injurious exposure rule to determine responsibility. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Eva R. Billings, 45 Van Natta 2142 (1993) (when actual causation is proved with respect to a specific employer, the last injurious exposure rule is not applicable). We note, however, the absence of any evidence in the record indicating that claimant's subsequent employment with Homebuilders or Palm Harbor caused a pathological worsening of her CTS condition.[1]

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability of her CTS condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this issue, we find that a reasonable fee for claimant's attorney's

[1] Indeed, both Dr. McDonald and Dr. Gottschalk opined that claimant's employment with Fleetwood was the major contributing cause of her overuse condition and her bilateral CTS and that her subsequent employment activities caused an increase in symptoms only. (Exs. 40, 41).

services on review is $1,500, payable by Fleetwood. 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 16, 1996, as reconsidered October 15, 1996, is affirmed in part and reversed in part. That part of the order that set aside Fleetwood's May 14, 1996 denial insofar as it denied an aggravation of claimant's injury claim is reversed and the aggravation aspect of the denial is reinstated and upheld. The occupational disease ("current condition") aspect of the denial is set aside and the occupational disease claim is remanded to Fleetwood for processing according to law. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded $1,500, payable by Fleetwood.

February 26, 1997 Cite as 49 Van Natta 205 (1997)

In the Matter of the Compensation of
JOSE L. URENDA, Claimant
WCB Case No. 96-03073
ORDER ON REVIEW
Rodolfo A. Camacho, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that upheld the self-insured employer's denial of claimant's aggravation claim. On review, the issue is aggravation.

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

A plaintiff who has prosecuted one action against a defendant through to a final judgment is precluded by "claim preclusion" from prosecuting another action against the same defendant where the claim in the second action is based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Drews v. EBI Companies, 310 Or 134, 140 (1990). Claim preclusion does not require actual litigation. Where, as here, the May 1994 denial became final because claimant withdrew his request for hearing, he may not litigate the same claim or claims which arise from the same transaction or series of transactions.

We conclude that the effect of the May 1994 denial was to finally determine that claimant's mid and low back pain and right knee condition at that time was not compensable. Moreover, we agree with the ALJ's conclusions that the persuasive medical evidence indicates that claimant's condition has not changed from his condition at the time of the May 1994 current condition denial, nor were there conditions present at the time of the March 1996 denial that did not already exist when the May 1994 current condition denial was issued. The fact that claimant now asserts his claim by another legal theory does not alter the preclusive effect of the denial, which became final through operation of law. Million v. SAIF, 45 Or App 1097, 1102 rev den 289 Or 337 (1980) (Res judicata applies not only to every claim included in the pleadings, but every claim which could have been alleged under the same aggregate of operative facts).

Accordingly, we find that under the doctrine of claim preclusion, claimant is barred from litigating the compensability of his present mid and low back and right knee condition. Because we have determined that claimant is precluded from litigating the merits of his present condition, we need not address the merits of his aggravation claim.

ORDER

The ALJ's order of July 24, 1996 is affirmed.

In the Matter of the Compensation of
PATRICIA A. DROPINSKI, Claimant
WCB Case No. 95-11522
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorneys
Alice Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) McKean's order that: (1) set aside its denial of claimant's injury claim insofar as it pertained to bilateral shoulder contusions, right elbow contusion, cervical strain, thoracic strain, ulnar neuropathy, right shoulder strain/impingement syndrome/sprain and muscle contraction headaches; and (2) set aside an Order on Reconsideration as premature. In her respondent's brief, claimant contests that portion of the ALJ's order that declined to assess penalties for allegedly unreasonable denials. On review, the issues are compensability, premature closure, and penalties. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

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

Claimant has a history of a cervical/thoracic strain arising out of a November 18, 1993 work incident for a previous employer. This incident resulted in pain in claimant's mid and upper back, neck, trapezius on both sides, right ankle and occasionally in her arms. Claimant also complained of headaches, numbness in the hands and weakness in the right hands. She was declared medically stationary on August 1, 1994, and was later awarded 18 percent unscheduled permanent disability for her neck.

On January 11, 1995, claimant sought treatment for right sided neck pain and headaches. She also complained of pain in the left hip following a fall. Dr. Stanford diagnosed occipital neuralgia and prescribed pain medication. On January 27, 1995, Dr. Stanford gave her an injection in the right side of the neck which relieved her neck discomfort. Claimant returned to Dr. Stanford on April 20, 1995, complaining, among other things, of pain in the right shoulder.

On July 5, 1995, claimant was working for the employer's restaurant and lounge as a cook and bartender. On her return from a trip to the store to buy groceries for her employer, she stepped in a pothole in the employer's parking lot and fell forward. She turned her right ankle and scraped her knees. She lost her footing again when she tried to get up and collect the bags of groceries she had been carrying. Claimant was taken to the hospital by her supervisor, Jean Mountjoy.

In the emergency room, claimant was diagnosed with bilateral knee abrasions and contusions and a right ankle sprain. (Ex. 35). An x-ray ruled out a right ankle fracture. Six days later, on July 11, 1995, claimant was examined by Dr. Kaesche. She complained of pain in both shoulders. Dr. Kaesche found limited range of motion in the shoulders and diagnosed a contusion of both shoulders along with a sprain of the right ankle. (Ex. 38). X-rays of claimant's shoulders showed narrowing of the A/J joints on both sides compatible with degenerative disease and a small calcium deposit near the rotator cuff on the right shoulder. (Ex. 40).

Claimant saw Dr. Kaesche again on July 26, 1995. She complained of right shoulder pain. He diagnosed post-traumatic bursitis in the right shoulder, left shoulder contusion resolved and improved sprained right ankle. (Ex. 42). Claimant then returned to Dr. Kaesche on August 7, 1995, complaining of right shoulder pain and tightness of the right trapezius muscle groups. Claimant also complained of neck pain and pain across her pectoral muscles near her shoulders on August 16, 1995. She received physical therapy for these conditions, without much improvement. (Exs. 47, 48, 49, 51, 52, 55).

On August 21, 1995, claimant went to the emergency room complaining of neck pain, right shoulder pain and severe headaches. Dr. Greenstreet diagnosed cervical neuritis/occipital neuritis and cervicromial bursitis or impingement syndrome. (Exs. 53, 54).

Claimant began treating with Dr. Lee on August 31, 1995. Claimant advised Dr. Lee that she sustained abrasions to both knees and her right elbow in the fall, and that she fell onto her arms forward, only to be cushioned by her purse. She complained of additional neck and shoulder pain, and tingling sensation from the neck down to the right elbow. Dr. Lee diagnosed cervical strain with persistent symptoms, muscle contraction headaches, thoracic and shoulder muscle strain and right shoulder tendinitis/bursitis. (Ex. 57). On September 8, 1995, Dr. Lee diagnosed cervical and thoracic strain, right shoulder strain/bursitis and right ulnar neuropathy. (Ex. 62).

Claimant was examined by Drs. Strum and Wilson at SAIF's request on September 20, 1995. They diagnosed right ankle sprain, resolved, and diffuse right upper extremity, head and neck pain and paresthesias in the right hand. They did not relate the claimant's upper extremity pain to her July 5, 1995 fall, based on the delayed presentation of symptoms and the mechanism of injury. (Ex. 65).

Claimant returned to Dr. Lee on September 22, 1995. He diagnosed persistent spasm in the neck, right shoulder and thoracic spine and right ulnar neuropathy. (Ex. 67). On December 5, 1995, Dr. Lee indicated that he did not fully concur with the findings of Drs. Strum and Wilson, in that he believed claimant suffered a right shoulder sprain in her fall. (Ex. 71).

On September 29, 1995, SAIF accepted a claim for a right ankle sprain and bilateral knee contusions arising out of the July 5, 1995 fall.[1] On December 11, 1995, SAIF denied that the following conditions were related to claimant's July 5, 1995 injury: bilateral shoulder contusions, right elbow contusion, cervical strain, thoracic strain, ulnar neuropathy, cephalgia, right shoulder tendinitis and bursitis right shoulder. (Ex. 73).

Dr. Lee found claimant medically stationary with regard to the accepted conditions as of December 1, 1995. Claimant returned to Dr. Lee on December 14, 1995 and reported that her right arm and shoulder remained painful, and that she experienced intermittent numbness in her right hand and elbow. A right shoulder x-ray showed evidence of calcific tendinitis, but no evidence of acute injury. (Exs. 74, 75).

On December 26, 1995, claimant was examined by Dr. Heusch on referral from Dr. Lee. Hr. Heusch diagnosed a probable strain of the right shoulder superimposed on functional component. (Ex. 76).

Dr. Gritzka reviewed claimant's medical records and later examined her at her attorney's request. Dr. Gritzka diagnosed impingement syndrome right shoulder (contusion right rotator cuff tendon), right cubital tunnel syndrome and muscle contraction headaches secondary to the impingement syndrome. (Exs. 80, 85, 88).

Meanwhile, SAIF closed claimant's claim with a January 4, 1996 Notice of Closure awarding temporary disability only. Claimant requested reconsideration and a March 27, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects. Claimant requested a hearing, which was consolidated with her prior request arising out of SAIF's denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's July 5, 1995 fall at work was a material contributing cause of her need for treatment for a left shoulder contusion, right shoulder contusion/strain/sprain, right shoulder impingement syndrome (contusion right rotator cuff tendon), right elbow contusion, ulnar neuropathy, right cubital tunnel syndrome and cervical strain.[2] The ALJ further found that the fall was the major contributing cause of her need for treatment of a thoracic strain and that her compensable right shoulder

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[1] Because the employer was found to be a non-complying employer at the time of claimant's fall, claimant's claim was sent to SAIF for processing. (Exs. 44, 45, 46).

[2] At hearing, SAIF also expressly denied the compensability of those conditions for which it had not issued a written denial, including right shoulder impingement syndrome, right cubital tunnel syndrome and muscle contraction headaches secondary to impingement syndrome. Following an oral request, all conditions were consolidated and litigated at the hearing.

impingement syndrome was the major contributing cause of her muscle contraction headaches.[3] Finding no evidence that any of these conditions were medically stationary, the ALJ set aside the Notice of Closure and Order on Reconsideration as premature.

SAIF challenges the compensability of each of these conditions on review. Specifically, SAIF contends that the medical reports supporting the compensability of these conditions are based on an inaccurate or incomplete account of claimant's July 5, 1995 fall, and are therefore unpersuasive. SAIF also asserts that claimant failed to prove that her claim was prematurely closed. We address each disputed condition and issue in turn.

Left Shoulder Contusion

We adopt and affirm that portion of the ALJ's order finding that claimant's July 5, 1995 fall was a material (and the major) contributing cause of claimant's need for treatment of a left shoulder contusion.

Right Shoulder Contusion/Strain/Sprain/Tendinitis/Bursitis

The ALJ found that claimant established the compensability of a right shoulder contusion, sprain and strain but did not show that her right shoulder tendinitis and bursitis were caused in major part by her July 5, 1995 fall. We affirm these findings for the reasons set forth below.

When an otherwise compensable injury combines with a preexisting condition, the combined condition is compensable only to the extent that the otherwise compensable injury is the major contributing cause of the need for treatment of the combined condition or the major contributing cause of disability from the combined condition. ORS 656.005(7)(a)(B).

Here, six days after the July 5, 1995 incident, Dr. Kaesche diagnosed a contusion/sprain of claimant's right shoulder resulting from her fall. He found limited range of motion in both shoulders and good strength of her rotator cuff. X-rays showed a (preexisting) small calcium deposit near the insertion of the rotator cuff. (Exs. 38, 39, 40). Two weeks later, when claimant remained tender over the insertion of the rotator cuff, Dr. Kaesche diagnosed post-traumatic bursitis of the right shoulder. (Ex. 42). He later opined that claimant's fall at least exacerbated her arm and shoulder pain, based on claimant's report that she fell on her outstretched arms. (Exs. 39, 89).

Dr. Lee, who first saw claimant on August 31, 1995, opined that claimant's fall was the major cause of a right shoulder strain/sprain. (Ex. 71, 82-2, 84-3, 84-4, 84-5). Like Dr. Kaesche, Dr. Lee also opined that her fall may have exacerbated her right shoulder tendinitis and bursitis. Dr. Lee acknowledged that claimant's fall combined with her preexisting right shoulder calcification to produce her symptoms but concluded that claimant's fall was not the major contributing cause of the right shoulder tendinitis and bursitis.[4] (Ex. 84-5)

Based on this medical evidence, we find, as did the ALJ, that claimant's fall was the major contributing cause of a right shoulder contusion/strain/sprain. Like the ALJ, we further find that claimant has not proven by a preponderance of the evidence that her fall was the major contributing cause of the subsequent tendinitis and bursitis of the right shoulder. Therefore, these latter two conditions are not compensable.

Right Shoulder Impingement Syndrome (Contusion Right Rotator Cuff Tendon)

The ALJ found claimant's right shoulder impingement syndrome compensable under the material cause standard. We disagree and reverse.

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[3] The ALJ further found that claimant's fall was not the major cause of claimant's right shoulder tendinitis or bursitis, and neither party challenges this finding on review.

[4] A December 18, 1995 x-ray of claimant's right shoulder also showed evidence of calcific tendinitis and mild degenerative changes at the AC joint but no evidence of acute injury. (Ex. 75).

We agree with the ALJ that this case creates complex medical questions regarding the causation of claimant's various conditions. Thus, expert medical evidence is required. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Where, as here, there is a dispute between medical experts, the greater weight will be given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986).

Dr. Gritzka is the only medical expert to diagnose right shoulder impingement syndrome/right rotator cuff tendon contusion (as opposed to bursitis and tendinitis) and to relate that condition to claimant's July 5, 1995 fall. (Exs. 85, 93). Unlike the ALJ, we are unpersuaded by Dr. Gritzka's causation opinion because it is based on an incomplete and inaccurate history. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (doctors' opinions based on an inaccurate history entitled to little or no weight).

Prior to reviewing claimant's medical records, Dr. Gritzka was advised by claimant's counsel that claimant fell on her right shoulder. (Ex. 80-2). When he examined claimant more than seven months after the fall, Dr. Gritzka understood that she landed on her right arm and shoulder and subsequently had an onset of right shoulder symptoms. (See Ex. 93-2). Based on this account of the fall, Dr. Gritzka opined that the July 5, 1995 incident was the major contributing cause of the impingement syndrome. (Ex. 93-2). Dr. Gritzka's understanding of the mechanics of claimant's fall, however, is inconsistent with the contemporaneous medical records, as well as claimant's testimony at hearing. The contemporaneous records indicate that when claimant fell, she landed on both knees and *both* arms and/or elbows. These records do not document any specific impact to the right shoulder. (See Exs. 39, 49-1, 50, 57). At hearing, although claimant denied she landed on both arms or elbows, there was no claim that she landed on her right shoulder. (Tr. 13, 25). Because the record does not support Dr. Gritzka's premise that claimant fell on her right shoulder, his opinion as to the cause of her impingement syndrome is unpersuasive.

Moreover, even if Dr. Gritzka's causation opinion was based on an accurate history, we would also find it unpersuasive for lack of explanation and analysis. Moe v. Ceiling Systems, 44 Or App 429 (1980). Dr. Griztka opined that claimant's July 5, 1995 fall was more likely than not the major cause of claimant's right shoulder impingement syndrome/right shoulder rotator cuff tendon contusion without addressing the relative contribution of claimant's preexisting right shoulder condition.[5] Nor did Dr. Gritzka address the relative contribution that claimant's previously diagnosed tendinitis and bursitis may have had in the development of the right shoulder impingement syndrome. Consequently, on this record, we conclude that claimant has not established the compensability of her right shoulder impingement syndrome by a preponderance of the evidence. 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).

Right Elbow Contusion

Based on the opinion of Drs. Lee and Grizka, the ALJ found that claimant established the compensability of a right elbow contusion. We find to the contrary, for the reasons set forth below.

A compensable injury must be established by medical evidence supported by objective findings. ORS 656.005(7)(a). Objective findings are verifiable indications of injury or disease. ORS 656.005(19). Here, despite claimant's testimony that she injured her right elbow when she fell on July 5, 1995,[6] there is no medical evidence supported by objective findings of a right elbow contusion. There is no reference to a right elbow abrasion or contusion in the July 5, 1995 emergency room report, nor any mention of an

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[5] As noted above, the x-rays of claimant's right shoulder showed that she had preexisting degenerative disease of the A/C joint and a calcification near the insertion of the rotator cuff. (See Exs. 40, 75). In light of Dr. Lee's opinion that the calcification combined with claimant's injury to produce her persistent right shoulder symptoms, we conclude (contrary to the ALJ) that claimant must establish that her compensable injury was the major contributing cause of her right shoulder impingement syndrome. See ORS 656.005(7)(a)(B).

[6] As discussed above, we agree with the ALJ's determination that, despite claimant's testimony to the contrary, the preponderance of credible evidence establishes that claimant struck both arms or elbows in the fall. (See Exs. 39, 49, 50, 57, indicating claimant landed on her "arms" or "both elbows").

elbow contusion in the chart notes of Dr. Kaesche, who examined claimant on four occasions between July 11 and August 16, 1995. Indeed, although claimant referenced her right elbow on the 801 form she completed on August 15, 1995, she did not specifically complain of right elbow symptoms until late August 1995. (Exs. 50, 53, 57).

Given the lack of objective findings and claimant's inconsistent statements concerning the nature of her elbow injury,[7] we find that claimant has not established that she sustained a right elbow contusion as a result of her July 5, 1995 fall. ORS 656.266.

Right Ulnar Neuropathy/Right Cubital Tunnel Syndrome

The ALJ found that claimant established the compensability of her right elbow condition. We find to the contrary.

Subsequent to her fall, the first time claimant reported symptoms specifically involving her right elbow was when she saw Dr. Lee on August 31, 1995.[8] She reported that she had pain and a tingling sensation from the neck down to the right elbow. Dr. Lee noted that axial compression produced pain in claimant's right elbow and hand, but did not make a specific diagnosis regarding claimant's right elbow. (Ex. 57).

When claimant returned to Dr. Lee on September 8, 1995, she reported she was still having shooting pain from the right ulnar groove down to the hand. Dr. Lee noted that the ulnar nerve at the cubital tunnel was extremely sensitive and diagnosed right ulnar neuropathy. (Ex. 62). Claimant complained of continued pain and numbness in her right elbow when she was examined by Dr. Lee on December 14, 1995 and of pain in the ulnar half of the right hand when she was seen by Dr. Gritzka on February 20, 1996. (Exs. 74, 85).

Based on the history that claimant fell on her right elbow and shoulder, Dr. Lee opined that the fall was a material cause of the ulnar neuropathy. (Ex. 84-5). Similarly, Dr. Gritzka opined that the July 5, 1995 fall was the major contributing cause of her cubital tunnel syndrome, based on claimant's report that she landed on the point of her right elbow while wearing a heavy jacket. (Exs. 85-1, 93-4). On the other hand, Dr. Kaesche, who examined claimant on several occasions in the five weeks following her fall and understood that she landed on both arms, opined that claimant's ulnar neuropathy was not related to the July 5, 1995 incident. (Exs. 39, 89).

Considering the record as a whole, especially the documents that were made much closer in time to claimant's July 5, 1995 fall, we conclude that the causation opinions of Dr. Lee and Gritzka are based on an inaccurate history. Both doctors assumed that claimant fell square on her right elbow and that she sustained a contusion and nerve damage as a result. Yet, as noted above, a preponderance of the evidence does not establish such a mechanism of injury.[9] Further, although she had complained of pain and numbness in her right arm and hand prior to the incident, claimant did not present with elbow symptoms after the incident until nearly two months had passed. Neither Dr. Lee's nor Dr. Gritzka's opinion addresses claimant's prior hand, arm and elbow complaints nor the delayed presentation of her symptoms after the fall.

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[7] Seven weeks after the July 5, 1995 incident, claimant reported to Dr. Lee that she sustained an abrasion on her right elbow. (Ex. 57). Claimant reported to Dr. Gritzka that she was wearing a heavy jacket when she fell on her right shoulder so that there was no particular injury noted by the emergency room. (Ex. 85-1). At hearing, claimant testified that she was wearing a flannel shirt, with the sleeves rolled up above her wrist and that she sustained only a minor scrape of her right elbow that caused no immediate discomfort. (Tr. 24). On the other hand, claimant's manager, who took claimant to the hospital following the fall, testified that claimant was wearing a short sleeved shirt, and that she did not observe any abrasions or markings on claimant's elbows. (Tr. 76).

[8] Claimant also complained of radiating pain and numbness into her right arm and hand following her 1993 cervical injury. (See, e.g., Exs. 9, 11,19, 28).

[9] In this regard, we are more persuaded by the contemporaneous records of Dr. Kaesche indicating that claimant landed on both of her arms and initially experienced contusion and pain in *both* shoulders. (See Exs. 39, 41, 42, 43).

Consequently, because the medical opinions supporting the compensability of claimant's right ulnar neuropathy and cubital tunnel syndrome are conclusory and based on an inaccurate history, they are unpersuasive. See Miller v. Granite Construction Co., supra; Moe v. Ceiling Systems, supra. Thus, claimant has failed to establish the compensability of these two conditions.[10] See ORS 656.266.

Cervical Strain

The ALJ concluded that claimant established the compensability of her cervical strain. For the reasons that follow, we find to the contrary.

When claimant was seen at the emergency room on the day of her fall, Dr. Brown examined her neck and reported that it was nontender and moved well. (Ex. 35). Similarly, claimant did not report neck discomfort to Dr. Kaesche in her follow-up visits on July 11, July 26 or August 7, 1995. She did, however, note cervical pain to the physical therapist on August 15, 1995 (Ex. 49-2) and seek emergency treatment on August 21, 1995. Dr. Lee noted reduced range of motion, spasm and pain in claimant's cervical spine area when he examined her on August 31, 1995.[11]

Both Dr. Lee and Dr. Gritzka opined that claimant's neck pain was consistent with the mechanism of injury. (Exs. 80-2, 82-2, 84-2). Dr. Kaesche, on the other hand, did not believe claimant's cervical symptoms were attributable to her July 5, 1995 fall. (Ex. 89). Along the same line, Drs. Strum and Wilson did not relate claimant's cervical symptoms to the fall based on the delayed presentation of symptoms and the mechanism of injury. (Ex. 71).

Unlike the ALJ, we are more persuaded by the opinion of Dr. Kaesche, who had the opportunity to treat claimant on four occasions in the weeks immediately following her fall. See Weiland v. SAIF, 64 Or App 810, 814 (1983). As discussed above, we find the opinions of Drs. Lee and Gritzka unpersuasive because they did not have an accurate understanding of the July 5, 1995 incident and also because neither doctor considered the relative contribution of claimant's preexisting cervical condition. In addition, neither doctor had the opportunity to evaluate claimant immediately after the event. See, e.g., Cody L. Lambert, 48 Van Natta 115 (1996) (when treatment follows long after key event, Board will not give treating physician's opinion the usual deference).

Thoracic Strain

The ALJ also found claimant established that her thoracic strain was compensably related to her July 5, 1995 fall. We find to the contrary.

Claimant did not complain of upper back pain until August 1995, more than a month after her fall. Dr. Lee diagnosed a thoracic strain when he examined claimant on August 31, 1995. As with the cervical strain, both Dr. Lee and Dr. Gritzka believed that claimant's thoracic strain was consistent with the mechanism of injury. Dr. Lee further opined that the fall was the major contributing cause of claimant's thoracic condition, to the extent the injury combined with her preexisting thoracic strain. (Ex. 84-3).

Dr. Kaesche opined that claimant's thoracic condition was not attributable to the July 5, 1995 incident. Drs. Strum and Wilson found no objective evidence of a thoracic strain when they examined claimant in September 1995.

For the reasons set forth with regard to claimant's cervical condition, we rely on Dr. Kaesche's assessment and conclude that claimant has not established that her thoracic condition is compensably related to her July 5, 1995 fall. We are unpersuaded by the contrary opinions of Drs. Lee and Gritzka because they are conclusory and based on an incomplete or inaccurate history.

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[10] As noted above, Dr. Kaesche did not believe claimant's ulnar neuropathy was related to her fall.

[11] When claimant was examined by Drs. Strum and Wilson on September 20, 1995, they were unable to make objective findings to support her neck symptoms. (Exs. 57, 65).

Cephalgia/Muscle Contraction Headaches

The ALJ found claimant's headaches were compensable as a consequential condition. We find to the contrary.

Following the July 5, 1995 incident, claimant was diagnosed with headaches related to her neck and shoulder pain by several treating doctors. Dr. Lee first diagnosed cephalgia secondary to the cervical strain on August 31, 1995. (Ex. 57, 58, 59). After examining claimant in February 1996, Dr. Gritzka diagnosed muscle contraction headaches which he believed were caused in major part by her right shoulder injury and impingement syndrome. (Ex. 85-6; 93-4).

Given our determination that claimant's right shoulder bursitis, tendinitis and impingement syndrome and her cervical strain are not compensably related to her fall of July 5, 1995, we also conclude that claimant has not established the compensability of her muscle contraction headaches.

Premature Closure

The ALJ determined that the claimant's claim closure was premature. We find to the contrary.

Claims shall not be closed until the worker's compensable condition has become medically stationary. ORS 656.268(1). Medically stationary means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Here, claimant has an accepted claim for knee abrasions and right ankle sprain.[12] Dr. Lee reported on December 15, 1995 that these conditions were medically stationary as of December 1, 1995. (Ex. 72). Therefore, the claim closure was not premature.

Because there is no evidence in the record indicating claimant sustained any permanent impairment due to her accepted conditions and because claimant did not challenge the rating of these conditions at hearing or on review, we affirm the Notice of Closure and Order and Reconsideration in this regard. See OAR 436-35-007(1).

Even though the claim closure was not premature, SAIF is nevertheless required to process as required by law those conditions found compensable post-closure (i.e., the left shoulder contusion and right shoulder contusion/strain/sprain), including payment of any compensation to which the claimant would be entitled as a result of these "post-closure" compensable conditions. See Anthony J. Telesmanich, 49 Van Natta 49 (1997), on recon 49 Van Natta 166 (1997); Rodney V. Boqua, 48 Van Natta 357 (1996). To the extent claimant objects to SAIF's processing of these post-closure compensable conditions, she may request a hearing at the appropriate time. Id.

Unreasonable Denials

We adopt and affirm that part of the ALJ's order finding that SAIF's denial of the shoulder contusions was not unreasonable.

Attorney Fees

The ALJ awarded claimant a $4,000 attorney fee pursuant to ORS 656.386(1) for prevailing over SAIF's denials of the shoulder contusions/strain, right shoulder impingement syndrome, right elbow contusion, cervical and thoracic strain and right ulnar neuropathy. Because we have reversed part of the ALJ's order and uphold the compensability of the left shoulder contusion and right shoulder consusion/strain/sprain only, we reduce the ALJ's attorney fee award to $2,500 for claimant's counsel's services at hearing. In reaching this conclusion, we have considered the factors set forth in OAR 438-015-0010(4), particularly the time devoted to the issues (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.

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[12] We make no determination as to the medically stationary status of the left shoulder contusion and the right shoulder contusion/strain/sprain found compensable by this order.

In addition, claimant's counsel is entitled to an assessed fee for services on review with regard to the compensability of the left shoulder contusion and right shoulder contusion/strain/sprain. ORS 656.382(2); See also Rodney V. Boqua, supra (holding that when conditions are considered separately and the carrier appeals the compensation awarded for every condition, the claimant is entitled to an assessed fee for successfully defending against the carrier's challenge if compensation for at least one condition is not reduced). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review with regard to the compensable conditions is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to these compensability issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 31, 1996 is affirmed in part, reversed in part and modified in part. That part of the order setting aside the denial of claimant's right elbow contusion, right ulnar neuropathy, right cubital tunnel syndrome, cervical strain, thoracic strain, right shoulder impingement syndrome and muscle contraction headaches secondary to right shoulder impingement syndrome is reversed, and SAIF's denials of these conditions are reinstated and upheld. That part of the ALJ's order setting aside the Order on Reconsideration as premature is reversed, and the Order on Reconsideration is reinstated and affirmed. The ALJ's assessed attorney fee award is modified. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded $3,500 for services at hearing and on review, payable by SAIF. The remainder of the order is affirmed.

February 27, 1997 Cite as 49 Van Natta 213 (1997)

In the Matter of the Compensation of
KYLE A. HARSIN, Claimant
WCB Case No. 96-05019
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that declined to award temporary disability from June 11, 1993 to June 22, 1995. On review, the issue is temporary disability.

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

The ALJ declined to award claimant substantive temporary disability from June 11, 1993 to June 22, 1995 because claimant was medically stationary during the period in dispute.[1] The ALJ reasoned that entitlement to substantive temporary disability does not include times during which a claimant is medically stationary.

The ALJ was correct. In Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992), the court held that a worker is substantively entitled to temporary disability benefits only until the condition is medically stationary, and that the Board has no authority to award temporary disability benefits beyond the medically stationary date.[2] See Kenneth P. Bundy, 48 Van Natta 2501, 2503 (1996) (substantive entitlement to temporary disabilty proven by evidence that a claimant is disabled due to compensable injury before being declared medically stationary).

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[1] Claimant does not contest the ALJ's finding that he was medically stationary during the period in question.

[2] Former OAR 436-30-036(4) (WCD Admin. Order 94-059, effective 1/1/95) also provided that a worker is not entitled to temporary disability for any period in which the worker is medically stationary.

Claimant, however, cites our decision in Sylvia Aranda, 48 Van Natta 579 (1996), in which claimant asserts that we awarded temporary disability beyond the date the attending physician declared the claimant medically stationary. Like the ALJ, we find claimant's reliance on Aranda misplaced.

In Aranda, the claimant sought and was awarded temporary disability for her cervical condition. Although the claimant's attending physician had declared her low back condition medically stationary, there is no indication from the facts of Aranda that the claimant's cervical condition was declared medically stationary during the period for which the claimant sought temporary disability. Inasmuch as there is no contention that claimant's condition is not medically stationary, we find that Aranda does not support claimant's argument.

ORDER

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

February 27, 1997 Cite as 49 Van Natta 214 (1997)

In the Matter of the Compensation of
ANDREW S. HOLUKA, Claimant
WCB Case No. 96-04129
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order which: (1) declined to admit exhibits 56A and 57 into evidence; and (2) upheld the self-insured employer's denial of claimant's left knee injury claim. On review, the issues are evidence and compensability.

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

The July 29, 1996 hearing in this matter was continued for the deposition of Dr. Yarusso, who had earlier written a report based on his review of the medical records. (Tr. 1). After the deposition, the parties appeared on August 29, 1996 before the ALJ for closing arguments. At that time, claimant's counsel submitted for inclusion in the record Exhibit 56A, an August 1, 1996 medical report from Dr. Yarusso. Claimant's counsel explained that the medical report was an unsolicited product of a pre-deposition telephone conference between counsel and Dr. Yarusso. (Tr. 3, Day 2). Claimant also submitted Exhibit 57, an August 5, 1996 medical report from Dr. Brenneke, claimant's attending physician and surgeon. Dr. Brenneke wrote this report in response to a pre-hearing request for a narrative report by claimant's counsel. (Tr. 5, Day 2).

After the employer objected to the admisssion of this evidence, the ALJ declined to admit the disputed exhibits into evidence because they were submitted "post-hearing" and because claimant failed to show that they could not have been obtained prior to hearing with due diligence. Moreover, the ALJ noted that the hearing had been continued only for the deposition of Dr. Yarusso.

On review, claimant contends that the ALJ abused his discretion in not admitting the medical reports. For the following reasons, we disagree with claimant's contention.

ALJ's are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. They may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

Here, the record was left open for the deposition of Dr. Yarusso, although there was no formal agreement to "freeze" the evidentiary record. (Tr. 1). Moreover, we agree with the ALJ that claimant failed to establish that he could not have obtained Dr. Brenneke's "post-hearing" report with due diligence prior to the hearing. Thus, the ALJ did not abuse his discretion in declining to admit Dr. Brenneke's August 5, 1996 medical report. James D. Brusseau II.

With respect to Dr. Yarusso's unsolicited August 1, 1996 medical report, we need not decide whether the ALJ abused his discretion in making his evidentiary ruling. That is, even if we considered Dr. Yarusso's medical report, we would agree with the ALJ that claimant failed to satisfy his burden of proof.[1]

ORDER

The ALJ's order dated September 13, 1996 is affirmed.

[1] In his initial medical report, Dr. Yarusso concluded that claimant's work activities were not the major contributing cause of his need for treatment of his left knee condition. (Ex. 55-2). Dr. Yarusso reiterated that opinion in his deposition. (Ex. 58-6). Although Dr. Yarusso stated in his unsolicited August 1, 1996 medical report that claimant's work activity on January 19, 1996 was the "straw that broke the camel's back," Dr. Yarusso did not opine that claimant's work was the major contributing cause of his left knee condition. (Ex. 56A). Moreover, to the extent that Dr. Yarusso's August 1, 1996 report supports a finding of major causation, we would find that this report is unpersuasive because it is inconsistent with Dr. Yarusso's prior medical report and deposition testimony. See Kelso v. City of Salem, 87 Or App 630 (1987).

In the Matter of the Compensation of
ANGELA D. HUTCHISON, Claimant
WCB Case No. 96-03804
ORDER ON REVIEW
Brothers, et al, Claimant Attorneys
Meyers, Radler, 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) Howell's order that set aside its denial of claimant's current right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, age 25 at the time of hearing, compensably injured her right shoulder on October 21, 1994, while moving shopping carts into the employer's store. Claimant treated for right shoulder pain, and returned to regular work without pain or weakness within three weeks.

Claimant compensably reinjured her right shoulder on August 24, 1995. She experienced a sudden, sharp pain while lifting a case of beer. The employer accepted the injury as a continuation of claimant's accepted October 1994 right shoulder strain. Claimant treated for right shoulder pain for approximately two weeks, and was released to work with restrictions on lifting and repetitive right shoulder use on September 5, 1995.

Claimant left work for reasons unrelated to her injury on September 16, 1995. Shortly thereafter, she relocated to central Oregon. Claimant experienced some right shoulder discomfort when she lifted with her arms extended away from her body and had numbness in her arm when she raised it overhead, but did not seek treatment throughout the remainder of 1995.

On January 8, 1996, claimant's October 1994 injury claim was closed without an award of permanent disability.

In February 1996, claimant experienced a popping sensation and immediate pain in her right shoulder when she lifted her 35-pound daughter overhead.[1] The pain was more severe than at the time of her previous injuries, and her shoulder became stiff. Claimant sought treatment with Dr. Coe on February 23, 1996. Dr. Coe diagnosed impingement syndrome with possible small rotator cuff tear.

[1] Claimant testified that she was lifting her daughter up in the air above her head, then swinging her down and lifting her back up in a repetitive fashion. (Tr. 22).

Claimant filed a claim for an aggravation of her October 1994 right shoulder injury. The employer denied the aggravation, as well as the compensability of claimant's current right shoulder condition.

In April 1995, claimant was examined by Dr. Farris, an orthopedic surgeon, at the employer's request. Dr. Farris diagnosed right shoulder pain, primarily due to bicipital tendinitis.

On June 25, 1995, Dr. Coe performed arthroscopic surgery on claimant's right shoulder.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had established her entitlement to medical services for her current condition because both medical experts agreed that claimant's October 1994 injury was at least a material cause of her current right shoulder condition.[2] On review, the employer argues that the condition is not compensable because claimant failed to establish by a preponderance of the evidence that her compensable injury is the major contributing cause of her current condition.[3] We agree with the employer.

ORS 656.245(1) requires the employer to provide medical services for conditions caused in material part by the injury. This section further provides, however, that "for consequential and combined conditions described in ORS 656.005(7)," the employer is liable only for those medical services "directed to medical services caused in major part by the injury."

Here, the medical evidence establishes that claimant's current shoulder condition is a combined or consequential condition described in ORS 656.005(7). Although Drs. Coe and Farris disagree on the diagnosis of claimant's current condition,[4] both physicians agree that it resulted from a combination of factors, including her preexisting "hooked" acromion, the October 1994 injury, and the lifting of her 35-pound daughter. (See Exs. 27B, 29, 29C, 30). Therefore, under ORS 656.245(1), claimant must prove that her accepted injury is the major contributing cause of her current need for treatment.

Given the various factors contributing to claimant's current right shoulder condition, we find that the causation issue is a medically complex question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993). In resolving such complex medical causation issues we rely on medical opinions which are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259 (1986).

As noted above, both Dr. Coe and Dr. Farris offered opinions concerning the cause of claimant's current right shoulder condition. After considering both doctors' reports, we are more persuaded by the well-explained opinion of Dr. Farris. As the ALJ noted, Dr. Farris obtained and reported a very thorough and accurate history of claimant's right shoulder problems. Consistent with claimant's testimony at hearing, Dr. Farris understood that claimant experienced the sudden onset of shoulder pain in February 1996 when she lifted her daughter over her head. Dr. Farris was further advised that this pain was worse than it had been at the time of claimant's original injury, and that claimant then experienced stiffness and numbness in the arm. (Ex. 29-3; Tr. 22-24). Based on this history, Dr. Farris concluded that the major contributing cause of claimant's current condition was the February 1996 lifting incident along with her preexisting Type II acromion. Dr. Farris further reported that the shoulder strain injury of October 1994 and the recurrence of symptoms in August 1995 might be a material cause of claimant's current condition, but could not be considered the major cause because these symptoms largely resolved and she was essentially asymptomatic until her February 1996 injury.[5] (Ex. 29-9; 30-3).

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[2] The parties do not challenge that portion of the ALJ's order that upheld the employer's denial of claimant's aggravation claim.

[3] In her respondent's brief, claimant concedes that the ALJ should have applied the major contributing cause standard under ORS 656.245(1). Claimant asserts, however, that she has met this higher standard of proof.

[4] Dr. Coe diagnosed impingement syndrome with possible partial thickness rotator cuff tear related to the injury of October 1994, whereas Dr. Farris diagnosed bicipital tendinitis due to the more recent injury of February 1996 and claimant's preexisting acromion type.

[5] Claimant testified that she experienced some discomfort in her right shoulder after she left her employment, but that she was able to perform the activities of daily living without difficulty until the February 1996 off-work incident. (Tr. 19-21).

Unlike Dr. Farris, it is not clear whether Dr. Coe understood that claimant's need for treatment in February 1996 was precipitated by the acute symptoms she experienced while lifting her daughter overhead.[6] (See Exs. 16, 23). In addition, although Dr. Coe acknowledged claimant's preexisting condition (a hooked acromion which predisposed her to shoulder impingement problems), it is not evident that he weighed the relative contribution of this and other factors contributing to claimant's condition in concluding that the October 1994 work injury was the major cause. Because Dr. Coe's conclusion is not accompanied by a thorough explanation and is based on an inaccurate history, it is unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is less persuasive).

Consequently, on this record, we conclude that claimant has failed to prove that her current need for treatment is caused in major part by her accepted injury. We therefore reinstate the employer's current condition denial.

ORDER

The ALJ's order dated August 23, 1996 is reversed in part and affirmed in part. That part of the order that set aside the employer's denial of claimant's current condition is reversed, and the employer's 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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[6] Dr. Coe initially understood that claimant's right shoulder symptoms recurred without any specific incident. He was later advised that claimant's symptoms were exacerbated in February 1996 when she "attempted to lift her child, who weighs between 25-30 pounds, to chest level," (Ex. 27A-2) but even this history is inconsistent with claimant's testimony at hearing.

In the Matter of the Compensation of
DONALD W. JONES, Claimant
WCB Case No. 96-04742
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability.

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

The employer argues that claimant has not established the existence of an occupational disease by medical evidence supported by objective findings. See ORS 656.802(2)(d). For the following reasons, we agree with the ALJ that objective findings support claimant's claim.

The ALJ found that the medical reports documented diminished range of motion and muscle spasm and that these findings constituted objective findings under ORS 656.005(19).[1] According to ORS 656.005(19), range of motion and palpable muscle spasm are considered "objective findings." The employer argues, however, that the "muscle spasm" reported by Dr. Dunn could be related to claimant's surgical scar from his prior 1981 lumbar surgery rather than to a new problem.

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[1] " '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."

After reviewing Dr. Dunn's chart note, we find no indication that Dr. Dunn related the muscle spasm to claimant's scar or prior surgery. However, for the following reasons, we agree with the ALJ that claimant's diminished range of motion findings constitute objective findings.

The employer argues that claimant's diminished range of motion does not constitute an "objective finding." It bases its argument partly on Dr. Rosenbaum's statement that claimant had "some limitation of range of motion of the lumbar spine secondary to discomfort but this is not objective." In Tony D. Houck, 48 Van Natta 2443 (1996), we noted that "range of motion" findings were specifically included as an example of "objective findings" even though range of motion is based on a worker's subjective responses. Id at 2448. We further concluded in Houck, that subjective responses to physical examinations that are "reproducible" are included as "objective findings." Id at 2449.

Here, although Dr. Rosenbaum believed that claimant's range of motion findings were "subjective," ORS 656.005(19) provides that range of motion findings are considered "objective findings," if they are reproducible. Because the diminished range of motion findings were noted by more than one physician in this record (Drs. Dunn and Rosenbaum), we find that they are "reproducible" and that they meet the statutory definition of an "objective finding." Tony D. Houck, 48 Van Natta at 2449. In reaching this conclusion, we note that Dr. Rosenbaum does not state that he believes that range of motion findings are invalid or that claimant was manipulating his range of motion. Under such circumstances, we find that the "objective findings" requirement has been met. We also conclude that Dr. Rosenbaum directly relates claimant's reduced range of motion to his diagnosed musculoskeletal strain.

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

ORDER

The ALJ's order dated September 16, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
PATRICK K. RICHARDS, Claimant
WCB Case No. 96-04824
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Galton's order which awarded attorney fees pursuant to ORS 656.386(1) for claimant's counsel's efforts in obtaining rescission of an alleged "de facto" denial of a the radicular component of an accepted cervical spondylosis condition and pursuant to ORS 656.382(1) for unreasonable resistance to the payment of compensation. On review, the issues are attorney fees. We reverse.

FINDINGS OF FACT

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

On March 8, 1996, a prior ALJ issued an order which set aside SAIF's denial of claimant's cervical and thoracic strain and cervical spondylosis with radiculopathy. On April 18, 1996, SAIF issued a Notice of Closure, which awarded unscheduled permanent disability, which was affirmed by a May 17, 1996 Order on Reconsideration. On May 18, 1996, claimant requested a hearing on the reconsideration order and "de facto denial of compensable conditions."

On June 27, 1996, SAIF issued a Notice of Claim Acceptance, in which it stated: "Per the March 8, 1996 Opinion and Order the following conditions have been accepted * * * cervical spondylosis." (Ex. 23A). In a July 1, 1996 letter to SAIF, claimant asked it to accept "cervical spondylosis with radiculopathy," among other conditions. (Emphasis added).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that SAIF had "de facto" denied compensability of "cervical spondylosis with radiculopathy" and awarded claimant an assessed attorney fee for prevailing against the denial. The ALJ found that SAIF failed to issue an acceptance after the claim was ordered accepted by the prior ALJ until after claimant filed his request for hearing, and that claimant had complied with the communication requirements of ORS 656.262(6)(d). The ALJ concluded that SAIF had failed to comply with a final order "by 'de facto' denying and continuing 'de facto' to deny compensability of the radiculopathy portion of claimant's cervical spondylosis."

On review, SAIF contests the ALJ's award of an assessed fee under ORS 656.386(1) because there was no "denied claim" within the meaning of that statute, and under ORS 656.382(1) because there is no evidence of unreasonable resistance to the payment of compensation. We agree with SAIF's contentions.

Attorney Fee - ORS 656.386(1)

Under ORS 656.386(1), a claimant's attorney is entitled to an attorney fee in cases involving "denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined under the statute as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation."

We held in Michael J. Galbraith, 48 Van Natta 351 (1996), that there was no "denied claim" under ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable, i.e., whether there is evidence that the carrier has refused to pay compensation because it questioned causation.

In this case, as in Galbraith, there is no contention that any benefits for the compensable condition have been unpaid. Moreover, the record does not establish that SAIF refused to pay compensation on the "express ground" that the radicular component was not compensable or did not give rise to an entitlement to compensation. (See record and transcript generally).[1] Under such circumstances, we conclude that a "denied claim" has not been established and that no attorney fee may be awarded under ORS 656.386(1). See Jerrie L. Jones, 48 Van Natta 833 (1996).

Attorney Fee - ORS 656.382(1)

ORS 656.382(1) provides:

> "If an insurer or self-insured employer refuses to pay compensation due under an order of an Administrative Law Judge, board or court, or otherwise unreasonably resists the payment of compensation, [with an exception not relevant here], the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee * * *."

As discussed above, there is no evidence that any compensation for the radiculopathy portion of the cervical spondylosis condition was unpaid. Therefore, there was no unreasonable resistance to the payment of compensation that would allow for the assessment of an attorney fee under ORS 656.382(1). See SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993); Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991).

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[1] SAIF's response to claimant's request for hearing denying "that there has been a de facto denial" does not constitute proof that the carrier questioned causation. Galbraith, 48 Van Natta 351-52; compare Emily M. Bowman, 48 Van Natta 1199 (1996) (Carrier's response to a request for hearing denying that claimant sustained a work-related injury or occupational disease was a refusal to pay compensation on the express ground that the condition was not compensable).

ORDER

The ALJ's order dated August 29, 1996 is reversed in part and affirmed in part. The ALJ's $1,000 award of attorney fees under ORS 656.386(1) and 656.382(1) is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
IVAN J. ADAMS, Claimant
WCB Case No. 95-13621
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that claimant's aggravation claim was properly closed; (2) affirmed an Order on Reconsideration which awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of claimant's left ankle; and (3) found that the insurer was authorized to deduct previously overpaid temporary disability compensation from unpaid permanent disability benefits without first paying claimant an "out-of-compensation" attorney fee awarded by the Director. On review, the issues are claim processing, extent of scheduled permanent 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

Claim Processing and Extent of Permanent Disability

We adopt the ALJ's opinion on these issues, with the following supplementation.

We agree with the ALJ that the insurer was not required to issue a denial under ORS 656.262(7)(b) before closing claimant's aggravation claim in this case, because the insurer had not accepted a combined condition. See Robin W. Spivey, 48 Van Natta 2363 (1996) (Before ORS 656.262(7)(b) applies, a condition must have been accepted under ORS 656.005(7) as a combined condition).

In addition, we note claimant's alternative argument that he is entitled to permanent disability compensation for his venous stasis condition. Claimant is not entitled to compensation on this basis, because the venous stasis condition is not compensable as a matter of law. (See Ex. 17-7).

Attorney Fees

A November 17, 1995 Order on Reconsideration awarded 3 percent scheduled permanent disability for loss of use or function of claimant's left leg. It also authorized deduction of overpaid temporary disability benefits from unpaid permanent partial disability benefits and directed the carrier "to pay claimant's attorney, out of any additional compensation awarded, an amount equal to 10% of any additional compensation awarded to the worker. . . ." (Ex. 34-2).

The carrier apparently paid no additional compensation to claimant and no attorney fee to claimant's attorney, because the amount of overpaid temporary disability benefits was greater than the amount of permanent disability benefits awarded on reconsideration.

Claimant argues that the insurer should have paid the reconsideration order's "out-of-compensation" attorney fee to claimant's attorney before offsetting prior overpaid temporary disability compensation.

Because all the compensation due claimant had already been paid to him as of the time of the reconsideration order, the ALJ reasoned that no authority existed to direct the insurer to pay an attorney fee to claimant's attorney directly, "in addition to claimant's compensation." (O&O p. 5). We disagree.

ORS 656.268(6)(c) provides:

> "In any reconsideration proceeding under this section in which the worker was represented by an attorney, the department shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker."

In this case, the reconsideration order authorized an offset (deduction of overpaid temporary disability benefits from unpaid permanent partial disability benefits) and directed the insurer "to pay to claimant's attorney, out of any additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker. . . ." (Ex. 34-2). Thus, the order awarded additional compensation[1] and an attorney fee. The issue is whether the insurer was authorized to offset compensation previously overpaid to claimant before paying the attorney fee ordered paid "to claimant's attorney."

In Volk v. America West Airlines, 135 Or App 565 (1995), the court upheld the Board's refusal to order an insurer to pay an attorney fee under ORS 656.386(2) to the attorney directly where the full amount of the worker's compensation had already been paid to the worker. In reaching this conclusion, the court reasoned that there was no specific statutory authority for direct payment of attorney fees. Volk, 135 Or App at 573.

We are not persuaded that the Volk court's reasoning applies in the present case, based on the following reasoning. First, in Volk, there was no overpayment.[2] Second, this case arises under ORS 656.268(6)(c), rather than 656.386(2).

Paragraph (1) of ORS 656.386 provides that attorney fees for prevailing over denied claims shall be "allowed" (i.e., paid in addition to the claimant's compensation) and paragraph (2) provides that all other fees "shall be paid from the increase in the claimant's compensation, if any, except as expressly otherwise provided in this chapter." (Emphasis supplied). Because ORS 656.268(6)(c) expressly directs the department to order the insurer to pay a 10 percent attorney fee "out of the additional compensation awarded" and the Order on Reconsideration states that the permanent disability award is "in addition to any previous awards," we find that the statute otherwise expressly provides for an attorney fee, as noted in ORS 656.386(2). Under these circumstances, we do not find that Volk compels a conclusion that we lack authority to enforce the Department's fee award in the present case.

We further note that ORS 656.386 nowhere specifies to whom a fee shall be paid, while 656.268(6)(c) expressly states that the fee authorized thereunder shall be paid "to claimant's attorney." ORS 656.268(6)(c) allows the Director no discretion in awarding the fee, and specifies who pays, how much, and to whom the fee will be paid. Considering the plain language of the statute, we conclude that the insurer should not escape liability for the properly awarded fee in this case. Moreover, we find no precedent[3] for offsetting an overpayment to claimant against an attorney fee in a case such as this.[4]

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[1] See Judy A. Jacobson, 44 Van Natta 2393, on recon 44 Van Natta 2450 (1992). (Where the claimant had been paid benefits exceeding those awarded after litigation, the subsequent awards were nonetheless "increased" compensation for attorney fee purposes); Anthony E. Cochrane, 42 Van Natta 1619 (1990) (Where the first substantive entitlement to temporary disability was secured by a referee's order, claimant's attorney was instrumental in obtaining those benefits, even though the benefits had already been paid).

[2] We also find the recent decision in Nix v. Freightliner Corporation, 145 Or App 560 (1997), similarly unhelpful in resolving this dispute, because that case arose under former OAR 438-15-085(2), which does not apply here. See also Weyerhaeuser Co. v. Sheldon, 86 Or App 46 (1987).

[3] In Joslin A. McIntosh, 46 Van Natta 2445, 2448 (1994), we declined to "enforce" the correct attorney fee award (when the department mistakenly awarded a fee of less than 10 percent of the increased compensation), because the attorney did not first seek a remedy with the Department, before requesting a hearing. McIntosh, 46 Van Natta at 2448-49. We find the present case distinguishable from McIntosh, because claimant's counsel could have sought correction of the Department's error. Here, in contrast, the Department's order contained no error and there was nothing for claimant to complain of until the insurer failed to pay the attorney fee awarded in the order.

[4] We note that ORS 656.268(13), which authorizes the Department to make necessary adjustments in compensation, does not mention offsetting against an attorney fee. We further note that ORS 656.268(15)(a) authorizes an insurer or self-insured employer to offset any compensation payable to the claimant to recover an overpayment from a claim with the same insurer or self-insured employer. We find that neither of these statutes supports the insurer's offset against the attorney fee in this case.

Accordingly, we direct the insurer to pay to claimant's counsel the attorney fee granted by the Order on Reconsideration. The insurer is also authorized to offset this payment against claimant's future compensation.

ORDER

The ALJ's order dated June 14, 1996 is reversed in part and affirmed in part. That portion of the order that declined to direct the insurer to pay the November 17, 1995 Order on Reconsideration's out-of-compensation attorney fee to claimant's attorney is reversed. The insurer is directed to pay to claimant's attorney an attorney fee equal to 10 percent of the permanent disability awarded by the Order on Reconsideration. The insurer is authorized to offset this payment against claimant's future compensation. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARTIN GARCILAZO, Claimant
WCB Case No. 96-07238
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Neal's order that set aside its 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 low back strain as a result of a 1989 injury. In July 1996, the insurer denied claimant's current low back condition. Relying on the treating physician's opinion, the ALJ found that claimant proved compensability. The insurer asserts that, under any of the medical opinions, claimant must show that the compensable injury is the major contributing cause of the current low back condition and the treating physician's opinion is insufficient to meet such standard of proof.

For the reasons discussed by the ALJ, we agree that Dr. Stewart, claimant's long-standing treating orthopedic surgeon, provided the most persuasive opinion. According to Dr. Stewart, claimant has a chronic iliolumbar fascitis syndrome, or attachment syndrome. (Exs. 27, 29). Dr. Stewart described the condition as "a post strain phenomenon." (Ex. 29). Although agreeing that the lumbar strain had resolved, Dr. Stewart indicated that the strain caused the iliolumbar fascitis syndrome. (Ex. 32).

By stating that the current low back condition resulted from the compensable condition and not the injurious 1989 event, the iliolumbar fascitis syndrome constitutes a consequential condition. See Roseburg Forest Products v. Zimbelman, 136 Or App 75, 79 (1995) (under ORS 656.005(7)(a), the compensable injury is the medical condition that results from the accidental injury and is not the aftereffects of that condition). Thus, claimant must show that the compensable injury is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Dr. Stewart considered whether claimant's preexisting spondylolisthesis condition was a factor in his condition, as found by the examining physicians. Based on the location of claimant's pain, Dr. Stewart found that the spondylolisthesis was asymptomatic and not contributing to claimant's symptoms. (Exs. 27, 29, 30). Instead, Dr. Stewart attributed the current low back condition only to the compensable lumbar strain. Because Dr. Stewart implicated only the lumbar strain and rejected the preexisting condition as a cause, we find his opinion shows that the compensable injury was the major contributing cause of claimant's current low back condition. See Freightliner Corp. v. Arnold, 142 Or App 98, 105 (1996) (the Board may rely on medical opinion that does not contain the term "major contributing cause"). Thus, claimant proved the compensability of his current low back condition. ORS 656.005(7)(a)(A).

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 November 13, 1996 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
BERNARD G. HUNT, Claimant
WCB Case No. 95-12437
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside SAIF's denial of claimant's left foot drop condition; (2) increased claimant's unscheduled permanent disability award for a low back injury from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 14 percent (44.8 degrees); and (3) awarded 7 percent (9.45 degrees) scheduled permanent disability for loss of use or function of the left foot, whereas the Order on Reconsideration awarded no scheduled permanent disability. On review, the issues are compensability and permanent disability (scheduled and unscheduled). We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction and supplementation. Dr. White, neurosurgeon, performed a record review for SAIF; he did not examine claimant. (Ex. 35B).

On October 25, 1995, claimant requested that SAIF accept his left drop foot condition. (Ex. 31-1). On November 3, 1995, SAIF issued a partial denial of claimant's left foot drop condition. (Ex. 30). On December 22, 1995, Dr. Scheinberg, orthopedic surgeon, performed a medical arbiter examination, which was limited to the accepted L5-S1 herniated disc condition. (Ex. 33). The January 16, 1996 Order on Reconsideration was also limited to the accepted L5-S1 herniated disc condition and specifically noted SAIF's partial denial of the left foot drop condition. (Ex. 34-4).

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Unscheduled Permanent Disability

We adopt and affirm the ALJ's reasoning and conclusions regarding the unscheduled permanent disability issue.

Scheduled Permanent Disability

The sole issue on review concerning scheduled permanent disability is whether claimant has established entitlement to an impairment rating for the left foot drop condition. The ALJ awarded 7 percent scheduled permanent disability based on the assessment of Dr. Scheinberg, medical arbiter, that claimant sustained 4/5 graded weakness of the dorsiflexors of the left foot, evertors of the left foot, and

dorsiflexors of the toes. In determining this award, the ALJ apparently relied on the opinion of Dr. Gritzka, examining orthopedist, in concluding that claimant's left foot and ankle weakness is the result of an injury to the L-5 nerve root. On review, SAIF argues that the ALJ improperly relied on reports other than those from the attending physician or the medical arbiter to determine this scheduled impairment. Furthermore, SAIF argues, because none of the physicians permitted to rate scheduled impairment identified the affected nerve root pursuant to former OAR 436-35-007(14), claimant failed to establish any scheduled permanent disability. For reasons that follow, we need not address SAIF's argument that the existing record does not support any scheduled permanent disability.

By Notice of Closure dated May 16, 1995, SAIF closed the accepted L5-S1 herniated disc claim, awarding temporary disability and 9 percent unscheduled permanent disability, but no scheduled permanent disability. (Ex. 25). On October 25, 1995, claimant requested that SAIF accept his left drop foot condition. (Ex. 31-1). On November 3, 1995, SAIF issued a partial denial of the left foot drop condition. (Ex. 30). On November 6, 1995, claimant requested reconsideration of the Notice of Closure, raising issues regarding impairment and requesting appointment of a medical arbiter. (Exs. 31, 32). Both the medical arbiter, Dr. Scheinberg, M.D., and the January 16, 1996 Order on Reconsideration identified the accepted condition as a L5-S1 disc herniation and focused on that condition. (Exs. 33, 34). In addition, in addressing the issue of scheduled permanent disability, the Order on Reconsideration noted that SAIF had issued a partial denial of the left foot drop condition, stating that "[t]here is no evidence in the claim that the Insurer accepted any condition that involves a scheduled body part or condition." (Ex. 34-4).

Compensability of the left foot drop condition had not been determined by the date of the medical arbiter's examination or the Order on Reconsideration. Therefore, any impairment due to that condition was not considered in the Order on Reconsideration. At hearing, the left foot drop condition was determined compensable. However, compensability of this condition remained at issue on review. Although we have adopted and affirmed the ALJ's determination that the left foot drop condition is compensable, that decision does not necessarily result in a finding that we may proceed to rate the extent of permanent disability regarding that condition.

In several prior cases we have determined that, where an ALJ or the Board determines that a condition is compensable in the first instance, the ALJ or the Board may proceed to rate permanent disability related to that condition, without requiring that the claim be remanded to the carrier for processing to closure, so long as the condition found compensable is medically stationary at claim closure. See Nellie M. Ledbetter, 43 Van Natta 570 (1991) (holding that the Hearings Division has authority to determine the extent of a claimant's disability where a claimant requests a hearing from a Determination Order and the Referee[1] determines compensable a partially denied condition not considered in the Determination Order); Lance M. Kite, 44 Van Natta 18 (1992) (the same, citing Ledbetter, supra); George A. Rankins, 42 Van Natta 1585 (1990) (accepted claim closed by Determination Order and carrier subsequently issued a current condition denial; Board found the current condition compensable and medically stationary at the time of hearing, and held it had authority to determine extent of the claimant's permanent disability). But see Carl V. Dumler, 42 Van Natta 2466 (1990) (current condition denial issued prior to closure of accepted claim, with Determination Order stating the denied condition was not considered; Board remanded claim to carrier for processing in accordance with law, finding that the claim had never been processed in accordance with law and never been closed by the Evaluation Section).

In addition, in Virgil R. Hutson, 43 Van Natta 2556 (1991), we reversed that portion of a Referee's order that set aside as premature a Determination Order that had closed the claimant's claim without considering a partially denied psoriasis condition that the Referee had found compensable. Although agreeing that the psoriasis condition was compensable, we found that condition medically stationary at claim closure and proceeded to rate it. In Hutson v. Precision Construction, 116 Or App 10 (1992), the court affirmed our decision, finding that, although initial responsibility for evaluating a claim

[1] Prior to the 1995 legislative amendments to the Workers' Compensation Law, ALJ's were called Referees.

was with DIF[2] or the insurer, the Board had authority to review extent of disability. Finding that DIF had closed the back injury claim without considering the claimant's psoriasis, the court determined that the Board properly took the psoriasis condition into account in determining the claimant's permanent disability award.

We find all of these cases distinguishable in that the reconsideration process established and developed by legislative amendments in 1990 and 1995 did not apply to any of these cases. The reconsideration process significantly limits the record regarding impairment and claim closure issues available for review by the Hearings Division and the Board. Most significantly, no issues may be raised and no evidence may be admitted at hearing or on review regarding a notice of closure or determination order that were not raised or submitted at the reconsideration required by ORS 656.268. ORS 656.283(7), 656.295(3) and (5).

Furthermore, because the left foot drop condition was in denied status at the time of the medical arbiter examination and during the reconsideration process, we find that any impairment issue relating to that condition was necessarily not fully developed. In this regard, the medical arbiter stated that his examination concerned "the accepted condition of herniated disc at L5-S1." (Ex. 33-1). In addition, the Appellate Reviewer specifically noted that SAIF had denied the left drop foot condition and stated that there was no evidence that SAIF had accepted any condition involving a scheduled body part or condition.[3] (Ex. 34-4). Therefore, on this record, because the left foot drop condition was in denied status at the time of the reconsideration process but has subsequently been found compensable, we find it appropriate to remand the left foot drop condition claim to SAIF for processing according to law.[4] See Anthony J. Telesmanich, 49 Van Natta 49 (1997), on recon 49 Van Natta 166 (1997) (where carrier 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).

Finally, we acknowledge that we reached a different result in Diane M. Shipler, 45 Van Natta 519 (1993). In Shipler, the ALJ set aside the carrier's partial denial of a current low back condition and set aside a Determination Order and an Order on Reconsideration as "premature," reasoning that, because the Evaluation Division failed to consider the claimant's then-current back condition, there had been no administrative closure of the accepted claim.

On review, we determined that: (1) the record presented no reason to believe that the Evaluation Division failed to consider claimant's compensable condition in closing the claim; and (2) upon the claimant's request for hearing from the Determination Order and Order on Reconsideration, the ALJ had authority to determine all matters concerning claimant's claim, including the extent of disability stemming. Because the claimant conceded her claim was medically stationary, we found the claim properly closed and proceeded to rate the disability, finding that the claimant had failed to establish any injury-related permanent disability.

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[2] The Department of Consumer and Business Services was previously know as the Department of Insurance and Finance (DIF).

[3] In making this statement, the Appellate Reviewer cited "(temp) OAR 436-35-007(1), Admin. Order 95-063," which provides, in relevant part, "a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted injury and/or its accepted conditions." (Ex. 34-4). Claimant's claim was closed by Notice of Closure dated May 16, 1995; therefore, as the ALJ found, WCD Admin. Order No. 6-1992, as modified by WCD Admin Order No. 93-056, applies to rate claimant's permanent disability. However, although citing the wrong rule, it is apparent from this citation that the Appellate Reviewer limited her inquiry to impairment caused by conditions accepted at the time of the reconsideration order.

[4] In reaching this decision, we acknowledge that we are authorized to remand to the ALJ for further evidence taking where we determine that a case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). However, because the ALJ is also statutorily limited to the evidence and issues presented during the reconsideration process, any remand to the ALJ would not result in further development of the record regarding any impairment or closure issues pertaining to the left foot drop condition. ORS 656.283(7). Thus, it is appropriate to remand the left foot drop condition claim to SAIF for further processing.

For several reasons, we find Shipler inapposite. First, here, there is evidence that SAIF failed to consider claimant's compensable left foot drop condition in closing the claim. Specifically, SAIF awarded no scheduled permanent disability and subsequently denied the left foot drop condition. In addition, the Evaluation Division declined to address the left foot drop condition in the Order on Reconsideration because that condition had been denied. Although claimant did not concede medically stationary status of the drop foot condition, neither does he contest it.[5]

A further distinction is that, in Shipler, a low back condition had been previously accepted and a current low back condition had been subsequently denied. There, although the Board agreed the current condition denial should be set aside, we also found no compensable injury-related impairment based on the attending physician's evaluation of the low back condition. Here, in contrast, the foot drop condition had never been accepted; therefore, no closing-type evaluation has been performed. As explained above, the proper procedure under these circumstances is to remand the drop foot condition claim to SAIF for further processing according to law. Anthony J. Telesmanich, supra.

Accordingly, we vacate the ALJ's award of 7 percent scheduled permanent disability for loss of use or function of the left foot. In addition, we remand the left foot drop condition to SAIF for processing in accordance with law.

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for services on review regarding the issues of compensability and extent of unscheduled permanent disability. 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 these issues is $1,250, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to these issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated June 19, 1996 is vacated in part and affirmed in part. The ALJ's award of 7 percent (9.45 degrees) scheduled permanent disability is vacated. The ALJ's out-of-compensation attorney fee from the scheduled permanent disability award is likewise vacated. The remainder of the ALJ's order is affirmed. The left foot drop condition claim is remanded to the SAIF Corporation for processing in accordance with law. For services on review regarding the issues of compensability and extent of unscheduled permanent disability, claimant's attorney is awarded an assessed fee of $1,250, payable by SAIF.

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[5] In his request for reconsideration, although requesting that impairment for the left foot drop condition be rated, claimant did not raise the issue of premature closure. (Exs. 31, 32). Therefore, pursuant to ORS 656.283(7), 656.295(3) and (5), claimant is prohibited from raising the issue of the medically stationary status of the left foot drop condition in this proceeding, even if he so desired. Furthermore, because we find it appropriate to remand the left foot drop condition claim to SAIF for processing according to law, we need not address whether that condition was medically stationary at closure.

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

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's current L3-4, L4-5 facet inflammation condition. 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 there are no "objective findings" pursuant to ORS 656.005(19) to support claimant's claim. However, Dr. Corrigan, claimant's treating physician, did find that, upon examination, claimant was "tender in the midline principally at L3-4 and also the lumbosacral junction." (Ex. 19-8). Reports from Dr. Rabie also establish that upon palpation, there was "tenderness in the mid to lower lumbar area from about L2-L4." (Ex. 6-1). Dr. Rabie also discussed claimant's "subjective" findings, and then listed "left lower back tenderness today" under "objective" findings. (Ex. 12). Accordingly, we conclude that claimant has established objective findings to support his claim. See Tony D. Houck, 48 Van Natta 2443 (1996); Rosalie A. Peek, 47 Van Natta 1432 (1995).[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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), 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 counsel is awarded an assessed attorney fee of $600, to be paid by the employer.

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[1] Board Member Haynes has approved this order, as she believes she is bound by the Houck case, and the principle of stare decisis. Nevertheless, Board Member Haynes directs the parties to her dissent in Houck, supra.

In the Matter of the Compensation of
JAMES R. MANNHEIMER, Claimant
WCB Case No. 96-03371
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded 11 percent (35.2 degrees) unscheduled permanent disability for claimant's mid back condition, whereas an Order on Reconsideration had awarded 20 percent (64 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and "Findings of Ultimate Fact," with the following modification. The second paragraph on page 4 is replaced as follows:

Claimant's work during the five years preceding his April 10, 1992 injury is most accurately described by a combination of DOT 660.280-010, cabinet maker (woodworking) and DOT 763.684-062, plastic top assembler (furniture).

CONCLUSIONS OF LAW AND OPINION

The sole issue on review is the adaptability value. Specifically, whether claimant's Base Functional Capacity (BFC), is best described by DOT 660.280-010, cabinet maker (woodworking), or a combination of DOT codes. Claimant argues that BFC should be based on the highest strength requirement for a combination of DOT 660.280-010 and DOT 763.684-062, plastic top assembler (furniture), because the latter includes heavy lifting of the sort claimant performed at work, but the former includes no such lifting. The SAIF Corporation responds that the plastic top assembler is inappropriate for claimant, because claimant handled no plastic and he did not stack sheets of materials in a process of manufacturing laminated tops.

Claimant became medically stationary on November 11, 1995 and his claim was closed on January 1, 1996. Accordingly, the applicable standards regarding the adaptability issue are set forth in WCD Admin. Order 93-056 (effective December 14, 1993), as amended by WCD Admin. Orders 96-068 (effective August 19, 1996 (Temp.)) and 96-072 (effective February 15, 1997). OAR 436-035-0003(1), (2), and (3).

Former OAR 436-35-310(4)(a) provides that a worker's BFC is evidenced by the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. 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 worked for about five years as a shop worker manufacturing closets. (Ex. 28-2). We agree with the parties that the DOT job description for cabinet maker (woodworking), 660.280-010, at least partially describes claimant's pre-injury work. However, claimant's uncontroverted reporting that his work included heavy lifting is not reflected in the cabinet maker job description. (See Exs. 10-1, 11-4). Accordingly, because DOT 763.684-062, plastic top assembler (furniture), includes heavy lifting of the sort claimant performed, we find that claimant performed significant aspects of both DOT 660.280-010 and DOT 763.684-062 during the five years before his injury. Compare Mary Hoffman, 48 Van Natta 730, 731 n.1 (1996) (Where the record was inadequate to establish that a combination of DOT codes most accurately described claimant's job at injury, a single DOT was used to determine claimant's BFC). The latter position constituted "heavy" work, while the former involved "medium" work. Thus, the highest strength for the combination of codes, "heavy," applies here to establish claimant's BFC. See former OAR 436- 35-310(4)(a). See Lynda D. Streeter, 48 Van Natta 243 (1996).

Consequently, in comparing claimant's BFC (heavy) to his RFC (light), he is assigned a value of 5 for adaptability. See OAR 436-035-0310(6). When the adaptability factor, 5, is multiplied by the age/education factor, 2, the result is 10. When that value is added to claimant's 5 percent impairment value, the result is 15 percent unscheduled permanent disability.

ORDER

The ALJ's order dated July 29, 1996, as amended August 6, 1996 and reconsidered September 4, 1996, is modified in part and affirmed in part. In lieu of the Order on Reconsideration's unscheduled permanent disability award, and in addition to the ALJ's 11 percent (35.2 degrees) unscheduled permanent disability award, claimant is awarded 4 percent (12.8 degrees) for a total award to date of 15 percent (48 degrees) unscheduled permanent partial disability. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to the attorney. The remainder of the order is affirmed.

February 28, 1997 Cite as 49 Van Natta 228 (1997)

In the Matter of the Compensation of
FERNANDITA NICHOLS, Claimant
WCB Case No. 96-01546
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the right forearm from 16 percent (24 degrees), as granted by an Order on Reconsideration, to 18 percent (34.56 degrees) for the loss of use or function of the right arm; and (2) increased claimant's unscheduled permanent disability award for a shoulder/neck condition from 5 percent (16 degrees), as granted by an Order on Reconsideration, to 19 percent (60 degrees). The insurer also contends that claimant was precluded from challenging scheduled permanent disability at hearing. On review, the issues are extent of scheduled and unscheduled permanent disability.

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

Claimant has an accepted claim for bilateral carpal tunnel syndrome and overuse syndrome involving the hand, arms, shoulders and neck. In September 1995, the insurer issued a Notice of Closure awarding 5 percent scheduled permanent disability for each wrist and no unscheduled permanent disability.

We modify "Finding of Fact" number 8 as follows. After the Notice of Closure issued, claimant requested reconsideration, in part challenging impairment. In particular, claimant asserted that her treating physician "failed to assess permanent disability in the neck and shoulders" and requested a medical arbiter to assess impairment. (Ex. 53).

Based on the medical arbiter's findings, the Order on Reconsideration increased claimant's scheduled permanent disability awards and awarded unscheduled permanent disability. Claimant and the insurer requested a hearing with regard to the scheduled permanent disability awards. The insurer also requested a hearing to challenge the unscheduled permanent disability award. The ALJ increased the awards of scheduled permanent disability for the right arm and unscheduled permanent disability.

On review, the insurer contends that claimant was precluded from challenging the scheduled permanent disability awards because she did not raise the issue when requesting reconsideration. The insurer relies on ORS 656.268(8)[1] and 656.283(7).[2]

In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute, including other provisions of the same statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). If the legislature's intent is clear, no further inquiry is necessary. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. at 611-12.

The language in both provisions clearly prohibits a party from raising an issue at hearing that was not raised by either party at reconsideration. The statutes also clearly provide an exception to that rule: an issue "arising out of the reconsideration order" may be decided at hearing. We find that such language shows that the legislature intended to allow parties to raise at hearing an issue that was addressed by the Order on Reconsideration even if such matter was not raised in the request for reconsideration. See Ronald L. Tipton, 48 Van Natta 2521, 2424-25 (1996) (insurer could raise issue of offset at hearing, even though it did not raise the issue during the reconsideration proceeding, because the matter arose out of the reconsideration order).

Here, claimant's request for reconsideration did not object to the rating of scheduled permanent disability since she expressly asserted only that impairment had not been rated for her neck and shoulders.[3] Conversely, claimant's request for reconsideration also indicated that she disagreed with the impairment findings (which are relevant to both scheduled and unscheduled disability), to rate her permanent disability. Under such circumstances, we are inclined to find that claimant's scheduled permanent disability was an issue that was raised during the reconsideration proceeding.

However, we need not resolve that question because we consider scheduled permanent disability to be an issue "arising out of the reconsideration order" which could be addressed and resolved at hearing. Consistent with former OAR 436-30-115(3), which provides that the Department

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[1] ORS 656.268(8) provides:

"No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing."

[2] ORS 656.283(7) in relevant part provides:

"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."

[3] Impairment of the neck and shoulders is rated as unscheduled, rather than scheduled, permanent disability. ORS 656.214.

will do a "complete review" of the closure order at the reconsideration proceeding, the Department asked the medical arbiter to make findings and respond to questions regarding the right elbow/wrist/hand/fingers/thumb, as well as the shoulder, neck and thoracic/dorsal spine. Furthermore, following its consideration of the medical arbiter's report, the Department issued its Order on Reconsideration, which addressed impairment to claimant's scheduled body parts, increasing the awards of scheduled permanent disability. Consequently, we conclude that claimant was not precluded by ORS 656.268(8) and 656.283(7) from raising scheduled permanent disability at hearing.

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

ORDER

The ALJ's order dated July 31, 1996 is affirmed. For services at hearing, claimant's attorney is entitled to an assessed fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
FARADZH SAADIYAYEV, Claimant
WCB Case No. 96-04962
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which affirmed an Order on Reconsideration and Determination Order that awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant contends that OAR 436-035-0270(2) and OAR 436-035-0280(1), which require the presence of permanent impairment before unscheduled permanent disability can be awarded, are invalid because they are in conflict with ORS 656.214(5), which requires unscheduled permanent disability be based on lost earning capacity. We disagree.

While ORS 656.214(5) states that the criteria for rating unscheduled permanent disability is the "permanent loss of earning capacity due to the compensable injury," the statute also states that "Earning capacity" is to be calculated using the standards in ORS 656.726(3)(f). That subsection in turn provides that "The criteria for evaluation of disability under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job." ORS 656.726(3)(f)(A) (emphasis supplied).

Taken together, these statutory provisions clearly provide that permanent impairment is an essential component of any calculation of unscheduled permanent disability. Accordingly, we conclude that the administrative rules that require the presence of permanent impairment before an award of unscheduled permanent disability can be granted are in harmony with the statutory scheme and, thus, are not invalid as claimant asserts.

ORDER

The ALJ's order dated September 17, 1996 is affirmed.

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

Reviewed by Board Members Haynes and Biehl.

On January 29, 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 disapprove the proposed disposition.

The total consideration in the CDA for claimant's release of her rights to future workers' compensation benefits is a waiver, by the SAIF Corporation, of its right to recover a $3,599.92 overpayment. We have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. See Timothy W. Moore, 44 Van Natta 2060 (1992). With the parties' CDA, we also received SAIF's request, through its counsel, that we reconsider the rationale behind Moore, in light of ORS 656.268(15).[1] In response to SAIF's request, we wrote the parties on February 6, 1997 and requested written documentation regarding whether claimant currently has any other workers' compensation claims with SAIF.[2]

In Moore, we disapproved a CDA in which the total consideration for the agreement was the carrier's waiver of recovery of a $6,399 overpayment. In doing so, we reasoned that:

> "* * * although the carrier is precluded, as a practical matter, by the parties' agreement from recovery by future offset of its overpayment, such preclusion does not convert the overpayment into 'agreement proceeds.' In this regard, a carrier may only recoup an overpayment from a future award, if any, of permanent disability. Therefore, a carrier's recovery of an overpayment is always speculative in that it is dependent upon a condition subsequent. For this reason, we conclude that a carrier's contractual forbearance of its speculative right to pursue an offset in the future cannot qualify the amount of the overpayment as 'agreement proceeds.' " Id at 2061.

Moore was decided prior to the 1995 enactment of ORS 656.268(15)(a). The new statute now allows a carrier to offset overpayments from any other workers' compensation claim that the worker may have with the same carrier. SAIF asserts that the new statute makes it more likely and "less speculative" that overpayments will be recovered and it makes the waiver of an overpayment more valuable to a worker.

While we agree with SAIF that ORS 656.268(15) increases the odds that a carrier will be able to recoup an overpayment, recovery of an overpayment remains speculative under the statute. In this regard, a worker may or may not have another accepted claim with the same carrier from which future compensation may become payable and subject to offset under ORS 656.268(15)(a).

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[1] ORS 656.268(15)(a) provides: "An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker."

[2] In response, SAIF has advised that claimant has a 1980 claim and has also filed a January 3, 1997 SAIF claim which is currently in deferred status. In our letter, we also granted claimant an opportunity to respond to SAIF's request. However, no response was received within the time allowed. Accordingly, we have proceeded with our review of this matter.

Here, the parties have indicated that claimant has a 1980 claim with SAIF and a January 3, 1997 SAIF claim which is currently in deferred status. Based on this information, we find that it is speculative whether SAIF will be able to recoup its offset. The January 1997 claim is not currently in accepted status.[3] Moreover, it is unclear whether the 1980 claim is open or whether any benefits are payable in that claim.[4] Because recovery of an offset remains an uncertain event, even after enactment of ORS 656.268(15), we decline to disavow our holding in Moore.

Accordingly, consistent with the rationale expressed in Moore and because the proposed agreement provides for no other consideration for claimant's release of her workers' compensation benefits, we find that the CDA is unreasonable as a matter of law and we decline to approve it. See Kristy R. Schultz, 46 Van Natta 1819 (1994).

Inasmuch as the proposed disposition has been disapproved, SAIF shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-060-150(5)(k) and (7)(e).

Following our standard procedure, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

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[3] If the 1997 claim was in accepted status and compensation was payable, we would be more inclined to find that the waiver of the overpayment was tangible and valuable consideration to claimant for the release of her rights in the CDA.

[4] Given the age of the 1980 claim, it is unlikely that aggravation rights remain. See ORS 656.273(4). If the aggravation rights have expired, the possibility that temporary disability might become payable under ORS 656.278(1)(a) is speculative. Thus, the likelihood of recovering the overpayment in this November 1992 claim from the 1980 claim is also speculative and unlikely.

March 3, 1997 Cite as 49 Van Natta 232 (1997)

In the Matter of the Compensation of
ANTHONY J. McKENNA, Claimant
WCB Case Nos. 95-07570, 95-02480 & 94-07262
ORDER OF ABATEMENT
Karl Goodwin (Saif), Defense Attorney
Bottini, et al, Defense Attorneys

Claimant, pro se, requests reconsideration of our January 31, 1997 Order on Review. Specifically, claimant challenges our conclusions that: (1) he had not proven an aggravation claim for his compensable low back strain and L4-5 disc derangement; (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.

In order to further consider claimant's contentions, we withdraw our January 31, 1997 order. The insurers are granted an opportunity to respond. To be considered, their respective responses must be filed within 21 days from the date of this order. Claimant's replies, if any, must be filed within 21 days from the date of mailing of each insurer's response. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
SCOTT CAMPBELL, Claimant
WCB Case No. 96-04550
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our February 11, 1997 Order on Review that reversed the Administrative Law Judge's (ALJ's) order awarding 13 percent (41.6 degrees) unscheduled permanent disability for a cervical and thoracic condition. In concluding that claimant did not prove entitlement to permanent disability, we found more reliable the opinion from claimant's treating physician, Dr. Gaskell, that claimant had no permanent impairment resulting from the compensable injury.

In requesting abatement and reconsideration, claimant argues that the preponderance of evidence from Dr. Gaskell supports permanent impairment. Although conceding that Dr. Gaskell specifically noted "no permanent disability with this injury," claimant contends that this statement is "overwhelmed" by other evidence from Dr. Gaskell. In particular, claimant relies on Dr. Gaskell's comments that claimant could expect to experience chronic intermittent neck or back pain, as well as on diminished range of motion measurements taken by a physical therapist and Dr. Gaskell during his closing examination.

We are not persuaded by claimant's assertions. Dr. Gaskell's comments of future chronic intermittent neck pain and the range of motion measurements, along with his specific statement that there was no permanent impairment from the injury, at best show that, even if impairment was present (either from pain or diminished range of motion), it was not caused by the compensable injury. Consequently, we continue to conclude that claimant failed to prove any unscheduled permanent disability resulting from the injury.

Accordingly, we withdraw our February 11, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our February 11, 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
ROBERT C. HILL, Claimant
Own Motion No. 66-0438M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On January 2, 1997, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable 1964 left little finger injury. SAIF recommended that the Board deny medical benefits for claimant's current condition, contending that claimant's current left little finger tendinitis is not related to the industrial injury of 1964.

Because claimant's industrial injury occurred prior to January 1, 1966, ORS 656.245, which provides lifetime medical services for compensable injuries, does not apply to that injury. William A. Newell, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. See ORS 656.278(1)(b); Carl M. Price, 46 Van Natta 514 (1994), aff'd mem 132 Or App 376 (1995).

We recite a brief history of claimant's left fifth finger injury. On December 16, 1964, claimant sustained an industrial injury to his left little finger when a 150-pound spindle was dropped on that finger, and "cut the finger on the dorsal aspect to the bone." (See Dr. Cohen's March 25, 1965 medical report.) Claimant's injury resulted in an oblique laceration over the dorsal side of the proximal interphalangeal (PIP) joint, which split the extensor tendon longitudinally. In his March 25, 1965 report, Dr. Cohen, claimant's treating physician, noted that an x-ray revealed no fractures. Dr. Cohen opined that, as a result of the accident, although the extensor tendon "appears to have healed satisfactorily," a new periosteal bone formation had occurred on the dorsal aspect of the middle phalanx. Dr. Cohen further opined that there remained "a tender prominence over the dorsal aspect of the finger at the scar site, which probably is at the place where the periosteal new bone formation has occurred." Finally, Dr. Cohen opined that, although he felt that the motion in claimant's left little finger would improve, "[t]here will probably always remain some limitation of motion of the proximal and the distal interphalangeal joints." On June 10, 1965, Dr. Cohen opined that claimant was medically stationary, but that claimant "probably will always have some slight limitation of the left little finger, and some thickening over the dorsal aspect of the middle phalanx." Claimant was awarded a 40 percent loss of function of his left little finger.

There are no other medical reports in our record until claimant requested treatment for his left little finger from Dr. Lewis on November 20, 1995. In her chart note of that date, Dr. Lewis noted that claimant had developed swelling and pain in his left little finger. On examination, Dr. Lewis observed that claimant had swelling and mild erythema over the proximal interphalangeal portion of his left fifth finger. Dr. Lewis further noted that an x-ray was taken, "which revealed a bone spur in the same area of [claimant's] finger, which [claimant] states corresponds to a previous fracture." Dr. Lewis opined that claimant's current condition "represents tendinitis, related to an old fracture." Dr. Lewis prescribed Relafen, and advised claimant to elevate and ice his finger. According to the record, claimant sought no further treatment since that time.

As its basis for recommending that claimant's claim for medical treatment be denied, SAIF submitted a July 24, 1996 report from Mr. Eklund, RN, Nurse Consultant. In his report, Mr. Eklund noted that he was to determine "the major contributing cause of [claimant's] current tendonitis." From the record, Mr. Eklund concluded that, because "30 years later the worker states he experienced fracture," and because claimant was apparently "asymptomatic" since his injury with respect to his left little finger, claimant's 1964 injury was not the major contributing cause of his current condition. Rather, Mr. Eklund asserts, an unidentified "idiopathic situation" appeared to be the major cause of claimant's current condition. In his report, Mr. Eklund further states that there is only a "temporal relationship between [claimant's] current need for treatment and the original injury based upon the location of the current symptoms." Finally, Mr. Eklund proposes that:

> "The major cause [of claimant's current condition] appears to be some idiopathic situation not identified by the worker in the history provided Dr. Lewis. The lack of follow up with Dr. Lewis indicates the treatment she rendered was effective and therefore, in all probability, her diagnosis was correct."

Our review of the record persuades us that, although Dr. Lewis refers to claimant's misstatement that his current complaint was related to a previous "fracture" (x-rays taken in 1964 revealed no fracture), Dr. Lewis also noted that, from her interpretation of the current x-ray, the bone spur was in the same area of claimant's finger which corresponds to a previous injury. Thus, regardless of whether claimant recalled the injury as a fracture or as tendon damage with resulting bone spur, Dr. Cohen opined in 1965 that the bone spur or "new bone formation" was a result of claimant's injury. That bone spur still exists (in the same area of claimant's finger that he remembers a "fracture"), and it is at that particular site that Dr. Lewis opined that the tendinitis has developed. Furthermore, Dr. Cohen previously opined that claimant would always have limited extension and flexion in the proximal and distal interphalangeal joints. Therefore, regardless of the lapse of time between his 1964 injury and his current complaints, it was anticipated by claimant's physician that claimant would always have limited mobility with respect to his left little finger. (See Dr. Cohen's June 10, 1965 medical report.)

Dr. Lewis diagnosed tendinitis in claimant's left little finger related "to an old fracture." The "fracture" is in the same proximal interphalangeal area of the finger in which the injury-related bone spur exists. Dr. Lewis did not even conjecture that claimant may have sustained "some idiopathic situation," as claimant's finger did "not feel warm or red and he has had no other problems" which might indicate recent or intervening trauma or other injury. There is no evidence in the record that Dr. Lewis' diagnosis is incorrect. Therefore, because there is no evidence that claimant's current condition exists in a different area or as a result of a different event than that which was accepted at the time of the original injury, we conclude that his current condition is compensably related to his accepted condition.

Finally, because Dr. Lewis is a qualified physician, and Mr. Eklund is not, we rely on Dr. Lewis' opinion that claimant's current condition is related to his previous injury, rather than Mr. Eklund's proposal that claimant's current condition is the result of "some idiopathic situation." Therefore, because no physician has opined that claimant's current condition is related to any event or injury other than his December 16, 1964 compensable injury, we conclude that the major contributing cause of claimant's current left little finger tendinitis occurring at the PIP joint, is his 1964 industrial injury.[1]

Accordingly, on this record, we authorize the reopening of claimant's 1964 injury claim for the payment of medical services related to his 1964 left little finger injury. Authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. 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] It appears that ORS 656.005(7)(a)(A) would require claimant to prove that the compensable injury is the major cause of his consequential condition. However, we need not decide that question since claimant has carried his burden under either the material or major contributing cause standards.

March 5, 1997 Cite as 49 Van Natta 235 (1997)

In the Matter of the Compensation of
THOMAS J. KOLLEN, Claimant
WCB Case No. 96-03549
ORDER OF ABATEMENT
Flaxel & Nylander, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our February 7, 1997 Order on Reconsideration that affirmed the Administrative Law Judge's (ALJ's) order 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 the holding in this case.

In order to consider this matter, we withdraw our February 7, 1997 Order on Reconsideration. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACQUELINE D. BRADFORD, Claimant
WCB Case No. 96-04373
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We offer the following summary of relevant facts.

On February 22, 1996, claimant finished her regular work shift at 4:30 p.m. and a friend picked her up at her workplace. Claimant and her friend had dinner at a restaurant and attended a Portland Trailblazer game, which ended at about 9 p.m. Claimant returned to a parking garage near her workplace to pick up her car. She injured her left ankle when she slipped and fell in the garage.

The ALJ found that claimant was within the course of her employment when she was injured, because the injury occurred in a garage where she was required by the employer to park her car and she was obliged to obtain her car from that garage after work. The ALJ found that the injury arose out of claimant's employment because the employer exercised control over the parking area, required claimant to park there, and, because claimant was required to walk through the garage to retrieve her car, she was thus exposed to hazards existing in the parking area. We disagree.

ORS 656.005(7)(a) provides that a " 'compensable injury' is an accidental injury * * * arising out of and in the course of employment. . . ." "The 'arising out of' prong of the compensability test requires that some causal link exist between the employee's injury and his or her employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366, (1994). The 'in the course of' prong requires that the time, place, and circumstances of the employee's injury justify connecting that injury to the employment. Ibid." Krushwitz v. McDonald's Restaurants, 323 Or 520, 525-26 (1996). The two prongs constitute a unitary work-connection test, that is, "whether the relationship between the injury and the employment is sufficient that the injury should be compensable." Norpac, 318 Or at 366. Both the "arising out of" and the "in the course of" prongs must be satisfied to some degree. Krushwitz, 323 Or at 531. We first consider whether the "in the course of" prong is satisfied.

Under the "going and coming" rule, injuries sustained while an employee is traveling to or from work do not occur in the course of employment and, consequently, are not compensable. E.g., Cope v. West American Ins. Co., 309 Or 232, 237, 785 P2d 1050 (1990). The rule is grounded on the rationale that "[t]he relationship of employer and employee is ordinarily suspended from the time the employee leaves his work to go home until he resumes his work, since the employee, during the time that he is going to or coming from work, is rendering no service for the employer." Heide/Parker v. T.C.I. Incorporated, 264 Or 535, 540, 506 P2d 486 (1973) (internal quotation marks omitted).

Claimant argues that the "parking lot" exception to the "going and coming" rule applies to the facts of this case, bringing her injury within the course and scope of her employment. We disagree, based on the following reasoning.

We note at the outset that claimant's injury occurred about five hours after her work shift ended on February 22, 1996. After working and before the injury, claimant had dinner and attended a sporting event. Thus, she had terminated all work-related activities long prior to the injury. See Seidl v. Dick Niles, Inc., 18 Or App 332 (1974). There is no evidence that claimant intended to return to work that day or that she returned to the garage that evening for any reason other than to pick up her personal vehicle. Under these circumstances, we do not find that claimant was "going from work" at the time of her injury. See Johnson v. Employee Benefits Ins. Co., 25 Or App 215, 217 (1976) (The "going and coming" rule had no application where the claimant was neither going to nor coming from work.).

Instead, we find that the time (about five hours after stopping working), place (a parking garage, off the employer's premises), and circumstances (picking up a personal vehicle) do not suggest that claimant was in the course and scope of her employment at the time of her injury.

We proceed to consider whether claimant satisfied the "arising out of" prong of the unitary work-connection test.

> "An injury arises out of employment where 'the totality of the events that gave rise to claimant's injury was causally related to [her] employment.' SAIF v. Marin, 139 Or App 518, 522, 913 P2d 336, rev den 323 Or 535 (1996)." SAIF v. Burke, 145 Or App 427, 430 (1996).

It is undisputed that the employer leased spaces in the garage for its employees and that employees were required to park in the garage when they were at work (and, in fact, whenever they were in the neighborhood). In addition, it is generally necessary to walk to and from a parking place when entering or leaving work. Thus, as in Marin, 139 Or App at 525, "in a general sense walking through the parking lot to [her] car could be viewed as a condition of claimant's employment."

Here, however, claimant was not injured when she was leaving work. She was injured about 5 hours after she stopped working. During that time, claimant had dinner and attended a basketball game. Only then did she return to the parking garage, where her car had remained parked for her personal convenience.[1] Claimant's activity at the time of injury (picking up her car) was not for the benefit of the employer and it was not an ordinary risk of or incidental to her employment as a computer operator. Claimant was not on paid time when she injured her ankle and her activity did not occur on the employer's premises. Retrieving a personal vehicle from the parking garage was generally contemplated by and acquiesced in by the employer. However, claimant was on a personal mission of her own when she entered the parking garage after 9 p.m. on February 11, 1996.[2] See Mellis v. McEwan, Hanna, Grisvold, 74 Or App 571, 574 (1985); Sumner v. Coe, 40 Or App 815, 819 (1979) (Where the worker had completed his work, left the employer's premises, and returned solely on a personal errand, the facts were insufficient to make the worker an employee at the time of the incident.)

Considering these factors, we conclude claimant's act of walking to retrieve her car was of a personal, rather than work-related, nature. See Marin, 139 Or App at 525 (Where the claimant's activities, jump starting a car in the employer's parking lot, were sufficiently removed from his normal egress from work to break the causal connection between his normal employment conditions and the injury, the claim was not compensable); Albee v. SAIF, 45 Or App 1027, 1030 (1980) (Where the

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[1] There is no evidence that the restaurant where claimant had dinner or the stadium where she watched the Blazers were located in the neighborhood where the employer prohibited employee parking.

[2] We acknowledge claimant's testimony that she injured her left ankle because she slipped on a slick substance. These circumstances at best indicate a "neutral" risk, particularly because there is no evidence that the employer maintained the parking garage or could require the lessor to maintain it. See Marin, 139 Or App at 524.

claimant slipped and fell while putting chains on his tires in the employer's parking lot, the claim was not compensable because claimant had left work for the day and was putting chains on for personal benefit).[3]

In sum, we cannot say that claimant's work conditions put her in a position to injure her left ankle. Other than the mere fact that claimant was injured in an employer-provided parking facility, we find no other "risk" connected with claimant's employment. See James Hoffman, 47 Van Natta 394, 395 (1995) (citing William F. Gilmore on remand 46 Van Natta 999, 1000 (1994)). Accordingly, because claimant has not established that her injury arose out of or in the course of her employment, we conclude that the claim must fail.

ORDER

The ALJ's order dated September 6, 1996 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

[3] Compare Boyd v. SAIF, 115 Or App 241 (1992) (Work connection established where the employer controlled the parking lot, instructed its employees to park there, and claimant was injured on her way home from work).

In the Matter of the Compensation of
THOMAS T. FRANK, Claimant
WCB Case No. 96-00302
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order which awarded claimant 5 percent (16 degrees) unscheduled permanent disability, whereas a Notice of Closure, which was affirmed by an Order on Reconsideration, granted no permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

We begin with a summary of the pertinent facts. Claimant sustained a compensable low back injury on October 18, 1992, which SAIF accepted as a nondisabling lumbosacral strain. On July 27, 1994, claimant reinjured his low back and filed a new injury claim. A July 5, 1995 Stipulation was approved reopening the claim as an aggravation of the 1992 injury. Claimant's attending physician, Dr. Plewes, declared claimant medically stationary on June 29, 1995. (Ex. 44). A September 7, 1995 Notice of Closure awarded no permanent disability. Claimant requested reconsideration and was examined by Dr. Martens, medical arbiter. (Ex. 59). A January 3, 1996 Order on Reconsideration affirmed that portion of the Notice of Closure that awarded no unscheduled permanent disability on the grounds that there was no permanent worsening as defined in former OAR 436-35-005(9). A hearing was held on March 29, 1996.

Reasoning that the "redetermination" requirements of former OAR 436-35-007(5) and 436-35-005(9) did not apply in this case, as claimant's claim had not had a prior closure, the ALJ rated claimant's disability without regard to the "permanent worsening" requirement under those rules. Based on the findings of Dr. Martens, arbiter, who examined claimant on December 5, 1995, the ALJ determined that claimant's unscheduled permanent disability was 5 percent, based on impairment alone.

On review, SAIF first contends that the ALJ erred in concluding that the above-cited rules were inapplicable, as those administrative rules apply to all aggravation cases without exception. Citing Stepp v. SAIF, 304 Or 375 (1987), and Dany R. Armstrong, 46 Van Natta 1666 (1994), SAIF further contends that the Order on Reconsideration correctly evaluated claimant's unscheduled permanent disability because claimant failed to prove a permanent worsening of his low back condition since he was declared medically stationary and released to regular work in 1993. We disagree with SAIF's contentions.

Former OAR 436-35-007(5) (WCD Admin. Order 6-1992) provides:

"When a claim has been reopened pursuant to ORS 656.273, the worker's condition at the time of determination is compared with the worker's condition as it existed on the last award or arrangement of compensation. If the worker's condition has permanently worsened, the worker is entitled to have the extent of permanent disability redetermined. If the workers' condition has not permanently worsened, the worker is not entitled to have the extent of permanent disability redetermined under these rules. If a claim has multiple accepted conditions which are either newly accepted since the last arrangement of compensation and/or which have permanently worsened, the extent of permanent disability shall be redetermined. There shall be no redetermination for those conditions which are either unchanged or improved. In any case, the impairment value for those conditions not permanently worsened shall continue to be the same impairment values that were established at the last arrangement of compensation."

Former OAR 436-35-005(9) provides:

" 'Permanently worsened' is established by a preponderance of medical evidence concerning the worker's condition as it existed at the time of the last arrangement of compensation. A worker has permanently worsened when the changes in condition result in a loss of earning capacity for unscheduled claims, or when the loss of use or function for scheduled claims is greater than previously. An increase in impairment for unscheduled injuries does not mean that the worker has permanently worsened unless that additional impairment reduces earning capacity."

The application of former OAR 436-35-005(7) and 436-35-005(9) is contingent on a previous permanent disability award. Consequently, these rules are inapplicable in the absence of a prior permanent disability award. See Calvin L. Williams, 47 Van Natta 444 (1995).

In Williams, the claimant's 1989 injury claim was closed by a May 1991 Notice of Closure that awarded 29 percent unscheduled permanent disability. The claimant requested reconsideration. Prior to reconsideration, the claim was reopened for surgery. In November 1991, an Order on Reconsideration issued which reduced claimant's unscheduled award to 27 percent. Claimant appealed the reconsideration order, but the hearing was postponed pending claim closure. Subsequently, a June 1992 Notice of Closure issued which awarded no additional permanent disability. The claimant requested reconsideration, which resulted in a medical arbiter's examination. Another reconsideration order issued in January 1993, which did not award additional permanent disability on the grounds that the claimant's condition had not worsened since the last arrangement of compensation in 1991. The claimant's appeal of that reconsideration order was consolidated for hearing with his appeal of the earlier reconsideration order.

The ALJ in Williams, reasoning that the claimant was not required to demonstrate a permanent worsening of his condition since the first claim closure in 1991, rated the claimant's disability as of the June 1992 closure. On review, the employer argued that the ALJ erred in redetermining the claimant's unscheduled permanent disability because the claimant failed to prove a permanent worsening of his condition since the 1991 Notice of Closure. The Board held that, inasmuch as neither the May 1991 Notice of Closure nor the November 1991 Order on Reconsideration was a final award or arrangement of compensation, the claimant was not required to prove a permanent worsening of his condition since the 1991 claim closure. See id. at 444.

Here, as in Williams, there has been no final award or arrangement of compensation. Accordingly, claimant is not required to prove a permanent worsening as a result of the compensable 1994 aggravation claim in order to have his permanent disability determined at the time of the September 1995 claim closure. See id. at 446 fn. 1 (although former OAR 436-35-005(9) does not refer to a "final" arrangement of compensation, the Board interprets this rule as requiring a "final" award or arrangement of compensation).

Moreover, neither Stepp, nor Armstrong, 46 Van Natta 1666 (1994), require a different result. As the Board noted in Williams, 47 Van Natta at 445, the lesson from Stepp is that a claimant cannot relitigate extent of disability in the guise of an aggravation claim when there has been no permanent

worsening of the claimant's condition. Thus, where a claimant has not received a prior final award of permanent disability, a claimant is not relitigating permanent disability in the guise of an aggravation claim. Accordingly, the Board concluded that the Stepp rationale was not applicable to the facts of Williams and that, therefore, the claimant in Williams was not required to prove a permanent worsening as a result of his 1991 aggravation claim. Similarly, here, where claimant did not receive a prior final award of permanent disability, the Stepp rationale is not applicable. Thus, claimant is not required to prove a permanent worsening as a result of his aggravation claim.[1]

Alternatively, SAIF contends that claimant failed to prove that he is entitled to an award of unscheduled permanent partial disability because he has failed to show that he has any permanent impairment. We disagree.

The ALJ awarded permanent impairment for reduced range of motion in the lumbar spine based on the findings of the medical arbiter. (Ex. 59-2, 3). SAIF asserts that the ALJ's reliance on those range of motion findings was in error because the arbiter stated that the range of motion findings were "within normal," and thus indicated that claimant had no impairment as a result of his lumbar strain. SAIF also notes that Dr. Plewes stated that claimant had no objective evidence of permanent impairment. (Exs. 38-1, 44). Thus, SAIF contends that a preponderance of the medical evidence establishes that claimant has no ratable impairment from loss of range of motion.

Here, the medical arbiter was specifically instructed to rate permanent impairment due to the accepted condition, using an inclinometer to measure the active range of motion as provided in the AMA's Guides to the Evaluation of Permanent Impairment, 3rd edition, rev. (1990) and the Department's Bulletin No. 242, and report the findings on the Spinal Range of Motion form. (Ex. 58-1, -3). The arbiter followed these instructions and made findings of reduced range of motion for lumbar extension and right and left flexion. He also made range of motion findings for lumbar flexion. In his comments regarding the validity of the findings, he stated: "The inclinometer measurements of range of motion of lumbar flexion meets the reproducibility criteria, but not the straight leg raising validity check. However, in my opinion, these ranges of motion are within normal, and are valid." (Ex. 59-3).

Our reading of the arbiter's statement indicates that the antecedent of "these ranges of motion are within normal, and are valid," is "inclinometer measurements of range of motion of lumbar flexion." SAIF's reading of "these ranges of motion are within normal," which is taken out of context, would include all of the range of motion measurements and would negate the arbiter's findings. We conclude that SAIF's contention is unsupported by the record, as the arbiter's statement that these findings are valid is supported by the findings recorded on the Spinal Range of Motion form.[2] (Ex. 59-6).

In addition, these reduced range of motion findings are consistent with claimant's compensable injury and the arbiter did not attribute them to causes other than the compensable injury. Thus, we conclude that the arbiter made valid, verifiable, objective findings of reduced range of motion, which establish that claimant has permanent impairment as a result of his lumbar strain. See, e.g., Kim E. Danboise, 47 Van Natta 2163, 2164, recon 47 Van Natta 2281 (1995) (if a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that the impairment is due to the compensable injury).[3]

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[1] For the same reasons that Stepp is inapplicable, Dany R. Armstrong, supra, is inapplicable to this case. In Armstrong, the claimant had received a final award of permanent disability. His claim was reopened as an aggravation. The aggravation claim was closed without an award of additional permanent disability. The issue before the ALJ and the Board was whether the claimant had established a permanent worsening of his compensable condition since the prior award or arrangement of compensation, which, as noted above, is not the case here.

[2] We agree with the ALJ's conclusion that the lumbar flexion measurements do not provide a basis for an impairment finding. Former OAR 436-35-360(19). Accordingly, we limit our discussion to the remaining range of motion findings.

[3] Board Member Haynes notes that, under the doctrine of stare decisis, she is obligated to follow the majority's holding in Kim E. Danboise. Nevertheless, she directs the parties' attention to the reasoning expressed in the partial dissent in Danboise. She continues to disagree with the majority's reasoning that construes impairment findings that are consistent with a claimant's compensable injury and are not attributed to some other cause as showing that the impairment is due to the compensable injury, rather than requiring at least some direct medical evidence that the impairment is due to the claimant's industrial injury.

Moreover, because the arbiter's examination was conducted closer in time to the reconsideration order and because his report is a thorough and well-reasoned evaluation of claimant's injury-related impairment, the ALJ properly relied on the arbiter's range of motion findings over those of Dr. Plewes. See Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

SAIF requested review and we have found that claimant's compensation should not be reduced. Therefore, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 September 26, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by SAIF.

In the Matter of the Compensation of
KENDALL C. KEITH, Claimant
WCB Case No. 96-05179
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for lumbar spondylosis and degenerative osteoarthritis; and (2) awarded 18 percent (57.6 degrees) unscheduled permanent disability for a low back condition, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issues are compensability and extent of unscheduled permanent disability.[1] We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked for the employer for 30 years in various positions, performing mostly physical labor. Claimant injured his back at work on December 19 and December 20, 1995. On December 20, 1995, claimant signed an "801" form, stating that he had pulled or strained a back muscle. (Ex. 1). Dr. Bosworth diagnosed a lumbosacral strain. (Ex. 2).

An MRI on January 15, 1996 revealed moderate to marked canal stenosis at L3-4 and L4-5 and mild canal stenosis at L2-3, together with bilateral foraminal stenosis at L3-4, L4-5 and L5-S1. (Ex. 17). Surgery was not recommended and conservative treatment continued.

On February 29, 1996, claimant was examined by Dr. Rosenbaum on behalf of the insurer. Dr. Rosenbaum diagnosed a lumbar strain (resolving) and lumbar spondylosis (degenerative osteoarthritis).

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[1] Claimant's counsel submitted a cross-reply brief. The insurer objected to this submission. Since claimant did not file a cross-request for review, he is not entitled to submit a cross-reply brief on review. See OAR 438-011-0020(2); Rosalie Naer, 47 Van Natta 2033 (1996). Accordingly, we reject claimant's cross-reply brief and decline to consider it on review.

(Ex. 26-3). Dr. Rosenbaum reported that claimant's lumbar strain, which was caused in major part by the December 19, 1995 industrial event, had "nearly resolved." (Ex. 26-4). The underlying degenerative osteoarthritis was preexisting and not related to the work incident. (Id.) Dr. Rosenbaum felt that claimant was medically stationary. (Ex. 26-3, -4). Dr. Mortimer-Lamb concurred with Dr. Rosenbaum's report. (Ex. 30).

On March 5, 1996, the insurer accepted a lumbar strain. (Ex. 28). The lumbar strain claim was closed by a Determination Order issued on March 26, 1996, which awarded claimant 18 percent unscheduled permanent disability. (Ex. 31).

On May 21, 1996, the insurer issued a "partial denial of the lumbar spondylosis and osteoarthritis conditions only." (Ex. 33). The insurer said:

> "Medical reports indicate that you have pre-existing conditions diagnosed as lumbar spondylosis and osteoarthritis. Based on a review of the medical records, it is our opinion that lumbar spondylosis and osteoarthritis was not caused in major part by your injury of December 19, 1995 or by your work activities at [the employer]." (Id.)

The insurer requested reconsideration of the Determination Order on May 23, 1996. (Ex. 33A). An Order on Reconsideration issued on July 24, 1996, reducing claimant's permanent disability award to zero. (Ex. 35). The worksheet attached to the Order on Reconsideration indicated that there were no objective findings of impairment related to the accepted condition of a lumbar strain. (Ex. 35-5).

Claimant requested a hearing of the insurer's May 21, 1996 "partial" denial and the Order on Reconsideration.

At hearing, claimant contended that his lumbar spondylosis/degenerative osteoarthritis was not injury-related, but rather was an occupational disease. (O & O at 3). Based on Dr. Bosworth's opinion, the ALJ concluded that claimant's occupational disease claim for lumbar spondylosis/degenerative osteoarthritis was compensable. The ALJ also concluded that claimant was entitled to have the 18 percent unscheduled permanent disability award granted by the Determination Order "reinstated."

The insurer argues that Dr. Bosworth's opinion is not persuasive and claimant failed to prove that his work conditions were the major contributing cause of the lumbar spondylosis or degenerative osteoarthritis conditions.

After reviewing the record, we adopt the ALJ's reasoning and conclusion regarding the compensability of claimant's lumbar spondylosis and degenerative osteoarthritis.

Regarding the extent of claimant's unscheduled permanent disability for his low back condition, the insurer argues that claimant is not entitled to an award for impairment or social/vocational factors.

Claimant contends that Dr. Rosenbaum made valid range of motion findings, although he found no impairment related to the accepted lumbar strain. Claimant asserts that the ALJ correctly concluded that the impairment findings in this case related to the accepted osteoarthritis and lumbar spondylosis conditions.

To begin, we clarify the issue on appeal. The July 24, 1996 Order on Reconsideration determined claimant's permanent disability related to the accepted lumbar strain claim. At that time, the insurer had denied the osteoarthritis and lumbar spondylosis conditions as unrelated to the lumbar strain claim and also as a new occupational disease claim. No decision had issued as to the compensability of those conditions. At hearing, the ALJ found those conditions compensable as an occupational disease claim, and we have affirmed that decision. In light of the ALJ's compensability determination, the insurer is responsible for processing this separate occupational disease claim, which necessarily includes classifying the claim, calculating claimant's compensation, and, when and if appropriate, closing the claim and evaluating the extent of permanent disability for his compensable osteoarthritis and lumbar spondylosis conditions. Since that occupational disease claim has not been closed and this determination pertains to the closure of claimant's compensable lumbar strain claim, it would be premature for us to address whether claimant has sustained any permanent disability related to osteoarthritis and lumbar spondylosis conditions. We proceed to analyze whether claimant has sustained any permanent disability related to the accepted lumbar strain claim.

To be entitled to permanent disability compensation for his lumbar strain, claimant must establish that the impairment is due to his compensable condition. ORS 656.214(5). Under OAR 436-035-0005(7) (WCD Admin. Order 96-051), "impairment" is defined as "a permanent loss of use or function of a body part/area or system due to the compensable condition, determined in accordance with these rules, OAR 436-010-0080 and ORS 656.726(3)(f)(C)." OAR 436-035-0007(12) provides, in part: "Impairment findings made by a consulting physician or other medical providers * * * at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings as prescribed in OAR 436-010-0080."[2]

Dr. Mortimer-Lamb, claimant's attending physician, did not make specific impairment findings. Under OAR 436-035-0007(12), the impairment findings made by Dr. Rosenbaum may be used to determine impairment if Dr. Mortimer-Lamb concurred with the findings.

In reporting claimant's lumbar range of motion deficits, Dr. Rosenbaum reported that claimant's lumbar strain, which was caused in major part by the December 19, 1995 industrial event, had "nearly resolved." (Ex. 26-4). He said that the underlying degenerative osteoarthritis was preexisting and not related to the work incident. (Id.) Dr. Rosenbaum also said that the degenerative osteoarthritis was not altered by the injury. Although Dr. Rosenbaum recorded restricted lumbar ranges of motion, he opined that there were "no objective clinical findings relating to the patient's complaints." (Id.) However, he found that claimant's subjective symptoms appeared appropriate.

Dr. Mortimer-Lamb concurred with Dr. Rosenbaum's report. (Ex. 30). In a later concurrence letter from the insurer's attorney, Dr. Mortimer-Lamb agreed that the range of motion deficits noted in Dr. Rosenbaum's February 29, 1996 report related to claimant's lumbar spondylosis, osteoarthritis and obesity, rather than the work-related injury. (Ex. 32-1). Dr. Mortimer-Lamb also agreed that claimant had no permanent partial disability resulting from the December 19, 1995 work injury. (Ex. 32-2).

Although Dr. Rosenbaum recorded restricted lumbar ranges of motion, those findings are questionable since he also opined that there were "no objective clinical findings relating to the patient's complaints." (Ex. 26-4). Furthermore, he did not specify whether those restrictions were due to the lumbar strain or the preexisting underlying degenerative osteoarthritis. However, in light of Dr. Rosenbaum's conclusion that claimant's compensable lumbar strain had "nearly resolved" and the degenerative osteoarthritis was not altered by the injury, his report indicates that claimant's lumbar ranges of motion, even if valid, were not due to the lumbar strain injury. Rather, when read as whole, Dr. Rosenbaum's report indicates that any lumbar range of motion deficits were related to the preexisting degenerative osteoarthritis.

Dr. Mortimer-Lamb believed that the range of motion deficits noted in Dr. Rosenbaum's February 29, 1996 report did not relate to claimant's December 1995 work-related injury and claimant had no permanent impairment resulting from that injury. (Ex. 32). Under these circumstances, we are unable to find claimant entitled to a permanent disability award for his compensable lumbar strain. See ORS 656.266; 656.726(3)(f)(A)&(B).[3]

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 $750, 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.

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[2] We note that former OAR 436-010-0080 has been amended and renumbered to OAR 436-010-0280 (WCD Admin. Order No. 96-060).

[3] In light of our disposition, we need not address the insurer's argument that claimant is not entitled to an award for social/vocational factors. See OAR 436-035-0270(2) (if there is no measurable impairment, no award of unscheduled permanent partial disability shall be allowed).

ORDER

The ALJ's order dated September 3, 1996 is reversed in part and affirmed in part. The ALJ's award of permanent disability is reversed. The Order on Reconsideration is affirmed. Claimant's counsel's out-of-compensation attorney fee from that award is also reversed. The remainder of the ALJ's order is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded $750, payable by the insurer.

In the Matter of the Compensation of
SARAH A. STRAYER, Claimant
WCB Case No. 96-02833
ORDER ON REVIEW (REMANDING)
Peter O. Hansen, Claimant Attorney
Ronald Atwood & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that dismissed, without a hearing, her request for hearing from the self-insured employer's denial of her claim for lumbar, thoracic, and cervical strain based on claimant's alleged unjustified delay in pursuing her hearing request. On review, claimant seeks remand for a fact-finding hearing. We vacate the ALJ's order and remand.

FINDINGS OF FACT

The employer denied claimant's injury/occupational disease claim for a left ankle condition on March 4, 1996. A hearing was scheduled on June 17, 1996 after claimant requested a hearing. On June 11, 1996, the employer's counsel received a claim for lumbar, thoracic and cervical strains. The next day (June 12, 1996), the employer denied the new claim. The June 17, 1996 hearing was then postponed in light of the new claim.

On July 15, 1996, the employer notified claimant and her attorney of an insurer-arranged medical examination (IME) scheduled for August 27, 1996. Claimant's counsel objected to the IME, alleging that claimant had no duty to attend since her claim had been denied. The employer then filed a Motion to Compel claimant's attendance, to which claimant filed a Motion for Protective Order and Response to Motion to Compel.

On August 23, 1996, the ALJ issued an interim order finding that the employer was entitled to the IME, but declining to compel claimant's attendance at the examination. The ALJ stated, however, that failure to attend the IME could be grounds for dismissal of the hearing request pursuant to OAR 438-006-0071.[1]

Claimant failed to attend the August 27, 1996 IME. The employer then moved to dismiss claimant's hearing request.

CONCLUSIONS OF LAW AND OPINION

The ALJ declined claimant's request for a fact-finding hearing and oral argument. Based on the representations and admissions made in the various motions, the ALJ proceeded to make factual findings in the context of deciding whether claimant's hearing request should be dismissed. The ALJ

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[1] OAR 438-006-0071 provides that: "A request for hearing may be dismissed if a referee finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days."

granted the employer's motion to dismiss, finding that claimant's failure to attend the "post-denial" IME prevented the employer from "preparing and processing its case." According to the ALJ, this constituted conduct that resulted in an unjustified delay in the hearing of more than 60 days. Id.

On review, claimant reiterates her request for a hearing. Alternatively, claimant requests en banc review and presents numerous arguments regarding why she was not required to attend a "post-denial" IME and why the ALJ improperly dismissed her hearing request. The employer provides extensive arguments in support of the ALJ's decision. We need not address the merits of the employer's motion to dismiss, because, for the following reasons, we vacate the ALJ's order dismissing claimant's hearing request without a hearing.

In Richard L. Saunders, 46 Van Natta 1726 (1994), the employer moved to dismiss a request for hearing. Submitting supporting affidavit and exhibits, the employer contended that, inasmuch as the claimant was not a subject worker, the Hearings Division lacked jurisdiction over the dispute. Contending that he was an Oregon subject worker for an Oregon subject employer, the claimant argued that the motion for dismissal should be denied. Noting that the claimant did not dispute the facts recited in its motion, the employer replied that the dispute could be resolved without a hearing. Prior to the scheduled hearing, the ALJ (then Referee) dismissed the claimant's hearing request for lack of jurisdiction. The ALJ adopted the argument in the employer's motion that the claimant was not a subject worker.

On review, we concluded that it was not appropriate for the ALJ to reach the merits of the denial and dismiss the hearing request for lack of jurisdiction, without taking any evidence. In reaching this conclusion, we acknowledged that neither the claimant nor the employer apparently disputed the material facts surrounding the subjectivity issue. Nevertheless, we found that there was no express stipulation by the parties as to the relevant facts. Had there been such a stipulation, we reasoned that it would have been appropriate for the ALJ and this forum to perform our review function based on those stipulated and undisputed facts. However, we were unable to conclude that the parties mutually agreed to present the dispute for resolution based on stipulated facts. In fact, based on claimant's opposition to the employer's motion to dismiss the hearing request, we concluded that claimant desired that the matter proceed to hearing.

Therefore, we held that the ALJ's dismissal of the claimant's hearing request without first conducting a hearing was inappropriate. Because the ALJ improperly dismissed the claimant's request for hearing, and because he did not admit any documentary evidence or take any testimony, we further concluded that the record had been incompletely developed. See ORS 656.295(5). Accordingly, we remanded to the ALJ for an evidentiary hearing.

In this case, the ALJ also dismissed claimant's hearing request without admitting any evidence or taking any testimony, even though claimant desired an evidentiary hearing. Like Saunders, there was also no express stipulation by the parties as to the relevant and material facts. In fact, claimant disputes some of the ALJ's "findings of fact" and some of the representations made in the employer's submissions in the motions filed in this case. Thus, in contrast to Saunders, where the parties did not dispute the material facts surrounding the subjectivity dispute, it is even more apparent in this case that there may be factual issues in need of resolution, particularly with respect to claimant's conduct in response to the employer's scheduling of an IME.

Therefore, in the absence of an express stipulation by the parties as to the relevant facts, we conclude, as we did in Saunders, that it was inappropriate for the ALJ to decide the merits of the parties' dispute and dismiss claimant's hearing request without conducting a hearing and taking any evidence.

As we noted in Saunders, 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). Because the ALJ dismissed claimant's request for hearing, and because she did not admit any documentary evidence or take any testimony, we conclude that the record has been incompletely developed. Accordingly, we remand to ALJ Garaventa for further

proceedings consistent with this order to be conducted in any manner that the ALJ determines will achieve substantial justice to all the parties.[2]

ORDER

The ALJ's order dated October 25, 1996 is vacated and claimant's hearing request is reinstated. The matter is remanded to ALJ Garaventa for further proceedings consistent with this order.

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[2] The ALJ concluded that claimant's failure to attend the IME delayed the hearing for more than 60 days. However, the ALJ made insufficient findings to support this conclusion. In this regard, we note that the June 17, 1996 hearing was postponed ostensibly because of the new claim for additional conditions, not because of claimant's failure to attend an IME. Although the hearing has apparently not been reset, the file created for the June 1996 hearing does not establish that any delay in resetting the hearing is due to claimant's refusal to attend an IME. On remand, the ALJ should receive evidence and make specific findings regarding the issue of whether claimant's conduct has delayed the hearing in this matter for more than 60 days.

In the Matter of the Compensation of
MICHAEL J. COOMER, Claimant
WCB Case No. 96-05195
ORDER ON REVIEW
Max Rae, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order which: (1) upheld the insurer's denial of his low back injury claim; and (2) declined to award penalties or an attorney fee for an allegedly unreasonable denial. On review, the issue is compensability, penalties 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, a manufacturing laborer, allegedly sustained a compensable low back injury on October 16, 1995, when he felt a "pop" and then pain in his low back while dumping the contents of a 55 pound bag into a pit. The ALJ determined that claimant's unrebutted testimony, as well as an October 23, 1995 chart note of Dr. Alley, from whom claimant initially sought treatment, established that the alleged incident caused his low back pain. However, the ALJ upheld the insurer's May 22, 1996 denial because claimant did not establish that his injury was compensable by medical evidence supported by "objective findings." See ORS 656.005(7)(a). In reaching this conclusion, the ALJ reasoned that, although Dr. Alley documented reduced range of low back motion, the finding was subjective (secondary to pain) and not "reproducible." See ORS 656.005(19).

On review, claimant contends that Dr. Alley's observation of reduced range of motion satisfies the "objective findings" requirements of ORS 656.005(7)(a) and ORS 656.005(19). The insurer argues, however, that, even if it does, the claim still fails for lack of an affirmative medical opinion that proves that the alleged incident caused claimant's need for treatment. Claimant responds that, because the medical causation issue is uncomplicated, he need not adduce expert medical evidence to establish a compensable claim. For the following reasons, we find claimant's arguments persuasive.

Objective Findings

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."

We analyzed this statute in Jairo J. Garcia, 48 Van Natta 235 (1996). Specifically, we addressed the question of whether the claimant's subjective pain complaints of "tenderness" were sufficient to constitute "objective findings" under amended ORS 656.005(19). We concluded that, in the absence of findings that were "reproducible, measurable or observable," the claimant's injury claim based on his "subjective response" was not compensable because it was not based on "medical evidence supported by objective findings" as required by ORS 656.005(7)(a).

Here, on October 23, 1995, Dr. Alley first examined claimant and reported that, although he did not appear clinically ill, claimant experienced pain with lateral flexion or forward flexion or extension. (Ex. 2). Claimant did not again seek treatment until June 17, 1996, when he once more consulted Dr. Alley, who reported that claimant had "good" range of motion. (Ex. 5). On August 26, 1996, Dr. Alley confirmed that claimant had reduced range of motion on October 23, 1995, although it was not "reproducible." (Ex. 9). The ALJ determined that claimant's reduced range of motion did not constitute an objective finding because it was subjective, i.e., due to pain, and was not reproducible.

Subsequent to the ALJ's order, we observed in Tony D. Houck, 48 Van Natta 2443 (1996), that two of the four examples provided in amended ORS 656.005(19) that meet the definition of "objective findings" are based on a worker's subjective responses -- "range of motion" and "muscle strength." In this regard, we noted that both a loss of range of motion and a loss of muscle strength may be due to a worker's subjective response to pain in performing certain tasks. In other words, we reasoned that it is pain that limits the worker's motion and/or strength. However, the legislature specifically included these "subjective" limitations as examples of permissible "objective findings." Therefore, although the legislature intended that a physician's indication that the worker experiences pain would not satisfy the requirement of "objective findings," we concluded that it obviously did not intend to eliminate the consideration of a worker's verifiable subjective responses to pain.

Finally, we noted in Houck that the second sentence of amended ORS 656.005(19) is written in the negative and states, in pertinent part, that "'[o]bjective findings' does not include . . .subjective responses to physical examinations that are not reproducible, measurable or observable." Furthermore, we observed that the requirements of "reproducible, measurable or observable" are expressed in the disjunctive, rather than the conjunctive. Thus, we reasoned that meeting any one of these requirements is sufficient to support a finding of "objective findings."

In this case, although claimant's reduced range of motion was not "reproducible" according to Dr. Alley, this does not preclude it from being an "objective finding" since it is "measurable" and "observable." Moreover, even though claimant's subjective response to pain may have limited his range of motion, this does not preclude that finding from being an "objective finding." Tony D. Houck, 48 Van Natta at 2448. Accordingly, based on our reasoning in Houck, we find Dr. Alley's findings of limited range of motion are "verifiable indications of injury" under ORS 656.005(19).[1] Accordingly, we conclude that claimant's low back injury claim is supported by "objective findings."[2]

Causation

Inasmuch as we have determined that claimant's injury claim was supported by "objective findings," it is necessary to address the medical causation issue. As previously noted, the ALJ determined that claimant had established causation based on Dr. Alley's October 23, 1995 chart note and claimant's unrebutted testimony. The insurer correctly observes that neither this chart note, nor Dr. Alley's other medical reports, contain an affirmative medical opinion that claimant's alleged injury on October 16, 1995 was a material contributing cause of his need for medical treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). We agree with claimant, however, that expert medical evidence is not required to establish medical causation in this case.

In Barnett v. SAIF, 122 Or App 279, 283 (1993), the court recited from Uris v. Compensation Department, 247 Or 420 (1967), the relevant factors for determining whether expert testimony of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

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[1] Claimant correctly notes that we have held in numerous other cases that reduced range of motion constitutes an "objective finding." See Constance A. Asbury, 48 Van Natta 1018 (1996); Gayle A. Jaynes, 48 Van Natta 758 (1996); Naomi Whitman, 48 Van Natta 605, on recon 48 Van Natta 891 (1996); aff'd mem Eagle Crest Partners v. Whitman, 146 Or App 519 (1997).

[2] We recognize that on June 17, 1996 claimant had "good" range of motion. (Ex. 5). Moreover, on August 18, 1996, Dr. Alley agreed in a "check-the-box" concurrence letter written by the insurer's counsel that he was unable to make any objective findings in support of claimant's subjective complaints. (Ex. 7). However, claimant's counsel subsequently provided the statutory definition of "objective findings" to Dr. Alley, which resulted in his August 27, 1996 report that confirmed that claimant had demonstrated reduced range of motion on October 23, 1995. Although it appears from his responses to the inquiries from legal counsel that Dr. Alley does not consider reduced range of motion to be an objective finding, "objective findings" is a legal, not a medical, term. Thus, Dr. Alley's opinion as to what constitutes an "objective finding" is not relevant, if the requirements of ORS 656.005(19) are otherwise met. See Catherine Gross, 48 Van Natta 99 (1996). Since Dr. Alley's August 27, 1996 report was based on the legal definition of "objective findings," we conclude that it is the most probative evidence in this record and establishes the presence of "objective findings" on October 23, 1995.

Here, the circumstances of claimant's injury claim are uncomplicated. Claimant performed intensive physical work for the employer on October 16, 1995. Claimant immediately experienced low back pain as a result of the "dumping" incident. Claimant provided unrebutted testimony that he promptly informed his supervisor of his injury. (Tr. 7). The record does not indicate that claimant has a preexisting condition, and there is no expert medical evidence that the alleged work events could not have been the cause of the injury.

Although claimant did not begin treatment with Dr. Alley until October 23, 1995, claimant credibly testified that he hoped that his back pain would subside on its own, but when it did not, the employer referred him to Dr. Alley. (Tr. 8). There is no indication of an off-the-job injury or explanation for claimant's back pain, and Dr. Alley's records do not refer to functional overlay or exaggerated complaints. Because the circumstances of claimant's injury do not raise any of the factors requiring expert medical evidence as enumerated in Uris or Barnett, we conclude that expert medical evidence regarding the cause of claimant's back strain is not required. Cf. Martin Mendoza, 48 Van Natta 586 (1996) (expert medical evidence not required even though no treatment sought until 6 days after alleged work incident).

Consequently, we find that claimant has established a material connection between his low back condition and the alleged October 16, 1995 incident. Therefore, we set aside the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review for prevailing over the insurer's denial is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this 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.

Penalties and Attorney Fees

The ALJ declined to award penalties or attorney fees because of an allegedly unreasonable denial, concluding that, since the insurer's denial had been upheld, there were 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. Inasmuch as we have now set aside the insurer's May 22, 1996 denial, we must address the issue of whether it was unreasonably issued.

The reasonableness of a denial is determined on the basis of whether the carrier had a "legitimate doubt" about its liability for a claim based on information available at the time of the denial. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). In this case, we conclude that the insurer had a "legitimate doubt" about its liability, given claimant's delay in seeking medical treatment and the lack of affirmative medical evidence that related claimant's low back condition to his employment. Moreover, until Dr. Alley confirmed "post-denial" that claimant demonstrated reduced range of motion on October 23, 1995, it was not clear from that chart note whether claimant had "objective findings" to support his claim. Under these circumstances, we are persuaded that the insurer's denial was reasonably issued. Therefore, we affirm the ALJ's decision declining to award penalties or attorney fees.

ORDER

The ALJ's order dated September 27, 1996 is reversed in part and affirmed in part. That portion which upheld the insurer's denial is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,500, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
DONALD L. GRANT, Claimant
WCB Case No. 92-06280
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board en banc.[1]

Albany Retirement Center (Albany), a noncomplying employer, requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) held that Albany's hearing request was null and void; (2) found that the SAIF Corporation's acceptance of claimant's claim was appropriate; (3) found that the Hearings Division lacked jurisdiction to grant Albany's request for equitable relief; and (4) awarded a $12,500 attorney fee under ORS 656.382(2). On review, the issues are jurisdiction, compensability, equitable estoppel 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

Validity of Hearing Request

Albany, a corporation, has challenged SAIF's acceptance on its behalf of claimant's claim for a right heel injury. Albany filed its hearing request in this matter while not represented by an attorney. The ALJ concluded that Albany's hearing request was void under ORS 9.320, since the hearing request was not filed by an attorney. We disagree.

ORS 9.320 provides:

> "Any action, suit, or proceeding may be prosecuted or defended by a party in person, or by attorney, except that the state or a corporation appears by attorney in all cases, unless otherwise specifically provided by law. Where a party appears by attorney, the written proceedings must be in the name of the attorney, who is the sole representative of the client of the attorney as between the client and the adverse party, except as provided in ORS 9.310."

In Allen Ehr, 47 Van Natta 870 (1995), we addressed whether a claim disposition agreement (CDA) must be signed by an attorney on behalf of an insurer which was a corporation. We concluded that the pivotal inquiry was whether the submission of a CDA constituted an "action, suit or proceeding" for purposes of ORS 9.320. We held that a contested case "hearing" was a proceeding, and that the concern over representation arises where the layperson is participating in activities such as cross-examining witnesses and making evidentiary objections. On that basis, we found that a CDA did not involve a contested case hearing and was not a "proceeding" requiring attorney representation.

In our prior decision in this matter, Donald L. Grant, 47 Van Natta 816 (1995), we found that, although Albany's representative was not an attorney and could not proceed under ORS 9.320 with a hearing on Albany's behalf, the representative could "appear" for the purpose of obtaining a continuance in order to have sufficient time to secure legal counsel. We reasoned that to deny Albany a hearing for failure to retain an attorney representative, when it received no prior notice of the necessity to do so, would not be consistent with our notion of substantial justice.

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[1] Board Member Moller has recused himself from participation in the review of this case. OAR 438-011-0023.

Under ORS 9.320, a non-attorney may not represent a corporation in "any action, suit, or proceeding." Prior to the filing of a hearing request[2] in a workers' compensation matter, there is no "proceeding." Allen Ehr, 47 Van Natta at 870. Thus, we find that the filing of a hearing request is analogous to the pre-hearing actions in Ehr and in our prior decision in Grant, which precede the actual commencement of a contested case "proceeding." Moreover, we note that filing of a hearing request does not result in the layperson participating in pre-hearing motions or activities such as examining witnesses or making evidentiary objections. Accordingly, we find that ORS 9.320 does not bar the filing of a hearing request by an unrepresented corporation.[3] However, we note that once a hearing request has been filed under ORS 656.283(1), a corporation may not proceed with litigation of its hearing request without an attorney.

Compensability

In finding claimant's right heel condition compensable, the ALJ relied on the opinion of Dr. Murphy, a podiatrist who treated claimant's right heel condition. We adopt that portion of the ALJ's order which finds claimant's right heel condition is compensable and was properly accepted by SAIF. We add the following supplementation.

Albany argues that Dr. Murphy's opinion is unpersuasive because the doctor was unaware how long claimant had been obese and based his opinion on a temporal association. Albany also argues that there are no objective findings supporting claimant's claim.

First, based on his deposition testimony, Dr. Murphy believed that claimant's obesity was longstanding. (Ex. 46-14, 17). Albany does not assert that this is not true. Although Dr. Murphy did not specifically know how long claimant had been obese, he was aware that this condition had existed for some time. Furthermore, Dr. Murphy also stated that he had considered claimant's obesity in coming to his conclusions regarding causation. Under such circumstances, we do not find that Dr. Murphy's history was incorrect.

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[2] We note that ORS 656.283(1) allows any "party" to request a hearing at any time. "'Party' means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." ORS 656.005(21). Thus, ORS 656.283(1) contemplates the filing of a hearing request by an employer.

[3] In reaching his decision that the request for hearing was null and void, the ALJ cited several cases. For the following reasons, we find those cases distinguishable.

In Oregon Peaceworks Green, PAC, v. Secretary of State, 311 Or 267 (1991), the Court held that a non-attorney could not represent an unincorporated political action committee before state courts. The Court's opinion discussed the interaction between ORS 9.160, which prohibits non-attorneys from practicing law and ORS 9.320, which contains an exception to ORS 9.160 allowing a person to represent himself. The Court held that a non-attorney violated ORS 9.160 by representing others before the state courts. Because it decides an issue that is different from the one presently before us, Oregon Peaceworks is not helpful.

Likewise, State ex rel. Juvenile Dept. of Lane County v. Shuey, 119 Or App 185 (1993) is also inapposite. Shuey held that ORS 9.320 was preempted by a federal law allowing Indian tribes to intervene in child custody proceedings involving Indian children.

Finally, we also conclude that Te-Ta-Ma Truth Foundation--Family of Uri, Inc. v. Vaughn, 114 Or App 448 (1992) is distinguishable. There, the plaintiffs' complaint in intervention in a prior action had been struck by the trial court and the case dismissed with prejudice partly because a non-attorney attempted to represent the plaintiffs, one of which was a corporation. The plaintiffs brought a second action and their claims in the second action duplicated those in the earlier action. The court's opinion notes that the plaintiffs' complaint in the first action had been struck by the trial court in part because the plaintiffs were not ready to proceed on their complaint because they had failed for over a year to obtain new counsel. The court held that res judicata barred the plaintiff's second action. The court rejected the plaintiffs' arguments that the time for filing the new action was extended by ORS 12.220.

Here, unlike in Vaughn, Albany obtained counsel in a timely manner after receiving notice that, as a corporation, ORS 9.320 required it to be represented by an attorney in order to proceed. In addition, the propriety of the trial court's dismissal of the complaint in the first action was not the issue before the court in Vaughn. Accordingly, we do not find that Vaughn requires dismissal of the hearing request.

Next, Albany asserts that Dr. Murphy's opinion is based solely on the temporal relationship between moving the tables at work and the onset of claimant's symptoms. While it is true that Dr. Murphy relied on the timing of the symptoms, he also considered and ruled out other potential factors such as claimant's obesity and calcaneal spurs. (Ex. 46-19).

Finally, Albany argues that claimant had no objective findings of injury. According to Dr. Murphy, claimant had objective findings. (Ex. 46-18). In addition, a review of Dr. Murphy's records shows that claimant had an antalgic gait and pain in a particular location (centered over the plantar medial heel). We find that such findings meet the requirements of ORS 656.005(19)[4] because they are verifiable indications of injury or disease which are observable. See Tony D. Houck, 48 Van Natta 2443 (1996).[5]

After reviewing this record, we agree with the ALJ's conclusion that claimant established compensability of his right plantar fascitis condition based on Dr. Murphy's opinion. Thus, we find that SAIF's acceptance of the claim was appropriate.

Equitable Relief/Estoppel

We adopt the ALJ's discussion of this issue with the following supplementation.

Albany, a noncomplying employer, seeks equitable relief in an effort to bar the Department of Consumer and Business Services (Department) from recovering claim costs under ORS 656.054(1).

First, this issue is not ripe since there is no evidence that the Department has yet attempted to recover any costs from Albany. Secondly, this matter is not a matter concerning a claim that is within the Board's jurisdiction since the claimant's right to compensation is not directly at issue. See ORS 656.704(3) (Board's authority limited to "matters concerning a claim" which are defined as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue").

Attorney Fee

The ALJ awarded an attorney fee of $12,500 to claimant's counsel. Albany first argues that claimant is not entitled to an attorney fee and also argues that, if an attorney fee is appropriate, the $12,500 fee was excessive.

Albany asserts that claimant is not entitled to an attorney fee under ORS 656.382(2) because his compensation was not at risk as a result of Albany's request for hearing. We disagree.

Here, the noncomplying employer, Albany, has challenged SAIF's acceptance of claimant's claim. If the noncomplying employer were to prevail and SAIF's claim acceptance were set aside, SAIF would no longer have a duty to process the claim. See Lasiter v. SAIF, 109 Or App 464 (1991). Thus, we conclude that claimant's compensation was placed at risk by Albany's challenge to SAIF's acceptance. Accordingly, we find that an attorney fee under ORS 656.382(2) is appropriate.

We now address Albany's contention that the amount of the fee awarded by the ALJ was excessive. OAR 438-015-0010(4) sets forth the following factors considered in determining a reasonable fee: (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.

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[4] 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."

[5] Although obligated to follow the majority's holding in Houck, Member Haynes directs the parties' attention to her dissenting opinion in Houck.

After review of the hearing record and considering the above factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that $12,500, is a reasonable fee. We note that this fee is for services in finally prevailing after three remands to the hearing level and for services on Board review on those prior occasions. ORS 656.388(1). In reaching our conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs regarding the Board's prior reviews), the complexity of the issue, and the value of the interest involved.

Because claimant's compensation was also at risk on Board review, claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,000, payable by SAIF, on behalf of Albany, the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review devoted to the ALJ's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 15, 1996 is affirmed and reversed in part. That portion of the ALJ's order which dismissed Albany's request for hearing is reversed. The hearing request is reinstated. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded $2,000, payable by SAIF, on behalf of the noncomplying employer.

Board Chair Hall specially concurring.

Although I agree that a corporation can file a hearing request without "appearing" through an attorney, I base my conclusion on reasoning which is different than that expressed in the lead opinion.

ORS 9.320 provides, in part, that: "Any action suit or proceeding may be prosecuted or defended by a party in person, or by attorney, except that the state or a corporation appears by attorney in all cases unless otherwise specifically provided by law." ORS 656.283(1) allows any "party" to request a hearing on any matter concerning a claim. The statutory definition of a "party" includes the employer. ORS 656.005(21). Surely ORS 656.005(21) contemplates employers which are incorporated. Thus, ORS 656.283(1) provides an exception to ORS 9.320 ("unless otherwise specifically provided by law") whereby the incorporated employer may make an initial appearance without an attorney by requesting a hearing. On the basis of this reasoning, I concur with the lead opinion's ultimate conclusion.

March 10, 1997 Cite as 49 Van Natta 253 (1997)

In the Matter of the Compensation of
BONNIE L. TURNBULL, Claimant
Own Motion No. 96-0148M
OWN MOTION ORDER OF ABATEMENT
Daniel M. Spencer, Claimant Attorney
Alice Bartlett (Saif), Defense Attorney

Claimant requests reconsideration of our February 10, 1997 Own Motion Order, in which we declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she 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. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHAWN P. HAROLD, Claimant
WCB Case Nos. 93-10705 & 93-05259
ORDER ON REMAND
Darris K. Rowell, Claimant Attorney
Alice Bartelt (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. SAIF v. Harold, 142 Or App 204 (1996). The court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's headaches, dizziness, and conversion disorder conditions. Citing Volk v. America West Airlines, 135 Or App 565 (1995), the court has remanded for reconsideration in light of the 1995 statutory amendments.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, as corrected by our April 5, 1995 Order on Review.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

On Friday, January 19, 1993, claimant suffered a compensable head injury, when a two and a half pound heat defuser grate fell about 20 feet and struck his head. He began having headaches soon thereafter and treated with ibuprofen.

Claimant returned to work the following Monday. Claimant's wife and co-workers noticed that claimant's speech was somewhat slurred. During the next month, claimant's speech problems worsened gradually. He complained of dizziness and continuing headaches and began experiencing "twitches," which he described as seizures.

Claimant first sought medical treatment for these problems on February 12, 1993. A CT scan and MRI were normal, except that claimant had a right-sided sinus condition.

By late March 1993, claimant was having profound difficulties with speaking (he could not speak even a single syllable), walking, and standing erect. Claimant's wife observed claimant having "twitches." Dr. Tindall provided psychological counseling.

On April 27, 1993, SAIF issued a denial of claimant's speech problems, seizures, dizziness and headaches.

The ALJ analyzed claimant's dizziness and headaches as direct consequences of the work injury and concluded that they were compensable under the material contributing cause standard of proof. The ALJ determined that claimant's conversion disorder (including his speech problems and "seizures") were properly analyzed as indirect consequences of the work injury. The ALJ concluded that the latter condition(s) were compensable under the major contributing cause standard of proof. See ORS 656.005(7)(a)(A).

On review, we adopted and affirmed the ALJ's order. SAIF requested judicial review. While this matter was pending before the court, the 1995 legislature amended the Workers' Compensation Law. The court has remanded this matter for reconsideration in light of Senate Bill 369. Consistent with the court's mandate, we proceed with our reconsideration.

The issue on remand is whether claimant's headaches, dizziness, and conversion disorder conditions (including speech problems, "seizures," and ongoing headaches and dizziness) are compensable.

SAIF argues that claimant must prove that his work injury is the major contributing cause of his condition under ORS 656.005(7)(a)(A) or (B). In this regard, SAIF contends that claimant had a preexisting psychological condition which was the major contributing cause of his current conditions. Alternatively, SAIF argues that claimant's problems are at best only indirectly related to his head injury and the injury was not their major cause. We disagree with SAIF's contentions.

ORS 656.005(7)(a)(A) provides: "No injury is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). ORS 656.005(7)(a)(B) provides that where a compensable injury combines with the preexisting condition, the injury is not compensable unless the "otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition." ORS 656.005(24) provides: "'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease. . . ."

At the outset, we disagree with claimant's argument that the compensability of his dizziness condition is not before us on remand because SAIF's sole contention before the court was that the case should be remanded for application of the 1995 statutory amendments. Inasmuch as this matter has been remanded to us for reconsideration, our previous order is a nullity. See Kim D. Wood, 48 Van Natta 482, 483 n.1 (1996). Accordingly, we address the issues raised at hearing, beginning with the compensability of the headache condition.

Application of the 1995 statutory amendments does not affect our previous conclusion regarding SAIF's denial of claimant's initial headaches, because we continue to conclude that the work injury caused them directly. See ORS 656.005(7)(a); Gasperino, 113 Or App at 411. Moreover, insofar as claimant's subsequent symptoms or conditions, including dizziness, were indirect, rather than direct results of the compensable injury, we find that they are compensable under ORS 656.005(7)(a)(A), based on a preponderance of the persuasive medical evidence.

The opinions of Drs. LaFrance, Smucker, Crossen, and Tindall persuasively establish that claimant's condition was an indirect consequence of his work injury once neurological and physiological causes for claimant's continuing problems were ruled out and the injury-related conversion disorder diagnosis emerged (and explained claimant's speech problems, "seizures," and ongoing headaches and dizziness). (See Exs. 15-12, 15A, 15B-5, 15C, 18, 19, 20, 21). See ORS 656.005(7)(a)(A).[1] Based on the same medical evidence, we agree with the ALJ that claimant has proven that his work injury was the major contributing cause of his conversion disorder condition (including symptoms other than the initial headaches). (Id.). See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, we adopt the ALJ's reasoning and conclusions on the merits, as supplemented above, except for the findings and discussion related to claimant's "predisposition" on page 14.[2]

Claimant has finally prevailed after remand. Under the circumstances, he is entitled to a reasonable attorney fee for services before every prior forum. See ORS 656.388(1). Since claimant's counsel provided services at hearing, on Board review, before the court and on remand before the Board, a reasonable fee for such efforts shall be awarded.

We first note that neither party objected to the ALJ's $7,000 attorney fee award or our prior $2,400 attorney fee award. Accordingly, those awards are republished. In addition, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services before the court and before the Board on remand is $5,000, 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 amended petition for attorney fees), the complexity of the

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[1] We do not find that claimant had a predisposition or a preexisting condition which contributes to his current problems. (Predispositions are included within the definition of preexisting conditions under amended ORS 656.005(24).) The evidence arguably supporting a such a conclusion is provided primarily by Drs. Turco and Binder. (See also Ex. 25). Dr. Turco noted claimant's turbulent adolescence and opined that claimant had a preexisting personality disorder which was the major cause of his current conversion disorder. (Ex. 16). Dr. Binder opined that claimant must have a preexisting condition in order to suffer a conversion reaction. (See Ex. 29-15). However, claimant had at least 10 years without psychological problems before his head injury. Thus, because Drs. Turco and Binder's assumptions and conclusions are inconsistent with claimant's history, we conclude that they are not persuasive. (See e.g., Exs. 11A,18, 19, 20, 21). See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Accordingly, ORS 656.005(7)(a)(B) does not apply.

[2] We acknowledge claimant's constitutional and "Americans with Disabilities Act" arguments against retroactive application of the 1995 statutory amendments. However, we need not address those arguments, because we conclude herein that the statutory changes do not affect the outcome in this case.

issues, the value of the interest involved, and the risk that counsel may go uncompensated.[3] We have also taken into consideration claimant's unsuccessful efforts regarding the motion to dismiss and motion for sanctions before the court, as well as his unsuccessful contention on remand that we are not authorized to reconsider the compensability of his dizziness condition.

Accordingly, on reconsideration, we republish our April 5, 1995 order that affirmed the ALJ's August 19, 1994 order, as modified and supplemented herein. In addition to the ALJ's $7,000 attorney fee award and our prior $2,400 attorney fee award for services before the appellate court and on remand, claimant's attorney is awarded a $5,000 attorney fee, payable by the SAIF Corporation.

IT IS SO ORDERED.

[3] We have not used claimant's counsel's "contingency multiplier" in a strict mathematical sense; i.e., we have not simply multiplied claimant's counsel's hourly fee by the contingency factor. Rather, in conjunction with the other relevant factors, the risk that claimant's counsel might go uncompensated for his services has been factored into our overall determination of a reasonable attorney fee for efforts devoted to the compensability issues. In arriving at such a determination, we have also taken into consideration claimant's above-described unsuccessful efforts on some issues.

In the Matter of the Compensation of
MELVIN A. MELTON, Claimant
WCB Case Nos. 96-01545, 95-13549 & 95-04150
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Liberty Northwest Insurance Corporation requests review of that portion of Administrative Law Judge (ALJ) Howell's order that: (1) set aside its denial of claimant's occupational disease claim for her right wrist arthritic condition and consequential right carpal tunnel syndrome and ganglion cyst conditions; and (2) upheld the SAIF Corporation's denial of claimant's claim for the same conditions. On review, the issues are compensability and responsibility. We affirm.

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

On review, Liberty first contends that the ALJ incorrectly found that claimant had established a compensable occupational disease claim. Liberty argues that, pursuant to ORS 656.802(1)(C), claimant has not shown that he has been exposed to a series of "traumatic events or occurrences" at work which caused his arthritis condition. We disagree.

The ALJ found that claimant had experienced numerous incidents at work involving his right wrist. Dr. Wilson explained that claimant's arthritis was caused by "multiple" incidents or "histories" of work activities which involved getting "hit all the time" or falling on his wrist, which would result in a ligament tear and arthritis. (Ex. 39A-10). We conclude that claimant's testimony and Dr. Wilson's explanation sufficiently establish that claimant was exposed to a series of traumatic events or occurrences at work which caused his arthritis. ORS 656.802(1)(C).

Liberty next argues that Dr. Becker and the doctors who examined claimant on behalf of the insurer, Drs. Dordevich and Fuller, provided the most persuasive opinion with respect to the issue of causation. However, we agree with the ALJ, for the reasons stated in his "Conclusion," that Dr. Wilson, claimant's treating surgeon, provided the most well-reasoned and persuasive expert medical opinion in this case.

With respect to the issue of compensability of claimant's right ganglion cyst, Liberty argues that, in 1993, claimant entered into a Disputed Claim Settlement (DCS) in which claimant agreed that his ganglion cyst was not compensable. Accordingly, Liberty argues that, because claimant's current ganglion is the same ganglion that was present in 1993, claimant cannot establish compensability against Liberty.

We conclude that the ALJ properly found the current ganglion cyst compensable as a consequence of claimant's compensable arthritis condition. Dr. Wilson explained that although claimant's second ganglion was located in the same area as the previous cyst, it was "really a different ganglion...As a matter of fact, the other ganglion was taken out surgically....". (Ex. 39-62A). Accordingly, we do not agree that the current ganglion is the same one that was settled by the 1993 DCS. Therefore, the ALJ correctly concluded that the DCS did not preclude litigation of the second ganglion condition.

Finally, Liberty argues that the ALJ incorrectly applied ORS 656.308 in assigning responsibility for claimant's condition. Liberty contends that it originally accepted a right carpal tunnel condition, and claimant's current condition is arthritis. Therefore, Liberty argues that it is not proper to apply ORS 656.308(1) which only applies when the new injury or occupational disease involves the "same condition" as the one previously accepted.

We conclude that, regardless of whether ORS 656.308(1) applies, Liberty is responsible for claimant's condition. As SAIF notes, it is not necessary to rely on the last injurious exposure rule for determining responsibility in cases where actual causation is established with respect to a specific employer. Runft v. SAIF, 303 Or 493 (1987); Eva R. Billings, 45 Van Natta 2142 (1993). Here, Dr. Wilson has explained that the major contributing cause of claimant's arthritis condition was his work activities caused by successive injuries, prior to the time that SAIF was on the risk. (Ex. 39A-55). Accordingly, we find that, whether the case is analyzed pursuant to ORS 656.308(1) or an "actual causation" analysis, Liberty is responsible for claimant's right wrist condition.

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

ORDER

The ALJ's order dated July 19, 1996 is affirmed. For services on review, claimant's counsel is awarded an asssessed attorney fee of $1,000, to be paid by Liberty Northwest.

March 11, 1997 Cite as 49 Van Natta 257 (1997)

In the Matter of the Compensation of
JAMES D. ORTNER, Claimant
Own Motion No. 96-0543M
SECOND INTERIM OWN MOTION ORDER
CONSENTING TO DESIGNATION OF PAYING AGENT UNDER ORS 656.307
Welch, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

The self-insured employer, Johnston & Culberson, Inc., requests reconsideration of our February 14, 1997 Interim Own Motion Order Consenting to Designation of Paying Agent pursuant to ORS 656.307 in claimant's 1987 injury claim. The employer specifically requests that the Board "withdraw that portion of the order that requested the self-insured employer to pay temporary disability benefits." The employer contends that the Board was unaware that claimant has a 1974 injury claim with the SAIF Corporation, and that the Board should "issue an Amended Interim Order requesting that the Department designate a paying agent consistent with ORS 656.307 and the Department's own rules." The request is denied.

On November 14, 1996, Johnston & Culberson submitted to the Board claimant's request for temporary disability compensation for his right medial meniscal injury. Claimant's aggravation rights on that claim expired on January 19, 1993. The employer recommended that the Board deny authorization of the reopening of claimant's 1987 injury claim for the payment of temporary disability compensation, contending that it was not responsible for claimant's current right lateral meniscus condition.

On December 19, 1996, the SAIF Corporation also submitted to the Board claimant's request for temporary disability compensation for his compensable right knee strain injury. Claimant's aggravation rights on his 1974 injury claim with SAIF expired on March 24, 1981. Thus, claimant's 1974 injury claim is also subject to ORS 656.278. SAIF denied responsibility for claimant's current right knee condition.

On February 12, 1997, the Benefits Section of the Workers' Compensation Division notified the Board that it was prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. In its February 12, 1997 letter, the Department acknowledged that both claimant's 1974 and 1987 claims are subject to ORS 656.278 and the Board's Own Motion authority. Therefore, the Department requested that the Board consider both requests, and decide whether, "on its Own Motion, [the Board] will consent to this Order [issued by the Department]."

Because the record established that claimant's current condition requires surgery, and, thus, has met the requirements of ORS 656.278 for authorization of temporary disability compensation, we concluded that claimant would be entitled to own motion relief if either of the own motion carriers should be ultimately responsible for the payment of compensation. See Gary W. Yeager, Sr., 48 Van Natta 2293 (1996); Steven M. Rossiter, 47 Van Natta 34 (1995); Robyn Byrne, 47 Van Natta 213 (1995). Thus, under OAR 438-012-0032, we notified the Benefits Section that we consented to an order designating a paying agent in either claim, and we issued two separate Interim Own Motion Orders consenting to the Department's order designating a paying agent.

Our orders acknowledged respectively that, if either Johnston & Culberson or SAIF was found to be responsible for claimant's current condition, we authorized ("consented to") the Department's decision to designate a paying agent to pay interim temporary disability compensation to claimant beginning the date claimant undergoes surgery. Finally, our February 14, 1997 orders contained no appeal rights, as those orders did not require action by a carrier, but merely allowed the Department to choose the appropriate own motion carrier to pay interim compensation.

Each of our February 14, 1997 orders verified that the subject claim had met the statutory requirements for authorization of temporary disability compensation under ORS 656.278, and that we "consented" to the designation of either carrier to pay interim compensation. However, as our orders further noted, an order authorizing interim compensation is not a final order or decision authorizing a reopening of either claim under ORS 656.278 and the Board's rules. (See first complete paragraph on page 2 of February 14, 1997 order.) Rather, our orders specify that it is the Department's decision as to which carrier, if any, it will assign the designation as paying agent for temporary disability compensation.

Johnston & Culberson mistakenly assumes that we issued only one order consenting to the designation (by the Department) of a paying agent under ORS 656.307. However, as we have noted, on February 14, 1997, we issued two separate orders, one addressing the 1974 SAIF claim, and the other addressing the 1987 Johnston & Culberson claim. Both of our February 14, 1997 orders specifically consented to the designation of a paying agent in this matter.

Furthermore, Johnston & Culberson contends that, following the issuance of our "order," the Department issued its order, in which the Department indicated that the Workers' Compensation Board "has declined to provide consent for an Order pursuant to ORS 656.307 for temporary disability benefits." In the event that the Department interpreted our orders as denying consent in one or both claims, that is an incorrect interpretation. Because our orders specifically consented to a Department order to designate the payment of interim temporary disability compensation, the Department may have other reasons for declining to authorize interim compensation.[1] Johnston & Culberson assumes that we

[1] We cannot comment on the particular reason for the Department's refusal to designate a carrier for the payment of interim temporary disability compensation. Our jurisdiction is confined to our authority under ORS 656.278 to authorize temporary disability compensation in those claims where aggravation rights have expired. However, payment of temporary disability compensation in qualifying claims can only begin on the date the claimant undergoes surgery or enters the hospital for inpatient hospitalization. ORS 656.278(1)(a). Furthermore, the Department does not have authority to order the payment of interim compensation unless claimant has currently met the requirements of ORS 656.278. Therefore, because we are unaware whether claimant has undergone surgery, the Department may decline to pay interim compensation until such time as claimant qualifies for such payments pursuant to ORS 656.278. See Lewis W. Standiford, 48 Van Natta 130 (1996).

have the authority to require the Department to "reconsider" its decision regarding the designation of a paying agent. However, the Board, in its Own Motion jurisdiction, does not have authority to choose which own motion carrier, if any, should be assigned that designation under ORS 656.307. Therefore, Johnston & Culberson's request for reconsideration should be directed to the Workers' Compensation Division for further consideration of its Order.

Accordingly, we withdraw our February 14, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our February 14, 1997 order in its entirety. The parties' rights of reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

March 12, 1997 Cite as 49 Van Natta 259 (1997)

In the Matter of the Compensation of
SHIRLEY J. COOPER, Claimant
WCB Case No. 96-00067
ORDER ON REVIEW
Henry C. Declerck, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that dismissed her hearing request for failure to appear at the hearing. On review, the issue is dismissal.

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

Although it does not appear that claimant is requesting a remand of this matter to the ALJ for a hearing on the merits, insofar as claimant's October 8, 1996 letter[1] could be construed as such a request, the request is denied for the following reasons.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. In order to satisfy this standard, the moving party must show that additional evidence is reasonably likely to affect the outcome of this case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, claimant has not made a showing that additional evidence is likely to affect the outcome of this case. It is undisputed that claimant failed to appear, and therefore waived appearance, at the scheduled hearing. OAR 438-006-0071(2) provides that "[i]f the party that waives appearance is the party that requested the hearing, the [ALJ] shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing." In claimant's letter, she has asserted no allegations which would support a finding of extraordinary circumstances to justify a postponement or continuance of the hearing. Under these circumstances, we conclude that the ALJ's dismissal was appropriate under OAR 438-006-0071(2).[2]

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[1] It does not appear that the SAIF Corporation was copied with claimant's October 8, 1996 letter. Therefore, a copy of the letter is enclosed with SAIF's copy of this order.

[2] We recognize that we have in other cases remanded to an ALJ to rule on a "post-dismissal order" request for postponement. See Jennie S. Debelloy, 49 Van Natta 134 (1997) (remand appropriate to rule on postponement motion where the claimant submitted a letter requesting review of ALJ's order, alleging that her failure to attend hearing was on advice of legal counsel); Mark Totaro, 49 Van Natta 69 (1997) (remand appropriate to consider "Motion to Postpone" when the claimant contended that ALJ's order was "erroneous" and that "injustice would result" if the ALJ's order was not reversed). However, claimant in this case has not offered any explanation concerning her failure to appear at the hearing. Under these circumstances, we find no compelling reason to remand to the ALJ for further proceedings. See James C. Crook, 49 Van Natta 65 (1997) (no compelling reason to remand when the claimant offered no explanation or argument concerning his failure to appear at hearing).

ORDER

The ALJ's order dated September 17, 1996 is affirmed.

March 12, 1997 Cite as 49 Van Natta 260 (1997)

In the Matter of the Compensation of
CURTIS K. JOY, Claimant
WCB Case Nos. 96-04417, 96-02385, 96-02310 & 95-11616
ORDER ON REVIEW
Jolles, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys
John E. Snarskis, Defense Attorney
Reinisch, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation, on behalf of Rapid Auto Glass, requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for bilateral Raynaud's syndrome; and (2) upheld the responsibility denials issued by SAIF (on behalf of Gresham Glass, Inc.), Industrial Indemnity Company (on behalf of Washington Glass, Inc.) and EBI Insurance Company (on behalf of Washington Glass, Inc.) for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. After the sixth sentence of the second paragraph on page 2, we add: "Claimant used a pneumatic air knife while employed at Rapid Auto Glass."

CONCLUSIONS OF LAW AND OPINION

Claimant is an auto glass installer who began using a pneumatic air knife in approximately 1988 to install automobile glass. In August 1995, claimant filed a claim for Raynaud's syndrome with SAIF's insured, Rapid Auto Glass (SAIF/Rapid). (Ex. 17). On September 11, 1995, SAIF/Rapid issued a denial of compensability[1] and responsibility for claimant's bilateral hand condition. (Ex. 19). The denial notified claimant that he might want to file other claims against other potentially responsible carriers. Claimant filed claims against three other carriers, which were joined in the proceeding.

At hearing, claimant testified that he began working for Heritage Glass Service in approximately April 1996. (Tr. 37-38). Claimant said that, although he used the pneumatic tool at that employment as little as possible, his symptoms were worse. (Tr. 41-42). Heritage Glass Service was not joined in the present proceeding.[2]

The ALJ found that the medical evidence established that all of claimant's use of the pneumatic vibrating tool at work contributed to his current condition of Raynaud's syndrome. The ALJ determined that the "onset of disability" was in 1989, when claimant was working for Industrial Indemnity Company's insured, Washington Glass, Inc. (Industrial Indemnity). The ALJ shifted responsibility forward to SAIF/Rapid. Although SAIF/Rapid argued that a carrier subsequent to claimant's employment with Rapid Auto Glass was responsible, the ALJ rejected that argument because SAIF/Rapid raised the contention for the first time in closing argument. Moreover, the ALJ noted that SAIF/Rapid had not requested that any subsequent employer be joined as a party and it had not requested a continuance to join a subsequent employer.

[1] At the beginning of the hearing, SAIF/Rapid conceded compensability.

[2] In his respondent's brief, claimant notes that, after the ALJ issued the order in this case, he filed timely occupational disease claims against Heritage Glass Service, as well as another employer.

SAIF/Rapid argues that the ALJ erred in concluding that it could not contend that a subsequent employer was responsible for claimant's condition. Citing amended ORS 656.308(2)(b), SAIF/Rapid argues that since it properly and timely denied responsibility for claimant's condition, it was entitled to seek responsibility against any of claimant's other employers, even if not joined in this action.

Claimant, EBI Insurance Company, on behalf of Washington Glass, Inc. (EBI) and Industrial Indemnity argue that since SAIF/Rapid raised the argument regarding a subsequent employer for the first time in closing argument, that issue should not be considered by the Board. In addition, claimant, EBI and Industrial Indemnity contend that, since SAIF/Rapid did not issue an amended denial pointing to a subsequent responsible party or request a continuance so that another employer could be joined as a necessary party, SAIF/Rapid implicitly waived its right to argue that a non-party was responsible for claimant's condition.

Even if we assume that SAIF/Rapid did not waive its right to argue that a subsequent carrier was responsible and we assume, without deciding, that ORS 656.308(2) does not preclude SAIF/Rapid from raising this argument, we do not consider SAIF/Rapid's argument because it was raised for the first time in closing argument.

There is no evidence in the record to suggest that SAIF/Rapid or any other carrier was aware of another potentially responsible employer until claimant testified at the May 22, 1996 hearing. Therefore, SAIF/Rapid could not have raised this argument until after claimant testified. At the request of SAIF/Rapid, the deposition of Dr. Edwards was taken on June 18, 1996. The record was closed after the hearing reconvened for closing arguments on August 29, 1996. None of the parties dispute the ALJ's finding that SAIF/Rapid raised the argument that a subsequent carrier was responsible in closing argument.

We have consistently held that we will not consider issues raised for the first time in closing argument. See e.g., Lawrence E. Millsap, 47 Van Natta 2112 (1995). Although SAIF/Rapid's argument could be characterized as a different theory of responsibility rather than an entirely new "issue," claimant would be prejudiced if we resolve this case by considering whether employers subsequent to SAIF/Rapid could be responsible. In previous cases, we have held that responsibility cannot be assigned to a non-joined carrier. See Jon O. Norstadt, 48 Van Natta 253, on recon 48 Van Natta 1103 (1996); Kristin Montgomery, 47 Van Natta 961 (1995). The parties litigated this case and submitted medical evidence to address the responsibility of the joined carriers. To decide the case by considering the potential responsibility of a non-joined carrier would be fundamentally unfair, and we decline to do so.[3] See, e.g., Lawrence E. Millsap, supra; Gunther H. Jacobi, 41 Van Natta 1031 (1989).

We proceed to address the issue of responsibility. The "last injurious exposure rule" provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

The ALJ found that the "onset of disability" was in 1989 when claimant was employed by Industrial Indemnity's insured, Washington Glass, Inc. The ALJ found, and the parties do not dispute, that responsibility was initially assigned to Industrial Indemnity. SAIF/Rapid argues, however, that the ALJ erred in concluding that the medical evidence established that responsibility should be shifted to SAIF/Rapid. SAIF/Rapid asserts that claimant's work activities for Rapid Auto Glass did not independently contribute to a worsening of claimant's underlying Raynaud's syndrome.

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[3] Rather than raising the argument about a subsequent carrier at closing argument, SAIF/Rapid could have argued that a subsequent carrier was responsible after claimant testified about "post-denial" employments. At that point, claimant could have decided whether to file a claim against other carriers and to request a continuance to join other carriers.

In light of our disposition, we need not address Industrial Indemnity's argument regarding SAIF/Rapid's stipulation at hearing that responsibility was the only issue.

In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must have actually contributed to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245, 249 (1995); see Bracke, 293 Or at 250 ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer").

Claimant began working for SAIF/Rapid about July 1995 and worked there for approximately one month. (Tr. 46, 48). Claimant testified that he used his pneumatic knife "three or four times" during his employment at Rapid for a total time of approximately "[a]n hour and a half."[4] (Tr. 23).

Dr. Sultany reported that Raynaud's syndrome can be caused by recurrent use of vibrating tools. (Ex. 27-3). He concluded that claimant's use of vibrating tools was the major cause of his current condition. Dr. Sultany commented that "all the use of vibrating tools contributes to the pathological worsening of [claimant's] condition." (Id.)

In a later report, Dr. Sultany noted that claimant's employment at Rapid Auto Glass was fairly brief, working there for approximately one month. (Ex. 37). Although Dr. Sultany reported that this short duration of activity might not have caused a "significant exacerbation" of his underlying Raynaud's phenomenon, a "significant exacerbation" is not required in order to shift responsibility to a later carrier. Rather, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke, 293 Or at 250. Dr. Sultany stated that the "continuation of using this tool, even through a short duration at Rapid Auto Glass, could contribute to his problems." (Ex. 37). Although not couched in terms of medical probability, Dr. Sultany indicated that claimant's employment at Rapid Auto Glass contributed to the underlying Raynaud's syndrome.

Dr. Edwards is board-certified in general surgery and vascular surgery and heads the Raynaud's clinic at the Oregon Health Sciences University. (Ex. 43-7). Dr. Edwards reported that claimant's use of vibrating tools at work was the major contributing cause of the Raynaud's syndrome. (Exs. 28, 31, 41, 42 & 43). On May 14, 1996, Dr. Edwards reported that "any use of a vibrating tool has contributed to [claimant's] condition. Since he has not reached the end stages of his disease, all use to-date has contributed toward his current condition." (Ex. 42).

In a deposition, Dr. Edwards adhered to his opinion that all use of the vibrating tool contributed to claimant's current condition, including the one and a half hours at Rapid Auto Glass. (Ex. 43-15, -16). Dr. Edwards distinguished between the cumulative nature of vibration-induced Raynaud's, where "every exposure causes some damage," and the inability to detect such a difference with testing. (Ex. 43-9, -13, -14). Dr. Edwards explained that the tests were not that sensitive and he was not aware of any test that would measure a small amount of damage. (Ex. 43-9, -14, -15). Dr. Edwards agreed that even a half hour of using pneumatic tools would cause microscopic changes to a medical probability. (Ex. 43-9). Dr. Edwards testified that "there's plenty of literature that says a small amount of exposure over a long period will cause damage, you know, an hour a day, half an hour a day, whatever, if it's used long enough, so each exposure must cause a little bit of damage." (Ex. 43-10). Dr. Edwards testified that failure to show a change based on testing did not mean there was no change in pathology. (Ex. 43-14).

Based on Dr. Edwards' opinion, as supported by Dr. Sultany, we conclude that claimant's employment with SAIF/Rapid actually contributed to the worsening of his Raynaud's syndrome. See Bracke, 293 Or at 250; Lott, 155 Or App at 74. Consequently, we agree with the ALJ that responsibility should shift to SAIF/Rapid.

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[4] SAIF/Rapid disputes claimant's contention that he used a pneumatic knife while working at Rapid Auto Glass. SAIF/Rapid relies on the testimony of three witnesses who worked at Rapid Auto Glass who said claimant had denied using the pneumatic knife at Rapid Auto Glass. The ALJ found that claimant was a credible witness. On de novo review, we agree with the ALJ's assessment of claimant's credibility. We conclude that claimant used the pneumatic knife while employed at Rapid Auto Glass.

Claimant's attorney is entitled to an assessed fee for services on review pursuant to ORS 656.382(2).[5] After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the SAIF Corporation, on behalf of Rapid Auto Glass. 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 September 4, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation, on behalf of Rapid Auto Glass.

[5] If SAIF/Rapid's appeal proved successful, claimant's compensation would have been reduced because responsibility cannot be assigned to a non-joined carrier. See Jon O. Norstadt, supra; Kristin Montgomery, supra. Furthermore, claimant's temporary total disability rate under the SAIF/Rapid claim is greater than his rate with the other carriers. (Tr. 106). Therefore, had SAIF/Rapid's appeal proved successful, claimant's compensation would have been reduced. Because there was a risk that claimant's compensation would be reduced on review had we found another carrier responsible, claimant is entitled to an insurer-paid attorney fee for services on review, to be paid by the SAIF Corporation, on behalf of Rapid Auto Glass. See Lynda C. Prociw, 46 Van Natta 1875 (1994).

In the Matter of the Compensation of
SHARRIE A. KING, Claimant
WCB Case No. 96-04269
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that awarded claimant 17 percent (54.4 degrees) unscheduled permanent disability for a left shoulder injury. In her respondent's brief, claimant contests the ALJ's evidentiary ruling which admitted, over claimant's objection, a report from claimant's attending physician which had been included in the Director's reconsideration record. On review, the issues are evidence and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of her finding that the parties stipulated to an adaptability value of (4).

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant 17 percent unscheduled permanent disability for her left shoulder condition, based on the following values: impairment (5); age (0); skills (3); and adaptability (4). The insurer asserts that claimant has no permanent impairment as a result of her compensable injury and, alternatively, if claimant does have permanent impairment, her adaptability value is (1), which would result in a total unscheduled permanent disability award of 8 percent. Claimant concedes that the parties did not stipulate to an adaptability value of (4); instead, she contends that her adaptability value is (2), which would result in a total unscheduled award of 11 percent.

Impairment

We adopt the ALJ's opinion on impairment, with the following supplementation.

The insurer contends that Dr. Geisler, claimant's attending physician, failed to explain his change of opinion after his concurrence with the report of Drs. Neumann and Tsai. In that January 10, 1996 report, the doctors noted that they had no medical records since September 1995 and they had no

opinion regarding whether claimant was capable of performing her job at injury (grocery checker), noting that claimant was under no limitations or restrictions in relation to her new job, which did not require lifting and loading items as a checker would do. They noted that claimant's condition had improved since being on the new job and found that claimant had no objective evidence of impairment. (Ex. 18).

Subsequent to his January 19, 1996 "check-the-box" concurrence with Drs. Neumann and Tsai's report, Dr. Geisler provided a permanent physical capacity evaluation in which he restricted claimant's reaching and pushing to 15 repetitions, and her lifting and carrying to a maximum of 10 pounds frequently. (Ex. 23).

In his April 15, 1996 supplemental report, Dr. Geisler stated that, although he had a copy of Drs. Neumann and Tsai's report, he had no record of having endorsed their findings. Relying on his own examination of claimant in November 1995, Dr. Geisler opined that claimant was unable to return to her work duties as a grocery checker because she has a chronic condition affecting the use of her left shoulder. He explained that claimant has periods of pain-free use of the left shoulder, but that it is aggravated by any repetitive motion. As an example, Dr. Geisler reported that claimant's shoulder became painful after the repetitive motions of vacuuming, which demonstrated why claimant should not perform repetitive motion involving the left shoulder. (Ex. 24).

Although Dr. Geisler's current medical opinion differs from his "check-the-box" concurrence, we find his change of opinion to be reasonable in light of his explanation, which is confirmed by the medical record of claimant's exacerbated condition after returning to her regular work as a checker and the restrictions he had placed on claimant in November 1995. See Kelso v. City of Salem, 87 Or App 630, 633 (1987). Consequently, Dr. Geisler's concurrence does not undermine his April 15, 1996 medical opinion that claimant has a chronic condition preventing the use of her left shoulder.

Moreover, because we rely on the most thorough, complete and well-reasoned evaluation of a claimant's injury-related impairment, Kenneth W. Matlack, 46 Van Natta 1631 (1994), we are more persuaded by the opinion of Dr. Geisler, who had the opportunity to observe claimant over an extended period of time and who had a more complete medical history than Drs. Neumann and Tsai, who lacked any medical reports subsequent to September 1995 and who were unaware that Dr. Geisler had placed restrictions on claimant's use of her left arm.[1] Accordingly, we agree with the ALJ's conclusion that claimant has established an impairment value of 5 percent for a chronic condition limiting repetitive use of her left shoulder.[2]

Adaptability

Claimant concedes that her base functional capacity (BFC) is light. The adaptability factor is measured by comparing the worker's 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). 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 or other medical evaluation which includes but is not limited to the worker's capacity for e.g., lifting, carrying, and pushing/pulling. Former OAR 436-35-310(5).

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[1] Moreover, because Dr. Geisler's April 28, 1996 opinion is the most thorough and well-reasoned of his reports regarding claimant's ability to work, we find that opinion more persuasive than his February 19 and February 28, 1996 "check-the-box" releases to "regular" work, particularly in light of his restrictions on lifting, carrying, reaching and pushing in the latter report. See Exs. 22, 23.

[2] In her respondent's brief, claimant contests the ALJ's evidentiary ruling which admitted, over claimant's objection, Exhibit 19, a report from Dr. Geisler which had been included in the Director's reconsideration record. As our previous discussion shows, we have not relied on Exhibit 19 to determine impairment. Thus, our conclusion would not be different even if Exhibit 19 is not admissible. Consequently, we need not address claimant's evidentiary argument.

On November 6, 1995, Dr. Geisler released claimant to modified work, restricting her lifting to a maximum of 10 pounds frequently and 50 pounds occasionally, with restrictions on reaching and pushing. (Exs. 16, 23). "Light" means the ability to occasionally lift 20 pounds and frequently lift or carry up to 10 pounds. Former OAR 436-35-310(3)(f). "Sedentary/light" means the worker can perform the full range of light activities, but with restrictions. Former OAR 436-35-310(3)(e). Based on Dr. Geisler's release to work, we conclude that claimant's RFC is sedentary/light work. Accordingly, her adaptability factor is rated as 2. See OAR 436-035-0310(6).[3]

Disability Calculation

We now proceed to calculate claimant's unscheduled permanent disability award. The parties stipulated to claimant's age (0), formal education (0), and Specific Vocational Preparation (SVP) (3), which results in an age and education value of (3). After multiplying the sum of the age and education factors (3) by the adaptability factor (2), the product is 6. When that product is added to the impairment factor (5), the total unscheduled permanent disability award is 11 percent. Former OAR 436-35-280. We reduce the ALJ's award accordingly.

ORDER

The ALJ's order dated August 30, 1996 is modified. In lieu of the ALJ's award, claimant is awarded a total of 11 percent (35.2 degrees) unscheduled permanent disability for the left shoulder. The ALJ's attorney fee award is modified accordingly.

[3] 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 January 10, 1996 and her claim was closed by a February 5, 1996 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.

March 12, 1997 Cite as 49 Van Natta 265 (1997)

In the Matter of the Compensation of
CHERYL L. KOENIG, Claimant
WCB Case No. 96-05282
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's mid back condition. On review, the issue is extent of unscheduled permanent disability.

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

Assuming, without deciding, that Dr. Johnson, chiropractor, was claimant's attending physician for purposes of making impairment findings at claim closure, we would reach the same result because Dr. Johnson's opinion does not persuasively support a conclusion that claimant has permanent impairment due to her 1995 work injury.

On February 15, 1996, Dr. Johnson acknowledged that inclinometer measurements of range of motion may have been influenced by factors other than the injury in question.[1] Recognizing such

[1] Dr. Johnson specifically noted that such measurements can be influenced by "examiner method, patient compliance and patient status (pain level and flexibility at that time." (Ex. 13-2).

influences, Dr. Johnson deferred to a proposed second opinion examination, to be performed by Dr. Mayhall, and commented: "If [Dr. Mayhall's] findings also show a limited ROM over and above her previous disability rating, then [claimant] more likely than not did experience a worsening of her mid back as a result of her most recent work exposure. If the exam does not support my closing exam findings, then I would assume the findings were due to patient variability." (Ex. 13-1).

Dr. Mayhall examined claimant and included among his impressions, "Thoracic and lumbar sprain August 14 1995" and "History of chronic and ongoing pain in the thoracic spine, probably secondary to July 29, 1994 injury." (Ex. 15-8). He noted that claimant's low back range of motion measurements did not meet reproducibility criteria and, considering other variations, concluded: "[T]his examiner does not feel that the range of motions are likely to be accurate in [claimant's] case, for rating purposes, in any of the areas tested." (Ex. 15-6-7).

On April 19, 1996, Dr. Johnson indicated that he believed that his ROM testing "did meet reproducibility criteria," but otherwise agreed with Dr. Mayhall's opinions and discussion. (Ex. 17).

We find Dr. Johnson's unpersuasive because it is insufficiently explained. Dr. Johnson initially agreed that a second opinion regarding claimant's thoracic range of motion was desirable and explained how he would rely on it to determine whether and to what extent the 1995 injury impacted claimant's permanent thoracic impairment. Then, after Dr. Mayhall opined that claimant's range of motion measurements were not "accurate," Dr. Johnson agreed, except with regard to the "reproducibility" of his own range of motion measurements. Thus, in our view, Dr. Johnson doubted his range of motion measurements, then regained confidence in them without adequate explanation.[2] (See Exs. 13, 17, see also Exs. 8, 10). See Moe v. Ceiling Systems, 44 Or App 429 (1980); compare Kelso v. City of Salem, 87 Or 630 (1987). Accordingly, in the absence of a persuasive evidence relating claimant's thoracic impairment to her 1995 work injury, we conclude that claimant has not established entitlement to permanent disability under this claim.

ORDER

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

[2] Inasmuch as Dr. Mayhall expressly stated that his range of motion findings were not accurate, Dr. Johnson's qualified concurrence with Dr. Mayhall's opinion does not support a finding of permanent impairment due to the 1995 work injury.

In the Matter of the Compensation of
JAMES D. ORTNER, Claimant
Own Motion No. 96-0543M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Welch, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable right medial meniscal injury. Claimant's aggravation rights expired on January 19, 1993. The employer denied responsibility for claimant's current right lateral meniscal condition, on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 97-00996).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that Administrative Law Judge (ALJ) Neal, who is scheduled to conduct the hearing in WCB Case No. 97-00996 on April 23, 1997, submit a copy of the hearing order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

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

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

On our own motion, we wished to further consider the question of whether retroactive application of amended ORS 656.319(6) is prohibited by Section 66(6) of Oregon Laws 1995, chapter 332, in that the statute potentially alters a procedural time limitation. See Motel 6 v. McMasters, 135 Or App 583, 587 (1995); Brian D. Shipley, 48 Van Natta 994, 995 (1996), on recon 48 Van Natta 2280 (1996). To assist us in conducting our further consideration of this question, we granted the parties an opportunity to file supplemental briefs. We have received the parties' supplemental briefs and proceed with our reconsideration.

Prior to 1995, there were no statutory time limitations which applied to the issue of penalties. That is, a claimant could request a hearing raising the issue of penalties at any time, regardless of when the alleged unreasonable action or inaction had occurred. However, in 1995, as part of Senate Bill 369, the legislature added ORS 656.319(6) which provides that:

> "A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

Except as otherwise provided, Senate Bill 369 applies to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). One exception to the retroactive application of Senate Bill 369 is set forth in Section 66(6) which provides that "[t]he amendments to statutes by this Act and new sections added to Chapter 656 by this Act do not extend or shorten the procedural time limitation with regard to any action on a claim taken before the effective date of this Act." See McMasters, 135 Or App at 587.

ORS 656.283(1) in part provides that "[s]ubject to ORS 656.319, any party of the Director of the Department of Consumer and Business Services may at any time request a hearing on any matter concerning a claim. . ." As noted above, prior to the passage of Senate Bill 369, ORS 656.319 did not contain a time limitation for requesting a hearing relative to a carrier's processing of a claim. Therefore, under ORS 656.283(1), a party could request a hearing concerning a carrier's claims processing at any time.

Inasmuch as there was no time limitation on requesting a hearing concerning a penalty prior to the passage of Senate Bill 369 and there is now a two year limit, it follows that ORS 656.319 has "shortened" a procedural time limitation. See Boone v. Wright, 314 Or 135 (1992) (Statute imposing a 120-day time limit on filing a petition for post-conviction relief shortened a procedural time limitation where the prior statute had contained no time limitation). Consequently, Section 66(6) prohibits the retroactive application of ORS 656.319(6) to hearing requests that were filed prior to June 7, 1995.

To the extent that Section 66(6) is ambiguous, the legislative history also supports this conclusion. In testimony before the House Committee on Labor, Representative Mannix, a co-sponsor of Senate Bill 369, stated:

> "Sub '6' 'the amendments to this chapter do not extend or shorten the procedural litigation time frames which began before the date of the passage of this act.' That is, if you had a time frame that was run or running, we're not trying to let anyone slip into the tent or let anyone slip out of the tent based on time frames that they already relied

upon. If there was a time frame relied upon, we leave that alone. After the date of the passage of this act, if there's any new time frames, those will apply, but not time frames from before the passage of this act." Tape Recording, House Committee on Labor, March 22, 1995, Tape 62, Side B.

Here, claimant is asserting that Liberty Northwest's processing of his claim in 1979 was unreasonable. Moreover, at the time claimant filed his request for hearing, he necessarily relied on the fact that there were no time frames which would prohibit litigation of the issue of Liberty Northwest's claims processing. Therefore, retroactive application of ORS 656.319(6) (which would limit that "claim processing" time frame to two years) would be contrary to the language of Section 66(6) as well as the legislative intent, and we decline to apply it retroactively.

Because we have herein concluded that ORS 656.319(6) does not apply to claimant's request for penalties regarding Liberty Northwest's failure to process his 1979 right shoulder claim, we must address the merits of that issue.

On the merits, we adopt and affirm the conclusions and reasoning as set forth in the "Penalties and Attorney Fee: de facto Denial" section of the ALJ's order with the following supplementation.

Inasmuch as penalties are not compensation for the purposes of ORS 656.382(2), claimant's counsel is not entitled to an attorney fee award for services on review/reconsideration regarding that issue. See Saxton v. SAIF, 80 Or App 631 (1986).

In light of our above conclusion, we replace the "Order" section of our October 7, 1996 order with the following language: "The ALJ's order dated September 29, 1995 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by Cigna."

Accordingly, on reconsideration, we republish our October 7, 1996 order, as modified herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Chair Hall and Member Moller, specially concurring.

We join that portion of the majority opinion which holds that ORS 656.319(6) cannot be retroactively applied to this matter.

March 12, 1997 Cite as 49 Van Natta 268 (1997)

In the Matter of the Compensation of
DORIS H. WALLS, Claimant
WCB Case No. 96-05945
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its partial denial of claimant's bilateral STT joint arthritis condition. The employer also requests remand for consideration of a medical arbiter report. On review, the issues are compensability and remand. We deny the employer's motion for remand and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the ultimate findings of fact, with the following changes. On page 1, we change the first sentence of the second paragraph to read:

"Claimant first sought medical treatment in October 1994. In January 1995, Dr. Bowman diagnosed overuse tendinitis affecting the median nerve. Claimant was treated conservatively."

CONCLUSIONS OF LAW AND OPINION

The issue in this case is the compensability of claimant's bilateral STT joint arthritis condition. Claimant has an accepted claim for a wrist tendonitis injury.

Claimant agrees that her bilateral STT joint arthritis condition preexisted the tendinitis condition. She relies on the opinion of her treating physician, Dr. Bowman, to establish compensability.

We briefly recap claimant's medical treatment. Claimant developed pain in both hands in September 1994, which later spread up to her wrists and arms. She was sought treatment in October 1994 from Dr. Peterson and was later referred to Dr. Bowman. On December 20, 1994, Dr. Bowman believed claimant had bilateral carpal tunnel syndrome that resulted from repetitive motion activities at work. (Ex. 36). He referred claimant for nerve conduction studies, which were normal. (Ex. 37). On January 10, 1995, Dr. Bowman diagnosed overuse tendinitis affecting the median nerve. (Ex. 38).

On February 6, 1995, the employer accepted a wrist tendonitis injury. (Ex. 43).

Dr. Bowman referred claimant to Dr. Kemple. On April 6, 1995, Dr. Kemple diagnosed bilateral upper extremity pain syndrome, noting that it was "difficult to clarify the role of injury-work exposure in this setting." (Ex. 58).

On May 19, 1995, claimant was examined by Drs. Rich and Marble on behalf of the employer. They diagnosed overuse syndrome, both upper extremities, with a major tendinitis component and a minor median nerve contribution. (Ex. 68-5). When asked whether any of claimant's conditions were related to the progression of any underlying and unrelated disease process, they said "no." (Id.) Dr. Bowman concurred with their report. (Ex. 69).

Claimant was taken completely off work on June 29, 1995. The employer made some job site modifications and claimant was released to return to work on September 20, 1995 at light duty. Subsequently, the employer took claimant out of her office job and she worked as a "greeter."

In October 1995, Dr. Bowman referred claimant to Dr. Buehler, who diagnosed bilateral STT joint arthritis. (Ex. 89). Claimant was given a cortisone injection into the right STT joint. On November 14, 1995, Dr. Buehler reported that claimant's bilateral STT joint arthritis "bears no relationship to her 2.5 years of employment as an invoice clerk" at the employer. (Ex. 93). Dr. Bowman concurred with Dr. Buehler's November 14, 1995 report. (Ex. 95).

On January 12, 1996, Dr. Buehler reported that claimant was medically stationary from her bilateral STT joint arthritis. (Ex. 98). Dr. Buehler reported on January 30, 1996 that the proper diagnosis for claimant was STT joint arthritis, not bilateral wrist tendinitis. (Ex. 99). He agreed that any permanent impairment would be the result of the arthritis rather than tendinitis. (Id.) Dr. Bowman concurred with Dr. Buehler's January 12 and January 30, 1996 reports. (Ex. 101).

Dr. Bowman referred claimant to Dr. Isaacs for evaluation of possible carpal tunnel syndrome. On April 23, 1996, Dr. Isaacs reported there was no evidence of carpal tunnel syndrome. (Ex. 107).

On May 2, 1996, Dr. Bowman wrote to the employer, stating that claimant's "problem is entering a realm outside of my treatment scope." (Ex. 109). He commented that she had chronic tendinitis and recommended treatment at a chronic pain center. (Id.)

On May 8, 1996, the employer issued a partial denial of claimant's bilateral joint STT arthritis condition, on the basis that the bilateral wrist tendinitis was no longer the major contributing cause of her current condition and/or need for treatment and disability. (Ex. 110).

In a "concurrence" letter from claimant's attorney, Dr. Bowman agreed that claimant's November 9, 1994 injury combined with her preexisting bilateral joint STT arthritis and the November 9, 1994 injury was the major contributing cause of the new combined condition. (Ex. 111). Dr. Bowman also agreed that claimant's November 9, 1994 injury was the major contributing cause of a pathological worsening of the pre-November 9, 1994 bilateral joint arthritis. (Id.) He noted that the pathological worsening was "based on minor x-ray changes and [claimant's] symptoms." (Id.)

When medical opinions are divided, we give the most weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Conversely, we give little, if any weight, to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports. Marta I. Gomez, 46 Van Natta 1654 (1994). While we generally defer to the opinion of the attending physician when the medical evidence is divided, see Weiland v. SAIF, 64 Or App 810 (1983), we find persuasive reasons not to do so in this case.

Dr. Bowman changed his mind several times regarding claimant's diagnosis and the causation of her condition. Dr. Bowman's final opinion is in stark contrast to his earlier opinions. Although Dr. Bowman originally agreed with Drs. Rich and Marble that claimant's conditions were not related to the progression of any underlying and unrelated disease process (Exs. 68, 69), he later agreed that she had preexisting bilateral joint STT arthritis. (Ex. 111). Moreover, although Dr. Bowman originally agreed with Dr. Buehler that claimant's bilateral STT joint arthritis had no relationship to her employment as an invoice clerk at the employer (Exs. 93, 95), he later agreed that her work was the major contributing cause of a combined condition, which included preexisting bilateral joint STT arthritis. (Ex. 111). Because Dr. Bowman did not offer a reasonable explanation for his change of opinion, we do not find it persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987). We give little weight to his unexplained, conclusory concurrence letter. See Marta I. Gomez, supra.

There are no other medical opinions that support compensability. We conclude that claimant has failed to establish the compensability of her bilateral STT joint arthritis condition.[1]

ORDER

The ALJ's order dated October 1, 1996 is reversed. The self-insured employer's partial denial of claimant's bilateral STT joint arthritis condition is reinstated and upheld. The ALJ's attorney fee is also reversed.

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[1] In light of our disposition, we deny the employer's motion for remand because consideration of the employer's medical arbiter report is not reasonably likely to affect the outcome of the case.

In the Matter of the Compensation of
PAUL J. BIEKER, JR., Claimant
WCB Case No. 96-05295
ORDER ON REVIEW (REMANDING)
Bennett, Hartman, et al, Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied his motion for a continuance of the hearing; and (2) upheld the insurer's denial of claimant's right shoulder condition. With his appellant's brief, claimant has submitted a medical report not admitted into the record at the time of hearing. We treat such submissions as a motion for remand. We vacate and remand.

On May 23, 1996, claimant filed a request for hearing on the insurer's "de facto" denial of his aggravation claim. The request for hearing was assigned WCB Case No. 96-05295, and a hearing was scheduled for August 26, 1996.

On July 24, 1996, the employer issued a written denial of claimant's aggravation claim. Claimant filed a supplemental hearing request on August 9, 1996, which referenced the July 24, 1996 denial.

On August 14, 1996, the employer requested that claimant's supplemental hearing request be consolidated with WCB 96-05295.

On August 22, 1996, claimant requested a postponement from the Assistant Presiding Administrative Law Judge (APALJ). The APALJ denied claimant's motion for a postponement, but noted that the ALJ could hold the record open for one deposition and one unscheduled deposition.

At the August 26, 1996 hearing, claimant requested that the ALJ leave the record open, in order to obtain the deposition of Dr. Wells, claimant's treating physician. Claimant's counsel asserted that Dr. Wells' July 11, 1996 concurrence had been received by his office while he was out of the state, and that following a further delay to attend a conference, counsel was unable to review the letter until mid-August.

The ALJ denied claimant's request, on the ground that claimant had not shown extraordinary circumstances beyond his control sufficient to justify a continuance.

On review, claimant contends that, because he had understood, based on a ruling from the APALJ, that the record would be left open, the ALJ erred in not adhering to that decision. Accordingly, claimant seeks remand to the ALJ for the taking of additional evidence, in the form of Dr. Wells' deposition.

In examining an ALJ's decision concerning a motion for continuance of the hearing, we review for an abuse of discretion. See John E. Noyer, 46 Van Natta 395 (1994). After conducting our review in accordance with this standard, we conclude that this matter should be remanded.

The Opinion and Order does not discuss any basis for the ALJ's decision to deny claimant's motion, other than the ALJ found no extraordinary circumstances beyond claimant's control. However, at the hearing, the ALJ questioned claimant's counsel regarding the date of receipt of Dr. Wells' concurrence, and the circumstances surrounding claimant's inability to obtain Dr. Wells' deposition prior to hearing. (Tr. 2 - 4). In addition to the circumstances regarding his absence from his office, claimant's counsel also contended that he had understood from the APALJ that the record would be left open for one scheduled deposition[1] and one unscheduled deposition.

The ALJ concluded that, under the Board's rules, OAR 438-006-0081 and OAR 438-006-0091, and its decision in Cathy A. Inman, 47 Van Natta 1316 (1995), 17 days was a "limit" or a "very bright line" necessary to show extraordinary circumstances. In other words, the ALJ concluded that, because claimant's request for a deposition in the present case was made 24 days after claimant received Dr. Wells' concurrence, Inman required the ALJ to find a lack of due diligence on the part of claimant's counsel. The ALJ further found that his discretion in such matters would only extend to circumstances where the request had been made less than 17 days after receipt of a report. (Tr. 5).

We conclude that the ALJ misinterpreted the administrative rule and the Inman holding. In Inman, the claimant requested a postponement or a continuance in order to obtain three depositions and a rebuttal report. The insurer objected to the claimant's motion[2], and the ALJ denied the motion. On review, we found that there had been a significant and unexplained delay with respect to the claimant's failure to obtain one of the depositions and the rebuttal report. We also found no abuse of discretion, under the facts of the case, regarding the ALJ's finding that the claimant's counsel had not acted with due diligence with respect to the remaining unscheduled depositions. Inman, 47 Van Natta 1318.

In the present case, however, the ALJ did not take the facts or circumstances of the delay into consideration. Instead, he construed Inman to stand for the proposition that a delay of more than 17 days requires an automatic finding that an attorney has not exercised due diligence. As we have stated above, we conclude that such an analysis of the case misinterprets our holding in Inman. Rather, we

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[1] At the employer's request, claimant agreed to allow the scheduled deposition to be canceled when the doctor became available to testify at hearing. At hearing, claimant argued that he would not have agreed to cancel the scheduled deposition if he had known that the ALJ was going to deny his request for a continuance. (Tr. 10).

[2] In the present case, claimant requested, at hearing, that the insurer be allowed to state its position for the record. However, the ALJ declined, on the ground that the employer's position was irrelevant, and the issue was up to the ALJ to decide. (Tr. 3). We conclude that, although the decision is ultimately the ALJ's to make, it was a further abuse of discretion to decline to permit a party to state its position for the record. Furthermore, we do not agree that the position of the other side is irrelevant. Although that position may not be dispositive with respect to whether the motion should be granted, it is an additional factor to be taken into consideration in resolving the motion.

conclude that the length of the delay in seeking depositions or further medical reports prior to hearing is merely one factor to be taken into consideration in deciding whether or not a postponement or continuance request should be granted. Furthermore, because the facts of each case vary, our decision in Inman should not be considered to set forth a strict "17-day" rule.[3]

Accordingly, because the ALJ did not apply an analysis beyond the application of a "17 day" rule, he did not consider the other circumstances argued by claimant. Therefore, because the ALJ did not rule on the remaining circumstances surrounding claimant's continuance request, we remand this case to the ALJ to reconsider claimant's motion.[4]

Accordingly, the ALJ's order dated September 26, 1996 is vacated. This matter is remanded to ALJ Hazelett for further proceedings consistent with this order. Those proceedings may be conducted in any matter that will achieve substantial justice. At those proceedings, the ALJ shall reconsider claimant's request for a continuance, which shall include taking the position of all parties and considering all of the circumstances surrounding claimant's request. If the ALJ denies claimant's motion for a continuance, the ALJ shall issue a final, appealable order. If the ALJ grants claimant's request, the hearing record shall be reopened, and the case continued until completion of the record. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[3] We also cited to the Inman case in our decision in Joseph J. Gymkowski, 48 Van Natta 747 (1996). However, our reliance on Inman in deciding the Gymkowski case should not be construed to mean that we were following a "17-day" rule of law. Rather, we did not find the facts presented in Gymkowski to be distinguishable from Inman. Specifically, we found that in Gymkowski, as in Inman, the claimant unpersuasively contended that his lack of preparation was based on an argument that his amended request for hearing raised an additional issue, and there was insufficient time to prepare for hearing. To the extent that Gymkowski can be read to apply the Inman holding as a "rule of law," such is hereby disavowed.

[4] On remand, the ALJ shall also determine whether the report submitted on review, but not previously admitted into evidence, shall be admitted into the record.

March 13, 1997 Cite as 49 Van Natta 272 (1997)

In the Matter of the Compensation of
JAMES D. ORTNER, Claimant
Own Motion No. 96-0544M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Welch, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable right knee strain injury. Claimant's aggravation rights expired on March 24, 1981. SAIF denied responsibility for claimant's current right knee condition, on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 97-00893).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that Administrative Law Judge (ALJ) Neal, who is scheduled to conduct the hearing in WCB Case No. 97-00893 on April 23, 1997, submit a copy of the hearing order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
Own Motion No. 94-0277M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Schneider, Hooton, Claimant Attorneys
Saif Legal Department, Defense Attorney

The Board issued a Second Own Motion Order on Reconsideration on March 26, 1996, in which we dismissed claimant's request for temporary disability compensation for his compensable right leg injury because we lacked jurisdiction to consider claimant's request. We based our order, in part, on Administrative Law Judge (ALJ) Poland's February 23, 1996 Opinion and Order in WCB Case No. 95-02636, which had enforced a prior ALJ's order that had remanded a claim to the Department to proceed with reconsideration under ORS 656.268. Reliance on that order led us to conclude that the Board, in its Own Motion jurisdiction, did not have authority to consider claimant's request for relief in a claim in which claimant's aggravation rights had not expired under ORS 656.273(4)(a) and (b).

However, ALJ Poland's order was subsequently appealed to the Board. In a December 31, 1996 Order on Review, the Board reversed ALJ Poland's order, concluding that the prior ALJ's order (a November 29, 1994 Opinion and Order issued by ALJ Davis) was invalid, and, thus, not "enforceable." James W. Jordan, 48 Van Natta 2602 (1996). The Board's order was subsequently appealed to the court.

Because the Board's holding affects our jurisdiction in this matter, we concluded that our March 26, 1996 Own Motion order was premature.[1] Therefore, on February 10, 1997, we abated and withdrew our prior Own Motion orders due to the particular extraordinary circumstances of this case, which justified reconsideration of our prior orders. In our abatement order, we set forth a briefing schedule, which allowed claimant 14 days from the date of our order to submit evidence and argument to the Board and to SAIF supporting his contention that he qualified for own motion relief. SAIF was allowed 14 days from the mailing date of claimant's submission to respond.

On February 19, 1997, claimant submitted his opening submission. SAIF has not responded to our order or to claimant's submission. Therefore, 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.

Claimant underwent left medial meniscus repair surgery on May 16, 1994. Therefore, 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 SAIF Corporation contends that claimant was not in the work force at the time of his May 1994 surgery. Claimant contends that he qualifies for temporary disability compensation because he was working at casual labor for cash remuneration at the time of his 1994 surgery. 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.

At the May 24, 1996 hearing, ALJ Poland took claimant's testimony regarding his work history. (Claimant has submitted a copy of the hearing transcript of that testimony for our review.) Claimant testified that, since about 1989, he has "lumped" trucks (he bids to help drivers unload trucks at various warehouses). Claimant also testified that he fixed sidewalks and driveways (concrete work) during the relevant time. Claimant identified various warehouses at which he worked, including Rudy Wilhelm,

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[1] Pursuant to OAR 438-012-0050, the Board's rules do not provide for holding a case in abeyance pending judicial review. See Patrick G. Mahlberg, 48 Van Natta 2405 (1996), on recon 49 Van Natta 89 (1997).

Marigold, Oregon Transfer, Continental, Kienows, United Grocers, and Safeway. However, claimant contends that he did not sign a W-2 form, so his wages were not reported. Claimant submitted a 1996 W-2 form, which, although not establishing that he was in the work force during the relevant time, does establish that, during 1996, claimant worked for wages doing concrete work. Furthermore, SAIF offers no evidence to rebut claimant's testimony regarding his work activities.

On this unrebutted record, we are persuaded that claimant has established that he was in the work force at the time of his May 1994 surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning May 16, 1994, the date he was 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.

In the Matter of the Compensation of
MARY E. CORDEIRO, Claimant
Own Motion No. 94-0703M
OWN MOTION ORDER OF DISMISSAL
Nancy FA Chapman, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

The self-insured employer initially submitted claimant's request for temporary disability compensation for her compensable 1986 right wrist industrial injury. Claimant's aggravation rights on that claim expired on September 1, 1991.

On July 25, 1995, the Board postponed action on the Own Motion request. We took that action to await resolution of related litigation at the Hearings Division. (WCB Case No. 93-04146). Specifically, claimant contended that her claim was not properly before the Board under its Own Motion jurisdiction. The issues to be decided at hearing included: (1) the employer's Motion for Dismissal (contending that the Hearings Division's lacked jurisdiction); and (2) extent of scheduled permanent partial disability or permanent total disability.

By Opinion and Order dated January 10, 1996, Administrative Law Judge (ALJ) Johnstone concluded that the Hearings Division did not have jurisdiction to award additional permanent disability in claimant's 1986 injury claim, because a May 25, 1995 "post-ATP" Determination Order had not been properly appealed and had become final as a matter of law. The ALJ further dismissed claimant's request for hearing.

Claimant requested Board review of the ALJ's order. On June 12, 1996, the Board issued an Order on Review, which affirmed that portion of the ALJ's order that found that the Hearings Division did not have jurisdiction over the "post-ATP" Determination Order, and reversed that portion of the ALJ's order which dismissed claimant's request for hearing. Mary E. Cordeiro, 48 Van Natta 1178 (1996).

Claimant appealed the Board's order to the court. On February 26, 1997, the court affirmed, without opinion, the Board's June 12, 1996 order. Cordeiro v. Tappan Co., 146 Or App 777 (1997).

By letter dated February 28, 1997, the employer notified the Board that it agreed with claimant that the matter was not properly before the Board in its Own Motion jurisdiction.

As both parties agree that the request for own motion relief should be withdrawn, the request is hereby dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOUIS M. MEDCALF, Claimant
Own Motion No. 95-0386M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Thomas J. Dzieman, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's November 25, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from March 22, 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.

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 25, 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 January 24, 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 February 10, 1997, however, no further response has been received from claimant. Therefore, we will proceed with our review.

In an October 27, 1995 chart note, Dr. Peterson, claimant's treating physician, opined that claimant "continues to have significant activity related back pain." Dr. Peterson recommended that claimant "has essentially three options" to consider. Those options / recommendations included that claimant could either: (1) seek new employment within his current physical limitations and accept probable permanent restrictions; (2) consider revision surgery posteriorly with regrafting and possible implantation of a bone growth stimulator; or (3) consider an anterior interbody fusion at L4-5. Dr. Peterson noted that claimant "will consider the options and notify us of his decision."

In a November 7, 1996 chart note, Dr. Peterson opined that claimant was "effectively medically stationary on 10/17/96." Although Dr. Peterson recommended several surgical options in October 1995, there is no evidence in the record to suggest that claimant has pursued surgery as an option to materially improve his compensable condition. Therefore, because claimant has not pursued further surgical treatment during the last year as recommended, we are persuaded by Dr. Peterson's November 7, 1996 opinion that claimant was medically stationary on October 17, 1996. Finally, Dr. Peterson'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. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's November 25, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSE SALAS-BARRASA, Claimant
WCB Case No. 96-10480
ORDER OF DISMISSAL
Hilda Galaviz, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Hoguet's January 24, 1997 order. We have reviewed the request on our own motion to determine if we have jurisdiction to consider this matter. Because we conclude that the request is untimely, we dismiss.

FINDINGS OF FACT

On January 24, 1997, in response to claimant's counsel's withdrawal of claimant's hearing request, ALJ Hoguet issued an Order of Dismissal. Parties to that order were claimant, claimant's attorney, the employer, its insurer and its attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On February 26, 1997, the Board received claimant's request for review. Claimant's letter, which was contained in an envelope (postmarked February 25, 1997) addressed to the Board's Portland office, stated that claimant wanted "a request for review" of the ALJ's order. Claimant's request did not indicate that copies of his request had been provided to the other parties to the proceeding.

On March 7, 1997, the Board mailed its computer-generated letter to all parties acknowledging its receipt of a request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal. Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992).

Here, the 30th day after the ALJ's January 24, 1997 order was February 23, 1997, a Sunday. Therefore, the last day on which to perfect a timely appeal of the ALJ's order was Monday, February 24, 1997. Anita L. Clifton, 43 Van Natta 1921 (1991). Because claimant's request was received by the Board on February 26, 1997, it was "filed" on that date. OAR 438-005-0046(1)(b).[1] Inasmuch as February 26, 1997 is more than 30 days after the ALJ's January 24, 1997 order, claimant's request was untimely filed. ORS 656.289(3).

Moreover, there is no indication that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Consequently, the record does not establish that the other parties received timely notice of claimant's request for Board review. John E. Bafford, 48 Van Natta 513 (1996).

Under such circumstances, we conclude that notice of claimant's request was neither filed with the Board nor provided to the other parties within 30 days after the ALJ's January 24, 1997 order. Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2).

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[1] Even if we considered the "postmark" date on the envelope containing claimant's request as the "filing" date, the appeal would still be untimely because February 25, 1997 (the "mailing" date) is also more than 30 days from the ALJ's January 24, 1997 order.

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

March 18, 1997 Cite as 49 Van Natta 277 (1997)

In the Matter of the Compensation of
RICHARD A. PHILBRICK, Claimant
WCB Case No. 96-05986
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, 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) Hoguet's order that set aside its denial of claimant's right knee injury claim. On review, the issue is compensability.

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

The ALJ found that claimant had established by a preponderance of the evidence that it was more likely than not that the alleged slip and fall incident occurred as claimant contends. The employer argues that claimant is not credible and he did not sustain the alleged on-the-job injury.

Although the ALJ did not make specific credibility findings, his conclusion implies that claimant's testimony was credible. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 4 Or App 282 (1987).

After our de novo review of the record, we agree with the ALJ's conclusion. We conclude that, although there were inconsistencies between claimant's testimony and the testimony of other witnesses, those inconsistencies do not detract from claimant's testimony or the evidence regarding the occurrence of his March 13, 1996 injury, the prompt reporting of the injury, and his receipt of medical services soon after the injury.

Finally, we agree with the ALJ that the emergency room records and the reports from Dr. Parent are sufficient to establish medical causation and that claimant's right knee condition is established by medical evidence supported by objective findings.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, 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 counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 16, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the self-insured employer.

In the Matter of the Compensation of
HEIDI R. SHOOP, Claimant
WCB Case No. 96-01379
ORDER ON REVIEW
Lavis, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for bilateral ulnar compression neuropathy/bilateral overuse syndrome of the upper extremities. Contending that the insurer's request is frivolous, claimant seeks sanctions under ORS 656.390. On review, the issues are compensability and sanctions.

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

Compensability

The insurer argues that claimant was not credible and none of the doctors who examined her were given an accurate history of her work or the onset of symptoms. We disagree.

Based on the ALJ's observation of claimant's attitude, appearance and demeanor, as well as review of the record, the ALJ concluded that claimant was a credible and reliable witness.

Although not statutorily required, the Board generally defers to the ALJ's determination of credibility when it is based on the ALJ's opportunity to observe the witnesses. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Since the ALJ's credibility finding was based in part on the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990).

When the issue of credibility concerns the substance of a witness' testimony, however, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review, we agree with the ALJ's analysis and conclusions. The ALJ gave detailed explanations for his decision that the discrepancies and inconsistencies in the record were insignificant to the question of causation and to an assessment of claimant's credibility. Inconsistent statements related to collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports her testimony. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

Sanctions

Claimant contends that she is entitled to sanctions for the insurer's frivolous request for review. According to claimant, we "must" defer to the ALJ's demeanor findings. Claimant contends that the employer filed the request for review, not because of the merits, but at "his client's insistence." Claimant asserts that the insurer's request for review was intended to harass her.

ORS 656.390(1) authorizes assessment of an appropriate sanction against an attorney who files a request for review if we find that the request is "frivolous or was filed in bad faith or for the purpose of harassment[.]" Under ORS 656.390(2), "frivolous" means "the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing."

Here, the insurer's request for review is not frivolous. Contrary to claimant's contention, we are not required to defer to the ALJ's demeanor findings. See, e.g., Erck, 311 Or at 528 ("Although the Board should seriously consider the testimony the [ALJ] believes to be reliable, the 'substantial evidence' standard does not require the Board to adopt the [ALJ's] findings or to 'explain away' disparities between the Board and the [ALJ's] determinations"); James P. Mishler, 48 Van Natta 2400 (1996) (giving the ALJ's demeanor-based credibility finding little weight in light of inconsistencies between the claimant's testimony and contemporaneous medical documents); John M. Hyde, 48 Van Natta 1553 (1996) (same). The insurer raised colorable arguments on review regarding claimant's credibility that were sufficiently developed so as to create a reasonable prospect of prevailing on the merits. See Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996); Gerard R. Schiller, 48 Van Natta 854 (1996).

Moreover, we find no evidence that the insurer's request for review was filed in bad faith or for the purpose of harassment. Claimant contends that the insurer "seeks a type of review that does not exist in order to harass" her. As we discussed earlier, our review of the ALJ's order is de novo. See ORS 656.295(6). Although we generally defer to the ALJ's determination of credibility when it is based on demeanor, we are not required to do so. See Erck, 311 Or at 528. Therefore, we reject claimant's underlying premise that the insurer sought a "type of review that does not exist." Although we have rejected the insurer's arguments on review, we do not find them legally frivolous and the record does not establish that the insurer's request for review was filed in bad faith or for the purpose of harassment. Accordingly, we do not impose a sanction under ORS 656.390(1).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $750, 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 a fee on review regarding the sanctions issue.

ORDER

The ALJ's order dated September 26, 1996 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded $750, payable by the insurer.

March 18, 1997 Cite as 49 Van Natta 279 (1997)

In the Matter of the Compensation of
KENNETH R. SMITH, Claimant
WCB Case No. 96-04631
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests, and the insurer cross-requests, review of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside the insurer's denial insofar as it denied claimant's aggravation claim for a low back strain condition; and (2) upheld the insurer's denial insofar as it denied claimant's L5-S1 disc herniation. On review, the issues are compensability and aggravation. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability of L5-S1 Disc Herniation

We adopt and affirm the conclusions and reasoning as set forth in the "Compensability of current condition" section of the ALJ's order.

Aggravation

The ALJ concluded that claimant had proven that his compensable low back condition had "actually worsened" thereby establishing an aggravation pursuant to ORS 656.273(1). We disagree.

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 "actual worsening," as that term is used in ORS 656.273(1) does not include a symptomatic worsening. SAIF v. Walker, 145 Or App at 305. Instead, the court

concluded that the statute "requires that there be direct medical evidence that a condition was worsened" and it was not longer permissible for the Board "to infer from evidence of increased symptoms that those symptoms constitute a worsening condition for purposes of proving an aggravation claim." Id.

Here, the record contains no medical evidence suggesting that claimant's compensable low back strain condition has pathologically worsened. Moreover, there is no direct medical evidence which establishes that the compensable condition has worsened. In this regard, the fact that Dr. Veroza released claimant from work and indicated that claimant's condition was not medically stationary is not sufficient to establish an "actual worsening" of claimant's compensable low back strain condition. (Exs. 24, 25, 30). SAIF v. Walker, 145 Or App at 305. Under these circumstances, claimant has not proven that his compensable low back strain condition has "actually worsened" to support a reopening of his claim under ORS 656.273(1). Consequently, the employer's aggravation denial must be upheld.

ORDER

The ALJ's order dated September 12, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which set aside the insurer's denial insofar is it denied claimant's aggravation claim is reversed. The denial is reinstated and upheld. The ALJ's award of an assessed attorney fee is reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
SAMANTHA L. SPENCER, Claimant
WCB Case No. 96-01951
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of claimant's right wrist injury claim. Claimant also moves to remand the case to the ALJ for a finding of credibility. On review, the issues are remand and compensability.

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

Claimant asserts that she proved she compensably injured her right wrist while working on December 10, 1995. At hearing, claimant testified that she had an onset of symptoms after lifting and pushing a bag of "kitty litter" into a truck bed. The ALJ found the medical evidence supporting causation unpersuasive because it was based on a different history of the onset of claimant's symptoms. Thus, the ALJ concluded that claimant did not establish medical causation.

Claimant argues that the opinions of treating physicians Dr. Corrigan and Dr. Feldstein establish a compensable injury under ORS 656.005(7)(a). Both physicians indicated that claimant's right wrist condition was caused by her work activities on December 10, 1995. (Exs. 14A, 21-39). They based their opinions on a history that claimant's symptoms gradually began on December 10, 1995 while she was working as a courtesy clerk at a grocery store bagging groceries and carrying them out to customers' cars without a specific event or injury. (Exs 14-1, 21-33). Claimant asserts that her testimony at hearing that she experienced an injurious event should not reduce the persuasiveness of the opinions since the "kitty litter" incident is consistent with her general work activities.

We disagree with claimant. Dr. Feldstein stated that her opinion was based on the history claimant initially provided, which did not include the "kitty litter" event. During a deposition, Dr. Feldstein also stated that her opinion was based solely on such history. (Ex. 21-25). Dr. Feldstein further stated that identifying whether the onset of symptoms is gradual or sudden with an event is important for identifying the appropriate diagnosis; according to Dr. Feldstein, the diagnosis of tendonitis in particular was based on overuse rather than a specific event. (Id. at 44).

Based on such evidence, we cannot assume, as claimant argues, that the history relied upon by Drs. Corrigan and Feldstein is sufficiently similar to the "kitty litter" incident that the persuasiveness of their opinions is not reduced by omission of the event. Rather, as Dr. Feldstein explained, whether an onset of symptoms is gradual or sudden is important information in evaluating the condition. Because Dr's. Corrigan and Feldstein based their opinions on a gradual onset of symptoms, which is different from claimant's testimony of sudden onset, we conclude that their opinions are not reliable and do not establish causation. Consequently, we agree with the ALJ's conclusion that claimant failed to prove compensability.

Claimant also requests that we remand the case to the ALJ for a credibility finding. According to claimant, "this case was primarily a credibility case" and it "would be an abuse of discretion for the Board to evaluate credibility without having had the opportunity to view the testimony of the various witnesses who appeared at hearing[.]" In response, we first note that we are not aware, and claimant provides no authority in support, of the proposition that it is an abuse of discretion if an ALJ does not evaluate credibility. Furthermore, our review is de novo and, although we defer to the ALJ's demeanor-based credibility finding, the Board is equally qualified to make its own determination of credibility based on the substance of a witness' testimony. Erck v. Brown Oldsmobile, 311 Or 519, 528 (1991); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

More importantly, as explained above, we agree with the ALJ's conclusion that claimant failed to prove compensability because there is an absence of persuasive medical evidence establishing causation. Therefore, claimant did not carry her burden of proof whether or not she is a credible witness. Consequently, we find no compelling reason to remand to the ALJ to determine credibility. See ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986) (in order to warrant remand, there must be a compelling reason established for doing so, including a reasonable likelihood that the evidence sought to be admitted on remand will affect the outcome of the hearing).

ORDER

The ALJ's order dated September 9, 1996 is affirmed.

March 19, 1997 Cite as 49 Van Natta 281 (1997)

In the Matter of the Compensation of
BARBARA J. FAIRCHILD, Claimant
WCB Case No. 95-13396
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial insofar as it pertained to claimant's current chronic myofascial pain syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Relying on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), the ALJ found that claimant's chronic myofascial pain syndrome was part of her accepted injury claim with the employer. Therefore, the ALJ set aside the employer's denial insofar as it pertained to current myofascial pain syndrome. We agree that the employer's denial should be set aside but do so based on the following reasoning.

Claimant sustained an injury to her left shoulder on June 13, 1992. (Ex. 2). Her injury was accepted by the employer as a left shoulder muscle strain. (Exs. 5, 7). In January 1993, claimant began treating with Dr. Gargaro, M.D. (Ex. 13). Dr. Gargaro diagnosed claimant's condition at that time as "upper thoracic back pain." (Ex. 13). In his deposition, Dr. Gargaro indicated that claimant exhibited positive trigger points on palpation. (Ex. 57-11). He explained that this corroborated the existence of a myofascial pain syndrome. (Ex. 57-18). Dr. Gargaro reported that the typical strain resolved in 6-8 weeks, and that he had not only treated claimant for a strain, but also for her chronic myofascial condition. (Ex. 57-8, 27). While Dr. Gargaro acknowledged that claimant did not have "classic" myofascial pain syndrome, in that she lacked a psychological component, he opined that claimant's condition could still be described as myofascial pain syndrome. (Ex. 57-22, 31). Finally, Dr. Gargaro opined that both claimant's strain and myofascial condition were directly related to the compensable injury. (Ex. 57-27).

Based on Dr. Gargaro's unrebutted opinion, we conclude that claimant's myofascial pain syndrome is a different condition than the strain condition initially diagnosed and accepted by the employer. See Geana K. Cannon, 47 Van Natta 945 (1995). In view of the uncontested medical evidence establishing that this condition is directly related to the compensable injury, we agree with the ALJ that the employer's denial should be set aside.

In reaching this conclusion, we reject the employer's argument that its denial did not encompass "non-classic" myofascial pain syndrome. It's denial specifically denied "chronic myofascial pain syndrome" and did not differentiate between a "classic" and "non-classic" condition. (Ex. 52). We find that this denial included "non-classic" myofascial pain syndrome, particularly when viewed in light of Dr. Gargaro's recognition of the two types of condition. (Ex. 57).

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 case, and the value of the interest involved.

ORDER

The ALJ's order dated August 30, 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.

March 19, 1997 Cite as 49 Van Natta 282 (1997)

In the Matter of the Compensation of
RICHARD E. JOHNSON, Claimant
WCB Case No. 96-02315
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral hearing loss condition. On review, the issue is compensability.

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

We do not adopt that portion of the ALJ's opinion that discusses his personal experience with firearms. In addition, we correct the first sentence of the findings of fact to state that claimant worked for the employer as an electrician from 1974 through his retirement in July of 1990. (Exs. 1A-1, 2-1).

At hearing and on review claimant argues that he is only making a claim for that portion of hearing loss in his left ear that exceeds the factor attributed to presbycusis. Claimant argues that, because he is not making a claim for his total hearing loss, he should not be required to show that his work-related noise exposure is the major contributing cause of his total hearing loss. Finally, claimant argues that the opinion of Dr. Ilecki, Ph.D., satisfies his burden of proving that work-related noise exposure is the major contributing cause of that portion of the hearing loss in his left ear that exceeds the hearing loss that would normally result from presbycusis.

First, we agree with the ALJ's analysis of the medical evidence and his conclusion that Dr. Ilecki's opinion is not persuasive because it is unexplained. Somers v. SAIF, 77 Or App 259 (1986) (greatest weight given to well-reasoned opinions based on complete and accurate information). Second, we disagree with claimant's argument that he can extract a portion of his hearing loss and that he need only establish that that portion is caused in major part by work exposure. In this regard, we agree with the ALJ that the requirements of ORS 656.005(7)(a)(B) apply to this case.

Claimant contends that the occupational disease statute "requires that the work-activities be the major-contributing cause of the occupational disease or it's [sic] worsening." (Appellant's Reply Brief, emphasis in original). As we interpret this statement, claimant is apparently contending that the level of hearing loss in the left ear above that attributable to presbycusis represents a "worsening" that he may establish is compensable in its own right, independent from any contribution due to presbycusis. We disagree.

ORS 656.802 is the "occupational disease" statute and ORS 656.802(2) provides:

> "(a) The worker must prove that employment conditions were the major contributing cause of the disease.
>
> "(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.
>
> "(c) Occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005 (7).
>
> "(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings.
>
> "(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."

Thus, the provisions regarding a "worsening" of an occupational disease refer to a worsening in the context of a preexisting disease or condition. ORS 656.802(2)(b), (d). In addition, where the worsening of a preexisting disease or condition is claimed, the worker must establish that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2)(b) (emphasis added). In addition, ORS 656.802(2)(c) provides that occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7). One of those limitations is set forth in ORS 656.005(7)(a)(B), which provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition." (Emphasis added).[1]

Therefore, contrary to claimant's argument, ORS 656.802 does not support his contention that he may extract a portion of his hearing loss condition and that he need only establish that that portion is caused in major part by work exposure. In addition, we rejected this same argument in Henry F. Downs, 48 Van Natta 2094, on recon 48 Van Natta 2199 (1996).

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[1] Dr. Hodgson persuasively explained that presbycusis is a term used to describe a loss of hearing due to age-related degeneration of the ear's auditory structures. Specifically, Dr. Hodgson explained that both age-related degeneration and excessive noise exposure combine to cause loss of hair cells in the ear necessary for hearing. (Ex. 9 pp. 13, 28-30).

In Downs, the claimant filed an occupational disease claim for bilateral hearing loss after retiring from 33 years of employment at a box factory. During this employment, the claimant had been regularly exposed to loud noises and had not consistently used ear protection. The claimant contended that the amount of hearing loss, as measured at retirement, which was above that caused by presbycusis was compensable. We found that the persuasive medical evidence established that the major contributing cause of claimant's bilateral hearing loss condition was presbycusis, not work-related exposure. Furthermore, we found that the claimant was not permitted by ORS 656.802 to extract a portion of the disease (hearing loss) and claim that only that portion was caused in major part by work exposure. Henry F. Downs, 48 Van Natta at 2094. We reach the same conclusion in the present case.

Here, at the time he began working for the employer in 1974, a baseline audiogram showed claimant had binaural hearing loss exceeding that expected from presbycusis, with the hearing loss in the left ear exceeding that in the right ear.[2] (Ex. 2-5, -8, 9-21). Furthermore, Dr. Hodgson, examining otolaryngologist, opined that the presbycusis present in 1974 progressed during claimant's employment and combined with hearing loss caused by noise exposure. (Ex. 9-30-31). However, both Dr. Ediger, examining audiologist, and Dr. Hodgson opined that the major contributing cause of claimant's hearing loss was presbycusis. (Exs. 2, 8, 9). In addition, Drs. Ediger and Hodgson explained their opinions, noting that claimant's audiograms do not resemble noise-induced hearing loss, and the work-related noise was ambient, which would not result in greater hearing loss in one ear, as claimant exhibited. Id. On this record, we agree with the ALJ that Dr. Ilecki's conclusory opinion does not meet claimant's burden of proof under ORS 656.802.

ORDER

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

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[2] We note that, after allowing for the presbycusis factor, this preexisting hearing loss was not sufficient to allow any "rating" for hearing loss in 1974 and for several years thereafter. (Ex. 2-8). However, for the following reasons, we do not consider that fact relevant. We consider claimant's preexisting but "nonratable" hearing loss comparable to an asymptomatic preexisting condition. It is not necessary to have a preexisting condition that is severe enough to result in impairment before such a condition is considered in determining causation under ORS 656.802 or ORS 656.005(7)(a)(B). See Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 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). In Dietz, the claimant had preexisting coronary artery disease (CAD); however, the condition was asymptomatic until an incident at work occurred. Nevertheless, the court agreed that the Board properly considered that preexisting condition in determining the relative contribution of different causes pursuant to ORS 656.005(7)(a)(B). Likewise, it is appropriate to consider claimant's preexisting hearing loss condition, including that portion caused by presbycusis.

In the Matter of the Compensation of
JOHN M. JONES, Claimant
WCB Case Nos. 95-07126 & 95-05247
ORDER ON REVIEW
Schoenfeld & Schoenfeld, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's claim for a current right hip condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. Claimant cross-requests review, but in his respondent's brief asks that the ALJ's order be affirmed. On review, the issues are compensability and responsibility.

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

A prior (unappealed) ALJ's order awarded 21 percent unscheduled permanent disability arising from a February 19, 1992 low back injury with Liberty's insured. (Ex. 26). The order expressly found that all of claimant's then current restrictions and impairment were due to claimant's compensable February 19, 1992 injury with Liberty's insured. (Ex. 26-3). The 1992 claim was reopened for vocational training and reclosed by a subsequent (unappealed) Determination Order which reduced claimant's permanent disability award to 20 percent. (Ex. 31). Under these circumstances, we agree with the ALJ that Liberty is precluded from denying claimant's low back condition. See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996).

In addition, because we agree that Liberty has not established that claimant suffered a "new injury" during SAIF's subsequent coverage, we also agree that responsibility for claimant's low back conditions remains with Liberty.

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

ORDER

The ALJ's order dated September 18, 1996, as amended September 25, 1996, is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by Liberty.

In the Matter of the Compensation of
DEANNA L. ROOD, Claimant
WCB Case No. 96-05608
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that found the insurer improperly failed to pay temporary total disability. On review, the issue is entitlement to temporary total disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and provide the following changes to the Opinion and Order. We replace the reference to "May 5" in the second paragraph of page 2 to "May 6." We replace the reference to "That day" in the next sentence to "On May 5,". We replace the reference to "The next day, May 6" in the third paragraph of the same page to "On May 6,".

CONCLUSIONS OF LAW AND OPINION

On May 6, 1996, claimant was treated by Dr. Utterback following an incident at work on May 4, 1996, when claimant fell to the floor. Dr. Utterback diagnosed thoracic strain and restricted claimant to light work for 10 days. (Exs. 11, 12). The same day, claimant met with her supervisor, Brett Jarvis, and was informed that her employment was terminated for excessive absenteeism.

The insurer has not paid any temporary disability, arguing that claimant is not entitled to such benefits under ORS 656.325(5)(b). The ALJ first agreed with the insurer, and concluded that claimant also was not entitled to any temporary disability benefits. On reconsideration, however, the ALJ decided that the insurer did not satisfy ORS 656.325(5)(b) and, thus, the statute did not provide a basis for its failure to pay temporary disability.

ORS 656.325(5)(b) provides:

> "If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210[1] and commence payments pursuant to ORS 656.212[2] when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

The insurer asserts that it satisfied the statutory requirements for ceasing payment of temporary disability. Specifically, the insurer argues that claimant was terminated for violation of work rules; because Dr. Utterback's work release was consistent with the employer's "standard modified job," the attending physician approved claimant's employment in a modified job that would have been offered to her if she had remained employed; and the employer has a written policy of offering modified work to injured workers.

In interpreting ORS 656.325(5)(b), 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. 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.

We first focus on what is required for "the attending physician [to] approve[] employment in a modified job that would have been offered to the worker if the worker had remained employed[.]" According to the insurer, it is enough for the attending physician to approve modified work that is consistent with the modified job that would have been offered.[3] We disagree.

We find that the language is most reasonably construed as indicating the attending physician must approve the same modified job that would have been offered to the worker. That is, it is not sufficient for the attending physician to merely release the worker to modified employment. Rather, because the statute requires the attending physician to approve "a modified job that would have been offered to the worker," we conclude that the attending physician must review and consent to the modified employment that the employer would have offered the worker had that person not been terminated.

The context of the statute is consistent with this interpretation of the text. Subsection (a) of ORS 656.325(5) requires the carrier to cease temporary total disability and begin temporary partial disability payments

> "when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

This provision clearly requires the employer to inform, and receive approval from, the attending physician of any proffered employment before it may cease temporary total disability payments under the statute. Inasmuch as subsections (a) and (b) both address when the carrier must cease temporary total disability benefits and pay temporary partial disability, we find further support in subsection (a) for our interpretation of subsection (b). That is, the clear intent in subsection (a) to require the attending physician to approve the actual job offered is further evidence of legislative intent that the attending physician must approve the modified job that would have been offered in order for the carrier to properly cease temporary total disability under subsection (b).

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[1] ORS 656.210 pertains to payment of temporary total disability.

[2] ORS 656.212 pertains to the payment of temporary partial disability.

[3] There is little dispute that the employer has a written policy to offer modified work to injured employees. (Ex. 16). Part of that policy outlines the job assignments for modified work. (Id. at 3). In July 1996, the insurer provided this modified job description to Dr. Utterback, asking whether claimant could perform the work. (Ex. 17-2). Dr. Utterback responded that he had not seen claimant since May 15, 1996 and was not aware of her current status. (Id.) On June 4, 1996, claimant began treating with Dr. Long, who has indicated that claimant is not capable of performing regular or modified work. (Ex. 13A-5).

To hold otherwise might well require us to substitute our judgment for that of a medical expert. Here, for example, we would need to determine whether Dr. Utterback's prohibition of any forward bending or lifting over 20 pounds was consistent with a modified job that involved bed making and lifting of up to 25 pounds. (Compare Exs. 11A and 17-3). We believe that the policy inherent in ORS 656.325(5) is that such decisions be made by the attending physician.

In conclusion, the attending physician, whether it is Dr. Utterback or Dr. Long, did not approve a modified job that would have been offered to claimant had she not been terminated. See note 3. Consequently, the insurer lacked authority under ORS 656.325(5)(b) to cease temporary total disability benefits.[4]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 9, 1996, as reconsidered October 4, 1996, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[4] Given this conclusion, we need not decide whether claimant's employment was terminated "for violation of work rules."

March 19, 1997 Cite as 49 Van Natta 287 (1997)

In the Matter of the Compensation of
JACK M. TUCKER, Claimant
WCB Case No. 96-04652
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the self-insured employer's denial insofar as it denied the compensability of claimant's current cervical and lumbar condition; and (2) decline to set aside a July 28, 1995 Notice of Closure as "void." On review, the issues are compensability and claim preclusion.

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

Claimant, a construction worker, was compensably injured on October 11, 1994 when he fell to the ground while framing a second story. The employer initially accepted an injury to claimant's left wrist, and on July 26, 1996, amended its acceptance to include left carpal tunnel syndrome, left shoulder impingement syndrome and adhesive capsulitis, neuroplaxic injury to the left median nerve, left elbow abrasions, sacral/coccyxgeal spine contusions and left wrist reflex sympathetic dystrophy.

On June 26, 1995, claimant's treating doctor, Dr. Webb, found claimant to be medically stationary from the standpoint of all of his left upper extremity injuries from the fall of October 11, 1994. In measuring claimant's impairment, Dr. Webb found a loss of grip strength and lost range of motion in the left hand and loss of repetitive use of the left forearm. Dr. Webb also noted claimant's cervical spine findings were essentially negative and that his shoulder findings were normal except for some discomfort and crepitance.

Claimant's claim was closed by a July 28, 1995 Notice of Closure awarding 39 percent scheduled permanent disability of the left forearm. Meanwhile, claimant continued to complain of pain in the left upper extremity and upper back. Dr. Webb opined that claimant's symptoms represented a waxing and waning of his compensable injuries.

Claimant returned to Dr. Webb in late February 1996, complaining of pain in the base of the neck, left side radiating into the left subscapular region and left sided low back pain radiating into the buttock and left posterolateral thigh. Dr. Webb diagnosed chronic cervical sprain/strain with possible disc herniation and chronic lumbosacral strain/sprain with possible disc herniation and recommended a MRI study. A March 22, 1996 cervical MRI showed moderate spinal stenosis at C5-6 resulting from a diffuse disc bulge and small posterior disc bulges at C4-5 and C6-7, with a minimal impression upon the central aspect of the cord at the C4-5 level. The lumbar MRI showed mild broad based disc bulges L1-2 and L4-5, slight annulus bulges at L2-3 and L3-4 and desiccation of the L1-2 through L4-5 discs.

On April 4, 1996, claimant returned to Dr. Webb for follow-up. Dr. Webb noted claimant had degenerative changes to both the neck and low back which required activity modification. Dr. Webb also reported that claimant remained medically stationary from the standpoint of his October 11, 1994 fall, and that no additional diagnoses were related to this incident.

On May 10, 1996, the employer issued a denial contending that claimant's condition had not worsened since his claim was previously closed and that his current complaints and need for treatment were related to congenital and degenerative changes rather than his accepted injuries.

The ALJ found that claimant's current cervical and lumbar complaints were unrelated, in either a material or major part, to his compensable injury and upheld the employer's denial. The ALJ also found that claimant was medically stationary as to his compensable injuries on June 28, 1995, and upheld the Notice of Closure.

Current Condition Denial

On review, claimant asserts that his current cervical and lumbar conditions are compensable. We find to the contrary.

Claimant has the burden of proving that his current condition is causally related to his compensable injury. ORS 656.266; ORS 656.005(7)(a). We agree with the ALJ that, to the extent Dr. Webb's February and March 1996 reports indicate that claimant's ongoing complaints could be related to his 1994 accident, this evidence is insufficient to sustain claimant's burden. The greater weight of the medical evidence, including the reports of Dr. Webb generated after his review of claimant's MRI studies, establishes that claimant's cervical and lumbar complaints are not related to his compensable injuries. Indeed, Dr. Webb specifically found that claimant's cervical and lumbar symptoms were related to degenerative disc disease. Similarly, Dr. Wilson, who examined claimant on two occasions on the employer's behalf, opined after reviewing claimant's MRI reports that the cervical spine changes were congenital and degenerative and not traumatic in origin.

Consequently, like the ALJ, we uphold the employer's denial of claimant's current cervical and lumbar spine condition.

July 28, 1995 Notice of Closure

Claimant asserts that the July 28, 1995 Notice of Closure is "void" because he was not at that time medically stationary from all accepted conditions resulting from his compensable injury. We find that claimant's attack on the Notice of Closure is precluded by the doctrine of claim preclusion.

When parties have had an opportunity to litigate a question prior to a final determination and a final judgment is entered that disposes of the matter, the principles of claim preclusion bar those parties from further litigating it. Drews v. EBI Companies, 310 Or 134, 140 (1990). Finality attaches to uncontested closure orders for purposes of claim preclusion. Id. at 150 n 13; Hammon Stage Line v. Stinson, 123 Or App 418, 423 (1993).

Here, claimant had the opportunity to litigate his medically stationary status by timely requesting Department reconsideration of the Notice of Closure.[1] He did not do so and the closure order became final by operation of law. Consequently, the Notice of Closure has become, in effect, a "final judgment" that disposed of the medically stationary matter. See, e.g., Michele S. Thomas-Finney, 47 Van Natta 174 (1995). As such, claimant is barred from further litigating issues regarding the medically stationary status of his accepted injuries as of July 28, 1995.

Even assuming claimant was not precluded from litigating this issue, we conclude, as did the ALJ, that a preponderance of the medical evidence establishes that he was medically stationary as to all of his accepted conditions at the time of claim closure. Indeed, on June 28, 1995, claimant's treating physician examined claimant's left upper extremity (including the shoulder) as well as his cervical spine and determined him to be medically stationary. Moreover, after seeing claimant on several subsequent occasions, Dr. Webb continued to report that claimant was medically stationary from his October 1994 injuries as of June 28, 1995. Therefore, the Notice of Closure was proper and not premature.

ORDER

The ALJ's order dated September 9, 1996 is affirmed.

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[1] ORS 656.268(4)(e) provides that if a worker objects to the notice of closure, the worker must first request reconsideration by the Department within 30 days of the date of the notice of closure.

Chair Hall specially concurring.

Although I agree with the result in this case, I write separately to address my concerns about the application of the "claim preclusion" doctrine. As discussed in my separate opinions in Rex A. Howard, 46 Van Natta 1265 (1994) (Board Member Hall, dissenting) and Sandra Miles, 48 Van Natta 553 (1996) (Chair Hall, specially concurring), I believe a Notice of Closure or Determination Order is rendered null and void as a matter of law ("void ab initio") by a subsequent order finding additional, non-medically stationary conditions compensable.

In this case, however, I am satisfied by the medical evidence that all of claimant's compensable conditions, including those accepted by the employer only two days prior to the Notice of Closure, were considered and found stationary by Dr. Webb on or before June 28, 1995. Therefore, the July 28, 1995 Notice of Closure was valid and not premature. However, if I were not persuaded that all of claimant's compensable conditions were medically stationary, I would disagree with the notion that claimant is precluded by the doctrine of claim preclusion from subsequently attacking the validity of the Notice of Closure. I continue to believe that an order which is rendered void by a subsequent order cannot form the basis of a res judicata analysis, because the former order no longer exists under the law.

In the Matter of the Compensation of
NOEL L. BAIER, Claimant
WCB Case No. 95-08744
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that awarded claimant temporary disability from June 1992 through January 19, 1993, less time worked. In her brief, claimant contends that we cannot consider "post-reconsideration" hearing testimony. In its reply brief, the employer argues that, because the parties did not agree, and claimant has not established, that the exhibits presented at hearing were part of the reconsideration record, none of the record evidence presented at hearing can be considered on Board review. On review, the issues are evidence and temporary disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second and fifth paragraphs on page 2, and with the following modification and supplementation.

Claimant worked for the employer as a physical therapist on a permanent, part-time schedule of eight hours a day, four days a week at the time she sustained a compensable lumbar strain on March 17, 1992. (Exs. 1, 10). On March 27, 1992, Dr. McDonald released claimant to modified work. (Exs. 2, 3, 4). On May 26, 1992, Dr. Battaglia continued claimant on modified work. (Ex. 5).

In June 1992, the employer combined two part-time physical therapy positions, including that of claimant, into one full-time position. Claimant was offered the choice of taking the full-time position or taking "on-call" work. (Employer's appellant's brief at 6). Claimant accepted the on-call position. (Ex. 6-2).

Claimant requested a hearing on the Order on Reconsideration, raising the issue of temporary disability benefits. The hearing was held on October 25, 1995. Exhibits 1 through 31 were submitted by the employer. Exhibit 29A, claimant's request for reconsideration, was submitted by claimant. The ALJ admitted all the exhibits and heard testimony.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant requested a hearing concerning an Order on Reconsideration, contending that she is entitled to additional temporary disability benefits. At hearing, the ALJ received "post-reconsideration" testimony that was not previously submitted at the reconsideration proceeding before the Department of Consumer and Business Services (Department). Citing Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), which issued subsequent to the ALJ's order, claimant contends that we cannot consider the "post-reconsideration" testimony on review.

In addition to claimant's challenge to the "post-reconsideration" testimonial evidence, the employer argues on review that, because the parties did not agree, and claimant has not established, that the exhibits presented at hearing were part of the reconsideration record, the entire evidentiary record presented at hearing cannot be considered on Board review. We agree with claimant's contention and disagree with that of the employer.[1] We begin by addressing claimant's argument.

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[1] Although neither party raised objections to the admissibility of testimony or the evidentiary record at hearing, amended ORS 656.283(7) generally mandates that evidence on an issue regarding a Notice of Closure that was not submitted at the reconsideration proceeding "is not admissible at hearing." Thus, we proceed to consider the admissibility of the testimonial and record evidence on review. See Joe R. Ray, 48 Van Natta at 327 n.3; David J. Rowe, 47 Van Natta 1295 (1995).

Hearing rights and procedures are addressed in ORS 656.283. As amended in 1995,[2] 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."

In Joe R. Ray, the claimant requested a hearing concerning an Order on Reconsideration, asserting entitlement to additional permanent partial disability (PPD) benefits. At hearing, the claimant testified regarding the extent of his permanent disability. Based on that testimony, the ALJ increased his PPD award. On Board review, the Board reduced the ALJ's PPD award. The Board found that the clear language and context of amended ORS 656.283(7), as well as its legislative history, supported the conclusion that evidence that is not submitted at reconsideration is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. 48 Van Natta at 329. Thus, the Board concluded that the claimant's testimony at hearing was inadmissible.

Because ORS 656.283(7) pertains to "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration," our holding in Joe R. Ray applies to proceedings involving the reconsideration procedure required by ORS 656.268. That is, when a party objects to a Notice of Closure or Determination Order, that party must first request reconsideration from the Department. ORS 656.268(4)(e), (5)(b). An evidentiary record is then developed by the Department on reconsideration. Based on the reconsideration record, the Department issues its Order on Reconsideration. The record of any subsequent hearing concerning the reconsideration order is limited to the reconsideration record that was developed by the Department. ORS 656.283(7); Dean J. Evans, 48 Van Natta at 1092; Joe R. Ray, 48 Van Natta at 325; see also Precision Castparts v. Plummer, 140 Or App at 231.[3]

Although the substantive issue in this case is whether claimant established entitlement to temporary disability benefits, in contrast to the permanent partial disability benefits in the cases cited above, this case underwent the same mandatory reconsideration procedure set forth in ORS 656.268. Given the posture of this case, we find that the temporary disability issue is "an issue regarding a notice of closure" within the meaning of ORS 656.283(7).[4] Therefore, by its express terms, the statutory exclusion in ORS 656.283(7) applies to the hearing in this case. Accordingly, we conclude that claimant's hearing testimony was inadmissible and do not consider it on review.

We next turn to the employer's evidentiary argument. The employer contends that, because the parties did not agree, and claimant has not established, that the hearing record was part of the reconsideration record, the entire evidentiary record presented at hearing cannot be considered on Board review.

We begin by noting that none of the evidentiary record admitted at hearing is dated after the July 20, 1995 Order on Reconsideration. Moreover, the explanatory notes in the Order on Reconsideration specifically refer to the employer's November 30, 1994 Notice of Closure (Ex. 25), as well as the medical arbiter examination (Exhibit 30); claimant's May 4, 1995 request for reconsideration

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[2] The statute went into effect on June 7, 1995, prior to the October 25, 1995 hearing. Therefore, the amended statute applies to this case. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996); Dean J. Evans, 48 Van Natta 1092, recon 48 Van Natta 1196 (1996); Joe R. Ray, 48 Van Natta at 325.

[3] Although the substantive issue in each of these cases was whether the claimant had established his entitlement to permanent partial disability benefits, we have also applied the statutory exclusion in ORS 656.283(7) where the substantive issue was entitlement to permanent total disability benefits. E.g., Virginia McClearen, 48 Van Natta 2536 (1996) (Chair Hall specially concurring).

[4] ORS 656.268(4)(b) provides, in part, that the notice of closure "must inform the worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the amount and duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the Department * * * ." (Emphasis added.)

(Ex. 29A); and Dr. Takacs' letter declaring claimant medically stationary (Ex. 23). See Ex. 31. Consequently, we conclude that the aforementioned documents were part of the reconsideration record. However, our inquiry does not end here, as the appellate reviewer's explanatory notes also state that the Order of Reconsideration is "based on a review of the entire closure." (Ex. 31-4).

Former OAR 436-30-020(9), which was in effect at the time the employer issued its Notice of Closure, provides:

> "When a claim is closed by the insurer pursuant to ORS 656.268, the relevant records used to issue the Notice of Closure shall be supplied to the Department, the worker or the worker's representative, if requested. Failure to supply this information in accordance with this rule may result in civil penalties pursuant to [OAR] 436-30-580."

Moreover, former OAR 436-30-050, which sets forth the rules governing the reconsideration process, provides:

> "(8) Upon written notice by the worker, or the worker's representative, of the intent to request reconsideration of a Notice of Closure or Determination Order, the insurer or self-insured employer shall, within six (6) working days of the mailing date of said request, furnish the Department, and the worker or the worker's representative, without cost, a copy of all documents pertaining to the claim or the specific documents so requested.
>
> "(9) An insurer failing to provide information or documentation as set forth in [Section] * * * 8 of this rule may be assessed civil penalties pursuant to OAR 436-30-580." (Emphasis supplied.)

All but one of the exhibits the employer moves to exclude[5] were provided by the employer, which stated the following in its September 25, 1995 cover letter addressed to the ALJ: "Enclosed are copies of all medical reports and other relevant material that we have in our file for inclusion in the record, together with our chronological Exhibit List. Copies of this material have been forwarded to claimant's attorney." (Emphasis provided.) Included in the employer's submission was Exhibit 25, the employer's Notice of Closure (which we earlier established was a part of the reconsideration record), and, according to the employer's representations in its cover letter, the same documentation the employer relied on when it issued its Notice of Closure as it was required to provide to the Department as part of the reconsideration process. See former OAR 436-30-020(9); 436-30-050.

We decline to infer that the employer failed to timely provide all documentation of its claim closure to the Department as required by former OAR 436-30-050. Moreover, there is no indication on the part of the employer that the documentation it provided for the reconsideration process was limited to a request for specific documents rather than the entire record at the time of claim closure. In sum, because none of the exhibits to which the employer objects was generated after the Order on Reconsideration, and because the employer timely and appropriately provided the required documentation in support of its Notice of Closure to the Department on reconsideration and provided the same documentation at hearing, we conclude that the employer has not established grounds for excluding the entire evidentiary record. Therefore, because the documents submitted at hearing were included in the reconsideration record, they are admissible at hearing. Accordingly, we consider the entire documentary record on review.

Temporary Disability Benefits

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

The ALJ concluded that, because claimant's modified part-time job was eliminated in June 1992 as a result of the employer's decision that it needed a full-time employee, the employer no longer had work within claimant's injury-related limitations. Accordingly, the ALJ awarded temporary total disability, less time worked, from June 1992 until January 19, 1993, the date that Dr. Wong, claimant's then-attending physician, declared claimant medically stationary and released claimant to regular work.

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[5] Exhibit 29A, claimant's May 4, 1995, request for reconsideration, was provided by claimant. As noted above, it was part of the reconsideration record.

On review, the employer contends that claimant was not entitled to temporary disability during that period because her attending physicians failed to authorize temporary disability, or, alternatively, because claimant chose not to work at a physically suitable, modified full-time job. We disagree with both contentions.

Inasmuch as claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. While a worker's procedural entitlement to temporary disability is contingent on the attending physician's authorization, there is no such requirement for determining substantive entitlement to temporary disability. Rather, a worker'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[6] showing that the 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); 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). Consequently, any alleged failure by claimant's attending physician to authorize temporary disability, in and of itself, is not determinative in establishing disability.

Here, the employer contends that, because claimant's attending physician, Dr. Wong, did not authorize time loss on August 18, 1992, subsequent to the time she accepted the "on-call" position, claimant is not entitled to temporary disability benefits after she accepted that position in June 1992. Dr. Wong initially saw claimant on July 16, 1992. He diagnosed claimant with chronic low back pain, for which he prescribed physical therapy. (Ex. 6). In her follow-up examination on August 6, 1992, Dr. Wong noted that claimant continued to experience right-sided low back pain with intermittent radiation into her right extremity, which indicated a right sacro-iliac joint problem. (Ex. 8). On August 18, 1992, Dr. Wong reported in response to the employer's questions that claimant continued to treat for her low back condition and that claimant was not medically stationary. Although Dr. Wong wrote that time loss was not authorized, we view that statement as indicating that claimant was able to perform the "on-call" job. (Ex. 9). Dr. Wong did not say that claimant was capable of performing her regular job at that time. Dr. Wong did not release claimant to regular work until January 19, 1993. (Ex. 19). Under these circumstances, we find that claimant remained partially disabled at the time of Dr. Wong's August 18, 1992 report.

Accordingly, based on the entire documentary record, a preponderance of the evidence establishes that claimant remained partially disabled until January 19, 1993, when Dr. Wong released her to regular work.

The employer also contends that claimant is not entitled to temporary disability subsequent to June 1992, because she chose not to accept the employer's offer of a modified full-time job. We disagree.

Temporary total disability (TTD) benefits for injuries are based on the worker's at-injury wage. ORS 656.210(2)(b)(A). Temporary partial disability (TPD) payments are based on that proportion of the payments provided for TTD which the loss of wages bears to the wage used to calculate TTD. ORS 656.212. Thus, the relevant date to determine entitlement to total temporary disability benefits is the date of injury. See Dale A. Warren, 47 Van Natta 917, recon 47 Van Natta 2091 (1995).

Here, at the date of injury, claimant was able to work a permanent part-time schedule without any modifications. However, as of March 27, 1992, Dr. MacDonald restricted claimant to no bending, twisting, squatting, pushing, pulling, patient transfers, and excess sitting. (Ex. 2). In other words, at the date of injury, claimant was able to work without any restrictions. However, as of March 27, 1992, claimant was limited to modified work. Therefore, we find claimant entitled to temporary partial disability, at least theoretically, as of March 27, 1992, the date of Dr. MacDonald's work restrictions.[7]

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[6] As noted above, we do not consider the parties' hearing testimony.

[7] We have held that, where a claimant is released to modified work at or above his or her regular wages, the claimant is temporarily and partially disabled, even though the actual rate of TPD may be computed to be zero. See, e.g., Kenneth A. Hinkley, 48 Van Natta 1043 (1996); Kenneth W. Metzker, 45 Van Natta 1631, 1632 (1993); Valorie L. Leslie, 45 Van Natta 929 (1993), rev'd on other grounds Leslie v. U. S. Bancorp, 129 Or App 1 (1994). Accordingly, claimant became entitled to TPD when Dr. McDonald imposed work restrictions on March 27, 1992, even though the rate of TPD may be zero.

Former OAR 436-60-030(4) (WCD Admin. Order 26-1990) (now renumbered OAR 436-060-0030(8)) provides that TPD shall cease and TTD shall begin when the job no longer exists or the job offer is withdrawn by the employer.[8] Here, in June 1992, claimant's modified, permanent part-time position no longer existed when the employer eliminated it upon deciding to combine two permanent part-time positions, including that of claimant, into one full-time position. At the time her position was eliminated, claimant remained able to work her modified part-time schedule. Accordingly, claimant was entitled to TTD benefits as of the date her job was eliminated in June 1992.[9]

In sum, based on the entire documentary record, a preponderance of the evidence establishes that claimant could only perform modified work as a result of her work injury until January 19, 1993. Accordingly, claimant was entitled to TTD benefits from June 1992, when her job no longer existed, until January 19, 1993, when she was released to regular work, less any wages she earned during this period.

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

ORDER

The ALJ's order dated November 24, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the self-insured employer.

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[8] Relying on Dawes v. Summer, 118 Or App 15 (1993) and Safeway Stores v. Owsley, 91 Or App 475 (1988), the employer argues that, because claimant refused a suitable modified position for reasons other than her injury, she is not entitled to time loss. We disagree. In Dawes, the claimant had been released to and returned to work following a compensable injury and was subsequently terminated for reasons not related to her injury. The court held that, because the claimant was fired for reasons not related to her claim, no wages were lost due to the compensable injury and the claimant was not entitled to temporary disability benefits. Similarly, in Owsley, the claimant was likewise fired for reasons unrelated to her claim. Here, unlike the circumstances in Dawes and Owsley, claimant was not fired from her job for reasons unrelated to her claim. In fact, claimant continued to work for the employer, albeit in a different capacity. Instead, the job was eliminated by the employer, which means it no longer existed. Thus, on the facts of this case, Dawes and Owsley are inapplicable.

[9] The employer also argues that claimant is not entitled to temporary disability benefits because she refused to work a suitable modified position for reasons other than her injury subsequent to her acceptance of the "on-call" job, as she allegedly refused some shifts. Because the baseline for comparison is the date of injury, it is irrelevant that claimant was working the modified "on-call" job.

In the Matter of the Compensation of
V. J. LOVE, Claimant
WCB Case No. 96-02600
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Bostwick, 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 claim for a left knee injury. On review, the issue is compensability.

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

For the reasons given by the ALJ, we find the opinions of Drs. Duff and Hanley to be conclusory and unpersuasive. By contrast, we find the opinion of Dr. Ferguson to be persuasive.

Dr. Ferguson based his causation opinion on the fact that the fall at work onto the cement floor involved greater trauma than the kneeling incident at home. On this basis, Dr. Ferguson believed that the fall at work was responsible for the tear. In addition, Dr. Ferguson indicated that his opinion was reinforced by the fact that claimant had immediate swelling after the November 1995 fall, and had constant mild pain after the fall and no left knee symptoms prior to the fall at work. (Ex. 14-33). After reviewing the medical opinions, we agree with the ALJ that Dr. Ferguson's opinion is well reasoned and based on an accurate history. See Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, we agree with the ALJ that claimant has established compensability of her left knee condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 August 6, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

March 20, 1997 Cite as 49 Van Natta 295 (1997)

In the Matter of the Compensation of
DIXIE L. STANTON, Claimant
WCB Case No. 96-02729
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its 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 with the following supplementation.

In August 1994, claimant was involved in a motor vehicle accident. She sought chiropractic treatment between August 15, 1994 and September 24, 1994. (Ex. A).

CONCLUSIONS OF LAW AND OPINION

In August 1995, claimant began "flipping" and stacking wood doors. She developed low back pain and sought treatment. In November 1995, the employer accepted a claim for nondisabling low back strain. In March 1996, however, the employer denied claimant's current low back condition. In April 1996, claimant underwent surgery.

The ALJ found that claimant carried her burden under ORS 656.005(7)(a)(B) of proving compensability. The employer challenges this conclusion, asserting that the more persuasive medical evidence shows that claimant's preexisting low back condition is the major contributing cause of her current condition.

We first note claimant's contention on review that the employer's March 1996 denial is procedurally improper under ORS 656.262(6)(c)[1] and 656.262(7)(b),[2] as well as constituting an improper "back-up" denial under ORS 656.262(6)(a).[3] Inasmuch as claimant did not raise these arguments at any time before the ALJ, we do not address them on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Robert L. Tegge, 47 Van Natta 1973 (1995).

There is no dispute that, because claimant has a preexisting degenerative arthrosis and that such condition combined with a strain, claimant must show that the compensable injury is the major contributing cause of her combined condition. ORS 656.005(7)(a)(B). There are opinions from three physicians concerning this issue.

Examining physician Dr. Neumann found that claimant experienced a strain secondary to the August 1995 work incident which became superimposed on the preexisting degenerative arthrosis. (Ex. 21-4). Dr. Neumann further found that, as of February 1996, the strain had resolved and claimant's symptoms were due only from the preexisting condition. (Id.) Dr. Neumann subsequently agreed with a report drafted by the employer's attorney stating that the strain did not cause any pathological worsening of the degenerative condition and reiterating that the preexisting condition was the major contributing cause of the need for treatment of the combined condition. (Ex. 25).

Dr. Johnson, claimant's treating orthopedic surgeon, first found that claimant "has mechanical dysfunction and this is related to her degenerative arthrosis at 4-5 and 5-1." (Ex. 17-1). Dr. Johnson then diagnosed degenerative spondylosis with superimposed strain or sprain. (Ex. 20). He also concluded that the major contributing cause of the need for treatment was the compensable injury. (Ex. 23).

Dr. Johnson subsequently explained that arthritis causes a "lack of flexibility" and "lack of tolerance to repetitive use or heavy loads" and that "sensitive worn joints should not be exposed to great repetitive lifting or stresses." (Ex. 26-2). Dr. Johnson gave as an example "Grandmother's knee" which was asymptomatic until a fall, when such incident "might precipitate ongoing dysfunction." (Id.) Dr. Johnson added that the "established diagnosis represents an acute injury that has now resulted in chronic pain superimposed on a relatively asymptomatic totally functional arthritic condition." (Id. at 5). Dr. Johnson concluded that "the major contributing cause of [claimant's] current condition and need for care is not the arthritis, but rather the injury on the job for the reasons stated above." (Id.)

Finally, Dr. Maloney, physical medicine specialist who treated claimant on referral, reported that, although claimant showed symptoms of a "soft tissue strain," the "low back pain etiology appeared to arise from mechanical components greater than soft tissue elements." (Ex. 28). Although

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[1] The statute 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:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

[3] The relevant portion of ORS 656.262(6)(a) 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 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 no compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance."

acknowledging the preexisting condition, Dr. Maloney stated that "the work activities resulted in [claimant's] pain complaints, disability and seeking of medical attention with subsequent lumbar effusion." (Id.)

The proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause. Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). Moreover, the precipitating cause is not necessarily the major contributing cause. Id.

Although lengthy, Dr. Johnson's explanation for his conclusion is difficult to understand. After careful review, however, we understand Dr. Johnson as indicating that claimant's preexisting condition caused her back joints to become more susceptible to a strain and, upon experiencing such stress, resulted in "failure" of the back joint. Moreover, we interpret Dr. Johnson as stating that the stress caused by the repetitive lifting precipitated claimant's symptoms, but that the source of the pain are the changes in her back due to the preexisting arthrosis. This understanding is consistent with Dr. Maloney's description of claimant's symptoms as being due more to mechanical changes than soft tissue injury and Dr. Neumann's opinion that the compensable injury resolved, leaving only the preexisting condition as the cause of claimant's pain.

Thus, we find that the medical evidence shows that the major contributing cause of claimant's "combined condition" is the preexisting condition. Consequently, the claim is not compensable. ORS 656.005(7)(a)(B). In view of this conclusion, we need not address the employer's argument that claimant's surgery is not compensable under ORS 656.225 or claimant's response that the employer's argument constitutes an impermissible amendment of its denial.

ORDER

The ALJ's order dated July 23, 1996, as reconsidered August 30, 1996, is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

March 20, 1997 Cite as 49 Van Natta 297 (1997)

In the Matter of the Compensation of
DONNA J. SUTTON, Claimant
WCB Case No. 95-05334
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order affirming a Determination Order which terminated claimant's prior award of permanent total disability (PTD). On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant was 62 years of age at the time of hearing. She sustained a herniated L5-S1 disk when she slipped and fell down some metal stairs while working for the employer on February 21, 1984. Following that injury, claimant experienced significant low back and leg symptoms. Dr. Danner, M.D., was claimant's treating physician. A laminectomy and diskectomy was performed on May 15, 1984. Claimant experienced significant improvement in her symptoms as a result of the surgery, and she was able to return to full-time work.

In October 1986, claimant moved to Montana. She has not been employed since that time. Claimant returned to Oregon in 1989, at which time Dr. Danner began treating her for a recurrence of low back and leg symptoms. Further diagnostic studies documented a significant amount of degenerative disk disease at the L5-S1 level. Claimant's symptoms worsened to the point that she received an award of permanent total disability (PTD) under a July 12, 1989 Opinion and Order which was subsequently affirmed by the Board and became final as a matter of law.

At the time claimant received her PTD award, she was experiencing a constant level of low back, hip and bilateral leg pain which required her to lie down three to four times every day, for fifteen to twenty minutes. Claimant could not drive, and she was able to do very little housework. She could not sit for more than ten minutes without getting up to relieve her pain, and she was limited to sedentary work that did not involve bending, squatting, crawling, climbing or repetitive use of her hands or feet. In addition, claimant experienced an average of three symptomatic flare-ups each month that required her to remain in bed all day, and sometimes for two or three days.

In November 1992, the employer filed a formal request for reevaluation of claimant's PTD award under ORS 656.206(5). On August 12, 1992, Northwest Occupational Medical Center (NOMC) performed a multidisciplinary medical and vocational evaluation of claimant. Based on that evaluation, a January 22, 1993 Determination Order revoked claimant's PTD award effective August 14, 1992.

In September 1993, Back In Action of Clackamas, Inc. performed a three-day evaluation of claimant's physical capacity at claimant's request.

On July 21, 1995, Dr. Mark Steinhauer, M.D., evaluated claimant for the employer.

On July 13, 1995, Mr. Scopacasa, vocational consultant, performed a vocational evaluation of claimant at the request of the employer. Mr. Scopacasa completed a supplemental evaluation on January 4, 1996. Both evaluations were based on claimant's medical and vocational record rather than an interview with claimant.

In December 1995, Ms. Ridley-Hartgrave, vocational consultant, completed a vocational evaluation of claimant at her request. That evaluation was based on a two-hour interview with claimant and a review of claimant's medical and vocational records.

Claimant has experienced a significant improvement in her medical condition since she was awarded PTD in 1989. Claimant's symptoms are now less severe and intermittent rather than constant. She currently has a sedentary lifting restriction, but is otherwise able to perform work in the light range. Claimant is able to sit continuously for 30 to 45 minutes and stand/walk for 30 to 60 minutes. She is able to drive and shop for groceries, perform light cooking and housework, quilt and knit. She walks for exercise on a regular basis. Claimant is usually able to control her pain without lying down throughout the day as she did at the time of her PTD award. She still experiences symptomatic flare-ups that require bed rest, but these do not regularly occur on a weekly or monthly basis. From time to time, claimant rides four-wheelers and snowmobiles and performs strenuous yard work. She experiences symptoms with this type of strenuous activity which she controls with pain medication and bed rest.

Claimant has a high school education. Most of her prior work experience is in the medium to heavy range. She spent over ten years as a french frier/drier machine operator, several years as a food production machine cleaner, over ten years as a farm laborer, several months as a fishing lure assembler, and five years as a food packager. She has also done occasional work as a waitress and bartender, and she operated a retail yarn business from her home.

Claimant has the following transferable skills: average or above average reading, spelling and arithmetic skills; following oral and written directions; driving a passenger vehicle; using hand tools; performing uncomplicated tasks using her arms, hands and fingers; operating a cash register; and assembling small products.

FINDING OF ULTIMATE FACT

Claimant is presently capable of performing at least part-time work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

Claimant's PTD award cannot be revoked unless she is presently capable of performing work at a gainful and suitable occupation. ORS 656.206(5); Harris v. SAIF, 292 Or 683, 696 (1982). Either

improvement in claimant's medical condition or circumstantial evidence of employability can be used to show that claimant is presently capable of performing work at a gainful and suitable occupation. Norton v. SAIF, 86 Or App 447, 453 n 3 (1987); Kytola v. Boise Cascade Corp., 78 Or App 108, 111, rev den 301 Or 765 (1986). To be currently employable, claimant must be able to sell her services on a regular basis in a hypothetically normal labor market. Harris, 292 Or at 695; Norton, 86 Or App at 452.

Here, the ALJ concluded that the employer has established that claimant is presently capable of performing work at a gainful and suitable occupation. On review, claimant argues that the ALJ based his decision on claimant's improved medical condition without regard to whether she would be competitive in the labor market. The employer argues that the burden of proof in this matter should rest with claimant, not the employer. The employer also contends that claimant has not established that she is willing to work. We agree with the ALJ's ultimate conclusion based on the following alternative analysis. Accordingly, we need not address the employer's alternative arguments regarding the burden of proof and claimant's willingness to work.

At the time claimant was awarded PTD in 1989, she experienced a constant level of low back, hip and bilateral leg pain which required her to lie down three to four times every day, for fifteen to twenty minutes. Claimant could not drive, and she was able to do very little housework. She could not sit for more than ten minutes without getting up to relieve her pain, and she was limited to sedentary work that did not involve bending, squatting, crawling, climbing or repetitive use of her hands or feet. In addition, claimant experienced an average of three symptomatic flare-ups each month that required her to remain in bed all day, and sometimes for two or three days.

Claimant's medical condition has improved since she received her PTD award. Claimant told the doctors at the Northwest Occupational Medical Center (NOMC) that her low back, hip and leg pain is less severe and intermittent rather than constant. Claimant testified that she is now able to drive, shop for groceries, perform light cooking and housework, and walk for exercise on a regular basis. While claimant also testified that she still experiences symptomatic flare-ups that require bed rest, she acknowledged that these flare-ups do not regularly occur on a weekly or monthly basis. Claimant's testimony and surveillance films submitted by the employer establish that claimant does, from time to time, ride four-wheelers and snowmobiles, perform yard work and engage in similar activity. Claimant explained that she is able to tolerate the increased symptoms associated with these activities with pain medication and bed rest.

The medical opinion in the record provides further evidence of claimant's improved physical condition. Physical capacity evaluations performed in August 1992 and September 1993 indicate that claimant is still limited to sedentary lifting and carrying but can now do the following: sit, stand and walk for longer periods of time; engage in occasional bending, squatting, kneeling, crawling, climbing of stairs and overhead/forward reaching; make frequent repetitive use of her arms; and make constant repetitive use of her wrists and hands. These physical capacity evaluations further indicate that claimant is able to perform sedentary-light work for at least twenty hours per week on a regular and reliable basis, so long as that work allows claimant to change from sitting to standing/walking. Drs. Danner and Steinhauer agree that claimant's physical capacity equals or exceeds this level of work. There is no contrary medical opinion.

The record also contains circumstantial evidence of claimant's employability. The multidisciplinary panel with Northwest Occupational Medical Center (NOMC) opined in August 1992 that claimant was not permanently and totally disabled from employment. As part of its evaluation, the NOMC panel conducted a seven-hour vocational assessment. The vocational consultants on the panel identified the following occupational categories as appropriate for further vocational research: laundry pricing clerk; ticket seller; gift wrapper; knitting demonstrator; appointment clerk; information clerk; mica-plate layer, hand; earring maker; atomizer assembler; and glazer. These positions all pay at or above the minimum wage in Oregon.

The record also contains an evaluation from vocational consultant Scopacasa, who reviewed claimant's medical and vocational record at the request of the employer. Mr. Scopacasa opined that claimant has the transferable skills and physical ability to be gainfully and suitably employed. Mr. Scopacasa relied on the physical capacity evaluations conducted in August 1992 and September 1993, as well as the vocational assessment conducted by NOMC. Mr. Scopacasa also conducted a labor market

survey in all population centers within commuting distance of claimant's home, including the Walla Walla, Washington area. Mr. Scopacasa made direct calls to employers and identified job openings during the past six months which claimant has the physical ability to perform and the minimum qualifications to be hired.

Based on claimant's work history, Mr. Scopacasa identified the following transferable skills: average or above average reading, spelling and arithmetic skills; following oral and written directions; driving a passenger vehicle; using hand tools; performing uncomplicated tasks using her arms, hands and fingers; operating a cash register; and assembling small products. Based on his labor market survey, Mr. Scopacasa identified the following suitable jobs in claimant's local labor market: billing clerk; circulation clerk; payroll clerk; general office clerk; video rental clerk; hospital admitting clerk; hotel/motel desk clerk; automobile rental clerk; cashier; telemarketer; teacher aide; security guard; floor attendant (bingo parlor); and telephone answering service operator. These positions all pay at or above the minimum wage in Oregon.

Claimant relies on the contrary opinion of her vocational expert, Ms. Ridley-Hartgrave, who opined that it was possible, but not probable, that claimant could find regular employment. Ms. Ridley-Hartgrave felt that claimant faced a significant competitive disadvantage because she experienced episodes of disabling pain during which she would not be able to work. Claimant's vocational expert also stated that many of the jobs identified by the employer's vocational experts were probably not within claimant's physical limitations. Finally, Ms. Ridley-Hartgrave opined that claimant did not have the necessary computer skills for many of the sedentary and light jobs identified by other vocational experts, and that claimant otherwise had minimal aptitude, skill and orientation for sedentary and light work.

The ALJ discounted Ms. Ridley-Hartgrave's opinion on the ground that it was based on the incorrect factual assumption that claimant lacked computer knowledge. We agree with claimant that this is not an appropriate basis for discounting Ms. Ridley-Hartgrave's opinion. Claimant's testimony and her discussions with medical and vocational experts merely establishes that she is able to play computer games so long as someone else opens up the "Windows" program. From this limited evidence, we are unable to find that claimant has computer knowledge that is transferable to the job market.

Nevertheless, we discount Ms. Ridley-Hartgrave's opinion for a number of other reasons. First, she did not investigate job opportunities in the Walla Walla, Washington area, which is the largest population center within commuting distance of claimant's residence. Also, Ms. Ridley-Hartgrave's opinion was somewhat speculative, as she did not conduct a direct labor market survey and actually discuss claimant's qualifications and employment barriers with individual employers. Furthermore, Ms. Ridley-Hartgrave's report equates gainful employment with full-time work at the minimum wage. The Board has, instead, concluded that "gainful employment" under ORS 656.206(1)(a) means either full-time or part-time work paying at least the minimum wage. Betty S. Tee, 47 Van Natta 939 (1995). In addition, the opinion of Ms. Ridley-Hartgrave is based, in part, on the "tight" labor market where claimant lives, and not on whether she is currently able to sell her services on a regular basis in a hypothetically normal labor market. See Mary J. Kamm, 47 Van Natta 1443 (1995) (vocational opinion unpersuasive where based on lack of job openings in a claimant's geographical area rather than on whether the claimant was employable in a hypothetically normal labor market). Finally, we are not persuaded that Ms. Ridley-Hartgrave had an accurate understanding of claimant's disabling symptomatic flare-ups. While claimant testified that she continues to experience such flare-ups, we are not persuaded that they occur frequently enough to be a permanent barrier to part-time employment.

Accordingly, based on claimant's testimony and the medical and vocational opinion as a whole, we find that the record establishes that claimant is presently capable of performing at least part-time work at a gainful and suitable occupation. Consequently, we conclude that the ALJ correctly affirmed the January 22, 1993 Determination Order that revoked claimant's PTD award.

ORDER

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

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

Claimant requests reconsideration of our February 26, 1997 Order on Review that awarded claimant 22 percent (70.4 degrees) unscheduled permanent disability award for a low back injury, whereas the Administrative Law Judge's (ALJ's) order had awarded claimant 34 percent (108.8 degrees) unscheduled permanent disability and 2 percent (3 degrees) scheduled permanent disability for loss of use or function of the left foot. Claimant asserts 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, who examined claimant closer in time to the Order on Reconsideration.

Claimant injured her low back at work on July 11, 1995. She was diagnosed with a low back strain and underlying, preexisting degenerative facet arthropathy. The employer accepted a claim for lumbar strain.

Between August 11, 1995 and October 9, 1995, claimant treated with Dr. Kho for low back pain. On October 9, 1995, Dr. Kho examined claimant and declared her medically stationary. He found reduced lumbar range of motion related to the compensable injury and permanently restricted claimant from lifting more than 20 pounds.

The employer closed the claim with a December 20, 1995 Notice of Closure awarding 2 percent unscheduled permanent disability for the low back. Claimant requested reconsideration and, on March 8, 1995, was examined by Dr. Gritzka, the medical arbiter. Dr. Gritzka found significantly decreased range of motion, but was only able to complete one cycle of measurement for lumbar flexion due to claimant's report of sharp pain in the left sacroiliac joint. Dr. Gritzka believed that claimant was not medically stationary and that she was in need of further physical therapy of the sacroiliac joint.[1] In response to Dr. Gritzka's report, Dr. Kho opined that claimant was medically stationary with regard to her injury on October 9, 1995, but had worsened.[2]

After reviewing the medical evidence, consisting of Dr. Kho's impairment findings at the time of claim closure and Dr. Gritzka's findings five months later, we found that Dr. Kho provided the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993) (In evaluating permanent disability, the Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment); see also Weiland v. SAIF, 64 Or App 810 (1983) (Board will generally rely on the medical opinion of the attending physician, absent persuasive reasons to do otherwise). We were unpersuaded by Dr. Gritzka's findings of impairment because he believed that claimant was not medically stationary and in need of further treatment.

Claimant argues that we cannot rely on Dr. Kho's findings because he did not examine claimant "at the time of reconsideration." We disagree. The fact that the medical arbiter examined claimant closer in time to the reconsideration order is not determinative.[3] See Charlene L. Vinci, 47 Van Natta

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[1] In our initial order, we erroneously found that claimant sought to postpone the reconsideration process due to Dr. Gritzka's report. Actually, pursuant to ORS 656.268(7)(B), the Director requested that the parties advise whether the proceeding should be postponed. Claimant agreed to a postponement but employer did not consent. Therefore, the reconsideration proceeding went forward. (See Exs. 27A, 28-4).

[2] Dr. Kho did not address whether the worsening related to claimant's accepted injury or to her preexisting condition.

[3] This is especially true where, as here, there is evidence that the worker did not remain medically stationary throughout the reconsideration process. See Lindon E. Lewis, 46 Van Natta 237, 239, aff'd mem Morgan Manufacturing v. Lewis, 131 Or App 267 (1994) (discussing procedural safeguards the in place to ensure that the worker's permanent disability is rated at a medically stationary level). Indeed, the Director's rules provide that a medical arbiter examination is not medically appropriate if a worker's condition subsequently becomes non-medically stationary. See former OAR 436-30-165(5) (WCD Admin. Order 94-059). In such cases, the Department must base its impairment rating on the medical opinion regarding impairment at the time of claim closure.

1919 (1995); David J. Rowe, 47 Van Natta 1295 (1995). Claimant's attending physician, Dr. Kho, examined claimant when she was medically stationary at the time of claim closure. We may rely on Dr. Kho's assessment of claimant's injury-related impairment in evaluating her permanent disability. See ORS 656.245(2)(b)(B).

Claimant also argues that we cannot reject the medical arbiter's findings simply because they were made at a time that her condition was "waxing." As noted above, the medical arbiter did not find that claimant was simply experiencing a "waxing" of her compensable injury. On the contrary, Dr. Gritzka determined that claimant had not reached maximum medical improvement related to her sacroiliac joint. Further, unlike Dr. Kho, Dr. Gritzka did not address the effect claimant's preexisting, underlying conditions (including her noncompensable degenerative facet arthropathy) had on her low back symptoms and restrictions. Thus, we did not rely on Dr. Gritzka's findings because we were not persuaded that they reflected permanent impairment caused by claimant's accepted lumbar strain.[4]

In conclusion, we adhere to our determination that a preponderance of the evidence establishes that claimant sustained 2 percent permanent impairment as a result of her compensable injury. This impairment value, when added to a value of 20 for her age, education and adaptability, entitles claimant to a total unscheduled permanent disability award of 22 percent.

Accordingly, our February 26, 1997 order is withdrawn. On reconsideration, as supplemented above, we republish our February 26, 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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[4] Generally, if there is no issue regarding the cause of the claimant's impairment, we construe the medical arbiter's findings as showing that the impairment is due to the compensable injury. See, e.g., Kim E. Danboise, 47 Van Natta 2163, 2164 (1995). On the other hand, where, as here, there is evidence that a noncompensable condition may be contributing to the claimant's impairment, we will not presume that the arbiter's impairment findings are due to the compensable injury. See, e.g., Dave Perlman, Jr., 47 Van Natta 709 (1995); Julie A. Widby, 46 Van Natta 1065 (1994).

In the Matter of the Compensation of
CONNIE S. PAYANT, Claimant
WCB Case No. 96-02597
ORDER ON REVIEW
Black, Chapman, et al, 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 which determined that her cervical, left shoulder and left jaw (mastoid) injury claim was not prematurely closed. On review, the issue is premature claim closure.

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

Finding that the self-insured employer had prematurely closed claimant's claim, a February 12, 1996 Order on Reconsideration rescinded the November 17, 1995 Notice of Closure (as amended on November 30, 1995), which found claimant's cervical, left shoulder and left jaw conditions medically stationary on October 11, 1995. The employer then requested a hearing, contesting the reconsideration order.

The ALJ found that a preponderance of the medical evidence established that claimant's compensable conditions were medically stationary on October 11, 1995. Accordingly, the ALJ reinstated the November 1995 closure notices.

On review, claimant contends that the left jaw (mastoid) component of her claim was not medically stationary on October 11, 1995. In support of her contention, claimant cites medical evidence indicating that she needed additional medical treatment and evaluation after that date.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that she was not medically stationary on the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence at the time of closure, as well as evidence submitted after closure; medical evidence, however, submitted after closure that pertains to changes in claimant's condition subsequent to closure is not properly considered. See Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). Furthermore, neither fluctuations (including improvement) in a claimant's medical condition after claim closure nor a need for continuing medical treatment necessarily proves that claimant was not medically stationary. See Maarefi v. SAIF, 69 Or App 527, 531 (1984).

Here, Dr. Purtzer, who previously performed cervical surgery, noted on May 22, 1995 that he, along with several other physicians (including claimant's attending physician, Dr. Malcolm), had extensively evaluated claimant's pain in the area near her jaw. (Ex. 58). On August 28, 1995, Dr. Purtzer wrote that he had last treated claimant in June 1995 and that he was not recommending further treatment. (Ex. 64).

Examining physicians, Drs. Maukonen and Neumann, then evaluated claimant's compensable conditions on October 11, 1995. In addition to claimant's cervical condition, the panel diagnosed a persistent area of tenderness and "fullness" on the left side of the neck below the ear of unknown etiology. (Ex. 65-6). Although recommending further evaluation by an ENT specialist, Neumann/Maukonen agreed that claimant's condition resulting from her compensable injury was medically stationary. (Ex. 65-6). Both Dr. Purtzer and Dr. Malcolm concurred with the Neumann/Maukonen report. (Exs. 71, 74).

Based on this medical evidence, we agree with the ALJ that claimant's jaw condition was medically stationary on October 11, 1995. We recognize that the Neumann/Maukonen panel recommended further evaluation of claimant's jaw condition and Dr. Malcolm recommended pain clinic treatment.[1] Moreover, claimant's jaw condition also appeared to improve with "post-closure" physical therapy. (Ex. 79).

However, continuing medical treatment/evaluation and post-closure fluctuations in a claimant's medical condition do not necessarily mean that a closure was premature. Maarefi, 69 Or App at 531. Moreover, no physician in this record opined that claimant was not medically stationary on October 11, 1995. To the contrary, Dr. Malcolm's suggestion of pain center treatment was based on her statement that "little else has been remedial." In light of this, as well as the substantial medical evidence affirmatively indicating that claimant was medically stationary on October 11, 1995, the ALJ properly found an absence of a reasonable expectation of material improvement that claimant's left jaw condition was medically stationary at the time of the November 1995 claim closure. Accordingly we affirm.

ORDER

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

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[1] On October 20, 1995, a consulting otolaryngologist, Dr. Mulcahy, recommended that claimant undergo an MRI scan. A neurosurgeon, Dr. Delashaw, reported on November 10, 1995 that the MRI scan was unremarkable except for the previous cervical surgery. (Ex. 73). Dr. Delashaw recommended a steroid block and further pain clinic evaluation. However, Dr. Delashaw noted that a prior block had been unsuccessful.

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

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's right hand and wrist condition; and (2) assessed a penalty for the employer's allegedly unreasonable failure to provide discovery. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant asserts that she developed a right hand and wrist condition as a result of her work activities on June 2, 1996, when she used scissors and a knife to cut 1,500 truffles for a food demonstration. Based on Dr. Fisher's chart notes, the ALJ concluded that claimant's work activities on June 2, 1996 were a material and sole cause of her right hand and wrist condition.

The employer argues that there is insufficient evidence to find the claim compensable because there is no medical opinion on causation. Alternatively, the employer argues that, assuming Dr. Fisher offered a medical opinion on causation, it is not persuasive.

Claimant does not dispute that expert medical evidence is required to determine causation, but she contends that causation is clear because her physicians related her condition to the June 2, 1996 work activities and Dr. Fisher advised her not to cut with knives and scissors for several weeks.

We agree with the parties that expert medical evidence is necessary in this case. Although claimant relates her condition to the June 2, 1996 work activities, she did not report any problems to her supervisor until about a week later (Ex. 2A-1), and she did not seek medical treatment until June 17, 1996. See Barnett v. SAIF, 122 Or App 279, 283 (1993).

The employer argues that the claim should be analyzed as an occupational disease. In determining the appropriate standard for analyzing compensability, the focus is whether claimant's right hand and wrist condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

The record supports the occurrence of an injury on June 2, 1996. The injury was unexpected, as claimant had not had the same kind of pain with her right hand and wrist. Moreover, claimant's condition was "sudden in onset" in that it occurred over a discrete, identifiable period of time. The fact that claimant's pain grew progressively worse over a short period of time does not make it "gradual in onset." Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Rickey C. Amburgy, 48 Van Natta 106 (1996). We agree with the ALJ that the claim should be analyzed as accidental injury, rather than an occupational disease.

The application of ORS 656.005(7)(a)(B) is contingent on the presence of a compensable injury which "combined" with a preexisting condition. Leon M. Haley, 47 Van Natta 2056, on recon 47 Van Natta 2206 (1995). Here, there is no medical evidence that claimant's June 2, 1996 injury "combined" with a preexisting condition. Dr. Fisher found no evidence of arthritis in claimant's hand, and she specifically noted that claimant's "condition was unrelated to her previous wrist problems (CTS)." (Ex. 5-2). Therefore, claimant need only prove that her June 2, 1996 work activities were a material contributing cause of her right hand and wrist condition.

As the ALJ noted, the parties did not obtain medical opinions expressly discussing the causation of claimant's condition. Nevertheless, we conclude that the chart notes of Dr. Fisher are sufficient to establish that claimant's June 2, 1996 work activities were a material contributing cause of claimant's right hand and wrist condition.

Claimant first sought medical treatment from Dr. Fisher on June 17, 1996. Dr. Fisher reported: "At work cut choc. truffles at food demo all day (6 hrs) - June 2nd - swelling dev. over next wk.. Rt. handed. Teaching calligraphy class weekly." (Ex. 5-1). Dr. Fisher said that claimant's range of motion was "ok but painful" and she had swelling in her hand. (Id.) Dr. Fisher ordered x-rays and prescribed medication, an ace wrap, and elevation and ice for the hand. On June 28, 1996, Dr. Fisher reported that the x-ray showed no arthritis. (Ex. 5-2). Her diagnosis was "overuse syndrome and extensor tendonitis." (Id.)

On claimant's "827" form, she wrote: "As a result of cutting 1,500 pieces of truffles for a food demo, my hand became cramped, swollen and I had semi-loss of feeling in 1st two fingers. Knuckle joint and soft tissue area below this was bruised." (Ex. 2). Regarding the nature and location of the injury, claimant wrote: "Was cutting truffles at Costco for demo on June 2, 1996 for 6 hours. Afterwards, R hand developed swelling over next week." (Id.) Dr. Fisher signed the form on July 2, 1996 and diagnosed "overuse syndrome and extensor tendonitis." (Id.)

On September 3, 1996, Dr. Fisher reported that claimant complained of wrist swelling and claimant "believed that she injured it by repetitive motion a couple of months ago." (Ex. 5-2). Dr. Fisher noted that claimant had decreased the use of her right hand and was only teaching one calligraphy class a week, although she had been doing calligraphy 3 times a week for one and one-half hours at a time. (Id.) Dr. Fisher also said that claimant noticed ulnar pain at the wrist while driving and gripping the steering wheel. (Id.) Dr. Fisher noted that claimant's "condition was unrelated to her previous wrist problems (CTS)." (Id.)

On October 3, 1996, Dr. Fisher reported that claimant had pain in her right hand and her right knuckle was still enlarged. (Ex. 5-3). Claimant was learning to use a knife and scissors with her left hand. Dr. Fisher diagnosed right "2nd metacarpal phalangeal joint pain." (Id.) Dr. Fisher recommended "[n]o cutting with knife or scissors in R hand for 4-6 weeks." (Id.)

Claimant was also treated by Dr. Harris, beginning June 26, 1996. On that date, Dr. Harris reported that claimant had right hand pain from overusing it at work. (Ex. 4-1). On July 17, 1996, Dr. Harris reported that claimant had swelling in the right second digit at the metacarpal joint, and it started at work after cutting with scissors repeatedly. (Ex. 4-2).

Based on the chart notes of Dr. Fisher, we conclude that claimant's June 2, 1996 work incident was, at least, a material contributing cause of claimant's right hand and wrist condition. The employer contends that claimant reported having ulnar pain in the wrist while driving. However, there is no evidence that claimant had pain while driving before the June 2, 1996 work incident. Similarly, the record does not establish that claimant was experiencing symptoms at work in general before the June 2, 1996 work incident. Although the employer asserts that the record indicated some concern about arthritis, Dr. Fisher reported that the x-rays showed no arthritis. (Ex. 5-2).

Finally, the employer contends that the ALJ erred in finding claimant credible. Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Since the ALJ's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990).

When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review of the record, we agree with the ALJ that claimant is a credible witness. Furthermore, we disagree with the employer's assertion that the medical opinions are unreliable because they are based on claimant's history.

In sum, we conclude that claimant's June 2, 1996 work incident was a material contributing cause of claimant's right hand and wrist condition and the employer is responsible for her condition.

Penalties

We adopt and affirm that portion of the ALJ's order that assessed a penalty for the employer's unreasonable failure to provide discovery.

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.

ORDER

The ALJ's order dated November 22, 1996 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the self-insured employer.

In the Matter of the Compensation of
DEBRA D. DAVIS, Claimant
WCB Case No. 96-03926
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the self-insured employer's partial denial of her left shoulder calcific tendinitis/impingement condition; and (2) upheld the insurer's denial of her aggravation claim for her current left shoulder condition. On review, the issues are compensability and aggravation.

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

On review, claimant renews her argument that the employer is precluded from denying the compensability of her calcific tendinitis/impingement condition, based on the award of permanent disability in the May 13, 1996 Order on Reconsideration. Claimant relies on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), and the court's conclusion that an insurer's failure to challenge a permanent disability award based on a noncompensable degenerative condition meant that the carrier was barred by claim preclusion from later denying that the condition was part of the compensable claim.

Here, the employer accepted claimant's left shoulder strain. Claimant argues that the arbiter's report references the preexisting calcific tendinitis and degenerative joint changes. (Ex. 29-4). Notwithstanding those references, however, we are unable to find that the Order on Reconsideration award for loss of range of motion was based upon the tendinitis condition. Rather, the evaluator noted only that Dr. Smith, the medical arbiter, had examined claimant and found tenderness, a positive impingement sign, and giveway weakness due to pain, although a neurological exam was normal. (Ex. 29-4).

After reviewing the record, including the prior ALJ's order which affirmed the Order on Reconsideration, we find no basis to support claimant's argument that the award of permanent disability was based on the calcific tendinitis condition, rather than the accepted strain condition. Accordingly, we agree with the ALJ that the employer was not precluded from denying claimant's calcific tendinitis condition. See Darrold D. Willis, 48 Van Natta 1782 (1996) (Board relied on absence in record of a connection between the range of motion and the degenerative condition to find that the claimant failed to prove that the award in the Notice of Closure based on range of motion was for the degenerative condition and, therefore, the employer was not precluded from denying the claimant's current condition).

ORDER

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

In the Matter of the Compensation of
JAMES D. HILL, Claimant
WCB Case No. 96-06090
ORDER OF DISMISSAL
Welch, Bruun, et al, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Mills' October 3, 1996 order. We have reviewed claimant's request on our own motion to determine whether we have jurisdiction to consider the matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On October 3, 1996, ALJ Mills issued an Opinion and Order which affirmed an Order on Reconsideration that did not award permanent disability for claimant's left forearm condition. Copies of that order were mailed to claimant, claimant's attorney, the employer, the SAIF Corporation, and their counsel. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for Board review must be mailed to the Board and to the other parties to the proceeding within the 30-day appeal period.

On March 17, 1997, the Board received claimant's letter, in which he stated that he had requested Board review of the ALJ's order "by sending a letter to your office on October 23, 1997." The letter, which was dated March 10, 1997, was not mailed by certified mail.

On March 18, 1997, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. Id.

Here, the 30th day after the ALJ's October 3, 1996 order was November 2, 1996, a Saturday. Therefore, the final day to perfect a timely appeal of the ALJ's order was Monday, November 4, 1996. Anita L. Clifton, 43 Van Natta 1921 (1991). Claimant's request for Board review of the ALJ's order was not mailed by certified mail, and was received by the Board on March 17, 1997. Therefore, in accordance with OAR 438-005-0046(1)(b), it was filed on March 17, 1997. Inasmuch as March 17, 1997 is more than 30 days after the ALJ's October 3, 1996 order, the request was untimely filed. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

Although claimant contends that he first made his request for Board review on October 23, 1996, the Board did not receive such a request.[1] Instead, the record establishes that the Board received

[1] In the event that claimant can establish that he mailed a request for review of the ALJ's order to the Board within 30 days of the ALJ's October 3, 1996 order (with copies of the request to the other party), he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Since our authority to consider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible.

claimant's request for review on March 17, 1997. Under such circumstances, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2). Accordingly, claimant's request for Board review is dismissed.

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. Alfred F. Puglisi, 39 Van Natta 310 (1987; Julio P. Lopez, 38 Van Natta 862 (1986).

IT IS SO ORDERED.

March 25, 1997 Cite as 49 Van Natta 309 (1997)

In the Matter of the Compensation of
JANALEE H. BREITELS, Claimant
WCB Case No. 96-06664
ORDER OF DISMISSAL
Philip H. Garrow, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requested review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's aggravation claim for a bilateral wrist condition. Prior to conducting our review, we received the parties' request that review be suspended to await Board approval of their Claim Disposition Agreement (CDA). On approval of that disposition, the parties further stipulated that this pending matter could be dismissed.

On March 24, 1997, we approved the parties' CDA, in which claimant released her past, present, and future rights to workers' compensation benefits (including aggravation rights, temporary disability, and permanent disability), except medical services, related to her April 1994 claim. The CDA also contained a provision stating that, on Board approval of the CDA, this pending request for Board review "shall be dismissed."

In light of the parties' prior announcement and our approval of the parties' CDA (including the aforementioned provision), we conclude that the ALJ's order has been rendered moot. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAED KHAMMASH, Claimant
WCB Case No. 95-13398
ORDER ON REVIEW
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral hearing loss condition. On review, the issue is compensability.

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

Our review of the ALJ's order must be based on the record certified to us. ORS 656.295(5). Consequently, we treat claimant's request for a "fair hearing" as a motion to remand for submission of additional evidence.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. Id. Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must 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. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

In this case, claimant argues that his hearing was unfair because the employer's expert was biased and claimant could not afford to hire another doctor or an attorney.[1] We disagree with claimant's contentions.

First, we note that claimants' attorneys are not "hired," they are retained on a contingency basis, i.e., had claimant prevailed over the employer's denial, his attorney's fee would have been paid by the employer. Furthermore, where, as here, an employer's denial is upheld, claimant's attorney is not allowed to receive a fee from his/her client. Thus, the record does not support a conclusion that lack of funds caused claimant to be unrepresented.

Second, the record does not support claimant's assertion that the "employer-referred" physicians were biased. We note that all of the medical evidence, including that provided by Dr. Wayman, claimant's treating physician, unanimously relates claimant's hearing loss to nonwork related causes. Under these circumstances, the record does not indicate experts' bias or suggest that additional medical evidence would likely affect the outcome of the case.

Third, we are not persuaded that claimant's "evidence" (or argument on review) was unobtainable at the time of hearing. Finally, after considering the ALJ's order and the record, we conclude that the record in this matter case has not been improperly, incompletely or otherwise insufficiently developed. Accordingly, claimant's request for remand is denied.

ORDER

The ALJ's order dated September 23, 1996, as amended September 24, 1996, is affirmed.

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[1] Given the opportunity at hearing, claimant did not request a postponement or continuance due to lack of representation or medical evidence at hearing. (See Tr. 4).

In the Matter of the Compensation of
CHRISTINE C. McMULLEN, Claimant
WCB Case No. 95-09378
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

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

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

Claimant worked as a commercial loan officer in a bank. In May 1994, David Imig became the branch manager and claimant's supervisor. In May 1995, claimant sought treatment and was diagnosed with an adjustment disorder.

After examining the incidents identified in the medical record and in claimant's testimony as being the events causing claimant's psychological condition, the ALJ found that some of the employment conditions qualified as those generally inherent in every working situation or did not exist in a real and objective sense. See ORS 656.802(3)(a), 656.802(3)(b). Thus, the ALJ concluded that claimant did not carry her burden of proving a compensable mental disorder.

On review, claimant asserts that the employment conditions should not be analyzed as separate incidents. Rather, claimant contends that her employment should be viewed "as a pattern of events directed at forcing the Claimant out of her job position[.]" In support of this assertion, however, claimant "review[s] the individual allegations by Claimant" and argues that the record does not support the ALJ's analysis and conclusions concerning the employment conditions.

After reviewing the record, including the documentary[1] and testimonial evidence, we agree with the ALJ's examination of the employment events underlying claimant's metal stress claim. Furthermore, for the reasons discussed by the ALJ, we agree that the claim fails.

ORDER

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

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[1] In her brief, claimant objected to the ALJ's admission of Exhibit C1, an E-mail transmission from David Imig to claimant regarding claimant's "profile cards." The ALJ admitted the document as impeachment evidence. (Tr. 200 (Day1)). We find that we need not decide whether or not the ALJ abused his discretion in admitting the document since we would reach the same conclusion concerning compensability even if the exhibit was not properly admitted and could not be considered on review.

In the Matter of the Compensation of
ROBERTO ROCHA-BARRANCAS, Claimant
WCB Case No. 96-07856
ORDER OF DISMISSAL
Willner & Associates, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Lipton's February 6, 1997 order. We have reviewed claimant's request on our own motion to determine whether we have jurisdiction to consider the matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On February 6, 1997, ALJ Lipton issued an Opinion and Order which, among other findings, determined that the rate of claimant's temporary total disability had been properly calculated. That order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On March 14, 1997, the Board received claimant's request for Board review of the ALJ's order. The request, which was dated March 5, 1997, was not mailed by certified mail. The envelope which contained claimant's request for review was postmarked March 13, 1997.

On March 18, 1997, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. Id.

Here, the 30th day after the ALJ's February 6, 1997 order was March 8, 1997, a Saturday. Therefore, the final day to perfect a timely appeal of the ALJ's order was Monday, March 10, 1997. Anita L. Clifton, 43 Van Natta 1921 (1991). Claimant's request for review was dated March 5, 1997, which was within 30 days of the ALJ's February 6, 1997 order. Nonetheless, the request for Board review of the ALJ's order was not mailed by certified mail, and was received by the Board on March 14, 1997. See Sandra E. Post, 48 Van Natta 1741(1996), on recon 49 Van Natta 22 (1997). Because claimant's request was received by the Board on March 14, 1997, it was "filed" on that date. OAR 438-005-0046(1)(b).[1] Inasmuch as March 14, 1997 is more than 30 days after the ALJ's February 6, 1997 order, the request was untimely filed. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

[1] Even if we were to consider the "postmark" date on the envelope containing claimant's request as the "filing" date, the appeal would still be untimely because March 13, 1997 (the "mailing" date) is also more than 30 days from the ALJ's February 6, 1997 order.

Based on the aforementioned reasoning, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

March 25, 1997 Cite as 49 Van Natta 313 (1997)

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

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that affirmed the Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability for claimant's mental condition. On review, the issue is the extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following changes. In the second paragraph on page 3, we change the fourth sentence to read: "Dr. Burt concluded that claimant was functioning in the Class 2, minimal range, on the basis of depressive symptoms and increased suicidal ideation off of medication." We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

On July 2, 1994, claimant was compensably injured when she slipped and fell. The employer accepted a right hip injury on May 24, 1995. On July 26, 1995, the employer accepted an adjustment reaction with anxiety and depression. (Ex. 17). Claimant became medically stationary on February 1, 1996. (Ex. 24). A Notice of Closure dated February 12, 1996 did not award any permanent disability. (Id.) An Order on Reconsideration dated July 2, 1996 awarded claimant 6 percent unscheduled permanent disability award for her compensable mental condition. (Ex. 32). The employer requested a hearing.

The ALJ found that, since the employer had challenged the Order on Reconsideration, it had the burden of establishing that the standards had been incorrectly applied. In affirming the Order on Reconsideration, the ALJ relied on the opinion of Dr. Burt, the medical arbiter.

On review, the employer argues that it does not have the burden of proof and it contends that the preponderance of evidence establishes that claimant's compensable mental condition resolved without any permanent impairment.

We conclude that, regardless of which party has the burden of proof, claimant is not entitled to an unscheduled permanent disability award for her compensable mental condition.

To be entitled to permanent disability compensation for her mental condition, claimant must establish that her permanent impairment is due to the compensable injury. ORS 656.214(2). Findings of permanent impairment may be made by: (1) the attending physician; (2) other physicians, if the attending physician concurs with the findings; and (3) if reconsideration is requested, the medical arbiter. See former OAR 436-035-0007(12), (13) (WCD Admin. Order 96-051).

Claimant was treated by Dr. Kjaer, psychiatrist, beginning on January 10, 1995. Dr. Kjaer prescribed the antidepressant, Amitriptyline, for pain control and insomnia, as well as Paxil for depression. (Exs. 8, 23).

On January 27, 1995, an independent psychiatric evaluation was conducted by Dr. Bellville, psychiatrist. At that time, claimant was taking Elavil and Paxil. (Ex. 9-1). Dr. Bellville's Axis I diagnosis was "[h]istory of adjustment reaction with anxiety and depression following the injury of record and currently resolved with continued prescribing of anti-depressants including Amitriptyline and Paxil." (Ex. 9-4). Dr. Bellville commented that there did not appear to be "any specific symptoms related to the work situation on a psychological basis." (Ex. 9-3). However, he noted that claimant might have symptoms if she were not taking anti-depressants. (Id.) Dr. Bellville expected that claimant would eventually be able to taper off anti-depressant medication and return to full functional capacity without any residual. (Ex. 9-4).

Dr. Kjaer concurred generally with Dr. Bellville's report, with some notations. (Ex. 23). Claimant became medically stationary on February 1, 1996. (Ex. 24).

Neither Dr. Kjaer or Dr. Bellville indicated that claimant had any permanent impairment due to her compensable condition of an adjustment reaction with anxiety and depression. Thus, claimant's entitlement to permanent disability rests on the opinion of the medical arbiter, Dr. Burt.

If a medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that the impairment is due to the compensable injury. See Kim Danboise, 47 Van Natta 2163, 2164, on recon 47 Van Natta 2281(1995); Edith N. Carter, 46 Van Natta 2400, 2401 (1994). However, where a medical arbiter relates the claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not considered persuasive evidence of injury-related impairment. See e.g., Manuel G. Garcia, 48 Van Natta 1139 (1996).

Before the arbiter examination, Dr. Burt was asked to report objective permanent impairment resulting from the "accepted psychological condition only." (Ex. 29-2; emphasis in original). In the June 6, 1996 report, Dr. Burt referred to claimant's accepted condition of adjustment reaction with anxiety and depression. (Ex. 31-1). Dr. Burt reported:

> "Due to the criteria used for the diagnosis of an adjustment reaction, I do not feel she currently meets criteria for this diagnosis. She appears to have a history of either recurrent depression or dysthymia. She has gotten some relief with the antidepressant Paxil, but has stopped it, recently, and has had some increase in hopelessness, with occasional suicidal ideation, which was presented in a somewhat offhand manner. There is also an anxiety component to her situation, but I do not feel she meets criteria for panic disorder, or another anxiety disorder at this time." (Ex. 31-7).

Dr. Burt indicated claimant may have an underlying personality disorder, but he did not feel comfortable making a firm diagnosis with limited information. (Ex. 31-8). Dr. Burt also considered the possibility of a somatoform pain disorder. (Id.) Dr. Burt explained:

> "However, it should definitely be noted that she has continued to work, despite her complaints of discrimination, harassment, and physical pain. I suspect her ongoing difficulties with the work environment, and the depression and anxiety she is experiencing in that situation, are related to underlying depressive symptoms, which currently do not meet criteria for major depression, coupled with her personality style, which tends to be confrontational. This has the claimant feeling victimized and harassed, likely out of proportion to what is existing. However, I do not have a work assessment to determine if this is the actual case, but her presentation today is suggestive of this." (Ex. 31-8).

Despite saying that claimant's underlying depressive symptoms did not currently meet the criteria for major depression, Dr. Burt's Axis I diagnosis was "Major depression - recurrent versus dysthymia. History of adjustment reaction with depression and anxiety, resolved. Rule out somatoform pain disorder." (Id.)

Dr. Burt reported that he did "not feel the accepted psychological condition is currently active." (Ex. 31-9). He believed that "due to claimant's difficulties with depression, which has been an ongoing problem throughout her life, and also some of her personality traits, she does have some difficulty adapting to certain stressors of life." (Id.) Dr. Burt felt that claimant would benefit from ongoing psychiatric treatment and additional medication. (Ex. 31-10).

Regarding permanent impairment, Dr. Burt reported:

> "In regard to a class of evaluation of permanent impairment, I would classify [claimant] as having function in the Class 2, minimal range. I base this 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, such as her glass work." (Ex. 31-11).

We find Dr. Burt's opinion to be, at best, inconsistent and confusing. Claimant has an accepted condition of adjustment reaction with anxiety and depression. Dr. Burt was asked to report objective permanent impairment resulting from the "accepted psychological condition only" (Ex. 29-2), and he concluded that claimant had function in the Class 2, minimal range. (Ex. 31-11). Nevertheless, Dr. Burt commented that he did "not feel the accepted psychological condition is currently active." (Ex. 31-9). He found that claimant did not currently meet the criteria for an adjustment reaction or a panic/ anxiety disorder. (Ex. 31-7). His diagnosis included "[h]istory of adjustment reaction with depression and anxiety, resolved." (Ex. 31-8; emphasis added). Dr. Burt reported that claimant had a "history of either recurrent depression or dysthymia." (Ex. 31-7). He explained that the "depression and anxiety she is experiencing in [the work environment], are related to underlying depressive symptoms, which currently do not meet criteria for major depression[.]" ((Ex. 31-8). However, Dr. Burt proceeded to diagnose "[m]ajor depression - recurrent versus dysthymia." (Id.)

In sum, Dr. Burt's comments that claimant did not currently meet the criteria for an adjustment reaction, and that the accepted psychological condition was not currently active, as well as his conclusion that the adjustment reaction with depression and anxiety had resolved, all weigh against the existence of a causal relationship between claimant's current function in the Class 2 minimal range and the compensable mental condition. Furthermore, Dr. Burt's reference to claimant's "recurrent" depression and his comments that she had an ongoing problem with depression throughout her life indicate that claimant's impairment was related to causes other than the compensable injury. Under these circumstances, we find that claimant is not entitled to an unscheduled permanent disability award.

ORDER

The ALJ's order dated October 21, 1996 is reversed. In lieu of the Order on Reconsideration's award of 6 percent (19.2 degrees) unscheduled permanent disability, claimant is awarded no permanent disability for her mental condition. Claimant's attorney fee is also reversed.

March 21, 1997 Cite as 49 Van Natta 315 (1997)

In the Matter of the Compensation of
SCOTT CAMPBELL, Claimant
WCB Case No. 96-04550
ORDER DENYING RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our February 11, 1997 Order on Review and March 5, 1997 Order on Reconsideration. For the second time, claimant requests reconsideration, again asserting that the "preponderance of the evidence from Dr. Gaskell indicates that claimant does have permanent impairment due to the injury and also diminished range of motion."

We consider our Order on Review and Order on Reconsideration as adequately addressing claimant's contention. Accordingly, we deny claimant's request for reconsideration. The parties' rights of appeal shall continue to run from the date of our March 5, 1997 Order on Reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHIRLEY A. BARTOW, Claimant
WCB Case No. 95-07905
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
James Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that set aside its denial of claimant's consequential condition claim for a prescription drug/alcohol dependency condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for a temporary employee agency and was assigned to work as a room attendant for the employer for about three years. In 1994, claimant was hired directly by the employer.

On November 17, 1994, claimant was injured when she was moving some furniture at work. (Exs. 1, 2). She had pain in her neck, shoulders, back and legs. (Ex. 1). On November 19, 1994, Dr. Conner diagnosed muscle pain from overuse and upper back strain, and prescribed Voltaren. (Exs. 1, 2). A November 25, 1994 report indicated that claimant had taken one day off work, but her pain was a little worse after working the past few days. (Ex. 3). Claimant was told to continue using Voltaren, as well as Flexeril.

On November 28, 1994, Dr. Tuft reported that claimant had ongoing soreness and diagnosed a muscular back strain, primarily upper back. (Ex. 4-1). Dr. Tuft recommended physical therapy and restricted claimant to sedentary work.

On December 7, 1994, SAIF accepted a disabling upper thoracic strain. (Ex. 6).

On December 22, 1994, Dr. Tuft reported that claimant had continued pain, although she was doing sedentary work. (Ex. 4-3). Dr. Tuft diagnosed upper thoracic nerve root irritation and trapezius muscle strain and continued claimant's physical therapy. (Id.) On December 26, 1994, Dr. Tuft prescribed Naprosyn instead of Voltaren and gave claimant Talwin NX for night time use. (Ex. 4-4).

Claimant testified that she had no problems with alcohol or drugs before the November 1994 injury. (Tr. 21-22). Claimant did not initially take all the medications prescribed after the injury because she was concerned about taking care of her son. (Tr. 17, 41). She left the extra pills on top of her refrigerator. (Tr. 18, 44). There were "a lot" of pills on her refrigerator. (Tr. 44). As the pain progressed, she began taking more of the pills. (Tr. 18). Claimant said she began to take more of the pills in the middle of February 1995 and into March 1995 because the pain was getting worse. (Tr. 18, 45). As the pain got worse, claimant started taking more medication than was prescribed, beginning sometime in February 1995. (Tr. 46- 48). Claimant testified that she started combining alcohol with the pain medication because the pills were not working. (Tr. 20). Claimant said the prescription drug problem began in mid-February 1995 and the alcohol problem began in late March/early April 1995. (Tr. 32, 50). Claimant said she did not take any drugs that were not prescribed for her. (Tr. 28).

When claimant was examined by Dr. Stewart on January 3, 1995, she complained primarily of right shoulder pain and some upper thoracic discomfort. (Ex. 8). Her low back discomfort had resolved. Claimant's medications were Flexeril, Flexall cream, Naprosyn and Talwin. Dr. Stewart diagnosed right shoulder impingement syndrome with supraspinatus and bicipital tendinitis, as well as probable subacromial bursitis and cervical and thoracic pain. (Id.) Claimant was given a subacromial bursa injection.

On January 19, 1995, Dr. Stewart reported that claimant had returned to working in the office and was doing well. (Ex. 9). The shoulder injection had helped her, but the physical therapy seemed to make her condition worse. Dr. Stewart thought claimant had a sleep disturbance and switched claimant from Flexeril to Elavil.

On February 7, 1995, Dr. Stewart reported that claimant had been given a promotion at work, which was helpful in limiting the amount of discomfort. (Ex. 9-2). However, she continued to be uncomfortable at her right trapezius and cervical paraspinals. At that time, claimant had no impingement signs of the right shoulder. (Id.) He released claimant to light duty, with physical labor two hours per day and desk work six hours per day.

On February 21, 1995, Dr. Stewart reported that claimant had increasing discomfort and had discontinued physical therapy and home therapy. (Ex. 9-3). Claimant had positive impingement signs at the right shoulder. Dr. Stewart felt that conservative care had failed and he ordered an MRI.

On March 4, 1995, claimant was examined by Dr. Greer for right shoulder complaints and high blood pressure. (Ex. 12). Dr. Greer told claimant to discontinue the Naprosyn and start taking Darvocet.

Claimant was seen in the emergency room on March 6, 1995 for severe right upper back pain. (Ex. 13). Claimant was given Vicodin and told to follow up with Dr. Stewart. On March 7, 1995, Dr. Stewart reported that claimant's MRI was within normal limits, but she continued to have right shoulder pain. (Ex. 14). Dr. Stewart reported that claimant had been in the emergency room and was given Vicodin, which she did not take, and had been given Darvocet by Dr. Greer, which she did not take. (Id.) Claimant was having significant sleep problems. Dr. Stewart also reported there were "significant issues regarding a past history of domestic violence and what is sounding more like a post traumatic stress type disorder related to this." (Id.) He felt those issues were affecting claimant's "ability to progress with her chronic pain in spite of reassurance as to the absence of specific neurologic deficits or orthopedic abnormality." (Id.) Dr. Stewart thought claimant needed a psychological evaluation. He increased her prescription for Elavil.

Dr. Sulkosky examined claimant on March 9, 1995 and commented that she should get back to modified work as soon as possible. (Ex. 15). Dr. Sulkosky recommended that "we don't do any kind of injections or really give her anything other than maybe some Aleve or something like that from a medical standpoint, as I think really she has a paucity of physical findings at this point in time to indicate further intervention." (Id.) Claimant had no crepitance with impingement testing and her neurologic exam was entirely normal.

On March 13, 1995, claimant complained to Dr. Tufts about her blood pressure and he prescribed Prinivil. (Ex. 4-5). She also had pain in the periscapular muscles. Dr. Tufts' March 20, 1995 chart note indicated that claimant was working out four hours a day and her shoulder was definitely better. (Ex. 4-6). Dr. Tufts increased the amount of Prinivil.

On March 27, 1995, Dr. Stewart reported that claimant had been making unusual phone calls to him and he was concerned about possible alcohol and/or drug abuse. (Ex. 9-7). Dr. Stewart examined claimant and found no impingement signs and a moderate degree of tenderness.

On April 5, 1995, Dr. Stewart reported that claimant had returned to work the previous week, but her pain had increased and she was not able to work. (Ex. 9-8). Dr. Stewart urged claimant to obtain a psychological evaluation and he noted that she had "significant financial stressors." (Id.) Claimant had no impingement signs of her right shoulder. Dr. Stewart commented that "there are a number of issues here which may be interfering with the patient's ability to successfully return to work." (Id.)

Claimant was seen in the emergency room on April 6, 1995 for alcohol and drug abuse. (Ex. 17). The report indicated claimant said she "drank too much booze, took too many pills[.]" (Id.) Claimant's treatment was "Do not mix Rx's - only take meds per Dr. Stewart's orders." (Id.)

Claimant was seen again in the emergency room on April 8, 1995 for alcohol and drug abuse and an unknown overdose. (Exs. 18, 19). Dr. Bell's report indicated that claimant said she took the medications and alcohol to help her sleep. (Ex. 19). Claimant told Dr. Bell she had recently received another eviction notice. (Id.)

Dr. Stewart reported on April 13, 1995 that claimant had been arrested for driving under the influence and had been to the emergency room twice in recent weeks "presumably under the influence of alcohol and multiple prescription medications." (Ex. 9-9). Claimant complained of continued right shoulder pain. Although claimant had not worked since at least March 30, 1995, Dr. Stewart felt she could return to work the following day, with seven hours of office work and one hour of cleaning rooms. Dr. Stewart prescribed Elavil.

On April 17, 1995, claimant was seen in the emergency room for an overdose of alcohol and drugs. (Exs. 21, 22). Claimant was admitted to the hospital by Dr. Tufts. (Ex. 22-2). On April 18, 1995, Dr. Tufts diagnosed alcohol and prescription drug abuse, chronic right shoulder and upper back strain, smoking addiction and hypertension, as well as "[c]hronic anxiety due to social situation." (Ex. 24). Dr. Tufts explained:

> "[Claimant] reports that at the initial stage of her injury she was given pain medication and she simply stored it. She did not have a history of alcohol abuse or drug abuse previously. She does not use street drugs. She did not choose to take the medication early in her disability because it affected how she felt about and dealt with her only son, Robert, an 8-year-old boy who is the light of her life. As the pain failed to improve and, as a matter of fact got worse in her mind, she began to use pain medication. Before she knew it she was using several pills of different types, Darvocet, muscle relaxants, and Vicodin every four hours. She began to drink and was drinking perhaps a half pint of vodka a day toward the end." (Ex. 24-1).

Dr. Tufts referred claimant to an alcohol and drug program. Claimant was treated by Julie Honig Smith, L.C.S.W. (Ex. 24A). Smith diagnosed claimant with alcohol dependence, sedative hypnotic dependence, opioid dependence and possible major depression. (Id.)

In a letter to SAIF on April 22, 1995, Dr. Stewart responded to questions about claimant's prescriptions:

> "As to the use of addicting medications, prescriptions have been fairly limited. Primarily she has been provided with anti-inflammatories and antidepressant, specifically Elavil. Dr. Tuft has, on a couple of occasions provided her with limited quantities of Talwin. When I initially saw her in January I gave her injections which she stated markedly increased her pain and I gave her twelve Vicodin. She has also been seen in the Emergency Room and in the Urgent Care Center in our Clinic and has apparently been provided with Darvocet and Vicodin at times again in small quantities. Therefore, I think that it is unlikely that she has become 'hooked' on prescription medications through the events following her industrial injury." (Ex. 27).

Claimant was seen by Dr. Whitehead, psychologist, on April 6, April 17 and April 18, 1995. Dr. Whitehead felt it was unlikely claimant's present problem was related to her work injury. (Ex. 28-2).

Claimant was discharged from the hospital on April 25, 1995. (Ex. 29). Dr. Tufts reported that "claimant had stored a number of the prescriptions she had obtained for pain and then began to take them with regularity." (Ex. 29-1). Claimant had used Darvocet, Vicodin, muscle relaxants, as well as alcohol. (Id.)

On May 24, 1995, SAIF issued a partial denial of claimant's alcohol/prescription drug abuse. (Ex. 30). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she developed a prescription drug/alcohol dependency condition as a consequence of her compensable thoracic strain. The ALJ relied on Ms. Smith's opinion and found that claimant's alcohol abuse and prescription drug overuse was directly caused by the pain which arose from her accepted injury. The ALJ set aside SAIF's consequential condition denial.

SAIF contends that claimant's compensable thoracic strain is not the major contributing cause of her alcohol and prescription drug abuse. In addition, SAIF contends that claimant's alcohol and prescription drug abuse did not result from prescribed treatment. SAIF asserts that alcohol was not prescribed and claimant took more medication than was prescribed.

Claimant contends that her abuse problem developed from taking the correct amount of medication and she argues that her dependency problems flowed directly from the compensable injury. We disagree.

When a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). 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, the claimant sustained an injury to his right ulnar nerve during physical therapy for 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. 130 Or App at 195. In contrast, in Robinson, the court held that the claimant's injury sustained during an insurer-arranged medical examination was not compensable because it did not flow "directly and inexorably" from the compensable injury. 143 Or App at 66-67.

Here, the issue is whether claimant developed a prescription drug/alcohol dependency condition as the direct result of reasonable and necessary treatment of her compensable thoracic strain.

There is no evidence that alcohol was ever prescribed for claimant's compensable condition. Furthermore, there are no medical opinions that explain why alcohol constituted "reasonable and necessary treatment" of claimant's thoracic strain. Since alcohol was not prescribed and was not "treatment" of claimant's compensable condition, we conclude that her alcohol dependency condition was not the direct result of reasonable or necessary treatment for her compensable injury. Therefore, claimant's alcohol dependency condition is not compensable.

Medication was prescribed for the pain claimant experienced after the November 17, 1994 injury. Claimant continued to have upper back and shoulder pain. She testified that she did not initially take all the medications prescribed because she was concerned about taking care of her son. (Tr. 17, 41). She left the extra pills on top of her refrigerator. (Tr. 18, 44). There were "a lot" of pills on her refrigerator. (Tr. 44). As the pain progressed, she began taking more of the pills. (Tr. 18). Claimant said she began to take more of the pills in the middle of February 1995 and into March because the pain was getting worse. (Tr. 18, 45).

Claimant testified that she started taking more medication than was prescribed, beginning sometime in February 1995. (Tr. 46- 48). By the end of March, claimant thought she was "abusing" prescription drugs. (Tr. 40). When claimant was taken to the emergency room on April 6, 1995 for alcohol and drug abuse, the report indicated claimant said she "drank too much booze, took too many pills[.]" (Ex. 17-2). Claimant's treatment was "Do not mix Rx's - only take meds per Dr. Stewart's orders." (Id.) When claimant was hospitalized on April 17, 1995 for an overdose of alcohol and drugs, Dr. Tufts reported that claimant had not taken the medication prescribed at the initial stage of her injury. (Ex. 24-1). Rather, she stored the pills and, when the pain got worse, she began using pain medication of different types, along with alcohol. (Id.)

Although claimant said that she did not take any drugs that were not prescribed for her, she testified that she had stored up medication and later began taking more medication than prescribed. Claimant began taking alcohol, which was not prescribed, in addition to the excessive pain medication. There is no evidence that claimant was advised to take more medication than was prescribed or that she was advised to take medication with alcohol.

Dr. Stewart reviewed the medications prescribed for claimant and reported that claimant's prescriptions had been "fairly limited." (Ex. 27). He felt it was unlikely claimant had become "hooked" on prescription medications through the events following her industrial injury. (Id.) Although Ms. Smith, L.C.S.W., said that claimant was treated for a prescription drug addiction that resulted from

coping with an injury (Ex. 39-25), she did not indicate or suggest that claimant's overuse of prescription drugs was reasonable or necessary treatment of her thoracic strain. In any event, Ms. Smith's medical training was limited to her master's education in social work. (Ex. 39-27, 28).

Under these circumstances, we conclude that claimant's use of alcohol and excessive prescription drugs did not constitute reasonable or necessary treatment for her accepted thoracic strain. Compare Don V. Myers, 46 Van Natta 1844 (1994) (the claimant's Demerol treatment was reasonable and necessary treatment related to the compensable injury and was the major contributing cause of the consequential acute respiratory distress syndrome) with Bradley B. Rogers, 48 Van Natta 1849 (1997) (the claimant's home exercise program did not constitute "medical treatment" for his compensable low back injury).

Moreover, since claimant testified that she took more medication than was prescribed, her drug and alcohol abuse did not flow "directly and inexorably" from her compensable thoracic strain. See Robinson, 143 Or App at 66-67. Consequently, we conclude that claimant has not established that her prescription drug/alcohol dependency condition arose as a direct result of reasonable and necessary medical treatment for the compensable thoracic strain injury. We therefore reinstate SAIF's denial.

ORDER

The ALJ's order dated September 19, 1996 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
DENARE R. HOOPER, Claimant
WCB Case No. 96-04386
ORDER ON REVIEW
Terry & Wren, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that found a Notice of Closure to be timely issued. Claimant also requests review, and the SAIF Corporation cross-requests review, of that portion of the ALJ's order that increased claimant's unscheduled permanent disability award for neck, back, and shoulder conditions from 38 percent (121.6 degrees) to 39 percent (124.8 degrees). On review, the issues are the timeliness of the Notice of Closure and extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Notice of Closure

We adopt and affirm that portion of the ALJ's order regarding this issue.

Extent of Unscheduled Permanent Disability

We adopt and affirm the relevant portion of the ALJ's order except for that part of the order computing impairment for the spine. We replace that portion of the order with the following.

Claimant has accepted conditions in the cervical, thoracic and lumbar spine. SAIF contends that the ALJ did not properly compute impairment for the spine. The ALJ added impairment values for each region pursuant to former OAR 436-35-360(22), which provides:

> "For a total impairment value due to loss of motion, as measured by inclinometer, in any of the cervical, thoracic or lumbosacral regions, add (do not combine) values for loss of range of motion."

SAIF contends that this rule merely indicates that range of motion is added within each region of the spine. According to SAIF, former OAR 436-35-360(23) is the appropriate rule to compute impairment for all the spinal regions. That rule provides:

> "In order to rate range of motion loss and surgery in one region, combine (do not add) the total range of motion loss in that region with the appropriate total surgical impairment value of the corresponding region. Combine the value of each region to find the total impairment of the spine."

We agree with SAIF's interpretation of the rules. Former OAR 436-35-360 related to loss of spinal range of motion. Subsections (1) through (12) applied when the physician used a goniometer to measure range of motion while subsections (13) through (23) applied when the physician measured using an inclinometer. Former OAR 436-35-360(1). On its face, because the first sentence in subsection (23) discusses rating range of motion when there is surgical impairment, the second sentence would also appear to apply only when there is surgical impairment. When examined in the entire context of the rule, however, we find that this provision should be read differently.

First, former OAR 436-35-360(11) provided that the total impairment values for lost range of motion in "either the cervical or thoracolumbar regions" were added. Former OAR 436-35-360(12) provided that, "[f]or total rating of multiple residuals, see section (23) of this rule." Under subsection (11), therefore, values in each region were added and then, if there were "multiple residuals," subsection (23) applied. Consequently, for goniometer measurements, it is apparent that subsection (23) did not apply only when there is surgical impairment. Rather, if there were "multiple residuals" which did not include surgical impairment, only the second sentence of the provision applied, which resulted in combining the values.

Those subsections' relation to impairment for inclinometer measurements largely paralleled the provisions for impairment measured by goniometer. For instance, subsection (22), like subsection (10), was stated in the disjunctive, providing that "total impairment value due to loss of motion * * * in any of the cervical, thoracic or lumbosacral regions" are added. (Emphasis added.) Thus, subsection (22), like subsection (10), added total impairment for each region.

Given this context of the rule, we find that spinal impairment with inclinometer measurements should be determined consistently with the approach for goniometer measurements. That is, we find that subsection (23) is applied when there are "multiple residuals" in the spine, whether or not the worker has surgical impairment. Any other conclusion would result in treating differently workers who have been measured by goniometer and those who, although measured by inclinometer, have surgical impairment in one or more regions. Furthermore, if subsection (23) is not applied, there would be an absence in the rule for determining the total impairment value of the spine for all regions, since subsection (22) provided only for the total impairment in each region of the spine.

When the spinal impairment values are combined, claimant is entitled to 38 percent unscheduled permanent disability, the amount previously awarded by the Notice of Closure, rather than the 39 percent granted by the ALJ's order. Thus, we conclude that claimant is awarded 38 percent unscheduled permanent disability.[1]

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[1] The Notice of Closure computed claimant's spinal impairment as 11 percent for the cervical region, 3 percent for the thoracic region, and 6 percent for the lumbar region. It also found impairment of 9 percent for the left shoulder and 2 percent for the right shoulder. The Notice of Closure erroneously found that the combined values resulted in 28 percent impairment (the correct computation is 27 percent). Based on age and education value of 2 and adaptability value of 5, the Notice of Closure found a total award of 38 percent unscheduled permanent disability. When 27 percent impairment is used, the award is 37 percent unscheduled permanent disability.

ORDER

The ALJ's order dated October 7, 1996 is affirmed in part and modified in part. In lieu of the ALJ's increased unscheduled permanent disability award and "out-of-compensation" attorney fee, the Notice of Closure awarding 38 percent (121.6 degrees) unscheduled permanent disability is affirmed. The remainder of the ALJ's order is affirmed.

March 26, 1997 Cite as 49 Van Natta 322 (1997)

In the Matter of the Compensation of
DENNIS E. HORNING, Claimant
WCB Case No. 96-06401
ORDER ON REVIEW
Dale L. Smith, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's claim for a torn left medial meniscus. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant struck his left knee on the front of a vehicle at work on July 1, 1995. Claimant did not seek immediate treatment for his left knee pain. On August 10, 1995, claimant treated with Dr. Kilzer for diffuse joint pain and an inability to close his left hand. Dr. Kilzer's chartnotes refer to a history of a prior right knee injury and surgery in 1975, but do not mention the July 1995 knee injury.

On September 29, 1995, claimant treated again with Dr. Kilzer for his hand condition. Dr. Kilzer noted claimant's report of a July 1, 1995 knee injury.

On October 3, 1995, Dr. Kilzer reported that claimant's left knee film was abnormal, and a bone scan was ordered. Following the bone scan, claimant treated with Dr. Ruggeri on referral from Dr. Kilzer.

On December 28, 1995, claimant treated with Dr. Ruggeri for his left knee symptoms. Dr. Ruggeri diagnosed a torn medial meniscus in the left knee, and recommended an arthrogram. That same day, Dr. Parker performed an arthrogram and reported a probable tear of the medial meniscus.

A December 28, 1995 bone scan showed increased uptake in claimant's shoulders, wrists, hands and knees, with the left greater than the right.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that, based on claimant's testimony and the report and chartnotes of Dr. Ruggeri, claimant had established compensability. We disagree.

The medical evidence is divided between the opinions of the Medical Consultants Northwest, who examined claimant on behalf of SAIF, and the final report of Dr. Ruggeri, claimant's treating doctor.[1] The Consultants opined that the major contributing cause of claimant's condition was his preexisting underlying condition. Dr. Ruggeri stated that claimant's probable torn meniscus which occurred at work on July 1, 1995, was the major cause of claimant's left knee pain.

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[1] Dr. Kilzer, who first treated claimant for his left knee condition, concurred with the report of the Consultants. (Ex. 13).

Given the multiple possible causes of claimant's left knee condition, we find the issue of the compensability of claimant's current left knee condition to be a complex medical question requiring expert medical opinion. Barnett v. SAIF, 122 Or App 279 (1993). 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 defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

Here, we find persuasive reasons not do defer to the opinion of Dr. Ruggeri. On June 3, 1996, Dr. Ruggeri indicated that he had reviewed the Consultants' report and concurred with their opinion. However, on September 12, 1996, Dr. Ruggeri subsequently reported that the major contributing cause of claimant's left knee pain "was his accident of 1 July 1995 and not his arthritis, if indeed he does have arthritis, in his left knee." (Ex. 15).

Accordingly, because Dr. Ruggeri changed his opinion without explanation, we do not find his opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987). Moreover, the Consultants noted that claimant had a history of multiple arthralgias.[2] Consequently, the Consultants concluded that claimant had a systemic or preexisting condition which could be contributing to his joint pain. The Consultants attributed claimant's current condition to his polyarthritic or underlying condition, rather than the work incident. The Consultants also questioned the diagnosis of a medial meniscus tear, due to the mechanism of the injury itself. Additionally, the Consultants noted that claimant related his symptoms as coming from the area of the origin of the medial collateral ligament proximally, which was the area previously described to Dr. Kilzer. (Ex. 11).

After considering the Consultants' report and the remainder of the record, we conclude that Dr. Ruggeri's final opinion regarding causation is conclusory and unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). In particular, we find that Dr. Ruggeri has not addressed the reasoning set forth in the Consultants' report with respect to preexisting conditions, the mechanism of the injury, or the location or origin of the symptoms. Rather, Dr. Ruggeri has merely related the probable tear to a work incident, and without any reasoning, has disregarded any contribution from an arthritic or preexisting condition. Without further explanation or discussion from Dr. Ruggeri, we are unable to find that his opinion meets claimant's burden of proof. See, e.g., Dotty C. Fowler, 45 Van Natta 1649 (1993) (Doctor's report which did not address the contrary opinion of the medical examiners was found to be not persuasive).

Accordingly, because Dr. Ruggeri's September 12, 1996 opinion is the only expert medical opinion regarding causation which supports claimant's case, we conclude that the ALJ's order must be reversed.

ORDER

The ALJ's order dated October 30, 1996 is reversed. The SAIF Corporation's May 29, 1996 denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

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[2] The ALJ rejected the Consultants' opinion on the ground that it was unclear whether the Consultants were reporting on the condition of the left or right knee. Although we agree that the Consultants erroneously described a right knee contusion on one page of their report, a review of the entire report shows that the error was typographical in nature, and the Consultants clearly understood that claimant's left knee was the one at issue. Accordingly, we do not find a reason to discount the Consultants' opinion. (Ex. 11-7).

In the Matter of the Compensation of
JEFFREY S. HUNTER, Claimant
WCB Case No. 95-12872
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Otto's order which: (1) found that the scope of its denial of claimant's L5-S1 herniated disc condition was limited to whether the condition existed; (2) set aside its denial of the herniated disc condition; and (3) set aside its denial of claimant's current low back condition. On review, the issues are the scope of the employer's denial and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the second paragraph of the "Findings of Ultimate Fact," which states that the employer was bound by the express language of its denial and that claimant did not agree to litigate any issues beyond the scope of the denial.

CONCLUSIONS OF LAW AND OPINION

On June 20, 1994, claimant sustained a low back injury that the employer accepted as a nondisabling low back strain. Dr. Lorish provided treatment for claimant's low back and left leg pain. An August 1994 MRI revealed degenerative disease at L4-5 and L5-S1, as well as a left-sided L5-S1 disc herniation. Dr. Waller performed a left L5-S1 microdiscectomy from which claimant successfully recovered with complete resolution of his left leg pain.

The employer denied the compensability of the disc herniation, and claimant requested a hearing. The claim was settled by execution of a Disputed Claim Settlement (DCS) in June 1995, whereby claimant agreed to withdraw his hearing request in exchange for a sum of money. The denial remained in full force and effect. In July 1995, the Board approved a Claim Disposition Agreement (CDA) regarding the compensable low back strain.

In late 1994 or early 1995, claimant had returned to work for the employer. On July 17, 1995, claimant again injured his back when a coworker used a hyster to lift and drop the hyster claimant was operating. Claimant sought treatment on July 20, 1995 from a neurosurgeon, Dr. O'Neill, for low back and left leg pain. After a July 26, 1995 MRI scan, Dr. O'Neill diagnosed an acute exacerbation of left S-1 radiculopathy from a recurrent L5-S1 disc herniation. Dr. O'Neill opined that the July 1995 hyster incident was the major contributing cause of the L5-S1 radiculopathy. (Ex. 33). Dr. Lorish, who began treating claimant once again, concurred with Dr. O'Neill's conclusions. (Ex. 34).

The employer accepted a low back sprain and, in response to claimant's October 25, 1995 request to expand the acceptance to include an L5-S1 disc herniation with S1 radiculopathy, issued a denial. The November 22, 1995 denial letter stated that the medical evidence indicated that the accepted low back strain was no longer the major contributing cause of claimant's low back condition. Thus, the employer denied the compensability of claimant's "low back condition." (Ex. 37). The denial also declined claimant's request to accept a herniated L5-S1 disc on the ground that "there is no convincing medical evidence that indicates that you suffer from this condition." Id.

Claimant requested a hearing. On May 1, 1996, the employer accepted claimant's left S1 radiculopathy. (Ex. 56). However, the parties proceeded to hearing regarding the compensability of claimant's L5-S1 disc herniation and current low back condition. The parties agreed to submit the matter based on the written evidentiary record without testimony.

The ALJ analyzed the denial of claimant's current condition and the denial of the L5-S1 disc herniation separately. The ALJ reasoned that the scope of acceptance issue analytically and chronologically preceded the issue of whether the compensable low back injury was the major

contributing cause of claimant's current low back condition. The ALJ set aside the employer's denial of claimant's L5-S1 disc herniation, finding that the medical evidence established that claimant was suffering from that condition. In reaching this conclusion, the ALJ limited the scope of the employer's denial to the question of whether claimant suffered from a herniated disc. The ALJ reasoned that there was no express or implied agreement to litigate the cause of the herniated disc. Finally, the ALJ set aside the employer's denial of claimant's current low back condition. The ALJ found that there was no evidence that any condition other the three compensable conditions (low back strain, S1 radiculopathy, and L5-S1 disc herniation) was responsible for claimant's current low back condition.

On review, the employer contends that the parties implicitly agreed through the course of litigation to litigate not merely the existence, but also the cause, of claimant's herniated L5-S1 disc. Moreover, the employer asserts that its "current condition" denial sufficiently raised the causation issue concerning the L5-S1 disc herniation. Finally, the employer argues that the medical evidence does not establish that the July 1995 hyster incident caused the herniated disc. For the following reasons, we agree with the employer's contentions.

Scope of Denial

The employer's November 22, 1995 denial not only denied claimant's low back disc herniation on the ground that the condition did not exist; it also denied claimant's current "low back condition." (Ex. 37). Inasmuch as claimant's L5-S1 disc herniation is part and parcel of his current low back condition, we agree with the employer that its general denial of claimant's current low back condition was sufficient by itself to raise a causation issue with respect to all unaccepted low back conditions, including the L5-S1 disc herniation, even though the existence of that condition was specifically denied elsewhere in the denial letter. Alternatively, even if the general current condition denial did not raise a causation issue with respect to the L5-S1 disc herniation, we find that the parties implicitly agreed to litigate the cause of that condition. We reach this conclusion for the following reasons.

A carrier is bound by the express language of its denial. Tattoo v. Barrett Business Services, 118 Or App 348 (1993). In Tattoo, the court reasoned that, to hold to the contrary, would allow an employer to change what it had expressly said in a denial to the detriment of all parties who have relied on the language. 118 Or App at 352.

In this case, the basis for the employer's denial of the specific L5-S1 disc herniation was limited to an allegation that claimant did not have the condition. No causation issue relative to the herniated disc is expressly raised by the employer's denial. Parties to a workers' compensation proceeding may, however, by express or implicit agreement, try an issue that falls outside the express terms of a denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990); Ronald A. Krasneski, 47 Van Natta 852 (1995); Judith M. Morley, 46 Van Natta 882, 883, on recon 46 Van Natta 983 (1994). For the following reasons, we disagree with the ALJ's conclusion that the parties did not implicitly agree to litigate the issue of whether the compensable July 1995 injury caused the disc herniation.

The parties solicited numerous medical reports and participated in multiple depositions in which the cause of claimant's herniated disc was addressed. (Exs. 33, 34, 35, 36, 40, 46, 47, 49, 50, 52, 53, 57). Claimant did not object during the course of litigation to the employer's generation of medical evidence on the causation issue. To the contrary, claimant fully availed himself of the opportunity to develop evidence addressing causation. We recognize that claimant did not expressly waive any objection to the employer's expansion of the scope of its denial beyond the ground expressly stated in the denial letter. However, we believe that our holding is in accordance with the court's rationale in Tattoo.

As previously noted, the court in Tattoo reasoned that preventing a carrier from changing the express language of its denial protected any party from detrimentally relying on the language of the denial. In this case, however, claimant has not detrimentally relied on the express language of the employer's denial, but rather has fully developed his "alternative" position that the July 1995 hyster incident caused his L5-S1 herniated disc. Given that claimant has not relied to his detriment on the express language of the employer's denial and has, through his conduct, acquiesced in the litigation of the causation issue, we find it appropriate to resolve the causation issue concerning claimant's "low back

condition" (including the L5-S1 disc herniation).[1] Having made this determination, we now proceed with our analysis of the causation issue.

Compensability

First, we agree for the reasons cited by the ALJ that claimant has a recurrent herniated disc at L5-S1. The parties agree, and we find, that claimant's compensable low back strain injury "combined" with the preexisting condition at L5-S1 to cause a need for medical treatment. Therefore, under ORS 656.005(7)(a)(B), to establish the compensability of the "combined condition," claimant must establish that the compensable injury was the major contributing cause of the recurrent L5-S1 disc herniation. Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993). We conclude for the following reasons that there is insufficient medical evidence that claimant's July 1995 injury was the major contributing cause of the L5-S1 disc herniation.

Several physicians have addressed the causation issue: Drs. O'Neill, Lorish, Farris, Young, Quilici and Jones. Dr. O'Neill diagnosed recurrent left S1 radiculopathy from a recurrent disc herniation at L5-S1. (Ex. 32). Dr. O'Neill opined that claimant's July 1995 injury was the major contributing cause of the "precipitation or recurrence" of the left S1 radiculopathy. Dr. O' Neill also opined that claimant's recurrent disc herniation was "temporally" related to claimant's injury. (Ex. 46). However, Dr. O'Neill testified in his deposition that he could not tell whether claimant's disc herniation occurred prior to the July 1995 compensable injury or whether the incident itself caused the disc herniation. (Ex. 53-9, 10, 28).

Dr. Lorish, claimant's attending physician, concurred with Dr. O'Neill's opinion that the July 1995 injury was the major contributing cause of claimant's S1 radiculopathy. (Ex. 34). Dr. Lorish was also deposed, testifying that, while the hyster incident caused radiculopathy, he could not state that claimant's injury caused the disc bulge or whether it preexisted the compensable injury. (Ex. 49-23). Dr. Lorish explained that in the absence of an MRI scan just prior to the July 1995 injury, no one could tell when claimant's disc herniation occurred. (Ex. 49-41, 42).

Dr. Farris, an examining physician, opined that claimant did not have a recurrent disc herniation at L5-S1. Dr. Farris explained that claimant had a small extradural defect at the level, but that it was an expected finding following a prior disc herniation and lumbar laminectomy. (Ex. 35-6).

Dr. Young, a radiologist, compared imaging studies of August 2, 1994 and July 26, 1995 and concluded that claimant had a recurrent disc herniation at L5-S1. Dr. Young opined that, to a degree of medical probability, the July 1995 injury was the major contributing cause of the herniated disc. (Ex. 40). In a follow-up report to claimant's counsel, Dr. Young emphasized that it was "immaterial" whether the recurrent disc herniation occurred prior to the July 1995 injury. According to Dr. Young, the July 1995 injury caused claimant to become symptomatic once again and, as a result, the compensable injury materially aggravated and caused a pathological worsening of the L5-S1 disc herniation. (Ex. 57).

Dr. Quilici, another radiologist, reviewed the MRI scan of July 26, 1995 and concluded that a portion of the extradural defect at L5-S1 represented a small disc protrusion. However, in a deposition, Dr.Quilici testified that he could not tell when the disc herniation occurred. (Ex. 52-33). Dr. Quilici emphasized that, while it was "possible" that the July 1995 injury caused the disc herniation, he was not prepared to say how likely it was in the absence of an MRI examination just before and just after the July 1995 injury. (Ex. 52-31).

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[1] Normally, the issues to be litigated are discussed before testimony is given when an evidentiary hearing is held. In this case, the parties agreed to submit the matter to the ALJ on the written evidentiary record without first clarifying the scope of the issues to be litigated. As demonstrated by the dispute which arose in this case, in the future, it is a far more preferable method for the parties to expressly discuss and clarify the issues to be litigated prior to submitting a matter to the ALJ on the written evidentiary record. Having said this, we are nevertheless persuaded that causation of the L5-S1 disc herniation was at issue, given the employer's general denial of claimant's current low back condition. Finally, in the alternative, considering the parties' "pre-hearing" conduct (including participation in depositions that addressed causation of the L5-S1 disc herniation), we are persuaded that causation of the herniated disc was implicitly placed at issue.

Finally, Dr. Jones, another radiologist who reviewed diagnostic studies at the employer's counsel's request, agreed that claimant had a small recurrent disc protrusion. (Ex. 47). However, Dr. Jones also stated that it was not possible to state when the disc herniation had occurred. Id.

In summary, a clear preponderance of medical evidence establishes the presence of a disc herniation at L5-S1, but, with the exception of Dr. Young, the physicians cannot relate the cause of the disc herniation to the July 1995 hyster incident. While this incident may have precipitated claimant's low back symptoms, given the presence of other contributing factors such as the prior injury/surgery, we are not persuaded that it is more than possible that the hyster incident is the major contributing cause of the L5-S1 disc herniation. See Dietz v. Ramuda, 130 Or App 397 (1994) (an event which precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms).

Therefore, based on our de novo review of the medical evidence, we conclude that the medical evidence does not preponderate in favor of a finding that the July 1995 low back injury was the major contributing cause of the disc herniation at L5-S1. In reaching this conclusion, we note that Dr. Lorish, claimant's attending physician, opined that it can not be determined whether the July 1995 hyster incident caused the herniated disc. Finding no persuasive reason not to defer to the opinion of the attending physician, see Weiland v. SAIF, 64 Or App 810 (1983), we, therefore, reverse the ALJ's order which set aside the employer's denial of the L5-S1 disc herniation.

Moreover, inasmuch as claimant's "current condition" consists of the recurrent herniated disc at L5-S1, and because we have determined that the medical evidence does not establish that the compensable injury is the major contributing cause of this condition, it follows that the employer's "current condition" denial must also be upheld. Accordingly, we also reverse that portion of the ALJ's order which set aside the employer's denial of claimant's current low back condition.

ORDER

The ALJ's order dated September 17, 1996, as reconsidered on September 27, 1996, is reversed in part and affirmed in part. That portion which set aside the employer's denial of claimant's L5-S1 disc herniation condition and its denial of claimant's current low back condition is reversed. The employer's denials are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
STEVEN R. LEWIS, Claimant
WCB Case No. 96-04169
ORDER ON REVIEW
Malagon, Moore, 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) Crumme's order that set aside its partial denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the second sentence of finding number 19.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. McGirr, attending physician, the ALJ found that claimant had met his burden of proving compensability of his current low back condition. SAIF argues that Dr. McGirr's

ultimate causation opinion is not persuasive both because it represents an unexplained change of opinion and it fails to meet the requirements set forth in Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). For the following reasons, we agree with SAIF's arguments.

Claimant sustained a central/left disc herniation at L3-4, confirmed by a myelogram and a MRI, as the result of a noncompensable motor vehicle accident (MVA) which occurred on February 7, 1993. (Exs. 5, 6, 8, 9). This injury resulted in low back pain which radiated into the right leg posteriorly to about the knee. Claimant received conservative treatment for this condition, including medication, physical therapy, and release from work. Eventually, Dr. McGirr became claimant's treating physician for his low back condition. Dr. McGirr continued claimant's conservative treatment. On October 26, 1993, Dr. McGirr opined that:

> "the disc herniation at L3-4 is both profound, and explicative of [claimant's] pain. However, being central, I believe it will be difficult to render this otherwise healthy young man back to fully productive levels of work even with surgery, as my experience with central, high lumbar disc extrusions are that they are 'bad actors.'" (Ex. 9).

Dr. McGirr obtained a second opinion regarding the possibility of surgical treatment from Dr. Matteri, orthopedist, who agreed with Dr. McGirr regarding the chances of a positive outcome with surgery to a central disc rupture. (Ex. 10). Both Drs. McGirr and Matteri recommended continued conservative treatment. (Exs. 9, 10). On January 4, 1994, after claimant completed more physical therapy, Dr. McGirr found him medically stationary from the MVA and released him to moderate lifting capacity. (Ex. 11).

In February 1994, claimant began working for SAIF's insured. From February 1994 through July 25, 1995, claimant had waxing and waning low back and right leg symptoms. However, those symptoms were not significant enough to require claimant to seek treatment during that period. On July 25, 1995, claimant sustained a thoracic back strain while pulling veneer at work. (Exs. 12A, 14). Claimant's examination that date also revealed mild tenderness in the low back paraspinous regions. (Ex. 12A). Claimant initially treated with Dr. Bailey for this injury. (Exs. 12A, 14, 15). By August 2, 1995, claimant was complaining of low back pain in addition to the thoracic pain. (Ex. 15). Thereafter, claimant's treatment focused on his low back pain. After initially improving, claimant's low back pain flared up again in October 1995, and Dr. Bailey referred claimant to Dr. McGirr for surgical evaluation. (Ex. 15). Subsequently, Dr. McGirr again became claimant's treating physician for his low back condition. In December 1995, claimant underwent another MRI which Dr. McGirr described "[a]s before," noting the MRI showed a central/left L3-4 disc bulge, with some degeneration within the disc at L3-4. (Ex. 19). Dr. McGirr continued to conclude that surgery on the L3-4 disc was not likely to be successful, given the fact that the herniation was centrally located. (Exs. 19, 20).

On September 14, 1995, SAIF accepted the thoracic strain as a nondisabling injury. (Ex. 16). There is no dispute that the compensable 1995 work injury combined with claimant's preexisting L3-4 disc herniation condition to cause or prolong his current disability and need for treatment. (Exs. 28, 31, 34, 39, 41). Therefore, in order to establish the compensability of his current low back condition, claimant must prove that the compensable 1995 injury is the major contributing cause of his current disability or need for treatment. ORS 656.005(7)(a)(B). In establishing the "major contributing cause" standard, claimant must establish that the compensable injury contributed more to his current low back condition and need for treatment than all other factors combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 298, 309-310 (1983). In evaluating the medical evidence concerning causation, we consider all potential contributors to claimant's current condition, not just the precipitating cause. Dietz v. Ramuda, 130 Or App at 401-02 (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).

Claimant has the burden of proving that his current low back condition is compensable by the preponderance of the medical evidence. ORS 656.266. Because of the multiple potential causal factors, the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). We generally defer to the opinion of the treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, only the opinions of Dr. McGirr, claimant's former treating physician, and Dr. Miller, claimant's current treating physician, might support compensability of claimant's low back condition. However, there are persuasive reasons not to defer to these opinions.

Where medical opinions are based on inaccurate medical histories, we find them unpersuasive and give them little weight. Somers v. SAIF, 77 Or App 259 (1986); Miller v. Granite Construction Co., 28 Or App 470 (1977). We agree with the ALJ that Dr. Miller's opinion is unpersuasive because it is based on an inaccurate history that claimant's symptoms completely resolved after treatment for the 1993 MVA and that claimant's worsened low back symptoms first arose after one specific lifting incident on July 25, 1995. (Exs. 37, 40).

Regarding Dr. McGirr's causation opinions, on April 10, 1996, he confirmed his opinion that claimant's low back and thoracic strains "had resolved and/or had combined with [claimant's] preexisting herniated disk, and that the herniated disk was the major cause for his ongoing need for treatment." (Ex. 28-1). Dr. McGirr further agreed that he had informed claimant years ago that this condition would wax and wane, which was what Dr. McGirr felt was causing claimant's current need for treatment. Id.

On May 8, 1996, Dr. McGirr noted that SAIF had denied responsibility for the L3-4 herniated disc condition, the condition for which he was treating claimant. (Ex. 34). Dr. McGirr opined that SAIF's denial was incorrect, stating that "[a]lthough this condition was pre-existing of [claimant's] industrial injury of July 25, 1995, the exacerbation of symptoms from this pre-existing condition and the need for treatment currently is based on this July 25, 1995 injury." (Ex. 34).

Dr. McGirr later stated that the general consensus among the physicians examining claimant, including Dr. McGirr himself, is that the likely source of claimant's persisting discomfort is the centrally herniated disc at L3-4, a condition that has been chronically present and dates back to the February 1993 MVA. (Ex. 41-1). Dr. McGirr also stated that claimant had a significant increase in his symptoms after the July 1995 work injury, "albeit qualitatively the same as had been present chronically since [claimant's] MVA of 1993, and that this significant increase in symptomatology both no longer allowed [claimant] to work at his previous level of function and forms the basis for his current need for follow up treatments." (Ex. 41-2).

We find Dr. McGirr's opinions unpersuasive on two grounds. First, his later opinions represent an unexplained change of opinion. (Exs. 28, 34, 41). Claimant argues that Dr. McGirr's initial opinion was essentially a conclusory "check-the-box" opinion. Claimant urges us to rely on Terry R. Myers, 48 Van Natta 1039 (1996), to find that Dr. McGirr's later opinion, written in his own words, is persuasive despite an earlier "check-the-box" opinion to the contrary. We find Myers distinguishable on its facts. In Myers, the initial opinion was a "check-the-box letter," without any explanation, inquiring whether the present physician concurred with an earlier examining physician's opinion. Under these circumstances, we did not find that this earlier "concurrence" outweighed the physician's later well-reasoned opinion.

Here, we disagree with claimant's characterization of Dr. McGirr's initial opinion as a conclusory "check-the-box" opinion. Instead, that opinion is a summary of a conversation that Dr. McGirr had with representatives of SAIF and the employer. (Ex. 28). This conversation summary is not conclusory and Dr. McGirr explicitly agreed it was accurate. Id. Therefore, we find Dr. McGirr's later opinions represent a change of opinion. In addition, he offers no explanation for his change of opinion; instead, he simply ignores his earlier opinion when rendering his later opinions. Since Dr. McGirr offers no explanation for his change of opinion, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Second, Dr. McGirr's later opinions do not evaluate the relative causes of claimant's condition and determine the primary cause, as required by Dietz v. Ramuda, 130 Or App at 401-02. (Exs. 34, 41). Although Dr. McGirr acknowledges claimant's ongoing, chronic L3-4 disc herniation, a condition Dr. McGirr acknowledges has caused claimant to suffer waxing and waning symptoms since the 1993 MVA, he does not address the relative contribution of this preexisting condition. Instead, he opines that the work injury made the preexisting disc condition more symptomatic, although noting that "qualitatively"

the symptoms remained the same. At most, Dr. McGirr's opinion establishes that claimant's work injury was the precipitating cause of his current need for treatment.[1] That is insufficient to meet claimant's burden of proof. Id.; ORS 656.005(7)(a)(B). Accordingly, we find that claimant failed to prove his current low back condition is compensable.

ORDER

The ALJ's order dated October 19, 1996 is reversed. The ALJ's award of attorney fees is reversed. The SAIF Corporation's April 24, 1996 partial denial of claimant's current low back condition is reinstated and upheld.

[1] In support of his argument that Dr. McGirr's opinion meets claimant's burden of proof, claimant asserts that "Dietz v. Ramuda does not stand for the proposition that a precipitating cause cannot be the major contributing cause." Respondent's Brief, page 4. While we do not dispute this assertion, the problem is that Dr. McGirr did not evaluate the relative causes of claimant's condition, including the preexisting disc herniation condition. Instead, he focused on the work injury as the precipitating cause, without evaluating the contribution of the preexisting condition. Such reasoning does not meet claimant's burden of proof under Dietz v. Ramuda and ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
PATRICIA A. LANDERS, Claimant
WCB Case No. 96-03330
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Cowling, Heysell, Plouse, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that found that claimant is entitled to temporary disability benefits. On review, the issue is entitlement to temporary disability. We reverse.

FINDINGS OF FACT

In September 1987, the insurer accepted claimant's left knee injury claim. In September 1988, the insurer accepted claimant's injury claim for both knees. Both claims were closed by Determination Orders in November 1990. After claimant appealed the orders, a prior ALJ in December 1991 increased claimant's scheduled permanent disability award.

Meanwhile, in June 1990, claimant was found eligible for vocational assistance. After an authorized training program (ATP) ended, a November 1991 Determination Order reclosed the 1987 claim. A June 1992 Order on Reconsideration reduced claimant's scheduled permanent disability award. In March 1993, a prior ALJ reinstated the December 1991 award. Since the ATP ended in 1991, the only paid work claimant performed was in 1994, when she cared for her daughter's mother-in-law for an 8-month period.

On August 28, 1995, claimant made an aggravation claim for her 1987 claim. Dr. Bert, claimant's treating orthopedic surgeon, reported that claimant was capable of performing light work. Dr. Coletti, orthopedic surgeon, examined claimant in September 1995, and opined that claimant could perform light or sedentary work, if proper working ergonomics were observed. In June 1996, Dr. Bert opined that claimant could perform "at least" sedentary work.

In March 1996, an ALJ set aside the insurer's subsequent denial and also found that claimant proved the compensability of a chondromalacia condition. On August 26, 1996, the Board affirmed the ALJ's order.

On March 21, 1996, the insurer notified claimant that, although it was processing the aggravation claim pursuant to the March 1996 ALJ's order, it would not "be paying temporary disability benefits on the grounds that you have withdrawn from the workforce."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was entitled to temporary disability benefits. Specifically, the ALJ found that, although the medical evidence showed that claimant was physically able to perform "at least" sedentary work, claimant's limited skills prevented her from performing sedentary work. The ALJ concluded, therefore, that it was futile for claimant to look for work and that she had not voluntarily withdrawn from the work force. The insurer challenges the ALJ's order, asserting that claimant was not in the work force at the time of her September 1995 aggravation claim and that the record does not show that any job search was futile.

To be entitled to temporary disability, 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; (2) not employed, but willing to work and is seeking work; or (3) willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proving her entitlement to temporary disability benefits. ORS 656.266.

Here, the parties agree that claimant was not employed or making any effort to obtain employment at the time of her August 1995 aggravation and, thus, claimant must prove futility in order to be entitled to temporary disability. Based on the medical evidence, claimant is capable of performing light/sedentary work. (Exs. DD-10, B-8, 5). Claimant bases her entitlement to temporary disability on the ALJ's conclusion that she lacked the skill level to perform sedentary work.

We first note that the record is not clear concerning claimant's skills at the time of her aggravation in August 1995. Before participating in the ATP, claimant was noted to have a 6th grade education. (Ex. DD-4). The record also indicates, however, that claimant subsequently participated in Adult Basic Training and basic clerical training in 1991. (Exs. DD-4, DD-6). The record also shows that claimant additionally was provided with job development services. (Ex. CC-1). Vocational assistance then ended in March 1992 because claimant's "lack of suitable employment [was] no longer due to the disability caused by the injury." OAR 436-120-045(1). (Ex. CC-1).

The record contains no evidence, however, concerning claimant's skill level after vocational assistance ended. Claimant testified that she did not pass any of her clerical training courses. (Tr. 9-10). Such testimony, however, does not establish that claimant's educational and skill level remained unchanged following vocational assistance.

More importantly, we find a complete absence in the record establishing that claimant's skill level, whether improved or not, prevents her from performing light/sedentary work. In other words, the record, including claimant's testimony, provides no proof that claimant's skill level precludes light/sedentary employment.[1] Thus, we are not persuaded that it is futile for claimant to perform such work. Consequently, because claimant was not making reasonable efforts to obtain employment, and she failed to show that such efforts are futile, we conclude that claimant has not carried her burden to prove entitlement to temporary disability with regard to her aggravation claim.

ORDER

The ALJ's order dated July 25, 1996, as reconsidered August 30, 1996, is reversed. Claimant is not entitled to temporary disability benefits. The ALJ's attorney fee award is reversed.

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[1] Even if claimant were restricted solely to sedentary work, a decision that sedentary work requires a certain level of skills and education is not a fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." Thus, it is not the sort of evidence that we may take official notice. See Theresa R. Callahan, 47 Van Natta 1014 (1995). Furthermore, we find such evidence to be sufficiently complex to require expert testimony or opinion. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993) (applying rule to medical causation determinations).

In the Matter of the Compensation of
ALLEN D. OVERTURF, Claimant
WCB Case No. 96-07206
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
SAFECO Legal Department, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration which awarded claimant 3 percent (9.60 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

At all pertinent times, claimant worked for the employer, a television and appliance store, as a delivery truck driver. His job duties were heavy and entailed lifting and carrying appliances weighing up to 75 pounds. On October 21, 1995, claimant compensably injured his low back while delivering a console television.

The insurer accepted a claim for a low back strain. Claimant underwent conservative treatment and completed a work hardening program.

On February 21, 1995, Dr. Anderson measured claimant's lumbar range of motion in connection with claimant's completion of the work hardening program. Dr. Anderson found forward flexion of 51 degrees, extension of 22 degrees and lateral flexion of 32 degrees. (Ex. 5-2). Dr. Anderson reported that claimant had become medically stationary, and recommended that claimant be released to his regular job so long as he used a hand truck when moving appliances up and down stairs. (Ex. 5-3)

Two days later, in a February 23, 1996 closing examination, claimant's attending physician, Dr. McNabb, measured claimant's lumbar range of motion using the double inclinometer technique and found 45 degrees forward flexion, 20 degrees extension and 30 degrees lateral flexion. Dr. McNabb also found that claimant was medically stationary and agreed with Dr. Anderson that claimant was capable of returning to his regular work by using a hand truck to pull appliances up stairs. (Ex. 6).

Claimant's claim was closed by an April 1, 1996 Notice of Closure awarding temporary disability and a total unscheduled permanent disability award of 3 percent. The Notice of Closure was affirmed in all respects by a July 31, 1996 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. McNabb's concurrence with Dr. Anderson's recommendations, the ALJ found claimant was entitled to an impairment value of 3. In addition, the ALJ determined that although claimant had a base functional capacity ("BFC") of heavy,[1] he was not entitled to any value for the social and vocational factors under the applicable standards because his residual functional capacity ("RFC") was also heavy.

On review, claimant challenges his impairment rating and his RFC classification. With regard to impairment, claimant asserts the ALJ erred in relying on the range of motion measurements of Dr. Anderson over those of claimant's attending physician, Dr. McNabb. As for the RFC, claimant contends that it should be medium/heavy because he has not been released to his regular work and is not able to perform the full range of heavy activities. We address each issue in turn.

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[1] The ALJ found the job classification that most accurately reflected claimant's work activity was DOT Code 905.687-010, "Truck Driver Helper." We agree with this determination.

Impairment

Impairment is established by the attending physician except where a preponderance of the evidence establishes a different level of impairment. OAR 438-035-0007(13). Here, there were two sets of lumbar range of motion findings reported at the time of closure, those of attending physician Dr. McNabb on February 23, 1996 and those of Dr. Anderson on February 21, 1996. The findings on these two examinations were similar, although Dr. McNabb's findings showed slightly more limitation. Under these circumstances, we see no reason not to rely on the closing examination impairment findings of Dr. McNabb. See Weiland v. SAIF, 64 Or App 810 (1983).

Using Dr. McNabb's impairment findings, we conclude claimant is entitled to an impairment value of 4.[2] See OAR 436-035-0360(19)-(21).

Adaptability

Both Dr. McNabb and Dr. Anderson agreed that claimant could perform his regular job except that he needed to use a special hand truck when moving heavy appliances up and down stairs. (Exs. 5-3, 6). Dr. Anderson specifically found that claimant demonstrated the ability to work within the heavy physical demand level and did not set forth any restrictions other than the requirement that claimant use the hand truck. (Ex. 5-2).[3]

On this record, we agree with the ALJ that claimant's RFC is heavy. The limitation noted by the examining physicians (that claimant must use a hand truck to move heavy appliances up stairs) does not fall within the definition of "restriction" in OAR 436-035-0310(3)(l). Because claimant's RFC is the same as his BFC, claimant's adaptability value is zero. OAR 436-035-0270(4)(a). Therefore, claimant is not entitled to any additional value for social and vocational factors.

ORDER

The ALJ's order dated October 31, 1996 is modified. In addition to the Order on Reconsideration's and ALJ's award of 3 percent (9.60 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.20 degrees) unscheduled permanent disability for a total unscheduled permanent disability award of 4 percent (12.80 degrees). 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, to be paid directly to claimant's counsel.

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[2] Pursuant to OAR 436-035-0360(19), claimant is entitled to 2 percent for lumbar flexion of 45 degrees and, pursuant to OAR 436-035-0360(20), claimant is entitled to 2 percent for extension of 20 degrees. Claimant is entitled to a value of 0 under OAR 436-035-0360(21) for lateral flexion of 30 degrees.

[3] We note that claimant was using a hand truck when injured. (Ex. 1). Further, claimant's job analysis included the use of a "dolly" or hand truck. (Exs. 1B-2 and 10).

In the Matter of the Compensation of
JUSTEEN L. PARKER, Claimant
WCB Case No. 96-06453
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) increased claimant's unscheduled permanent disability award for a low back condition from 8 percent (25.6 degrees), as awarded by an Order on Reconsideration, to 22 percent (70.4 degrees); and (2) awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot, whereas the Order on Reconsideration awarded none. On review, the issue is extent of permanent disability, scheduled and unscheduled. We modify.

FINDINGS OF FACT

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

In lieu of the ALJ's finding that claimant's base functional capacity (BFC) was heavy, we find that her BFC was medium. In addition, we find that claimant successfully attained the SVP level of 6 as a forest technician.

CONCLUSIONS OF LAW AND OPINION

Scheduled Disability

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

Unscheduled Disability

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

The ALJ awarded 22 percent unscheduled permanent disability based on an impairment value of 10, an education (skills) value of 3, and an adaptability value of 4.[1] The insurer challenges the ALJ's rating of each value. For the following reasons, we adopt the ALJ's impairment value, but modify the education and adaptability values.

Impairment Value

The ALJ's impairment value (10) was based on the medical arbiter's measurements of lost ranges of motion (ROM) in the low back. The insurer contends that the ROM measurements are unreliable because the arbiter declared them to be invalid. As supporting authority, the insurer cites to Harvey Clark, 47 Van Natta 136 (1995), Christopher R. Garza, 47 Van Natta 99 (1995), and Carole R. Jeffries, 46 Van Natta 841 (1994). In those cases, the Board rejected examination findings of impairment as unreliable because they were deemed to be invalid.

Here, we agree with the ALJ that the medical arbiter, Dr. Rich, gave no persuasive explanation to support his conclusion that claimant's ROM findings were invalid.[2] The Director's administrative rule, OAR 436-035-0007(27), which became effective February 17, 1996, provides in pertinent part:

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[1] The applicable standards for rating claimant's permanent disability are set forth in WCD Admin. Order 96-051, as amended by WCD Admin Order 96-068. See OAR 436-035-0003(2).

[2] The ALJ concluded that the medical arbiter's lumbar flexion measurement is invalid because it did not meet the straight leg raising criteria for flexion validity. (See Ex. 15-2). The parties do not challenge that conclusion on review. Therefore, we do not consider the arbiter's flexion measurement in our rating of impairment.

> "Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid." (Emphasis supplied.)

Under this rule, an examining physician, including a medical arbiter, must provide a written opinion explaining why impairment findings were determined to be invalid. In the absence of such an opinion, the impairment findings must be rated.

The Board and ALJ's must apply the standards promulgated by the Director. ORS 656.283(7); 656.295(5). In this case, the medical arbiter stated that ROM measurements did not meet AMA (American Medical Association) validity standards, but he did not identify the validity standards that were not satisfied, nor did he provide a written explanation of why the ROM measurements did not meet validity standards. Applying OAR 436-035-0007(27) to the facts of this case, we conclude that the arbiter's ROM measurements (with the exception of the flexion measurement) must be rated as impairment. Therefore, we adopt the ALJ's impairment value of 10 percent.

The cases cited by the insurer--Clark, Garza and Jeffries-- are not on point. In Clark, the medical arbiter found exaggerated pain behavior and suggested that the functional component was the "overriding element." The finding of functional interference with the examination provided a satisfactory explanation for the arbiter's ultimate conclusion that his ROM measurements were not valid. In Garza, the examining physician also provided a satisfactory explanation by stating that the ROM findings were an "underestimate" of the claimant's true ability. Finally, in Jeffries, we agreed with the ALJ's determination that ROM findings were invalid, but the order does not explain the basis for our agreement. Therefore, we cannot determine from the order what written opinion, if any, was provided for concluding that the ROM findings were invalid. In any event, our decisions in Clark, Garza and Jeffries were issued before the Director's promulgation of OAR 436-035-0007(27) and, therefore, are not controlling here.

Education Value

We turn to the ALJ's education value of 3, which was based on the finding that claimant had attained an SVP (specific vocational preparation) level of 4 in her prior employments. Specifically, the ALJ based the SVP level on the DOT code for Physical Therapy Aide (355.354-010), the job that claimant performed in 1987. (Ex. 6-2). The insurer argues that the SVP level should be 6, based on the DOT code for Forest Technician (452.364-010). (Ex. 6-2). We agree.

Claimant argues there is no persuasive evidence that she performed the full duties of a forest technician for the 1-2 year training period required to attain the SVP level of 6. See OAR 436-035-0300(4). On her Work/Educational History questionnaire, however, claimant specifically reported that she worked as a "forest technician" for the U.S. Forest Service from February 1989 until February 1991. By claimant's own report, she worked as a forest technician for two years. The specific duties she reportedly performed in that job are consistent with the DOT code for Forest Technician. Because we find that claimant met the 1-2 year training period for that job, we conclude that she attained an SVP level of 6. Therefore, we reduce the ALJ's education value to 2. Id.

Adaptability Value

The ALJ's adaptability value (4) was based on the finding that claimant's BFC was heavy. The "heavy" BFC was taken from the DOT code for Forest-Fire Fighter (452.687-014). The insurer contends that the DOT code which best describes claimant's previous forestry job in 1989-91 is Forest Technician (452.364-010) which is rated as "medium."

In response, claimant argues that the insurer is precluded from challenging the "heavy" BFC finding because the Evaluations Section originally found that claimant's BFC was heavy and the insurer did not challenge that determination at reconsideration. Citing ORS 656.283(7) and 656.268(8), claimant argues that the insurer is now barred from raising the BFC issue on review. We disagree. ORS 656.283(7) and 656.268(8) bar a party from raising an issue at hearing that it did not raise at reconsideration. In this case, however, the "heavy" BFC finding was reduced to "medium" by the Appellate Unit on reconsideration, and it was claimant, not the insurer, that challenged the BFC finding at hearing. Because the BFC value was reduced at reconsideration and subsequently challenged at hearing by claimant, the insurer is not barred from raising the issue on Board review.

After comparing the two DOT codes and reviewing claimant's Work/Educational History questionnaire, we agree with the insurer that the DOT code for Forest Technician most accurately describes claimant's previous forestry job. Furthermore, we reject claimant's contention that she previously performed the job of Groundsman or Ground Helper (DOT 821.684-014). On her Work/Educational History questionnaire, claimant reported that she worked as a "flagger" for a cable company in 1994 and that her duties were flagging and "helping groundsmen." (Ex. 6-1). Claimant's assistance of groundsmen appeared to be no more than an incidental part of her flagging job. We do not find that she performed sufficient duties of a Groundsman or Ground Helper to qualify for that DOT code alone, or on the "combination of DOT codes" basis under OAR 436-035-0310(4)(a).

Therefore, we rely on the Forest Technician DOT code in determining claimant's BFC. See Thomas D. Porter, 45 Van Natta 2218 (1993); Kathyron D. Parsons, 45 Van Natta 954 (1993); William L. Knox, 45 Van Natta 854 (1993). Based on that DOT code, we find that claimant's BFC was medium. Comparing the "medium" BFC to the "medium/light" residual functional capacity, we reduce the ALJ's adaptability value to 2. See OAR 436-035-0310(6).

After combining the values for impairment, age, education and adaptability, we conclude claimant's unscheduled permanent disability award is 14 percent. We reduce the ALJ's award accordingly.

Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing against the insurer's appeal of the ALJ's scheduled permanent disability award. See ORS 656.382(2); Roseburg Forest Products v. Boqua, 147 Or App 197 (1997). 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 scheduled permanent disability issue is $200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 12, 1996 is modified in part and affirmed in part. In addition to the Order on Reconsideration award of 8 percent (25.6 degrees) unscheduled permanent disability, and in lieu of the ALJ's unscheduled permanent disability award, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, giving her a total unscheduled permanent disability award of 14 percent (44.8 degrees). The ALJ's scheduled permanent disability award is affirmed. The ALJ's "out-of-compensation" attorney fee award is adjusted accordingly. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $200, to be paid by the insurer.

March 27, 1997 Cite as 49 Van Natta 336 (1997)

In the Matter of the Compensation of
ESTELLA M. CERVANTES, Claimant
WCB Case Nos. 96-06147, 96-06037 & 96-05535
ORDER ON RECONSIDERATION
Vick & Conroyd, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Reinisch, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys

Fleetwood Homes/Matrix Companies (Fleetwood) requests reconsideration of our February 27, 1997 Order that set aside its occupational disease/current conditional denial of claimant's carpal tunnel syndrome (CTS). Contending that its denial was limited to right CTS, Fleetwood requests that the order be clarified to reflect that it is not liable for claimant's left CTS.

As a preliminary matter, we note that although the ALJ's order specifically remanded claimant's "bilateral carpal tunnel claim" to Fleetwood for processing, Fleetwood did not contest this aspect of the

order on review. Therefore, we are not inclined to address the issue on reconsideration. See Annette E. Farnsworth, 48 Van Natta 508 (1996). However, even having considered the issue, we adhere to our determination that Fleetwood is responsible for claimant's current bilateral CTS condition.[1]

Although Fleetwood formally denied only right-sided CTS, all of the parties at hearing (including Fleetwood's counsel) expressly agreed that the issues to be litigated included "compensability of and responsibility for claimant's bilateral carpal tunnel syndrome." (Tr. 4, 5). Under these circumstances, we consider Fleetwood's agreement with the ALJ's statement of issues as, in effect, an oral amendment of its occupational disease/current condition denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (the parties to a workers' compensation proceeding may, by agreement, try an issue that falls outside the express terms of a denial); see also, Dick M. Veldsma, 47 Van Natta 1470 (1995).

Because the parties agreed to litigate the compensability of claimant's bilateral CTS, we decline to limit our order in the manner requested by Fleetwood. Accordingly, our February 27, 1997 order is withdrawn. On reconsideration, as supplemented herein, we republish our February 27, 1997 order. The parties' rights of appeal shall run begin to run from the date of this order.

IT IS SO ORDERED.

[1] In February 1996, Dr. Radecki noted that claimant had symptoms consistent with CTS on both the right and the left. (Ex. 16). In April 1996, Dr. McDonald diagnosed bilateral CTS, right greater than left. (Ex. 17). Subsequently, both Dr. McDonald and Dr. Gottschalk specifically related claimant's bilateral carpal tunnel condition to her work activities at Fleetwood. (Exs. 40, 41).

In the Matter of the Compensation of
BILL H. DAVIS, Claimant
Own Motion No. 89-0660M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation requests authorization to suspend payment of claimant's temporary disability compensation pursuant to OAR 438-012-0035(5). Based on the following, we grant SAIF's request.

OAR 438-012-0035(5) provides that an own motion insurer may make a written request to the Board for suspension of temporary disability compensation, if the insurer believes that such compensation should be suspended for any reason. In addition, the insurer must send a copy of the request to the claimant by certified mail. Id. The claimant has 14 days within which to submit a written response to the Board, and the insurer has 14 days to submit a written reply to the Board regarding the claimant's response. Id. The insurer is not permitted to suspend compensation without prior written authorization by the Board. Id.

On November 22, 1996, SAIF requested authorization to suspend compensation under OAR 438-012-0035(5), and sent a certified copy of the request to claimant. We have received claimant's written response and SAIF's reply. Accordingly, we proceed to address the merits of SAIF's request.

On February 7, 1995, the Board issued an Own Motion Order Reviewing Carrier Closure. Bill H. Davis, 47 Van Natta 219 (1995). In that order, we found that the claim was prematurely closed and set aside SAIF's August 2, 1994 Notice of Closure. Our finding of premature closure was based on the fact that, although claimant's compensable back condition was medically stationary, Dr. Mulchin, claimant's treating urologist,[1] continued to recommend surgery for claimant's compensable neurogenic bladder condition at the time the claim was closed. Dr. Mulchin had first requested authorization for this proposed surgery in May 1993, and the surgery was authorized. However, Dr. Mulchin

[1] Dr. Mulchin was claimant's treating urologist when he resided in Texas. Claimant subsequently relocated to Iowa.

subsequently stopped performing this type of surgery and, by September 12, 1994, referred claimant to Dr. Sagalowsky for evaluation for this surgery. By letter dated June 13, 1994, Dr. Ryberg, claimant's treating neurologist, indicated that claimant was still planning on undergoing the surgery. Under these circumstances, we concluded that claimant's bladder condition was not medically stationary at claim closure because the proposed surgery was reasonably expected to materially improve claimant's compensable bladder condition, and claimant was apparently pursuing this surgical option.

In reaching this conclusion, we found claimant's case distinguishable from those cases where we had held that a claim is not prematurely closed where a claimant's medically stationary status is contingent upon undergoing recommended surgery and the claimant refuses the surgery. E.g. Stephen L. Gilcher, 43 Van Natta 319, 320 (1991); Karen T. Mariels, 44 Van Natta 2452, 2453 (1992). The distinction was that, here, claimant had not refused the surgery, although the surgery was delayed.

Finally, we emphasized that claimant is not required to undergo the proposed bladder surgery; that decision is up to him and his physicians. However, we noted that, should claimant fail to pursue the proposed surgery or decide not to undergo the surgery, the consequences of those actions could include: (1) suspension of his temporary disability benefits pursuant to OAR 438-012-0035; or (2) if claimant was otherwise medically stationary, SAIF could close the claim under the reasoning in Gilcher, 43 Van Natta at 320, and Mariels, 44 Van Natta at 2453.

On August 2, 1995, the Board issued an Own Motion Order denying SAIF's June 26, 1995 request to suspend claimant's temporary total disability compensation based on its contention that claimant had not pursued the proposed surgery. Bill H. Davis, 47 Van Natta 1448 (1995). We found that, although claimant had no success in contacting Dr. Sagalowsky, he had a scheduled appointment with a specialist, Dr. Nagley, regarding the bladder surgery. Under those circumstances, we concluded that claimant was pursuing the surgical option and, therefore, denied SAIF's request for authorization to suspend claimant's temporary disability compensation.

Subsequent to the above, claimant was referred by Dr. Nagley to Dr. Kreder, a urology specialist with the University of Iowa Hospital, for treatment of his neurogenic bladder condition. On October 10, 1995, Dr. Kreder first examined claimant. No treatment plan was discussed at that time. Instead, claimant was requested to obtain his prior medical records and schedule an appointment when those records were obtained. By letter dated October 20, 1995, claimant requested his medical records from Dr. Mulchin.

Claimant next saw Dr. Kreder on March 8, 1996. In his chart note on that date, Dr. Kreder noted that claimant was counseled regarding surgical intervention for his bladder condition. He stated that claimant would need a urodynamic study, IVP, and cystoscopy before doing the surgery, "if he does wish to have surgery." Dr. Kreder noted that "[a]t this time [claimant] wishes to try increasing" his medications to see if that would help his voiding dysfunction. (March 8, 1996 chart note from Dr. Kreder). Finally, Dr. Kreder noted that claimant was "to call in approx[imately] 6-8 w[ee]ks with a report on how the medication is working and whether or not he wishes surgery" at which time he would be scheduled for the above tests, "if he elects surgery." Id.

Claimant was next seen by Dr. Kreder on July 18, 1996. In his chart note of that date, Dr. Kreder indicated that claimant's medications were again changed and he was to report back in six weeks regarding the effect, if any, of this change. When claimant reported back, he would undergo the above tests and "make a decision as to whether he wants to undergo autoaugmentation or bowel augmentation of [his] bladder." (July 18, 1996 chart note from Dr. Kreder).

Claimant was next seen by Dr. Kreder on February 20, 1997, at which time the IVP and cystoscopy were performed. (February 20, 1997 chart note from Dr. Kreder). It was decided not to perform the urodynamics test. The IVP revealed no evidence of upper urinary tract disease and confirmed a small neurogenic bladder. The cystoscopy revealed severe trabeculation of the bladder consistent with its neurogenic state. Id. The "IMP/PLAN" section of the February 20, 1997 chart note indicated that: (1) claimant would need to continue catheterizing with or without the proposed surgery and "an augmentation [of the bladder] would only increase the interval between his catherizations;" (2) claimant "agreed that a surgery at this point may not be necessary for his [symptoms];" (3) some changes were made in claimant's prophylaxis for his catherizations and claimant should be evaluated on an annual basis for upper tract deterioration and creatinine levels; (4) Dr. Kreder was present for claimant's cystoscopy, review of claimant's chart, and formulation of the plan; and (5) claimant was "in full agreement." Id.

The "TEACHING PHYSICIAN PERSONAL NOTE" section of this chart note repeated/summarized much of the "IMP/PLAN" section and noted that claimant "is going to think about his options and decide if he wants to continue as he is, or undergo augmentation cystoplasty." Id. Finally, it noted that claimant would be seen back in "follow-up."

On this record, we find that surgery is not currently being considered for claimant's compensable bladder condition. In reaching this decision, we note that there is no clear-cut line as to whether surgery is recommended for a compensable condition or whether the worker refuses that surgery. Instead, these issues are driven by the particular facts of the case. See Christi L. McCorkle, 48 Van Natta 1766 (1996) (although there was no recommendation for surgery at the time of an earlier closure, the record clearly showed surgery was recommended at the time of a second claim closure about four months later; therefore, Board found second closure prematurely closed the claim); Richard Uhing, 48 Van Natta 465 (1996) (Board found claim closure premature where recommended surgery was pending at claim closure and there was no evidence that the claimant refused the surgery; rather, the claimant opted for other treatment prior to undergoing surgery); Henry Williams, 48 Van Natta 408 (1996), (Board affirmed a carrier's claim closure where, over the years, the claimant, rather than his treating physician, postponed a proposed surgery and the treating physician found the proposed surgery not medically necessary at the present time).

Here, the "IMP/PLAN" section of the February 20, 1997 chart note indicates that surgery may not be necessary for claimant's symptoms at this point. Moreover, the only treatment recommended for the bladder condition, unless there is a change in that condition, is an annual evaluation for upper tract deterioration and creatinine levels. Nor is there any indication that the "follow-up" mentioned in the "TEACHING PHYSICIAN PERSONAL NOTE" section refers to anything other than this annual evaluation. Given these facts, we conclude that surgery is not currently being considered for claimant's compensable bladder condition.[2]

Accordingly, we authorize suspension of claimant's temporary disability benefits pursuant to OAR 438-012-0035(5). However, if surgery is again recommended by claimant's physician, SAIF is to reinstate payment of temporary disability compensation. Finally, SAIF is directed to close the claim pursuant to OAR 438-012-0055 when claimant's compensable condition is medically stationary.

IT IS SO ORDERED.

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[2] We acknowledge that the "TEACHING PHYSICIAN PERSONAL NOTE" section of the February 1997 chart note mentions that claimant "is going to think about his options and decide if he wants to continue as he is, or undergo augmentation cystoplasty." This statement can be read to support a finding that claimant has not decided against proceeding with the surgery. However, the situation has changed in that now the physician is no longer recommending the surgery. Therefore, claimant's surgical decision, or lack thereof, is not determinative.

March 28, 1997 Cite as 49 Van Natta 339 (1997)

In the Matter of the Compensation of
TONY L. MACKEY, Claimant
WCB Case No. 96-01442
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that dismissed his request for hearing which pertained to entitlement to "pre-closure" temporary disability benefits. In its respondent's brief, the self-insured employer seeks sanctions under ORS 656.390 for a frivolous appeal. In his reply brief, claimant moves to strike the employer's brief due to "numerous extra-record references." On review, the issues are jurisdiction, temporary disability, penalties, motion to strike, and sanctions. We reinstate claimant's request for hearing and, on the merits, deny claimant's request for temporary disability benefits and penalties and the employer's request for sanctions.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant's motion to strike does not specify what portions of the employer's respondent's brief reference "extra-record" evidence. In light of the vagueness of claimant's motion, we decline to grant it. In any event, as with any appellate brief, we only consider those portions which address evidence and matters that are properly present in this record.

Jurisdiction

Based on prior Board cases, the ALJ found that the Hearings Division lacked jurisdiction over claimant's request for procedural temporary disability benefits. Consequently, the ALJ dismissed claimant's request for hearing.

Subsequent to the ALJ's order, we issued our decision in Alfredo Martinez, 49 Van Natta 67 (1997). In Martinez, we held that the Hearings Division has jurisdiction over disputes concerning a claimant's entitlement to procedural temporary disability benefits, regardless of whether or not the claimant's claim had subsequently been closed. While claim closure affects the Hearings Division and Board's authority to award procedural temporary disability benefits pursuant to the court's decision in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), it does not divest the Hearings Division of jurisdiction over the dispute. In reaching this conclusion, we disavowed Patricia R. Gade, 48 Van Natta 746 (1996), to the extent it interpreted our decision in Galvin C. Yoakum, 44 Van Natta 2403, on recon 44 Van Natta 2492 (1992), to mean that the Hearings Division lacked jurisdiction over disputes involving entitlement to procedural temporary disability benefits.

Based on our holding in Martinez, we find that the ALJ had jurisdiction over claimant's request for procedural temporary disability benefits. Consequently, we reinstate claimant's request for hearing.

Temporary Disability Benefits

Claimant asserts that he is procedurally entitled to temporary disability benefits from March 31, 1995 through August 13, 1995. We disagree.

Here, claimant's claim was closed by a March 22, 1996 Notice of Closure which awarded temporary disability benefits from August 14, 1995 through March 15, 1996. Thus, claimant's substantive entitlement to temporary disability benefits prior to the date of the Notice of Closure was determined to begin on August 14, 1995 and end on March 15, 1996. As discussed above, neither the Hearings Division nor the Board has the authority to impose a procedural overpayment by awarding temporary disability benefits for time periods other than those which have been substantively determined. Lebanon Plywood v. Seiber, 113 Or App at 654. Rather, claimant's remedy is to request reconsideration of the Notice of Closure pursuant to ORS 656.268. Accordingly, we decline to award the procedural temporary disability benefits that claimant seeks.

Penalties

Claimant asserts that he is entitled to a penalty for the employer's allegedly unreasonable failure to pay temporary disability benefits. Although we lack the authority to award temporary disability benefits, a penalty may be assessed provided the carrier's failure to pay such benefits was unreasonable. See John R. Heath, 45 Van Natta 466, 467 (1993), aff'd Anodizing, Inc. v. Heath, 129 Or App 352 (1994).

Since claimant's request for temporary disability benefits was based on the assertion that he had sustained an aggravation, his entitlement to procedural temporary disability benefits depends on whether the employer received notice or knowledge of a medically verified inability to work resulting from a compensable worsening pursuant to ORS 656.273(1). ORS 656.273(6): Ilene M. Herget, 47 Van Natta 2285 (1995). In addition, no procedural temporary disability benefits are payable unless authorized by a worker's attending physician. See ORS 656.262(4)(f); Kenneth P. Bundy, 48 Van Natta 2501, 2505 (1996).

As found by the ALJ, prior to June 12, 1995, there were no medical reports received by the employer which indicated that claimant was released from work due to the compensable injury or a worsened condition. Therefore, the employer had no duty to begin paying temporary disability benefits prior to June 12, 1995. ORS 656.273(6). On June 12, 1995, claimant's counsel wrote the insurer requesting temporary disability benefits based on the reports of Drs. Daven and Karasek which accompanied the request. (Exs. 17-21). Dr. Karasek's report indicated that Dr. Daven would be "in charge of the time loss determination." (Ex. 18). Dr. Daven agreed that claimant should be on light duty, but indicated that he had only seen claimant one time on referral from claimant's primary care physician. (Ex. 20). In light of Dr. Karasek's deferral and Dr. Daven's indication that he was not claimant's attending physician, the employer's failure to pay temporary disability benefits following receipt of those reports was not unreasonable in light of ORS 656.262(4)(f).

Finally, the employer issued a denial of claimant's aggravation claim on July 14, 1995. Following the issuance of the denial, the employer was under no obligation to pay temporary disability benefits. Under these circumstances, we do not find the employer's failure to pay temporary disability benefits between March 31, 1995 and August 13, 1995 was unreasonable. Consequently, a penalty is not warranted.

Sanctions

The employer contends that claimant's request for review is frivolous and requests sanctions pursuant to ORS 656.390. In light of our modification of the ALJ's order, it follows that claimant's appeal was not frivolous. Accordingly, sanctions are not warranted.

ORDER

The ALJ's order dated October 30, 1996 is modified. Claimant's request for hearing is reinstated. Claimant's request for procedural temporary disability benefits and penalties is denied.

March 28, 1997 Cite as 49 Van Natta 341 (1997)

In the Matter of the Compensation of
PHILLIP L. SHORES, Claimant
WCB Case No. 96-04616
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a current cervical condition.[1] On review, the issues are scope of acceptance and compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On December 21, 1995, SAIF accepted claimant's injury claim for right shoulder tendinitis. (Ex. 36). On April 23, 1996, SAIF issued a partial denial of claimant's preexisting degenerative disc disease and "herniated disc C6-7 on the right." (Ex. 50). Claimant requested a hearing.

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[1] Claimant has cross-requested review of the ALJ's order, but he presents no objection to the order.

During closing argument, claimant argued that SAIF's denial was precluded under Georgia-Pacific v. Piwowar, 305 Or 494 (1988). Reasoning that SAIF had accepted the tendinitis claim based on symptoms (without determining the true cause of the symptoms, a herniated C6-7 disc), the ALJ concluded that the denial was precluded.

On review, SAIF argues that claimant's "Piwowar/preclusion" argument was not timely raised. We agree.

We have consistently held that we will not consider an issue raised for the first time during closing argument. Burton I. Thompson, 48 Van Natta 866 (1996).[2] Moreover, even if the "Piwowar/preclusion" argument was timely raised, we would uphold SAIF's denial, based on the following reasoning.

There is no evidence that, in accepting the claim, SAIF accepted anything more than the claim for "right shoulder tendinitis." See Boise Cascade Corp. v. Katzenbach, 104 Or App 732, 735 (1990), rev den 311 Or 261 (1991) (Carrier's acceptance of a "strain" is not an acceptance of the worker's underlying condition); Renee M. Wilshire, 47 Van Natta 1339 (1995) (Acceptance of carpal tunnel syndrome did not constitute acceptance of flexor tenosynovitis, because the conditions are separate and distinct). An acceptance must be specific, if it is to bar the insurer from denying a claim. See Davis v. R&R Truck Brokers, 112 Or App 485, 490 (1992).

Here, SAIF specifically accepted right shoulder tendinitis, not degenerative disc disease or a herniated disc. There is no evidence that tendinitis is a symptom of degeneration or a disc herniation. Compare Piwowar, 305 Or at 494 (Acceptance of symptoms constitutes acceptance of the condition causing the symptoms).[3] Consequently, assuming (without deciding) that claimant's "Piwowar/preclusion" argument is properly before us, we find that SAIF's denial of claimant's cervical condition is not precluded by its acceptance of the claim for right shoulder tendinitis. Id. Moreover, because we agree with the ALJ's reasoning and conclusion that the claim is not compensable on the merits, we adopt his opinion in this regard (on pages 3 and 4 of the Opinion and Order) and reinstate SAIF's denial.

ORDER

The ALJ's order dated September 20, 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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[2] Citing Leslie Thomas, 44 Van Natta 200 (1992); John C. Schilthuis, 43 Van Natta 1396, 1399 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989); Donald A. Hacker, 37 Van Natta 706 (1985).

[3] See also Nordstrom, Inc. v. Windom-Hall, 144 Or App 96, 98 (Where acceptance was limited to exposure-related symptoms, it did not encompass conditions not caused by that exposure); compare Ledbetter v. SAIF, 132 Or App 508, 510 (1995).

In the Matter of the Compensation of
RICHARD W. BOHLMAN, Claimant
WCB Case No. 95-13137
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's aggravation and current condition claims. In his respondent's brief, claimant contests that portion of the ALJ's order which declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

On review, we first address claimant's argument that, pursuant to Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), SAIF paid benefits pursuant to a Determination Order, and is now precluded from denying compensability of claimant's condition. We disagree with claimant's preclusion argument. The October 1991 Determination Order awarded permanent disability based on claimant's C4-5 spinal stenosis condition. (Ex. 32-2). However, according to claimant's treating doctor, claimant's current condition consists of a "left paracentral herniated disc, C6-7." (Ex. 71). Accordingly, we conclude that SAIF is not precluded from denying claimant's current condition, based on its failure to appeal a prior Determination Order award.

We next address SAIF's contention that the ALJ erred in relying on the opinion of Dr. Franks, claimant's treating physician. SAIF argues that Dr. Franks' opinion is based on his belief that a C6-7 disc herniation was present and documented in 1990, following the compensable 1989 injury. However, SAIF contends that surgery performed in August 1990 showed that there was no disc herniation at C6-7.

We do not find Dr. Franks' opinion to be inconsistent. Dr. Franks explained that claimant's 1989 injury caused a "pathological process at 6/7." Dr. Franks also acknowledged that, at the time of the 1990 surgery, the C6-7 herniation was not clinically symptomatic like the C4-5 disc which was the cause of claimant's original need for surgery. However, Dr. Franks nevertheless explained that the C6-7 herniation was documented at that time. (Ex. 72).

Dr. Franks' opinion is supported by the record. Dr. Schilling's impression of claimant's May 1990 cervical myelogram was that claimant had a "slight disc bulging of the C6-7 level." (Ex. 14). A CT scan performed at that time also showed a "disc hernation at the C6-7 level on the left." (Ex. 13). Furthermore, although SAIF relies on the surgical reports as failing to reveal a C6-7 herniation, the reports focused on the C4-5 level which was the location of the surgery. There is no evidence in the report of any consideration or observation of the C6-7 level, and no suggestion that a disc herniation at that level had been ruled out. (Ex. 17).

Finally, SAIF argues that Dr. Franks' opinion should be rejected on the basis that it relies on a temporal or "inciting" incident analysis. We do not agree that Dr. Franks' opinion is based merely on such analysis. Dr. Franks considered the mechanism of claimant's injury, the prior abnormal findings and the progression and nature of claimant's symptoms. (Ex. 72). Accordingly, we agree with the ALJ that Dr. Franks' opinion is persuasive. Based on that opinion, we conclude that claimant has proven that the work injury is the major contributing cause of his C6-7 condition.

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

ORDER

The ALJ's order dated October 1, 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.

In the Matter of the Compensation of
GARY G. BRITTON, Claimant
WCB Case Nos. 95-04539 & 95-02235
ORDER ON REMAND
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. SAIF v. Britton, 145 Or App 288 (1996). The court reversed our prior order, Gary G. Britton, 48 Van Natta 459, on recon 48 Van Natta 601 (1996), that found the SAIF Corporation, rather than Liberty Northwest Insurance Corporation, responsible for claimant's left carpal tunnel syndrome. Finding that the Board erred as a matter of law in the application of ORS 656.005(7)(a)(B), the court remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for Finding of Fact 16.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1984 claim with Liberty for bilateral carpal tunnel syndrome (CTS). In 1990, claimant underwent surgery for the right CTS. Claimant also has an accepted 1992 claim with SAIF for numerous injuries related to a motor vehicle accident. In November 1994, claimant sought treatment for increased left CTS symptoms. Liberty and SAIF denied responsibility for the condition, and claimant appealed.

The Administrative Law Judge (ALJ) upheld SAIF's denial, but set aside Liberty's denial. On review, we reversed. Relying on ORS 656.308(1) and 656.005(7)(a)(B), we stated that, "in order for responsibility to shift to SAIF, Liberty must show that the 1992 motor vehicle accident is the major contributing cause of the need for treatment." After finding that the treating physician, Dr. Jewell, provided the most persuasive opinion concerning causation, we concluded that Liberty had carried its burden of proof because Dr. Jewell showed that "the motor vehicle accident pathologically worsened the left CTS[.]" SAIF petitioned for judicial review.

The court found that we set forth the correct standard to determine responsibility of claimant's left CTS. Because we found only that the motor vehicle accident pathologically worsened claimant's CTS, however, the court concluded that we "erred as a matter of law in our application of ORS 656.005(7)(a)(B)" and reversed and remanded for reconsideration.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section."

In its decision, the court explained that, under the statute, "when a worker sustains a second injury to the same body part, whether the first injury is compensable or not, the subsequent employer is responsible only if the second injury constitutes the major contributing cause of the worker's disability or need for treatment for the combined condition." 145 Or App at 292. The court further stated that the "pertinent question here is whether the injuries claimant sustained to his left forearm in the 1992 motor vehicle accident constitute the major contributing cause of his current need for treatment for his left CTS." Id.

We republish that portion of our order setting forth the medical evidence and our reasoning for concluding that Dr. Jewell provided the most persuasive opinion. According to Dr. Jewell, the 1992 motor vehicle accident resulted in an "interval worsening" of claimant's "hand problem," resulting in his current need for treatment and disability. (Ex. 28-2). Dr. Jewell also stated that the current need for treatment "relates" to the 1992 car crash "as opposed to the earlier claim with Liberty Northwest." (Id.)

Dr. Jewell subsequently reported that "claimant's carpal tunnel syndrome has been advanced, and there has been pathological worsening due to the sequelae of the claimant's near fatal truck crash of 1/14/92." (Ex. 32B-3). In his final report, Dr. Jewell reiterated that claimant's current need for treatment "relates to the original accepted injury with Liberty Northwest" and that "the truck crash has independently contributed to the worsening of the claimant's left carpal tunnel syndrome, along with the production of chronic musculoskeletal pain disorder condition." (Ex. 36-2).

We understand Dr. Jewell's opinion as meaning that the motor vehicle accident combined with the preexisting left CTS, resulting in claimant's current need for treatment, and thus, the "combined condition" is the worsened left CTS. Because Dr. Jewell implicates only the motor vehicle accident, we also understand Dr. Jewell as indicating that the motor vehicle accident was the major contributing cause of the worsened left CTS, as opposed to the earlier Liberty claim or a natural deterioration of the CTS. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 111-12 (1991) (medical evidence need not mimic statutory language to satisfy standard of proof). Consequently, we conclude that claimant's 1992 motor vehicle accident with SAIF's insured is not merely a "precipitating cause" of his current need for treatment, but constitutes the major contributing cause of his "combined condition." Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995). Thus, Liberty proved a "new compensable injury" and responsibility shifts to SAIF. ORS 656.308(1); 656.005(7)(a)(B).

Accordingly, on reconsideration from the Court of Appeals, as modified and supplemented herein, we republish our prior orders which found SAIF responsible for processing claimant's left carpal tunnel syndrome claim. For services before the court, claimant's attorney is awarded as assessed attorney fee of $2,000, to be paid by SAIF. ORS 656.388(1). This amount is in addition to the prior attorney fee awards granted for claimant's counsel's services at hearing and on review.

IT IS SO ORDERED.

March 31, 1997 Cite as 49 Van Natta 345 (1997)

In the Matter of the Compensation of
MICHAEL D. STANLEY, Claimant
WCB Case No. 96-05609
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) found that claimant had established good cause for his untimely hearing request; and (2) set aside the employer's denial of claimant's claim for a low back condition. On review, the issues are timeliness of the request for hearing and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, after receiving the employer's January 16, 1996 denial, claimant called the claims adjuster in February. A settlement was discussed and a verbal agreement was reached. Sometime in late April or early May 1996, the claims adjuster sent claimant a Disputed Claim

Settlement. However, after reading the agreement, claimant disagreed with the terms and decided not to sign the document. Claimant retained an attorney on June 6, 1996, and a request for hearing was filed on June 13, 1996, which was amended by a June 24, 1996 hearing request.

The ALJ found that it was understandable that claimant would not request a hearing, based on his belief that the matter had been settled. Additionally, the ALJ found that claimant's concerns about the language of the settlement were justified, and claimant subsequently made diligent efforts to obtain an attorney. Accordingly, the ALJ held that claimant had established good cause for his failure to timely request a hearing. We disagree.

Here, there is no dispute that claimant's request for hearing was filed more than 60 days, but less than 180 days, following the employer's denial. Therefore, under ORS 656.319(1)(b), claimant has the burden of proving "good cause" for the late filing of his request for hearing. See Cogswell v. SAIF, 74 Or App 234 (1985). In this context, good cause means "mistake, inadvertence, surprise or excusable neglect," as defined under ORCP 71B(1). Hempel v. SAIF, 100 Or App 68, 70 (1990). Lack of diligence does not constitute good cause. However, good cause can be established through evidence that a claimant relied on the misleading statement of a carrier's representative. See Voorhies v. Wood, Tatum, Mosser, 81 Or App 336, rev den 302 Or 342 (1986).

We have held in numerous cases that, where the carrier's employee did not inform a claimant that the claim would be accepted, the claimant's reliance on the carrier's statements did not constitute good cause for an untimely filing. Altagrasia Lamm, 46 Van Natta 252 (1994); Joe Ann Aguilar, 43 Van Natta 246 (1991); Diane T. Lindholm, 42 Van Natta 447 (1990). For example, in the Lamm case, the claimant argued that the claims examiner informed her that the denial letter would be "re-reviewed," and the claimant would be contacted after that review. Nevertheless, because the claims examiner testified that at no time during her conversations with the claimant did she inform the claimant that the denial would be rescinded, we held that the claimant's reliance on such statements did not establish good cause. 46 Van Natta at 252.

Similarly, in the present case, claimant testified that he read and understood the denial. (Tr. 36). Furthermore, the claims examiner testified that she told claimant that the claim would remain denied, and she did not tell him that his claim would be accepted. (Tr. 61). Moreover, the claims examiner explained to claimant that the employer was standing by its denial, and because claimant believed the claim should not be denied, they had a "dispute." (Tr. 61).

Accordingly, we do not find that claimant's reliance on the claims examiner's statements regarding a settlement constitutes good cause for the untimely filing. There is no evidence that claimant was misled or told that his claim would be accepted, or told to disregard the denial. Additionally, there is no evidence that the claims examiner told claimant that the documents would be submitted to him by a certain date, or that he would still have time to file a hearing request if he disagreed with the terms of the settlement.[1] See e.g. Wayne A. Moltrum, 47 Van Natta (1995) (Confusion about the status of a claim does not constitute "good cause.").

Therefore, because we conclude that claimant has failed to prove good cause for his untimely filing, we dismiss claimant's request for hearing. ORS 656.319(1). Accordingly, the ALJ's order is reversed.

ORDER

The ALJ's order dated October 3, 1996 is reversed. The self-insured employer's denial is reinstated. The ALJ's attorney fee award is reversed. Claimant'S hearing request is dismissed.

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[1] Although claimant emphasizes his disagreement with the terms of the settlement, there is no evidence that the claims examiner misled claimant with regard to the terms of the agreement. Moreover, the disagreement did not arise until after the 60 days had expired, as claimant did not see the document until sometime after April 26, 1996.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

Cite as 324 Or 465 (1996) December 19, 1996

IN THE SUPREME COURT OF THE STATE OF OREGON

Karl J. TADSEN, *Respondent on Review,*
v.
PRAEGITZER INDUSTRIES, INC., a corporation, *Petitioner on Review.*
(CC 93-1208-L-2; CA A85428; SC S42765)

On review from the Court of Appeals.*
Argued and submitted May 6, 1996.
Charles R. Markley, of Greene & Markley, P.C., Portland, argued the cause and filed the petition for petitioner on review.
Joseph M. Charter, of Werdell, Charter & Hanson, Medford, argued the cause and filed the briefs for respondent on review.
Elizabeth McKanna and Lory Kraut, of Bennett, Hartman, Reynolds & Wiser, Portland, filed a brief on behalf of *amicus curiae* Oregon Trial Lawyers Association.
Before Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Graber, and Durham, Justices.**
VAN HOOMISSEN, J.,
The decision of the Court of Appeals and the judgment of the circuit court are affirmed.

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* Appeal from Jackson County Circuit Court, L. L. Sawyer, Judge. 136 Or App 247, 902 P2d 586 (1995).
** Unis, J., retired June 30, 1996, and did not participate in this decision.

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324 Or 467> This is an action under ORS 659.121[1] for unlawful employment practices in violation of ORS 659.415[2] and 659.425.[3] Defendant seeks review of a Court of Appeals decision

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[1] ORS 659.121 provides in part:

"(1) Any person claiming to be aggrieved by an unlawful employment practice prohibited by * * * [ORS] 659.415 [or] 659.425 * * * may file a civil suit in circuit court for injunctive relief and the court may order such other equitable relief as may be appropriate, including but not limited to reinstatement or the hiring of employees with or without back pay. * * *.

"(2) Any person claiming to be aggrieved by alleged violations of [ORS] 659.415 to 659.435 * * * may file a civil action in circuit court to recover compensatory damages or $200, whichever is greater, and punitive damages. In addition, the court may award relief authorized under subsection (1) of this section and such equitable relief as it considers appropriate."

[2] ORS 659.415 provides in part:

"(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position. * * * If the former position is not available, the worker shall be reinstated in any other existing position which is vacant and suitable."

[3] ORS 659.425 provides in part:

"(1) For the purpose of ORS 659.400 to 659.460, it is an unlawful employment practice for any employer to refuse to hire, employ or promote, to bar or discharge from employment or to discriminate in compensation or in terms, conditions or privileges of employment because:

"(a) An individual has a physical or mental impairment which, with reasonable accommodation by the employer, does not prevent the performance of the work involved;

"(b) An individual has a record of a physical or mental impairment; or

"(c) An individual is regarded as having a physical or mental impairment."

affirming a trial court's judgment for plaintiff, its former employee. *Tadsen v. Praegitzer Industries, Inc.*, 136 Or App 247, 902 P2d 586 (1995).[4] The issue is whether the trial court erred in denying defendant's motion to strike plaintiffs claim for future lost wages and benefits ("front pay").[5] For the reasons that follow, we hold that it did not err.

324 Or 468> On review of a trial court's order denying a motion to strike a claim for damages, this court views the evidence, and reasonable inferences from the evidence, in the light most favorable to the nonmoving party and considers whether there was any evidence to support the jury's award of damages. *See Brown v. J. C. Penney Co.*, 297 Or 695, 705, 688 P2d 811 (1984) (standard of review of denial of motion for directed verdict); Or Const, Art VII (Amended), § 3 (standard of review when a jury has rendered a verdict).[6]

Defendant hired plaintiff in March 1989 as a maintenance electrician and promoted him to maintenance supervisor in August 1990. Plaintiff's supervisory duties were not physically demanding. In October 1991, plaintiff injured his back while on the job. Plaintiff's injuries were covered by defendant's workers' compensation insurance. In April 1992, plaintiff took a two week medical leave of absence relating to his back injury. During that absence, defendant assigned plaintiff's supervisory duties to another employee. When plaintiff returned to work, he was assigned electrician duties and was treated by his supervisor in a manner that, according to plaintiff, indicated that he had been effectively demoted to a laborer position. If plaintiff had been reinstated to his former supervisory position, he could have performed that job. Plaintiff's new duties were far more physically demanding than his former supervisory duties. While performing those duties, plaintiff aggravated his back injury and, from May through October 1992, he took several medical leaves. On return to work in October 1992, plaintiff was assigned senior electrician duties that he could not physically perform. Plaintiff continued to take medical leaves and, in November 1992, defendant terminated his employment.

Plaintiff then brought this action, alleging unlawful employment practices under ORS 659.415 and 659.425. Plaintiff sought economic damages, primarily in the form of back pay and front pay, as well as noneconomic damages. A **<324 Or 468/469>** jury found that defendant had failed to reinstate plaintiff to his former position or had failed to offer him another existing or suitable position after his doctor approved his return to work, in violation of ORS 659.415, and also found that defendant had discharged plaintiff because he had a physical impairment which, with reasonable accommodation, did not prevent the performance of his work, in violation of ORS 659.425. The jury awarded plaintiff economic damages in the amount of $353,450 (the exact amount estimated by plaintiff's expert witness to be plaintiff's lost past wages and benefits plus front pay and benefits to retirement at age 63) and noneconomic damages in the amount of $70,000, for a total award of $423,450. Defendant appealed, challenging only the award of front pay.

In the Court of Appeals, defendant contended that the trial court had erred in denying its motion to strike plaintiff's claim for front pay. Defendant's attack on plaintiff's front pay award was two-pronged. First, it argued that, as a matter of law, an at-will employee such as plaintiff never can prove the requisite facts for an award of front pay. Second, it argued that plaintiff had failed to present evidence from which the jury reasonably could identify the period during which defendant's employment would have continued, but for the unlawful termination. The Court of Appeals rejected both arguments, concluding that plaintiff's evidence was sufficient to establish the period during which

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[4] Plaintiff's complaint also contained a claim for discrimination and discharge in retaliation for filing a workers' compensation claim in violation of ORS 659.410. The jury found for defendant on that claim, and it is not an issue on review.

[5] "Front pay" is a short hand term frequently used in federal courts and administrative agencies to refer to future lost pay and benefits. *See, e.g., Avitia v. Metropolitan Club*, 49 F3d 1219, 1231 (7th Cir 1995) (discussing the term).

Black's Law Dictionary, 669 (6th ed 1990), defines "front wages" as:

"Type of prospective compensation paid to a victim of job discrimination * * * until the victim achieves the position he would have attained but for the illegal and discriminatory act."

[6] Article VII (Amended), section 3, of the Oregon Constitution, provides in part:

"In actions at law, * * * the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any court of this state, unless the court can affirmatively say there is no evidence to support the verdict."

the plaintiff likely would have been employed by the defendant but for the disciimination. *Tadsen*, 136 Or at 252-55.[7] Accordingly, the Court of Appeals affirmed the judgment for plaintiff. *Id.* at 259. The Court of Appeals relied on its earlier decision in *Wooton v. Viking Distrib. Co.*, 136 Or App 56, 899 P2d 1219 (1995), *rev den* 322 Or 613 (1996). In that case, the court held that, under ORS 659.121(2), "compensatory damages" includes front pay. *Id.* at 65. We allowed defendant's petition for review.

We first address the question whether front pay is a form of "compensatory damages" under ORS 659.121(2). **<324 Or 469/470>** That question calls for an interpretation of the statute. Thus, we apply the template set out in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). The first level of analysis under PGE requires that we examine the text and context of the statute. *Id.* at 610.

ORS 659.121(2) provides that " [a]ny person claiming to be aggrieved by alleged violations of [ORS 659.415 or 659.4251 may file a civil action in circuit court to recover *compensatory damages*, * * * ." Black's Law Dictionary, 390 (6th ed 1990) states:

> "Compensatory damages are such as will compensate the injured party for the injury sustained, and nothing more; such as will simply make good or replace the loss caused by the wrong or injury. Damages awarded to a person as compensation, indemnity, or restitution for harm sustained by him."

Under that definition, front pay is a form of compensatory damages, because it restores the terminated employee to the economic position that the employee would have enjoyed, were it not for the employer's unlawful conduct. We assume that the 1987 legislature understood the usual meaning of the term "compensatory damages" when it provided for that form of remedy for unlawful employment practices by amending ORS 659.121(2).[8] *See McIntire v. Forbes*, 322 Or 426, 431, 909 P2d 846 (1996) (stating that "[a]nalysis of text also includes reference to well-established legal meanings for terms that the legislature has used"). Our inquiry into the text and context of ORS 659.121(2) demonstrates that the legislature intended "compensatory damages" to allow for a claim for front pay damages.

We next consider whether the fact that employment is "at-will" prevents recovery of front pay in all cases. Before the Court of Appeals, defendant argued that, notwithstanding a discriminatory discharge and its actual causal relationship to a loss of future earnings, an at-will employee cannot **<324 Or 470/471>** recover damages for that loss because, independent of the unlawful filing, the employee has no "right" to, or assurance of, any future employment with the employer. The premise that necessarily underlies that argument is that an employer should enjoy a conclusive presumption that, had it not discharged the employee illegally, it would have discharged him or her lawfully at any time after it in fact did so unlawfully.

Like the Court of Appeals, we find defendant's premise unconvincing. We decline to hold that an at-will employee never can prove the requisite facts for an award of front pay. The fact that at-will employment may be terminated for any nondiscriminatory purpose does not necessarily mean that the likely duration of that employment is incapable of proof to the required degree of certainty. At-will employment may be a factor that bears on whether the proof is sufficient in a particular case, but the right to terminate someone's employment does not establish as a matter of law that an employee cannot prove the existence of front pay damages.

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[7] Defendant also argued in the Court of Appeals that the trial court erred in failing to give defendant's requested jury instruction on economic damages. The Court of Appeals held that defendant was not prejudiced by the instruction actually given and, therefore, that any error was harmless. *Tadsen*, 136 Or App at 259. Defendant did not seek review of that holding, and we do not consider it.

[8] When ORS 659.121 originally was enacted in 1977, plaintiffs alleging unlawful employment practices were limited to "injunctive relief" and "such other equitable relief as may be appropriate, including but not limited to reinstatement or the hiring of employes with or without back pay," and they could not recover "compensatory damages." Or Laws 1977, ch 453, § 6. In 1987, the legislature amended ORS 659.121 to include compensatory and punitive damages as available remedies for plaintiffs claiming unlawful employment practices. Or Laws 1987, ch 822, § 1(2).

Finally, we examine defendant's argument that plaintiff failed to present any evidence that he would have continued working for defendant through the end of his work life expectancy, as he claimed. Defendant relies primarily on *Jenks v. Larimer*, 268 Or 37, 518 P2d 1301 (1974), for the proposition that, before a claim for front pay may be submitted to a jury, the plaintiff must establish by statistical or similar evidence the average length of employment in the particular industry of an at-will employee.

Before addressing defendant's specific argument, we first consider the preliminary question of the legal standard that governs the sufficiency of evidence of front pay in a statutory claim for unlawful employment practices. At present, that is an open question under ORS 659.121.

In several tort and contract cases involving claims for future lost profits, wages, or income, this court has applied a standard of "reasonable certainty." And, as plaintiff notes, this court recently approved a claim for "wrongful life" based on a failed tubal ligation and consequent future damages of expected expenses of raising the child and providing for its college education. *Zehr v. Haugen*, 318 Or 647, 659, 871 P2d 1006 (1994). The court rejected an argument that, as a matter of law, the claimed damages were "too speculative." **<324 Or 471/472>** *Id.* at 657-58. "Generally * * * when a plaintiff asserts a claim for damages for future harm, the question whether those damages are recoverable is a question of fact for the jury, the answer to which will depend on the evidence adduced at trial." *Ibid.*

As long ago as *Cont. Plants v. Measured Mkt.*, 274 Or 621, 624, 547 P2d 1368 (1976), this court explained that "reasonable certainty" is not a demanding standard:

> "What is actually meant by 'reasonable certainty' is discussed in McCormick, Damages 100, § 27 (1935), in which it is stated,
>
> " '* * * [I]t appears that the epithet "*certainty*" is overstrong, and that the standard is a qualified one, of "reasonable certainty" merely, or, in other words, of "probability." ' " (Emphasis in original.)

Applying that standard, this court held in *Cont. Plants* that the plaintiff had submitted sufficient evidence for the factfinder to conclude that the defendant's breach damaged the plaintiff. *Id.* at 625.

Our review of this court's relevant cases reveals that a claim for economic damages necessarily rests on some quantum of evidence that would allow the jury to find that certain events probably would have occurred, or that certain conditions probably would have existed, had it not been for a defendant's wrongful conduct. As this court stated in *Conachan v. Williams*, 266 Or 45, 55, 511 P2d 392 (1973), a case dealing with a claim of lost earning capacity (quoting with approval *Baxter v. Baker*, 253 Or 376, 392, 454 P2d 855 (1969) (O'Connell, J., dissenting)):

> " 'It is obvious that plaintiff's loss both before and after trial can be approximated only and that the calculation of the loss must rest upon factors which can be employed only in terms of probabilities * * *.' "

The lack of absolute certainty does not bar submission of a claim for front pay damages. Only reasonable probability is required. Expert testimony may aid the factfinder in placing a present value on future earning losses. In doing so, an expert may testify to economic assumptions that necessarily rest on estimates and predictions of uncertain future events. **<324 Or 472/473>** Any weakness can be explored by cross-examination or contrary evidence. *Wilson v. B.F Goodrich*, 292 Or 626, 631, 642 P2d 644 (1982). Whether the claimed damages were proven is a matter for the factfinder, under appropriate instructions.

Because the legislature incorporated the commonlaw term "compensatory damages" into the statute, the foregoing cases are persuasive in interpreting what is required under ORS 659.121(2). Nothing in the context of ORS 659.121(2) suggests a different result. Moreover, we see no logical reason to require a higher level of proof of damages in a statutory claim than is required in a claim based on contract or negligence.

Accordingly, we hold that a party claiming front pay in a statutory claim under ORS 659.121(2) for unlawful employment practices must prove such damages with reasonable probability. In that context, the threshold requirement of reasonable probability is satisfied if reasonable jurors could find that the plaintiff would have earned a particular amount of income in the future, were it not for the defendant's wrongful conduct.

We now return to defendant's principal argument in this case and examine the record to determine whether there was sufficient evidence, viewed in the light most favorable to plaintiff, the nonmoving party, to allow the jury to consider plaintiff's claim for front pay, keeping in mind the reasonable-probability standard by which the evidence of such a claim is tested.

Defendant argues that an at-will employee can satisfy plaintiffs evidentlary burden *only* by presenting statistical or other comparable evidence of the average duration of employment *in his particular industry.* Defendant asserts that no two industries provide the same amount of job security and that the factors that go into the equation of likely duration vary from one industry to another. Therefore, defendant argues, as a matter of law, the burden should be on the employee to present such statistical or similar evidence to allow the finder of fact to determine a probable duration of employments.[9]

324 Or 474> We reject defendant's argument, and we impose no such evidentiary requirement. Either party might have chosen to present statistical or other comparable evidence of the average duration of employment in the relevant industry in an attempt to persuade the jury that plaintiff either would or would not have continued in defendant's employ until retirement or for some other period. *See Wilson,* 292 Or at 631 (the weakness of a plaintiff's evidence may be explored by contrary evidence). However, the fact that such evidence may be probative of the front pay issue does not make it a necessary element of plaintiff's evidentiary showing.

Plaintiff presented evidence that his job satisfaction was high, that defendant was satisfied with plaintiff's work before he experienced his job-related back problems, and that he had received positive performance evaluations and merit salary increases. We agree with the Court of Appeals, *Tadsen,* 136 Or App at 255, that the jury reasonably could infer from that evidence that both parties wanted the arrangement to continue indefinitely. Plaintiff's vocational rehabilitation expert testified that persons in supervisory positions in plaintiff's field normally are hired from within the company, creating a reasonable inference that plaintiff probably would not have left defendant's employ to seek out a similar position elsewhere. The record also contains evidence respecting the other factors that enter into a calculation of front pay, including the amount that plaintiff would have earned in defendant's employ, offset by the amount that **<324 Or 474/475>** plaintiff is expected to earn in the future, reduced to present value. We conclude that plaintiff's evidence was sufficient to permit an inference that plaintiff's employment with defendant would have continued until the end of plaintiff's work life expectancy, which the jury found to be age 63 based on "work life expectancy" tables.

We hold that the trial court did not err in denying defendant's motion to strike plaintiff's claim for front pay.

The decision of the Court of Appeals and the judgment of the circuit court are affirmed.

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[9] The cases from other jurisdictions that defendant cites for this proposition do not support its argument. In two appellate decisions, the courts simply affirmed, on an abuse-of-discretion standard, the lower courts'denials of front pay damages. In *McKnight v. General Motors Corp.,* 973 F2d 1366, 1372 (7th Cir 1992), *cert den* 507 US 915 (1993), the court noted that the plaintiff had failed to submit the necessary data to make a front-pay calculation. In *Hayes v. Trulock,* 51 Wash App 795, 803, 755 P2d 830 (1988), *rev den* 111 Wash2d 1015 (1988), the court stated that the plaintiffs had failed to present any evidence that they would have continued to work for the defendant for another two years. Moreover, in *Lords v. Northern Automotive Corp.,* 75 Wash App 589, 607, 881 P2d 256 (1994), the court held that the trial court erred in limiting front pay to an arbitrary period of five years after termination, noting that the likely duration of employment is an issue of fact, not law. In none of those cases did the courts rule, as a matter of law, that the plaintiffs must submit statistical or other comparable evidence of the average duration of employment in his or her particular industry in order to present a triable issue of front pay damages. *Nichols v. Frank,* 771 F Supp 1075, 1080 (D Or 1991), *affd* 42 F3d 503 (9th Cir 1994), another case cited by defendant, simply involves the court's factual finding that the plaintiff had failed to prove that, but for the defendant's sexual harassment, she would have continued to work night and evening shifts.

Cite as 145 Or App 268 (1996) December 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Donna ARMSTRONG, *Appellant*,
v.
ROGUE FEDERAL CREDIT UNION, *Respondent*.
(94-2777-L-2; CA A89715)

Appeal from Circuit Court, Jackson County.
Mitchell A. Karaman, Judge.
Argued and submitted April 3, 1996.
Thomas C. Howser argued the cause for appellant. On the opening brief were Judith H. Uherbelau and Howser and Munsell.
Conrad E. Yunker argued the cause for respondent. With him on the brief was Kevin L. Mannix, P.C.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.
Armstrong, J., dissenting.

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145 Or App 270> The issue in this case is whether an employer commits an unlawful employment practice, within the purview of ORS 659.415, by rejecting an injured worker's demand for reinstatement during the pendency of litigation over whether the worker's injury is compensable. We affirm the judgment for defendant.

The facts are undisputed. On May 25, 1990, plaintiff's physician ordered her off work due to work-related stress and depression. On November 6, 1990, SAIF Corporation, on behalf of defendant, Rogue Federal Credit Union, denied plaintiff's claim for workers' compensation benefits. Plaintiff challenged the denial and an administrative law judge (ALJ) held a hearing on the matter. On May 22, 1992, before the ALJ had issued a decision, plaintiff was released to work by her physician. Plaintiff informed defendant of the release and demanded reinstatement under ORS 659.415. In response, defendant terminated plaintiff's employment effective June 15, 1992. On September 10, 1992, the ALJ issued an order upholding SAIF's denial of the claim, on the ground that her injury was not compensable. On September 27, 1993, the Board reversed the ALJ's decision and held that plaintiff's claim was compensable. Defendant did not seek judicial review of the Board's decision.

Following the Board's order, plaintiff filed this action, asserting, *inter alia*, that defendant had violated ORS 659.415 by failing to reinstate her. Before trial, and on stipulated facts, the court granted defendant's motion for partial summary judgment on plaintiff's claim under ORS 659.415. The court then entered judgment for defendant under ORCP 67 B, dismissing that claim:

> "The court hereby FINDS that at the time plaintiff made her demand for reinstatement pursuant to ORS 659.415, her work-related injury or disease was not compensable, and did not become compensable until some time later, after contested litigation in the administrative hearings process. Taking the facts in the light most favorable to plaintiff, her demand for reinstatement was premature and could not, as a matter of law, give rise to a cause of action under the statute."

145 Or App 271> ORS 659.415 provides, in part:

> "(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position. * * *
>
> "* * * * *
>
> "(4) Any violation of this section is an unlawful employment practice."

On appeal, plaintiff contends that the statute is not clear that the claim must be determined to be compensable when demand for reinstatement is made.[1] Defendant argues that the plain meaning of ORS 659.415 shows that plaintiff's injury must have been determined to be compensable by the time she demanded reinstatement in order for the failure to reinstate to constitute a violation. Defendant is correct. We agree with plaintiff that her suggested reading is plausible, but in context it is clear she is incorrect.

The Bureau of Labor and Industries (BOLI) is charged with the administration of the employment discrimination law. ORS 659.040 to ORS 659.103. That statutory scheme reveals that the legislature delegated broad authority to BOLI to develop the concept of reinstatement. ORS 659.103. Accordingly, BOLI promulgated OAR 839-06-120, stating that, "[t]o have rights under ORS 659.415 * * * a person must be an injured worker as defined in OAR 839-06-105(5)." OAR 839-06-105(5), effective March 12, 1996, defines "injured worker" as a worker who has had a compensable injury as determined by acceptance of the claim under the Oregon Workers' Compensation Statutes. Although OAR 839-06-105(5) does not address the precise issue presented in this case, it supports the conclusion that the determination **<145 Or App 271/272>** that an injured worker's injury is compensable is a condition precedent to the right to reinstatement.

An injured worker's right to reinstatement cannot be violated, and, thus, a claim for an unlawful employment practice under ORS 659.415(1) cannot accrue, until the employer fails to reinstate after the worker is released to return to work. *Barnes v. City of Portland*, 120 Or App 24, 2829, 852 P2d 265, *rev den* 317 Or 583 (1993). The question is not, then, as the parties have framed it, whether plaintiff's claim was compensable when reinstatement was denied, but whether defendant's conduct was wrongful when it occurred. Turning to the text of the statute, ORS 659.415 provides that an employer shall reinstate an injured worker upon demand when: (1) the worker has suffered a compensable injury; (2) the worker's former position "exists," and (3) the worker's former position is "available," as the term is later defined in the statute. At the time defendant denied plaintiff's demand for reinstatement, plaintiff's claim had not yet been determined to be compensable. Defendant could not have known that plaintiff's claim was compensable and that she was entitled to reinstatement. Its conduct would not at that time have supported an action for an unlawful employment practice.

By reading other provisions in ORS 659.415 in context, and construing them as a whole, we are satisfied that defendant is correct. ORS 659.415(3)(a) limits a worker's right to reinstatement by setting forth six grounds on which the right terminates. ORS 659.415(3)(a)(F) provides that a worker's right to reinstatement terminates three years from the date of injury. It follows then, that an injured worker's right to reinstatement may terminate *notwithstanding* the fact that the worker has sustained a compensable injury and that it may terminate *before* the worker can seek reinstatement. To recognize that an injured worker has a right to reinstatement pending the outcome of the contested litigation in the administrative hearings process would be inconsistent with the legislature's statutory scheme. That the legislature used the word "compensable" in reference to the accrual of an injured worker's right to be reinstated to her former position, but did not do so in relation to setting the date on which that right expires, persuades us that the right to reinstatement is dependent on the worker first sustaining a compensable **<145 Or App 272/273>** injury. *See Perlenfein and Perlenfein*, 316 Or 16, 22-23, 848 P2d 604 (1993) (the legislature's use of a particular term in one provision of a statute and omission of that term in a related provision leads to a conclusion that the legislature did not intend that the term apply in the provision from which the term is omitted).

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[1] Plaintiff does claim in this case that employer terminated her, and thereby committed an unlawful employment practice, because she filed a claim for benefits. ORS 659.410. Plaintiff does contend that "reinstatement should be required pending the [outcome] of the administrative process." We do not understand her contention to be that employer committed an unlawful employment practice because her request was continuing in nature, and, thus, the administrative determination that her injury was compensable triggered an affirmative duty on the part of employer to reinstate her.

The context in which ORS 659.415(1) occurs convinces us that the determination that a worker has sustained a compensable injury is a condition precedent to the right to reinstatement under ORS 659.415(1).[2] The trial court did not err.

We have considered and reject, without discussion, plaintiff's other arguments.

Affirmed.

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[2] *Former* OAR 839-06-105(4)(c) precisely addressed the present question by defining "Injured Worker" for the purposes of ORS 659.415(1) as

> "a worker who has had a compensable injury *as determined* by the Employer's acceptance of the claim under the Oregon Workers' Compensation Law, by stipulation of the parties, *by a finding of the Oregon Workers' Compensation Board or by a judicial opinion regarding a finding of the Board.*" (Emphasis supplied.)

BOLI's amendment simplifies the language in the rule, and we do not understand BOLI to have intended any substantive changes in the way the rule is applied. We do not believe it rational to assume that BOLI intended reinstatement rights to apply only when acceptance is voluntary and not when acceptance is compelled by Board orjudicial decision.

ARMSTRONG, J., dissenting.

The majority holds that ORS 659.415 requires a worker's injury to have been accepted as compensable before the worker's employer can be required to reinstate the worker to employment after such an injury. Because it is evident from the text and context of ORS 659.415 that the statute does not impose that requirement on a worker's reinstatement right, I dissent.

In interpreting a statute, the court's task is to discern the intent of the legislature. ORS 174.020; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). If we can discern that intent from the text of the statute, in context, no further inquiry is necessary. *Id.* at 610-11.

145 Or App 274> As the majority explains, ORS 659.415 requires an employer to reinstate an injured worker to the worker's job on demand if the worker has suffered a compensable injury and the former position exists and is available. 145 Or App at 272.[1] "Compensable injury" is not defined in the statute. Rather than turning to the definition of compensable injury in the Workers' Compensation Law to determine the meaning of that term, the majority simply concludes that the term requires a worker's injury to have been accepted as compensable in order for the reinstatement right to exist. It states that its conclusion is consistent with reinstatement rules adopted by the Bureau of Labor and Industries (BOLI) and with the other provisions of the statute.

The majority's conclusion improperly ignores, however, the definition of compensable injury in the Workers' Compensation Law. It also adds a requirement to ORS 659.415 that is not found in it. In effect, the majority inserts "accepted" in front of "compensable injury" in the statute.[2] ORS 174.010 prohibits us from doing that.

The Workers' Compensation Law is part of the context of ORS 659.415. As the Supreme Court has recognized, the principal purpose of ORS 659.415 is

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[1] ORS 659.415(1) provides:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position. A worker's former position is 'available' even if that position has been filled by a replacement while the injured worker was absent. If the former position is not available, the worker shall be reinstated in any other existing position which is vacant and suitable. A certificate by the attending physician that the physician approves the worker's return to the worker's regular employment or other suitable employment shall be prima facie evidence that the worker is able to perform such duties."

[2] See note 1 above for the text of the statute.

> "to guarantee that an employer shall not discriminate against a disabled worker for exercising the worker's rights under the Workers' Compensation Law."

Shaw v. Doyle Milling Co., 297 Or 251, 255, 683 P2d 82 (1984). Thus, when ORS 659.415 refers to a "compensable injury," it is logical to assume that the relevant definition of **<145 Or App 274/275>** that term is the one found in the Worker's Compensation Law.[3] That definition is found in ORS 656.005(7)(a), which provides that a

> " 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means[.]"

The definition requires a compensable injury (1) to be accidental, (2) to arise out of employment, (3) to occur in the course of employment, and (4) to require medical services or result in disability or death. It does not include a requirement that a claim for such an injury has to have been accepted as compensable in order for the injury to be a "compensable injury." Thus, a compensable injury, by definition, involves only the worker's condition and not the status of the worker' claim for that injury.

It is evident, then, that the requirement in OR 659.415 that a worker have a "compensable injury" in order to be entitled to reinstatement cannot properly be understood to mean that the worker's claim for such an injury has to have been accepted as compensable before the worker can invoke that right.[4] Therefore, plaintiff's claim does not depend on whether her employer had accepted her worker's compensation claim before she sought reinstatement. Hence the court erred in granting partial summary judgment to defendant on the ground that her reinstatement request predated the acceptance of her compensation claim. For that reason, I respectfully dissent from the majority's decision to affirm that judgement.

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[3] I recognize that a definition of a term in one statute does not control the meaning of that term in other statutes to which the definition does not expressly apply. *See, e.g., Enertol Power Monitoring Corp. v. State of Oregon*, 314 Or 78, 836 P2d 123 (1992). In this context, however, in which the statute protects rights secured by the Workers' Compensation Law, I have no doubt that the term "compensable injury" in ORS 659.415 is intended to have the same meaning that it does in the Workers' Compensation Law. That means that the relevant definition is the one found in ORS 656.005(7)(a).

[4] The other provisions of ORS 659.415 are consistent with that reading of the statute. *See* ORS 659.415(3) (outlining circumstances when the right to reinstatement is terminated). To the extent that BOLI's reinstatement rules are inconsistent with that interpretation, they are without legal effect. BOLI has authority to adopt reasonable rules "required to carry out the purpose" of ORS 659.415. ORS 659.103(1)(e). It is not permitted to alter the requirements of the statute in doing that.

Cite as 145 Or App 288 (1996) December 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gary G. Britton, Claimant.
SAIF CORPORATION and Rose Logging, Inc., *Petitioners,*
v.
Gary G. BRITTON, Mary's River Lumber and Liberty Northwest Insurance Corporation, *Respondents.*
(WCB 95-02235; CA A92670)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 4, 1996.
Michael O. Whitty argued the cause and filed the brief for petitioners.
David C. Force filed the brief for respondent Gary G. Britton.
Alexander Libmann argued the cause and filed the brief for respondents Mary's River Lumber and Liberty Northwest Insurance Corporation.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration.

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145 Or App 290> This workers' compensation case involves two successive injuries to the same part of claimant's body. Claimant was employed by a different employer at the time of each injury. SAIF Corporation seeks review of an order of the Workers' Compensation Board that shifted responsibility for claimant's left carpel tunnel syndrome (CTS) from Rose Logging Inc.'s (Rose) insurer, Liberty Northwest Insurance Corp. (Liberty), to Mary's River Lumber's (Mary's River) insurer, SAIF, due to injuries claimant received in a motor vehicle accident while working for Mary's River. SAIF argues that the Board misapplied ORS 656.005(7)(a)(B). We agree with SAIF and reverse the order.

In 1984, while employed for Mary's River doing heavy mill work, claimant submitted a workers' compensation claim for bilateral CTS. Liberty accepted his claim and, in 1990, claimant underwent right carpel tunnel surgery for his continuing symptoms. Claimant did not, however, pursue left carpel tunnel surgery, because that condition had improved. His claim was closed in 1990 with scheduled permanent partial disability awards of 32 percent for the left forearm and 15 percent for the right forearm.

Claimant later left his employment at Mary's River. In 1992, he was injured in a motor vehicle accident while employed as a truck driver for Rose. SAIF accepted his workers' compensation claim for numerous conditions. In November 1994, claimant sought treatment for a worsening of his left carpel tunnel symptoms. Both insurers denied responsibility for the condition, and claimant appealed.

The administrative law judge (ALJ) affirmed SAIF's denial but set aside Liberty's denial.[1] Liberty appealed to the Board and the Board reversed, finding that SAIF was responsible. SAIF petitioned for judicial review, contending that the Board misapplied the standard set out in **<145 Or App 290/291>** ORS 656.005(7)(a)(B).[2] We review the Board's order for errors of law, ORS 656.298(6); ORS 183.482(8), and reverse.

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[1] Claimant had also submitted an aggravation claim to Liberty for his worsened left carpel tunnel syndrome, and Liberty denied that claim. The ALJ affirmed that denial and claimant did not challenge that decision. Therefore, that question is not before us.

[2] ORS 656.005 provides, in part:

"(7)(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; * * *

" * * * * *

"(B) If an otherwise compensable injury combines * * * with a preexisting condition to cause * * * a need for treatment, the combined condition is compensable only if * * * the otherwise compensable injury is the major contributing cause of * * * the need for treatment of the combined condition."

ORS 656.308(1) specifies how responsibility will be shifted between employers of an injured worker who has successive injuries to the same body part. Under the statute, the first employer remains responsible for future compensable medical services and disability related to the accepted condition "unless the worker sustains a new compensable injury involving the same condition." *See also SAIF v. Drews*, 318 Or 1, 9, 860 P2d 254 (1993). The responsibility shifting mechanism under ORS 656.308(1) provides, in addition, that "[i]f 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 *SAIF v. Drews*, the Supreme Court explained how ORS 656.308(1) and ORS 656.005(7)(a)(B) work together to provide the responsibility shifting mechanism under the circumstances presented here: an accidental injury in combination with a preexisting condition. Specifically, the Supreme Court said that the determination of whether a claimant has suffered a new compensable injury involves the

> "application of the criteria found in ORS 656.005(7)(a), including the limitations found in subparagraphs (A) and (B) of that statute, in making an initial determination of compensability. If the accidental injury described in paragraph (a) combines with a preexisting condition, a determination is made under subparagraph (B) whether the accidental injury described in paragraph (a) is 'the major contributing cause of the disability or need for treatment.' * * *.
>
> **145 Or App 292>** "* * * If the accidental injury described in paragraph (a) of ORS 656.005(7) was found to be 'the major contributing cause' under subparagraph (B), *then* * * * a new *compensable injury has occurred,* and responsibility shifts to the subsequent employer." *Id.* at 8-9. (Emphasis supplied.)

By that, we understand the Supreme Court to mean that when a worker sustains a second injury to the same body part, whether the first injury is compensable or not, the subsequent employer is responsible only if the second injury constitutes the major contributing cause of the worker's disability or need for treatment for the combined condition.

The pertinent question here is whether the injuries claimant sustained to his left forearm in the 1992 motor vehicle accident constitute the major contributing cause of his current need for treatment for his left CTS. That inquiry requires a comparison of the relative contribution to his need for treatment of claimant's preexisting left CTS and the injuries claimant sustained in the work-related accident. *Dietz v. Ramuda*, 130 Or App 397, 401, 882 P2d 618 (1994), *rev den* 321 Or 416 (1995). The focus of the inquiry is a determination of the primary cause of claimant's need for treatment. *Id.* It is recognized that work activities that precipitate a claimant's need for treatment may be the major contributing cause, but that is not necessarily true. *Id.*

In addressing the question of the causation of claimant's current need for treatment, the Board set forth the proper standard:

> "There is no dispute that claimant's left CTS preexisted the 1992 compensable motor vehicle accident. Liberty's theory is that the motor vehicle accident combined with the left CTS, result[ed] in claimant's need for treatment. Under such a theory, in order for responsibility to shift to SAIF, Liberty must show that the 1992 motor vehicle accident is *the major contributing cause of the need for treatment.* ORS 656.308(1); ORS 656.005(7)(a)(B)." (Emphasis supplied.)

However, the Board provided the following explanation in reaching its decision:

> "Finally, by stating that the motor vehicle accident *pathologically worsened the left CTS,* we conclude that Dr. Jewell **<145 Or App 292/293>** showed that the compensable 1992 injury is the major contributing cause of the need for treatment. Thus, responsibility for claimant's condition shifts from Liberty to SAIF. ORS 656.308(1); 656.005(7)(a)(B)." (Emphasis supplied.)

The Board correctly set forth the standard under which it was to judge the compensability of, and responsibility for, claimant's current need for treatment. It is evident, however, that the Board failed to engage in the comparative analysis that it correctly understood was contemplated by the statute. The Board only concluded that claimant's motor vehicle accident pathologically worsened his

CTS. That inquiry falls just short of the mark. The Board failed to determine whether, when compared with the injuries he sustained in his motor vehicle accident, claimant's pre-existing CTS contributed to his current need for treatment. Under ORS 656.005(7)(a)(B), the quantitative contribution of each cause, *including the precipitating cause,* must be weighed to establish the primary cause of claimant's need for treatment. Accordingly, the Board erred as a matter of law in its application of ORS 656.005(7)(a)(B).

Liberty's and claimant's other arguments do not merit discussion.

Reversed and remanded for reconsideration.

Cite as 145 Or App 294 (1996) December 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Roland A. Walker, Claimant.

SAIF CORPORATION, *Petitioner,* and GOLD CREEK CENTER, INC., *Employer,*
v.
Roland A. WALKER, *Respondent.*
(WCB No. 93-07081; CA A89100)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted March 5, 1996; resubmitted in banc December 11, 1996.

Julene M. Quinn, Special Assistant Attorney General, argued the cause for petitioner. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Robert Wollheim argued the cause for respondent. With him on the brief were W. Todd Westmoreland, and Welch, Brunn, Green & Wollheim.

DEITS, J.

Reversed and remanded for reconsideration.

Armstrong, J., dissenting.

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145 Or App 296> Employer seeks review of an order of the Workers' Compensation Board allowing claimant's aggravation claim. We reverse and remand for reconsideration.

Claimant was injured in 1991 while working as a timber feller for employer. At that time, he injured his low back and left hip and leg. Dr. Buza diagnosed an L5-Sl disc herniation. The claim for this injury was accepted by employer. Claimant's condition was declared medically stationary on May 26, 1992. The closing report by Buza, the treating physician, describes the injury as moderate, but states that loss of function was minimal. It is also stated in the report that claimant continued to experience some low back pain and occasional pain in his left leg. Claimant was released to regular work on June 1, 1992. His work required lifting up to 100 pounds. A notice of closure was issued, and claimant was awarded 12 percent unscheduled permanent disability. Claimant requested reconsideration of the notice of closure. A medical arbiter's examination was conducted by Dr. Burr on February 1, 1993. He found that claimant had a chronic and permanent medical condition arising from the accepted condition.

On February 3, 1993, claimant experienced severe back and left leg pain while on the job. Claimant left work and again sought treatment with Buza, who noted that claimant's symptoms had significantly increased since his medically stationary date. Buza diagnosed "musculoligamentous strain, sclerotomal pain." The diagnosis was supported by reduced range of motion findings. In response to claimant's request for reconsideration, an order was issued on February 12, 1993, which increased claimant's award of unscheduled disability to 16 percent and affirmed the medically stationary date of May 26, 1992.

Claimant saw Buza again on March 9, 16 and 29. At Buza's request, claimant underwent a physical capacities examination. He was assessed as capable of light to medium work with lifting and carrying up to 35 pounds. Claimant then filed an aggravation claim, which employer denied. Claimant requested a hearing on employer's denial of the **<145 Or App 296/297>** aggravation claim. The administrative law judge (ALJ) set aside the denial, concluding:

> "Claimant is entitled to additional compensation for *worsened conditions* resulting from the original injury. To establish a compensable worsening of his unscheduled condition, *claimant must show that increased symptoms or worsening of the underlying condition resulted in diminished earning capacity.* Further, the medical worsening must be established by medical evidence supported by objective findings. Finally, because claimant received a disability award prior to his worsening, he bears the additional burden of establishing that the worsening is more than waxing and waning of symptoms of a condition contemplated by the previous permanent disability award. ORS 656.273.
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> "* * * * *
>
> "The medical and lay evidence establishes that claimant has *increased symptoms* that exceed the symptoms he experienced at the time of claim closure. At the time of closure claimant's symptoms were episodic. In February 1993 these symptoms dramatically changed. Dr. Buza described the increased symptoms as severe and disabling. Comparison of the May 26, 1992 closing report with the Dr. Buza's February 1993 report * * * indicates that the increased symptoms reflect more than a mere waxing and waning of symptoms. * * * Therefore, I find claimant has carried his burden of proof and established a compensable aggravation claim pursuant to ORS 656.273." (Emphasis supplied).

The Board adopted the ALJ's order.

Employer first argues on review that a remand of the Board's decision is required by the 1995 amendments to the Workers' Compensation Law. Or Laws 1995, ch 332, § 31. Specifically, employer contends that under the amended version of ORS 656.273, in order to prove an aggravation claim, a worker must show an "actual worsening" of the accepted condition. Employer asserts that, unlike the standard under the previous version of the statute, a worker may no longer prove an aggravation claim by showing a worsening of symptoms alone. Employer argues that because the Board decided this case on the basis of a symptomatic worsening, it must be **<145 Or App 297/298>** remanded to the Board for reconsideration under the amended version of ORS 656.273.

Claimant argues that it is not necessary to remand this case to the Board. He contends that remand is not necessary to interpret the amended language of the statute, because the Board has already done so in another case. Further, he asserts that a remand is unnecessary because under the Board's interpretation of the new language, the standard of proof used by the Board was the proper one.

We agree with claimant that the Board previously has considered the meaning of the amended statutory language and that, accordingly, it is not necessary to remand this case to the Board for the purpose of addressing that question in the first instance. *See Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 915 P2d 1053, *rev den* 324 Or 305 (1996). Therefore, we will consider whether the standard for proving an aggravation under the amended version of ORS 656.273 that the Board has applied in this case is correct.[1]

The pertinent language of ORS 656.273(l) now provides:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence *of an actual worsening of the compensable condition supported* by objective findings." (Emphasis supplied.)[2]

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[1] No one disputes that the amended version of the statute is applicable here. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

[2] *Former* ORS 656.273(1) provided:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings."

The emphasized language was added to the statute by the 1995 amendments. Under the words of the statute before it was amended, a worker could prove an aggravation by showing worsened symptoms *without* showing a worsening of the **<145 Or App 298/299>** underlying condition. *Perry v. SAIF*, 307 Or 654, 772 P2d 418, *on remand affd* 99 Or App 52 (1989); *Gwynn v. SAIF*, 304 Or 345, 353, 745 P2d 775 (1987). The question presented here is what did the legislature intend by its addition of the words "of an actual worsening of the compensable condition" to the statute?

The Board directly addressed this question in *Carmen C. Neill*, 47 Van Natta 2371 (1995). The Board concluded that the additional language, particularly when considered in the context of related statutes, in particular ORS 656.214(7), is ambiguous. The Board then looked to legislative history and concluded that, under the amended statute, an aggravation still may be proven by showing a symptomatic worsening. As the Board explained:

> "Based on the * * * legislative history, we reach the following conclusions with regard to what constitutes an 'actual worsening' under amended ORS 656.273(1). A pathological worsening of the underlying condition is sufficient to establish an actual worsening. In addition, a symptomatic worsening of the condition, that is greater than anticipated by the prior award of permanent disability, is also sufficient to establish an actual worsening." *Carmen C. Neill*, 47 Van Natta 2371, 2377 (1995). *See also Thomas P. Harris*, 48 Van Natta 985 (1996); *Terry L. Starnes*, 48 Van Natta 1002 (1996).

Our task in interpreting a statute is to discern the intent of the legislature. At the first level of analysis, we examine both the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). If the legislative intent is not clear from that inquiry, we then examine the legislative history to determine the legislature's intent. *Id.* at 611-612.

As discussed above, the pertinent language that was added to the statute is "actual worsening of the compensable condition." These terms are not defined in the statute. Under *PGE*, unless otherwise defined, we assume that words of common usage are to be given their plain, natural and ordinary meaning. Resorting to the plain meaning of the words at issue here, however, is not helpful because the ordinary meaning of these terms does not clearly indicate what the **<145 Or 299/300>** legislature meant by adding this language. Arguably, the amended language means that the underlying condition must actually worsen in order to prove an aggravation. On the other hand, this language could be read to mean that increased symptoms could constitute an "actual worsening" of the condition. The words used by the legislature here simply do not answer this critical question.

The context of these statutory terms also is not determinative. At the same time that ORS 656.273(1) was amended, the legislature also amended ORS 656.214(7) to provide that "[a]ll permanent disability contemplates future waxing and waning of symptoms of the condition." Interestingly, the legislature did not amend ORS 656.273(8), which provides that, where a worker has received a permanent disability award, an aggravation may be established by showing that "the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." It is not unreasonable to read those provisions together to mean that an "actual worsening" does include circumstances where symptoms worsen to a greater extent than the waxing and waning contemplated by the previous award. The Board, in fact, did so.

On the other hand, the text of a statute before it is amended also is considered part of its context. *Krieger v. Just*, 319 Or 328, 337, 876 P2d 754 (1994). As discussed above, the text of ORS 656.273(1), before this amendment, had been construed to allow an aggravation to be established by showing a symptomatic worsening. The requirement of the amended statute that the worsening be "actual" and be "of the condition," at a minimum, creates a question as to whether the legislature intended to change the standard for proving an aggravation. Further confusion as to what the legislature intended is created by the fact that, as the Board correctly points out, there is nothing in the statutes that explains how these provisions are to relate to each other. The meaning of ORS 656.273(1), as amended, is sufficiently ambiguous that it is necessary to look to legislative history to discern the legislature's intent.

Representative Mannix, a cosponsor of Senate Bill 369, the legislation amending the statute, testified before the **<145 Or App 300/301>** Senate Labor and Government Operations Committee concerning *amended* ORS 656.273(1). He explained:

"[ORS] 656.273(1) is a significant change in the law. All the changes to .273 are significant in the sense that they are trying to tell the courts what we thought we told them many times over as to what is an aggravation. An aggravation is a worsening of the compensable condition; that is, it's attributable to the industrial injury. A worsening of the condition.

"I would like to say the word condition a hundred times, but I won't. The courts keep insisting on coming up with alternatives, even though the last time I counted I think worsened condition is used seven times in the statutes to refer to aggravation. They keep coming up with alternative views of what is an aggravation. Doctors know what a worsened condition is. *We should know what a worsened condition is and a worsened condition is not a flare-up of symptoms.* Enough said." (Emphasis supplied.)

Representative Mannix also discussed ORS 656.214(7):

"We then get to ORS 656.214(6)[*sic*]. This restates the assumption that the condition of workers with permanent partial disability may fluctuate without the condition itself worsening. That is, there can be a fluctuation of symptoms. When we amended the law in 1990 with the special session, we thought we took care of it and we stated specifically that the condition of a worker with permanent partial disability may be expected to wax and wane. Recent cases said that provision only applies if the anticipated waxing and waning of symptoms was specifically stated at the time of the previous closure.

"That gets around the intention of the 1990 reforms. The idea is if you get a permanent disability award, there is an assumption that you have a permanent condition, and you may have good days and bad days with waxing and waning of symptoms. That's why you receive compensation for permanent partial disability. There is then an assumption anytime you have such a permanent disability award that there will be some fluctuation of symptoms. If there is not any anticipated fluctuation of symptoms, then you shouldn't be getting a permanent disability award. You should have fully recovered, which happens with many workers."

145 Or App 302> At a later time before the same committee, the following discussion took place between Senator Leonard, Representative Mannix, and Jerry Keene, a workers' compensation defense attorney:

"Sen. Leonard: Where do you draw the line between when you have an aggravation of a symptom and an injury?

"Rep. Mannix: The aggravation actually is of the condition and that's what we keep getting back to. A worsening of the condition as opposed to a flare-up of symptoms. *And the physicians will tend to make that - we'll ask them to make that distinction.* Was this a worsened condition or an actual flare up of symptoms. One of the things that we're trying to get at though is you've got a chronic bad back. In fact, your doctor told you to limit yourself to sedentary work and you got a permanent disability award. A year later you're moving and you spend all Saturday lifting heavy stuff. The end of the day you're in pain. The next day or Monday you go to the doctor, he gives you some medication to control your pain and says 'you ought to rest a couple of days.' Your condition - the doctor takes a look at it and says 'you just overdid it. You shouldn't have done that.'

"And, in fact, let's say you don't miss any work at all. You're just in pain. That's probably a better example, because if the doctor tells you not to do something he'll probably say you have a worsened condition. But, you've had a flare-up, you overdid it. Did you have an actual worsening that requires reopening of the claim, the payment of time loss, the reevaluation of permanent disability, or was this a flare up of symptoms? Physicians are used to being asked that question, but the courts have tended to say well, if you had - sometimes they've said in the past - well you just had increased pain with activity. That's enough to be an aggravation. Or we're going to take another

look at your earning capacity a year later and we think you've lost some earning capacity so that's an aggravation. *This turns around and says no, look at the pathological condition or the psychiatric condition. Do the physicians say there's actual worsening of the condition or is this waxing and waning of symptoms?* The kind of stuff you would have anticipated.

"Mr Keene: Waxing and waning came from the court decisions. It wasn't statutory language originally. We just took their language and put it in.

145 Or App 303> "Rep. Mannix: Like phases of the moon.

"Unidentified: That was a court wording, huh?

"Mr. Keene: Yeah, one of their better efforts.

"Rep. Mannix: We're trying to get back to clarifying no, that wasn't meant to be an aggravation. The original bill did that. This amendment, based on the Department's recommendation, they wanted to start out with a positive description of worsened condition and then talk about what's exempted, so we've reworded it to meet their request.

"Sen. Leonard: And who makes that determination with this language - whether its a waxing and waning of the symptom or an aggravation of an earlier approved condition?

"Rep. Mannix: It's based on the weight of the medical evidence.

"Mr. Keene: The doctor.

"Sen. Leonard: The doctor makes that decision?

"Mr. Keene: The doctor makes the initial decision, gives his opinion about whether it's happened or not - to the insurer when they send the bills for payment and, and trigger the claim on behalf of the worker.

"Sen. Leonard: So the insurer is going to have more latitude now with claims that are submitted for aggravations of approved claims - there's no dispute that the person was originally [injured]. The insurer will have more latitude to deny payment.

"Rep. Mannix: Yes.

"Mr. Keene: It draws a clearer line.

"Rep. Mannix: *It draws a clearer line and the physician can be asked very specifically - doctor, is this a worsened condition or is this a flare-up of symptoms?*

"Sen. Leonard: And doctors can tell you that? they can clearly say that is-

"Rep. Mannix: Well to be frank about it, the attending physician will tend to err on the side of caution and say well, looking at this * * * and evaluating this condition, yeah it's worse. Is it temporarily worse or permanently_**<145 Or App 303/304>** worse? That doesn't matter. If it's a worsened condition you'll get an aggravation. Then later you can look at whether it's permanent or temporary and reevaluating [sic] it. Oh they got better again, fine. They didn't get better, then you got some more permanent disability." (Emphasis supplied.)

Before the House Committee on Labor, Representative Mannix again discussed the difference between a worsening of symptoms and a worsening of a condition. In discussing ORS 656.214(7), he stated:

> *"This is designed to close the back door aggravation claims where you say even though I'm not worse, I've had more waxing and waning of symptoms than was contemplated.* And we get into that. In the aggravation statute we get back to no, ask the doctor has your condition worsened. Condition is a code word. Worsened is a code word. Waxing and waning of symptoms is a code phrase, too, because a doctor can give us the opinion based on the medical history, their prior examinations, what they expected in terms of waxing and waning symptoms. And let's be frank about this. *At some point somebody's symptoms will have increased so much that the doctor's going to come to the conclusion that there is actually a worsening of the condition. Let the doctor say so.* But let's not say that there are any other assumptions that somehow meant to having just the waxing and waning of symptoms reported that that meant you have an aggravation. Ask the doctor the question about the aggravation." (Emphasis supplied.)

Representative Mannix was asked by members of the House Committee on Labor whether ORS 656.214(7) should be part of ORS 656.273. He responded:

> "Well that's where I think that moving this over to the section dealing with ORS 656.273 the aggravation statute might be appropriate, because this is really intended to take the subjectivity out of the question of aggravation. *Aggravation ought to be a pathological worsening and the doctor can tell you whether or not there's been a pathological worsening.* It shouldn't be well, gee, this person's had symptom swings and we're trying to nail down that point. Waxing and waning of symptoms does not [mean that the person has had] an aggravation. So maybe it's best to put this language in there. Because then it's less subjective. What we've got is some objective standards and we're saying this **<145 Or App 304/305** subjectivity stuff doesn't rate an aggravation claim." (Emphasis supplied.)

There does not appear from the legislative history to have been any comments made in response to the above statements of Representative Mannix, Senator Leonard or Mr. Keene expressing disagreement with the statements. Accordingly, we conclude that the legislative history supports the conclusion that the legislature intended to change the standard for proving an aggravation to require a showing that the underlying condition has worsened. *See Zidell Marine Corp. v. West Painting, Inc.*, 322 Or 347, 359, 906 P2d 809 (1995); *Davis v. O'Brien*, 320 Or 729, 745, 891 P2d 1307 (1995).

After considering the text and context of the statute, together with the legislative history, we conclude that the legislature's use of the terms "actual worsening" was not intended to include a symptomatic worsening. Under the amended statute, in order for a symptomatic worsening to constitute an "actual worsening," a medical expert must conelude that the symptoms have increased to the point that it can be said that the condition has worsened. In other words, ORS 656.273(1), as amended, requires that there be direct medical evidence that a condition has worsened. 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. Here, both the hearings officer and the Board considered the claim under the old standard. The Board specifically held that an actual worsening of the condition may be proven by a symptomatic worsening, and it based its conclusion that claimant had proven an aggravation claim on evidence of claimant's increased symptoms. We hold that proof of a pathological worsening is required. Accordingly, it is necessary to remand this case to the Board for reconsideration under the correct standard and such further proceedings as the Board deems necessary.

Claimant also argues here that the Due Process Clause of the Fourteenth Amendment to the United States Constitution is violated by the retroactive application of SB 369 to this case in the absence of an emergency basis to **<145 Or App 305/306>** change the law. For reasons materially similar to those discussed in *Liberty Northwest Ins. Corp. v. Yon*, 137 Or App 413, 904 P2d 645 (1995), we reject this argument.

Reversed and remanded for reconsideration.

ARMSTRONG, J., dissenting.

I believe that the majority misinterprets ORS 656.273(1) by misapplying *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). According to *PGE*, before we resort to legislative history to interpret a statute, we are required to conclude that the text of the statute, when examined in context, is ambiguous. *PGE*, 317 Or at 611. The majority simply announces that ORS 656.273(1) is ambiguous, without identifying two plausible interpretations of the relevant language. Because I believe that an examination of the text of ORS 656.273(1), in context, establishes that there is only one plausible interpretation of it, I dissent.

In order to conclude that the board's interpretation of ORS 656.273(1) is not correct, I think that the court must explain how the statute could be interpreted to mean something different. We would have to do that in order to conclude that a contract is ambiguous. *See, e.g., Hoffman Construction Co. v. Fred S. James Co.*, 313 Or 464, 470, 836 P2d 703 (1992). I see no reason why the same principle does not apply to statutory construction under *PGE*. I believe that the majority fails to identify two plausible interpretations of the statute because it cannot.

The majority examines ORS 656.273 in context with ORS 656.214(7) and ORS 656.273(8) and concludes that "[i]t is not unreasonable to read those provisions together to mean that an 'actual worsening' does include circumstances where symptoms worsen to a greater extent than the waxing and waning contemplated by the previous award." 145 Or App at 300. That interpretation is a completely coherent interpretation of the statute, in context.

The 1995 amendment to ORS 656.273(1) added the requirement that there be an "actual worsening" of a condition in order to establish that there has been an aggravation **<145 Or App 306/307>** of it. That change indicates that a real worsening, as distinguished from an illusory one, is required. As the majority recognizes, the change meshes well with the 1995 amendment to ORS 656.214(7), which states that "[a]ll permanent disability contemplates future waxing and waning of symptoms of the condition," and with ORS 656.273(8), which provides that an aggravation can be established by showing that "the worsening [of the condition] is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." Taken together, the provisions establish that, to prevail on an aggravation claim, a claimant must establish that her condition has, in fact, worsened, and that the worsening of it represents more than the contemplated waxing and waning of its symptoms. I do not see how the words of the statute, in context, can be understood to require anything more.

The majority announces, however, that the meaning of the statute is ambiguous because "[a]rguably, the amended language means that the underlying condition must actually worsen in order to prove an aggravation." 145 Or App at 300. The majority argues that, because the legislature amended the statute to include new language, there is, "at a minimum," a possibility that the legislature intended to change the standard to prove an aggravation. *Id.* After examining the legislative history, the majority concludes that the legislature wanted to require claimants to show "proof of a pathological worsening." 145 Or App at 305. The legislature certainly can change the standard for proving an aggravation. However, when the new language in ORS 656.273(1) is considered in context, the majority's interpretation of the statute is implausible.[1]

In fact, the majority's construction of ORS 656.273(1) essentially renders ORS 656.214 and 656.273(8) superfluous. It concludes that ORS 656.273(1), as amended, establishes that symptomatic worsening is never sufficient to **<145 Or App 307/308>** establish an aggravation. If that is true, then it is unnecessary to say that waxing and waning of symptoms is an expected feature of every condition (ORS 656.214) and that an aggravation can be established by showing that "the worsening [of the condition] is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award" (ORS 656.273(8)). A focus on the waxing and waning of symptoms is irrelevant if increased symptoms are insufficient to establish that a condition has worsened, as the majority's construction of ORS 656.273(1) posits. The majority fails to explain how its construction of ORS 656.273(1) meshes with ORS 656.214 and OkS 656.273(8).

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[1] The majority correctly states that the text of a statute before it is amended is considered part of the statute's context. 145 Or App at 300. However, the prior statute cannot be considered in isolation. It must be considered with the other contextual cues. In this case, those include ORS 656.214(7) and ORS 656.273(8). When those statutes are considered, it is not possible to interpret the change in ORS 656.273(1) to do what the majority says it does.

The source of any ambiguity in the statute can be traced to the statute's legislative history rather than to the statute itself. It is the statements by some of the proponents of the 1995 workers' compensation bill that create confusion about the intended meaning of ORS 656.273(1). However, under *PGE*, we cannot turn to legislative history unless an ambiguity about the legislature's intent is evident from the text and context of the statute itself 317 Or at 311. There is no such ambiguity here. The only plausible construction of ORS 656.273(1) is that an actual worsening can be shown through a significant worsening of symptoms, as the Board concluded. Thus, the Board's interpretation should be affirmed.

Furthermore, much of the legislative history that is quoted by the majority is completely consistent with the interpretation of the statute that I've stated above. Representative Mannix, in particular, said in a variety of ways that the changes were intended to reconfirm one of the things that the 1990 amendments to the Workers' Compensation Law had sought to establish. That is that the symptoms of a permanent condition are expected to wax and wane, so a compensable aggravation of the condition requires a showing that the condition is worse than it was at the last arrangement, taking the expected waxing and waning of symptoms into account. For example, he said:

> "Do the physicians say there's actual worsening of the condition or is this waxing and waning of symptoms? The kind of stuff you would have anticipated."

145 Or App 309> That discussion makes no sense if the only way to establish a worsening is by showing a pathological worsening of the condition.

Representative Mannix also said that the worsening need not be permanent in order to constitute an aggravation:

> "Well to be frank about it, the attending physician will tend to err on the side of caution and say well, looking at this * * * and evaluating this condition, yeah it's worse. Is it temporarily worse or permanently worse? That doesn't matter. If it's a worsened condition you'll get an aggravation. Then later you can look at whether it's permanent or temporary and reevaluate it. Oh they got better again, fine. They didn't get better, then you got some more permanent disability."

In addition, however, Representative Mannix also said two other, very different things about the 1995 amendments to ORS 656.273 and 656.214. He said that the amendments were intended (1) to require a claimant to submit evidence from a doctor in which the doctor states that the condition has worsened and (2) to require a claimant to show a pathological, as opposed to a symptomatic, worsening of the condition. Those are not the same thing, as Representative Mannix, himself, recognized.

For example, he said that

> "[a]t some point somebody's symptoms will have increased so much that the doctor's going to come to the conclusion that there is actually a worsening of the condition. Let the doctor say so. But let's not say that there are any other assumptions that somehow meant [*sic*] to having just the waxing and waning of symptoms reported that that meant you have an aggravation. Ask the doctor the question about the aggravation."

That discussion suggests that increased symptoms beyond those contemplated in the normal waxing and waning of a condition can establish an aggravation, but that a doctor must say that the condition is worse. In other words, a doctor must use magic words, to wit, that the claimant's condition is worse, in order for the Board to conclude that there has been an aggravation. The Board cannot reach that conclusion on **<145 Or App 309/310>** its own based on the medical evidence. Under that understanding, increased symptoms can establish a worsening, as long as the magnitude of the increase is significant enough to lead a doctor to conclude that there has been a worsening.

Alternatively, Representative Mannix said that "[a]ggravation ought to be pathological worsening and the doctor can tell you whether or not there's been a pathological worsening." For that purpose, I understand the term "pathological" to mean structural or functional. *See Webster's Third New International Dictionary* 1655 (1976) (definition of pathology). If that is what the amendment sought to require, I'm not sure how the amendment adds anything to the existing requirement that the aggravation be based on "objective findings." The necessary objective findings will reflect a structural or functional change in the condition.

In any event, the addition of the words "actual worsening" to ORS 656.273(1) cannot reasonably be interpreted (1) to add a requirement that a doctor testify that there has been an actual worsening in order for the Board to find an aggravation or (2) to mean that the Board cannot find an aggravation on the basis of objective findings of increased symptoms that exceed those expected for the condition in the light of the expected waxing and waning of it. If the legislature intended to accomplish either of those two things, it needed to add different words to the statute than it did. The majority simply settles on a conclusion about the intended goal of the amendments and then announces that the amendments achieved that goal without explaining how the words chosen by the legislature, in fact, did that.

In contrast, the Board's interpretation of ORS 656.273(1) gives meaningful effect to all of the relevant provisions. The discussion of waxing and waning in ORS 656.214 and ORS 656.273(8) essentially explains what constitutes an actual worsening under ORS 656.273(1). They do that by establishing that increased symptoms are insufficient to establish an aggravation if they fall within those expected as part of the waxing and waning of symptoms that accompanies any permanent disability. The increased symptoms must be greater than those that were contemplated in the **<145 Or App 310/311>** prior award for the condition to be considered to have worsened. That is the only plausible construction that can be gleaned from the text and context of the statute. Therefore, I believe that the opinion errs in holding that the Board misinterpreted the relevant statutes.

Landau, J., joins in this dissent.

Cite as 145 Or App 330 (1996) December 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William R. Englestadter, Claimant.

LIBERTY MUTUAL INSURANCE and United Parcel Service, *Petitioners,*
v.
William R. ENGLESTADTER, *Respondent.*
(WCB 94-14109; CA A91707)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 17, 1996.
Richard D. Barber, Jr. argued the cause for petitioners. With him on the brief was Bostwick, Sheridan & Bronstein.
Philip Emerson argued the cause for respondent, With him on the brief was Brothers, Steelhammer & Ash.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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145 Or App 332> Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred as a matter of law in relying on a medical opinion that had been provided before claimant's medically stationary date to determine the level of his impairment, and that substantial evidence does not support the Board's findings concerning the extent of disability. We conclude that the Board's findings are supported by substantial evidence. We affirm the Board, and write for the purpose of explaining why the Board did not err in relying on the medical opinion that had been provided before claimant became medically stationary.

Claimant suffers from a compensable skin condition caused by prolonged exposure to sun in his job as a United Parcel Service driver. Claimant first began seeing his treating physician for the condition in 1986. Am initial claim previously had been accepted by employer and closed. In the meantime, defendant continued to undergo treatment, including surgery, and filed an aggravation claim for the condition in May 1993, which employer denied. In September 1993, in preparation for a hearing, claimant's treating doctor provided a deposition describing claimant's condition. An order issued by a referee in October 1993, found that the condition was compensable and set aside the denial. Employer

processed the claim and issued a notice of closure in January 1994, determining that claimant was medically stationary as of January 4, 1994. Claimant sought reconsideration of the notice of closure, and the administrative law judge (ALJ) relied on the September 1993, medical opinion of claimant's treating physician to determine the extent of claimant's disability. The Board affirmed the ALJ's order.

Employer contends that medical evidence provided before a claimant has become medically stationary may not be considered for the purpose of determining the extent of disability. Employer relies on ORS 656.268(2), 4(a), (b), which require that impairment be rated after the claimant is medically stationary. Focusing on those provisions, employer contends that medical evidence in existence before the date of closure may not be considered over medical evidence at the time of closure. In our view, although a claimant's condition **<145 Or App 332/333>** must be rated as of the medically stationary date, there is no legal prohibition to considering preclosure or premedical stationary evidence for the purpose of determining the extent of the claimant's disability, so long as the evidence bears on the claimant's condition on the medically stationary date. Here, the record supports the Board's finding that claimant's condition did not improve after September 1993. The medical opinion on which the Board relied had been provided some seven years after claimant first sought treatment from the physician. The physician was in a strong position to assess claimant's impairment. It was appropriate for the Board to consider the opinion as one factor in determining claimant's level of disability.

Affirmed.

Cite as 145 Or App 427 (1996) December 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James L. Burke, Claimant.

SAIF CORPORATION, *Petitioner,* and OREGON SHAKESPEARE FESTIVAL, *Employer,*
v.
James L. BURKE, *Respondent.*
(94-15422; CA A91479)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 17, 1996.
Julene M. Quinn argued the cause and filed the brief for petitioner.
Michael G. Balocca argued the cause and filed the brief for respondent.
No appearance for employer.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Affirmed.

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145 Or App 429> SAIF Corporation seeks review of a Workers' Compensation Board (Board) order holding that claimant's injury is compensable. ORS 656.298. The question is whether claimant's injury arose out of his employment. We affirm.

We take the facts from the Board's findings, which are supported by substantial evidence. ORS 656.298(6); ORS 183.482(7),(8). Claimant worked as a stage manager for the Oregon Shakespeare Festival (OSF). OSF's job description for stage managers requires that they "make quick decisions under pressure." Furthermore, OSF's mission statement for all employees provides:

> "We demonstrate that [our patrons] are important to us by treating each patron with dignity and respect. We want to exceed our patron's [*sic*] expectations in every way by providing them with the highest level of service possible."

Consistent with that mission, claimant sometimes assisted patrons during performances, such as by helping them to find their seats. After attending a weekly staff meeting on October 19, 1994, claimant

stopped to speak with several fellow stage managers. That conversation took place on "The Bricks," a cobblestone courtyard that is surrounded by the OSF administration building, claimant's office, and several OSF theaters. Claimant crossed The Bricks between four and ten times a day because his job required him to go from his office to the administration building and the theaters. When the conversation ended, claimant started walking toward his office. Simultaneously, an elderly man was riding a motorized three-wheeled scooter across The Bncks in the general direction of the theaters' ticket booth and restrooms. Claimant assumed that the man was a patron of the festival, because he "looked like a lot of our elderly patrons." Suddenly, the scooter started to tip over. Claimant dove to cushion the man's fall and twisted his own back in the process. That injury subsequently was diagnosed as a lumbar strain. SAIF denied claimant's claim, contending that his injury did **<145 Or App 429/430>** not occur in the course of his employment. The administrative law judge set aside SAIF's denial and the Board affirmed.[1]

SAIF first assigns error to the Board's conclusion that claimant's injury arose out of his employment. It concedes that claimant's injury occurred in the course of employment. Claimant responds that SAIF's concession, combined with the fact that "[c]laimant's employment put him in a position to be injured by the neutral risk," satisfies the unitary work-connection test. We review for errors of law and substantial evidence. ORS 656.298(6); ORS 183.482(7),(8).

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, 867 P2d 1373 (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, that is, "whether the relationship between the injury and the employment is sufficient that the injury should be compensable." *Id.* Both the "arising out of" and the "in the course of" prongs still must be satisfied to some degree. *Krushwitz v. McDonald's Restaurants,* 323 Or 520, 531, 919 P2d 465 (1996). However, "[d]eficiencies in the strength of one factor may be made up by the strength of the other." *Henderson v. S.D. Deacon Corp.,* 127 Or App 333, 335, 874 P2d 76 (1994).

Because SAIF concedes that claimant's injury occurred in the course of employment, the only question before us is whether claimant satisfied the "arising out of" prong. An injury arises out of employment where "the totality of the events that gave rise to claimant's injury was causally related to his employment." *SAIF v. Marin,* 139 Or App 518, 522, 913 P2d 336, *rev den* 323 Or 535 (1996).

145 Or App 431> It is undisputed that claimant's job required him to cross The Bricks between four and ten times a day. His job description required him to "make quick decisions under pressure," and he was aware of OSF's mission statement, which requires employees to provide patrons with "the highest level of service possible." Claimant believed that the man on the scooter was an OSF patron, and claimant had assisted patrons in the past. We conclude that the totality of those events gave rise to claimant's injury and that the injury was causally related to his employment. Consequently, the Board did not err in holding that claimant's injury arose out of his employment.

SAIF's second assignment of error is that substantial evidence does not support the Board's conclusion that OSF controlled The Bricks. However, the Board's discussion of control of The Bricks was in the context of its analysis of the "in the course of employment" prong of the compensability test. Because SAIF concedes that claimant's injury occurred in the course of his employment, we need not address that assignment of error.

Affirmed.

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[1] The Board relied on the so-called "rescue doctrine" to resolve the question of whether claimant's injury occurred in the course of his employment. Because SAIF concedes that claimant's injury did occur in the course of employment, we express no opinion about that doctrine under Oregon Workers' Compensation law.

Cite as 145 Or App 560 (1997) January 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Judith Nix, Claimant.
Judith NIX, *Petitioner,*
v.
FREIGHTLINER CORPORATION, *Respondent.*
(93-02704; CA A87100)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 24, 1996.

Donald M. Hooton argued the cause for petitioner. With him on the brief was L. Scott Lumsden.

Bruce L. Byerly argued the cause for respondent. With him on the brief was Moscato Byerly & Skopil.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Reversed and remanded for reconsideration.

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145 Or App 562> Claimant seeks review of an order of the Workers' Compensation Board (Board) holding that an award of attorney fees is subject to an offset based on prior overpayment of compensation. Claimant contends that the Board's own rules expressly prohibit such an offset. Employer contends that the Board's construction of its rules to allow an offset in the circumstances of this case is a reasonable one and should be upheld. We conclude that the Board's rules unambiguously prohibit offsetting an award of attorney fees based on prior overpayments. We therefore reverse the order and remand the case for reconsideration.

We take the facts, which are not in dispute, from the Board's order. Claimant was compensably injured in 1990 and initially received an award of 11 percent unscheduled permanent partial disability. Employer did not pay the award; it requested reconsideration, and, as a result, the award was reduced to 1 percent disability. Employer paid the 1 percent award. Meanwhile, an administrative law judge ordered employer to pay the 10 percent difference, which it owed pending its reconsideration request, and authorized an offset against future compensation for the overpayment. The overpayment offset totaled $3,200.

Claimant filed a claim for aggravation in 1992. Ultimately, the Board concluded that claimant was entitled to an additional 12 percent permanent partial disability. The Board further concluded that claimant's attorney was entitled to attorney fees in an amount equivalent to 25 percent of the increased compensation. That increase was valued at $3,840. Because employer was entitled to a $3,200 credit against the increased award of disability compensation, the question arose whether claimant's attorney fees of 25 percent were to be based on the award before or after the offset. If the offset were to be credited before the award, claimant's attorney would be entitled to $160, which is 25 percent of $640, the difference between the $3,840 aggravation award and the $3,200 offset. If, on the other hand, the offset were to be credited after the award, claimant's attorney would be entitled to $960, which is 25 percent of the entire $3,840 aggravation award.

145 Or App 563> The Board held that claimant's attorney fees should be divided into two parts. The first part, the Board concluded, consists of a fee based on 25 percent of an "actual increase" in compensation of $640, the difference between the aggravation award and the offset. The Board required employer to pay this amount, $160, directly to claimant's attorney. The second part, the Board held, consists of a fee based on 25 percent of the remaining $3,200, which already had been paid to claimant and is subject to an employer offset. The Board required claimant to pay that amount, $800, to her attorney.

On review, claimant argues that the Board erred in failing to order employer to pay the entire $960 in fees to her attorney directly, without first offsetting the $3,200 overpayment. According to claimant, OAR 438-15-085(2) expressly provides that attorney fees to be paid out of compensation are not subject to an offset for prior overpayments. Employer contends that the Board's decision is compelled by our decision in *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746, *rev den* 322 Or

645 (1996). It further contends that, in the light of *Volk* and the deference with which we review the Board's application of its own rules, we must affirm the Board's decision to offset the award of compensation for the prior overpayment before determining the attorney fee to be paid directly to employer.

We review the Board's decision for errors of law. ORS 183.482(8); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 202, 752 P2d 312 (1988).

OAR 438-15-085(2) provides:

> "An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court *shall not be subject to any offset based upon prior overpayment of compensation to the claimant.*"

(Emphasis supplied.) We had occasion to review the proper application of that rule in *Weyerhaeuser Co. v. Sheldon*, 86 Or App 46, 738 P2d 216 (1987).[1] That case, as the one before us **<145 Or App 563/564>** now, involved a prior overpayment. The question arose whether that overpayment must be offset against a subsequent award of compensation before payment of attorney fees to claimant's attorney. The Board held that the employer was not entitled to offset the overpayment against the increase in compensation before paying attorney fees to claimant's attorney. We affirmed, holding that the rule

> "provides that, even though there has been an overpayment for which an employer may otherwise be entitled to an offset in some amount from the increased award of compensation, the allowable offset is reduced by the amount necessary to cover an approved attorney fee payable out of the increased award."

Id. at 49.

We conclude that the rule is directly applicable and that its terms unambiguously preclude the Board from doing what it did in this case, that is, subjecting attorney fees to be paid out of increased compensation to an offset based on a prior overpayment of compensation to claimant.

We reject employer's contention that we should defer to the Board's implicit conclusion that the rule does not apply to this case. The Board's supposed construction of the rule cannot be squared with the language of the rule itself. Under the interpretive principles described by the Supreme Court in *Don't Waste Oregon Com. v. Energy Facility Siting*, 320 Or 132, 142, 881 P2d 119 (1994), we defer to an agency's construction of its own rules as long as that construction "is consistent with the wording of that rule." *Id.* at 142. In this case, the rule states that attorney fees to be paid out of compensation "shall not be subject to any offset based upon prior overpayment of compensation to the claimant." The Board's decision to subject the award of attorney fees in this case to an offset based upon the prior overpayment to claimant is directly at odds with the rule and cannot be justified by any reasonable construction of its wording.

145 Or App 565> Moreover, contrary to employer's suggestion, our decision in *Volk* has no bearing on the issues now before us. In *Volk*, the claimant initially was awarded 20 percent unscheduled permanent disability, and the employer paid the full amount of the award. The claimant requested reconsideration of the award, but on reconsideration the award was reduced to 11 percent. The claimant requested a hearing on the reconsideration order. Before the hearing, the parties entered into a stipulation that reinstated the award of 20 percent disability. The parties continued to dispute how

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[1] The wording of the rule has been changed since our decision in *Sheldon*, but not in any material respect. The former rule provided:

> "An attorney fee which has been approved * * * to be paid from increased compensation awarded by a referee, the Board or the Court of Appeals shall not be subject to any set-off based on prior overpayment of compensation to claimant by the employer or its insurance carrier. The employer or carrier shall pay the approved attorney fee to the claimant's attorney"

Former OAR 438-47-085(2).

attorney fees were to be calculated, and they submitted that matter to the Board. The Board approved fees based on the full 9 percent increase in compensation, but held that, because the claimant already had been paid all the compensation she was due, her attorney would have to seek payment of those fees directly from her. The Board reasoned that it lacked authority to order employer to pay attorney fees *in addition to* compensation. We affirmed, relying on the requirement of ORS 656.386(2) that attorney fees be paid "from the increase in the clainiant's compensation, if any, except as otherwise expressly provided in this chapter." We reasoned that, because no statute authorized payment of attorney fees in addition to compensation, the Board was correct in concluding that it lacked authority to do so.

In *Volk*, we expressly stated that our decision did not necessitate consideration of the validity of OAR 438-15-085(2). That makes sense, for the rule relates to overpayments, and in *Volk* there was no overpayment. Nor did we say anything in *Volk* that implicitly conflicts with OAR 438-15-085(2). We held that, in accordance with ORS 656.386(2), unless another statute expressly says otherwise, the Board lacks authority to order a payment of attorney fees in addition to an increase in compensation. The rule does not require payment of attorney fees in addition to compensation. It simply prohibits the Board from subjecting attorney fees to be paid out of compensation to an offset based on a prior overpayment of compensation. Thus, it governs only the timing and extent of an offset that may be taken against the increased compensation. As we said in *Sheldon*, the effect of the rule is to reduce the extent to which an offset may be taken against increased compensation; it does not require **<145 Or App 565/566>** payment of attorney fees in addition to the increased compensation itself. *Sheldon*, 86 Or App at 49.

Reversed and remanded for reconsideration.

Cite as 145 Or App 598 (1997) January 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Harry T. McCrea, Jr., Claimant.
Harry T. McCREA, Jr., *Petitioner,*
v.
ARRIOLA BROS., INC.; SAIF Corporation; and Weyerhaeuser Company,
Respondents.
(WCB 93-02507, 93-05231; CA A91991)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 22, 1996.

James L. Edmunson argued the cause for petitioner. With him on the brief was Coons, Cole, Cary & Wing, P.C.

John M. Pitcher argued the cause and filed the brief for respondent Arriola Brothers, Inc.

Michael O. Whitty argued the cause and filed the brief for respondents SAIF Corporation and Weyerhaeuser Company.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

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145 Or App 599> Claimant seeks reversal of an order of the Workers' Compensation Board (Board) that upheld the denial of the claim by employer based on ORS 656.262(10), as amended by Oregon Laws 1995, chapter 332, section 28.[1] In reaching its decision, the Board relied on its holding in *Craig L. Hiatt*, 47 Van Natta 2287 (1995) in which it incorrectly interpreted ORS 656.262(10). *Hiatt v. Halton Company*, 143 Or App 579, 922 P2d 1279 (1996); *see Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 915 P2d 1053, *rev den* 324 Or 305 (1996). Similarly, the Board incorrectly interpreted ORS 656.262(10) in this case.[2]

Reversed and remanded for reconsideration.

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[1] Employer argues that claimant did not preserve this argument below and, thus, that we should not address it. However, the Board *sua sponte* applied ORS 656.262(10) to the facts of this case.

[2] We do not decide whether claim preclusion applies in this case.

Cite as 146 Or App 50 (1997) January 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Deana F. Marshall, Claimant.
Deana F. MARSHALL, *Petitioner,*
v.
SAIF CORPORATION, *Respondent.*
(92-09708; CA A90412)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1996; resubmitted in banc December 11, 1996.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison.
Julene M. Quinn argued the cause for respondent.
RIGGS, J.
Reversed and remanded to Workers' Compensation Board for reconsideration.
Armstrong, J., concurring.
Leeson, J., dissenting.

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146 Or App 52> Claimant seeks review of an order of the Workers' Compensation Board (Board) that reinstated SAIF's denial of her claim on the ground that claimant had failed to provide corroborative evidence of compensability in addition to her own evidence, as required by ORS 656.128(3). We reverse the order and remand the case to the Board for reconsideration.

Claimant, a hairdresser, is the sole proprietor of a beauty salon. She elected workers' compensation coverage for herself under ORS 656.128(1) and (2). In April 1992, she filed a claim for a right arm and shoulder injury, which she alleged was caused by her work. SAIF denied her claim, relying on ORS 656.128(3):

> "No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant."

According to SAIF, claimant failed to present corroborative evidence that the injury was compensable. The administrative law judge (ALJ) set aside SAIF's denial on the ground that the corroborative evidence requirement pertains to proof of coverage, not to proof of compensability. The Board affinned the ALJ. In *SAIF v. Marshall,* 130 Or App 507, 510, 882 P2d 1115, *rev den* 320 Or 492 (1994) (*Marshall I*), we reversed the Board, holding that the corroborative evidence requirement of ORS 656.128(3) pertains to proof of compensability, and we remanded the case to the Board.

On remand, claimant proffered the medical reports of Dr. Rabie, who had examined her in February and March of 1992, as corroborative evidence of compensability. Based on claimant's own account of her injury and on his examination, Rabie reported that

> "all of [claimant's] conditions are secondary to the repetitive and fast type of activity carried out in hair dressing. Unfortunately[,] having worked five to six hours per day is probably a significant aggravating factor.
>
> " * * * * *
>
> "I believe that [claimant] suffers from a repetitive use type tendinitis * * * no doubt secondary to her work activities."

146 Or App 53> The Board was of the view that, because the doctor's opinion depended in part on a history that claimant herself had provided, the report was not "in addition to the evidence of the claimant." It held that "the record contains no corroborative evidence of compensability, in addition to claimant's evidence," and reinstated SAIF's denial.

Claimant assigns error to that holding. She contends that Rabie's medical reports are corroborative evidence of compensability, because they are "different in character [from claimant's evidence] and tend to confirm claimant's testimony on the compensability of her claim." SAIF argues that those medical reports are not corroborative evidence, because they "cannot confirm [that] the activity occurred at work," and do "not tend to strengthen or confirm the occurrence of the activity." Furthermore, SAIF argues, Rabie's reports are "not additional evidence, because [they have] claimant as [their] only source."

Other than in *Marshall I*, the meaning of the term "corroborative" as used in ORS 656.128(3) has not been considered in the cases, nor is it defined in the statute. In *Marshall I*, 130 Or App at 510, we said that the evidence must be corroborative of compensability. We did not discuss, however, what kind of evidence would be considered corroborative of compensability. As required by *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993), in interpreting the statute, we begin with its text, construing words of common usage according to their plain, natural and ordinary meaning. According to *Webster's Third New World Dictionary* 512 (1971), "corroborative" means "tending to make more certain." *Black's Law Dictionary* 414 (rev 4th ed 1968), defines "corroborating evidence" as

> "[e]vidence supplementary to that already given and tending to strengthen or confirm it; additional evidence of a different character to the same point."

As reflected in the dictionary definitions, in the context of ORS 656.128(3), the ordinary meaning of the term corroborative evidence is evidence, different from the evidence of the claimant, that tends to make more certain the compensability of the claim. Thus, any evidence that makes more certain **<146 Or App 53/54>** *either* the "arising out of" or "in the course of" prong of compensability is corroborative.[1]

The parties appear to agree that, as used in the statute "the evidence of the claimant" is something narrower than all the evidence put forth by a claimant. We need not define the precise limits of that phrase for the purpose of this case, however. SAIF asserts that the corroborating evidence must be in addition to claimant's own statements concerning her condition, including the medical history that she provided to her physician. We accept that premise for the sake of this discussion. SAIF takes the view that, because the doctor's opinion depended in part on the history that claimant herself had provided, the medical reports are not in addition to claimant's own statements and for that reason are not corroborative. That is wrong. Certainly, a doctor relies on a patient's history to formulate a medical opinion; but the opinion itself, as to diagnosis, causation and treatment, is the doctor's opinion, based collectively on the patient's history, a physical examination and the doctor's own expertise. The doctor's reports are evidence "in addition to" the claimant's evidence.

Not only are the medical reports "in addition to" claimant's statements, they do, in fact, corroborate compensability. They show that claimant described to her doctor the same employment conditions that she had reported on her claim and to which she testified. The doctor's opinion attributes claimant's injury and need for treatment to the employment conditions claimant described. The reports accordingly corroborate both the "arising out of" and "in the course of" components of proof of compensability, ORS 656.005(7), and satisfy the requirement of ORS 656.128(3), because they make more certain the compensability of the claim. In the light of our disposition of this first assignment of error, we need not consider the second assignment.

Reversed and remanded to Workers' Compensation Board for reconsideration.

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[1] The dissent and the majority part ways here, the dissent concluding that both prongs must be corroborated. In our view, evidence that corroborates either prong makes compensability more certain.

ARMSTRONG, J., concurring.

I join the majority because I agree with it that the Board erred in concluding that claimant had failed to submit corroborative evidence on her claim. I disagree, however, with its conclusion that the corroboration requirement in ORS 656.128(3) is satisfied if corroborative evidence is submitted on either element of the test for whether an injury or disease is work related. I agree with the dissent that the statute requires corroborative evidence to be submitted on both elements of the test.

LEESON, J., dissenting.

I would affirm the Board. Although I agree with the majority's definition of corroborative evidence, I disagree with its conclusion that Dr. Rabie's reports "corroborate both the 'arising out of' and 'in the course of' components of proof of compensability." 146 Or App at 54. In *SAIF v. Marshall, 130* Or App 507, 510, 882 P2d 1115, *rev den* 320 Or 492 (1994) (*Marshall I*), we held that the corroborative evidence requirement pertains to compensability, not coverage. In my view, the majority ignores the consequence of that decision, which is that a sole proprietor must present corroborative evidence in addition to her own evidence that her injury arose out of and occurred in the course of her employment. Accordingly, I dissent.

ORS 656.128(3) provides that "[n]o claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant." According to our opinion in *Marshall I,* that corroborative evidence requirement pertains to compensability, not to coverage. In order to be compensable, an injury must "arise out of" and occur "in the course of" employment. ORS 656.005(7)(a). The "arising out of" prong of the compensability test refers to the causal connection between the injury and employment, while the "in the course of" prong refers to the time, place and circumstance of the injury. *First Interstate Bank v. Clark, 133* Or App 712, 717, 894 P2d 499, *rev den* 321 Or 429 (1995). To establish compensability, a claimant must satisfy both prongs to some degree. *Krushwitz v. McDonald's Restaurants,* 323 Or 520, 531, 919 P2d 465 (1996). In the light of **<146 Or App 55/56>** *Marshall I,* I believe that sole proprietors must present corroborative evidence in addition to their own evidence regarding both prongs.

In this case, the only evidence that claimant presented was her own evidence and the reports of Dr. Rabie, which contained the following statements:

> "All of [claimant's] conditions are secondary to the repetitive and fast type of activity carried out in hair dressing. Unfortunately[,] having worked five to six hours per day is probably a significant aggravating factor.
>
> "* * * * *
>
> "I believe that [claimant] suffers from a repetitive use type tendinitis * * * no doubt secondary to her work activities."

I agree with the majority that Rabie's reports satisfy the "arising out of" prong of the compensability test, because they are some evidence in addition to claimant's evidence regarding causation. However, those reports are not corroborative evidence in addition to claimant's evidence regarding the time, place or circumstance of her injury. The medical history on which Rabie relied came from claimant and Rabie's diagnosis would be the same whether claimant's injury occurred at the beauty salon or during her nonworking hours while engaged in some other activity that involves rapid, repetitive hand movements. Therefore, his reports do not provide corroborative evidence in addition to claimant's evidence regarding the time, place or circumstance of claimant's injury.

The Board's majority opinion recognizes that ORS 656.128(3) makes it more difficult for sole proprietors than nonsole proprietors to prove the compensability of their injuries. However, that difficulty is not insurmountable. In this case, for example, as the Board majority observed,

> "corroborating evidence could be provided by another person who saw the injury happen, or by a person who could confirm that an injury happened at some time during a particular day (*e.g.*, by someone who saw the claimant before and after work). Corroborating evidence could also be provided by testimony that the piece of equipment that caused **<146 Or App 56/57>** the injury is located only at the claimant's workplace. In this case, for example, corroborating evidence could have been provided by the hairdressers who leased work space from claimant, or by her husband, regarding the type of activities involved in hair styling, claimant's arm complaints, or the increased hours claimant worked in early 1992."

The purpose of the corroborative evidence requirement of ORS 656.128(3) is to protect insurers from having to pay for nonwork related injuries merely because the sole proprietor claims that they are work related. That does not mean, of course, that the corroborative evidence rule should be construed to shield insurers from all claims by sole proprietors. In this case, claimant's injury is a type of tendinitis that could have its origin in many kinds of activities, both work related and nonwork related. Although she is a sole proprietor, claimant's work as a hairdresser puts her in contact with a variety of people who could provide evidence in addition to her evidence about the time, place and circumstances of her injury. This case does not involve a sole proprietor who has no contact with anyone else or whose injury is consistent only with the kind of work in which the sole proprietor engages or whose injury could be caused only by the equipment with which the sole proprietor works.

Because in my view Rabie's reports are not corroborative evidence in addition to claimant's evidence regarding the time, place and circumstance of her injury, I would hold that claimant has not satisfied ORS 656.128(3).

Furthermore, I do not believe that the Board abused its discretion by refusing to remand the case to the ALJ to take additional evidence. The Board's authority to remand a case stems from ORS 656.295(5), which provides only that the Board "may remand" if it determines that a case has been improperly, incompletely or otherwise insufficiently developed. The decision to remand falls squarely within the Board's discretion. *Liberty Northwest Ins. Corp. v. Griggs*, 112 Or App 44, 49, 827 P2d 921 (1992). In my view, the Board's conclusion that there was no compelling basis to remand and that claimant had failed to establish that relevant corroborative evidence was unavailable to her at the time of the hearing is well within the Board's discretion.

I respectfully dissent.

Landau, J., joins in this dissenting opinion.

Cite as 146 Or App 344 (1997) February 12, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael D. Quinton, Claimant.
Michael D. QUINTON, *Petitioner,*
v.
LT&L LOGGING, INC., and SAIF Corporation, *Respondents.*
(94-13396; CA A92673)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1996.
Meagan Flynn argued the cause for petitioner. On the brief were Daniel R. Guggenheim and Pozzi Wilson Atchison.
Michael O. Whitty argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Affirmed.

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146 Or App 346> Claimant seeks review of an order of the Workers' Compensation Board (Board) that upheld the denial of his claim for benefits on the ground that his injury in Colorado was not incidental to Oregon employment. We review for errors of law and substantial evidence, ORS 183.482(8)(a) and (c), and affirm.

Claimant, a timber worker, worked seasonally for employer from 1990 through 1994. Employer, an Idaho corporation, engaged in logging in Oregon until July 1994. In early July 1994, employer told claimant to stop working at the Oregon job site and offered him a job in Colorado. Claimant accepted the offer and went to Colorado. Employer moved the bulk of its equipment and employees to Colorado, established an office there and began logging.

On August 29, 1994, claimant was working for employer in Colorado when he injured his back while felling a tree. SAIF denied his claim for medical services. The administrative law judge and the Board affirmed that denial. The Board found that when employer "abandoned its Oregon logging activities in July 1994, there was no Oregon employment to which claimant could return" and, consequently, that when claimant was injured, he was not temporarily employed in Colorado incidental to Oregon employment.

Claimant argues that the Board did not properly apply the permanent employment relation test to determine whether his work outside Oregon was temporary and incidental to his Oregon employment. He contends that "the Board simply considered whether [he] had a 'reasonable expectation of returning to work for the employer in Oregon,' " and that the Board should have considered his "reasonable expectation" as one among several applicable factors.[1] He **<146 Or App 346/347>** contends that if the Board had considered all of the applicable factors, it would have concluded that his work in Colorado was incidental to his Oregon employment. SAIF responds that the Board correctly applied the permanent employment relation test and that claimant did not have a permanent employment relationship in Oregon after employer moved to Colorado.

Whether workers injured out of state are entitled to benefits under Oregon's workers' compensation system is governed by ORS 656.126(1), which provides, in part:

> "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 * * * is entitled to the benefits of this chapter as though the worker were injured within this state."

Workers subject to ORS chapter 656 who work outside Oregon generally continue to be covered by this state's workers' compensation system if Oregon is the place of their permanent employment and if their presence out of state is incidental to that employment. *SAIF v. Moe,* 142 Or App 62, 66, 919 P2d 533 (1996); *Berkey v. Dept. of Ins. and Finance,* 129 Or App 494, 498, 879 P2d 240 (1994). In determining whether claimant's work outside the state is temporary, the correct standard is the permanent employment relation test. *Moe,* 142 Or App at 67. That test allows consideration to be given to a number of factors, none of which is dispositive, including (1) the intent of the employer, (2) the understanding of the employee, (3) the location of the employer and its facilities, (4) the circumstances surrounding the work assignment, (5) the state laws and regulations to which the employer is subject, and (6) the residence of the employees. *Berkey,* 129 Or App at 498. It is not necessary that the Board make detailed findings on each factor that it considers. *Power Master, Inc. v. National Council on Comp. Ins.,* 109 Or App 296, 301-02, 820 P2d 459 (1991).

In this case, the Board applied the correct standard. It found that employer moved to Colorado because work in Oregon was "dying out;" that employer had abandoned its logging operations in Oregon in July 1994; that there was no **<146 Or App 347/348>** work for claimant to return to in Oregon; that only one of employer's logging employees, a truck driver, remained in Oregon after the operations moved to Colorado; that although initial paychecks had been drawn on an Oregon bank, claimant's subsequent paychecks were drawn on a Colorado bank; and that the last paperwork claimant received from employer came from New Mexico. Those findings are supported by substantial evidence in the record. Based on those findings, the Board did not err in concluding that claimant is not an Oregon subject worker.

Claimant's second assignment of error is that substantial evidence does not support the Board's finding that his expectation of returning to work for employer in Oregon was not reasonable. There is substantial evidence in the record to support that finding.

Affirmed.

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[1] Claimant also argues that the Board's consideration of the "reasonable expectation" factor was legal error. However, claimant did not raise this argument before the Board. In response to SAIF's argument that claimant's expectation of returning to work for employer in Oregon was not reasonable, claimant argued to the Board only that his expectation was reasonable. Because the argument was not raised below, we do not consider it for the first time on review. *Llewellyn v. Board of Chiropractic Examiners,* 318 Or 120, 127, 863 P2d 469 (1993).

Cite as 146 Or App 358 (1997) February 12, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marcia P. Trevisan, Claimant.
Marcia P. TREVISAN, *Petitioner,*
v.
SAIF CORPORATION and Karnopp, Peterson, Noteboom, Hubel, Hansen & Arnett, *Respondents.*
(95-00290; CA A92932)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 16, 1996.
Margaret H. Leek Leiberan argued the cause for petitioner. With her on the brief was Leiberan & Gazeley.
David L. Runner argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.

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146 Or App 360> Claimant petitions for review of a Workers' Compensation Board (Board) order holding that a Disputed Claim Settlement (DCS) precludes her from asserting a claim for headaches. We review for errors of law and substantial evidence, ORS 656.298(6), ORS 183.482(7) and (8), and reverse and remand.

Claimant is a word processor and computer systems manager. In September 1992, she developed cervical pain and was diagnosed with degenerative joint disease; she also complained of headaches. In November 1992, claimant filed a claim for spinal stenosis related to her work as a typist. SAIF initially denied the claim but in March 1993, SAIF and claimant entered into a Stipulated Settlement Agreement (SSA) in which SAIF agreed to accept the claim for cervical stenosis and discectomies. The SSA made no reference to headaches. Claimant's headaches continued after the discectomies, and in May 1993, she began receiving treatment from Dr. Eckman for the headaches.

In 1994, claimant filed a claim for bilateral temporomandibular joint (TMJ) problems, contending that the cervical collar she wore after her second discectomy was causing TMJ. On April 21, 1994, SAIF issued a partial denial of the TMJ claim. The denial made no mention of headaches. Claimant filed a request for hearing. She continued to receive treatment for headaches.

In May 1994, claimant began receiving treatment from Dr. Altrocchi for her headaches. She informed him that she had suffered headaches for as long as she could remember and that she had had them almost daily for the past three years. She also informed Altrocchi that her mother and her sister suffered from headaches. The medication that Altrocchi prescribed was not effective.

In July 1994, claimant and SAIF entered into a settlement captioned "Disputed Claim Settlement and Partial Denial." It provides, in relevant part, that:

> "The parties agree that a bona fide dispute exists between them as to the compensability of the conditions **<146 Or App 360/361>** and/or services *which have been denied.* Both parties have substantial evidence to support their contentions and *each desires to settle all issues raised or raisable at this time by entering into a disputed claim settlement under the provisions of ORS 656.289(4)* for the total sum of $3,300.00." (Emphasis supplied.)

The DCS also specifies that claimant's accepted conditions -- cervical stenosis and discectomy at levels C5-6 and C6-7 -- remain "in open status."

Meanwhile, claimant continued treatments with Altrocchi for her headaches. He referred her to a pain clinic in California. After her return from California, claimant was examined by Drs. Platt and Arbeene at SAIF's request. They were unable to relate claimant's headaches to the 1992 injury and, on December 12, 1994, SAIF issued a denial of treatment and disability related to headaches. It stated the reason for the denial was that the 1992 injury was not the major contiibuting cause of the headaches. Claimant requested a hearing.

The administrative law judge (ALJ) dismissed claimant's request for a hearing, and the Board affirmed. According to the Board, "the compensability of the headache condition could have been raised prior to entering into the DCS." Relying on *Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 867 P2d 543, *rev den* 319 Or 572 (1994), and *Safeway Stores, Inc. v. Seney*, 124 Or App 450, 863 P2d 528 (1993), the Board concluded that the "raised or raisable" provision in the DCS precludes claimant from asserting the headache claim.

Claimant's three assignments of error reduce to the proposition that the Board erred in holding that the DCS precludes her from asserting the headache claim. She contends that the only issue resolved by the DCS was the claim for TMJ. SAIF responds that the DCS unambiguously encompasses claimant's headache condition. In the alternative, SAIF contends that the SSA bars claimant from asserting the headache claim.

ORS 656.289(4) authorizes the parties to enter into a DCS "where there is a bona fide dispute over compensability **<146 Or App 361/362>** of a claim," and the parties have agreed to "make such disposition of the claim as is considered reasonable." OAR 438-009-0010(2)(b), adopted pursuant to ORS 656.289(4), specifies that a DCS shall include a statement that "the claim has been denied and the date of the denial." ORS 656.262(9), in turn, provides that when an insurer or other agent of an employer denies a claim for compensation,

> "written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant."

In this case, the DCS states that the denied condition is "bilateral temporomandibular joint problems." SAIF denied that condition on April 21, 1994. SAIF did not deny the headache claim until December 12, 1994, after the execution of the DCS. As a matter of law, the DCS did not settle claimant's headache claim, because the headache claim was not denied at the time that the parties entered into the DCS.[1]

Nonetheless, the Board held and SAIF argues that, under *Stoddard* and *Seney*, the "raised or raisable" language of the DCS precludes claimant from raising the headache claim, because the headache condition had been diagnosed and treated before the parties entered into the DCS. We disagree. *Stoddard* and *Seney* involved stipulated settlement agreements, which may resolve any contested matter. ORS 656.236(1). This case, by contrast, involves a DCS, which may be used only to settle denied claims. ORS 656.289(4); OAR 438-009-0010(1). At the time that the parties entered into the DCS, the only denied condition was TMJ. The "raised or raisable" language in the DCS refers only to conditions **<146 Or App 362/363>** associated with TMJ. SAIF did not deny the headache condition for another four months, and its denial declared that "[t]he September 10, 1992 injury is not the major contributing cause of your headaches."

We next consider SAIF's argument that the SSA provides an alternative basis for affirming the Board. By that agreement, SAIF rescinded its denial of claimant's neck and shoulder condition and accepted "cervical stenosis and discectomy at C5-6, C6-7." The SSA also stated that it settled "all issue(s) raised or raisable at this time * * *." According to SAIF, claimant's headache condition could bave been raised at the time of the SSA because "it had been diagnosed and at least tentatively related to the neck claim," and because "claimant could have demanded that the condition be accepted pursuant to ORS 656.262(6)(b)(A)." We find those arguments unpersuasive.

The record reveals that when the parties entered into the SSA for the 1992 injury, claimant had been having headaches for over ten years and that the cause of those headaches was unknown. As SAIF acknowledges, in 1993, claimant's headaches were only "tentatively" related to her cervical

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[1] SAIF contends that the phrase "Partial Denial" in the caption of the DCS demonstrates that the agreement "was intended as a 'partial denial' and settlement of conditions other than the TMJ problems," and that the partial denial included in the agreement "can only refer to the headache condition and any other unaccepted conditions existing at the time of the agreement." That argument is without merit. Denial of a claim must satisfy the requirements of ORS 656.263(9). Nothing in the DCS put claimant on notice of the condition that SAIF now claims it was denying, its reason for the denial, or claimant's appeal rights in the light of the so-called denial. *See In the Matter of the Compensation of Andrew C. Justice*, No. 91-16317, 1992 WL 145769 (Or Workers' Comp Bd June 1, 1992) (example of a partial denial in a DCS that contains the statutory requirements for a denial).

condition and there were other tentative diagnoses. Based on what was known about claimant's headaches in 1993 when SAIF accepted the cervical stenosis and discectomy conditions, we cannot conclude that claimant could have demanded that the headache condition be accepted or that headaches were "raised or raisable" as part of the SSA.[2]

In sum, neither the DCS nor the SSA bars claimant from challenging SAIF's December 1994 denial of her headache condition.

Reversed and remanded.

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[2] SAIF's December 1994 denial of the headache condition is an indication that SAIF itself did not believe that the SSA encompassed the headaches.

Cite as 146 Or App 553 (1997) March 5, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bobby Williams, Claimant.
Bobby WILLIAMS, ***Petitioner,***
v.
WEST COAST GROCERY, ***Respondent.***
(WCB 94-10536; CA A92578)

Judicial Review from the Workers' Compensation Board.
Argued and submitted November 18, 1996.
Dennis O'Malley argued the cause and filed the brief for appellant.
Travis L. Terrall argued the cause for respondent. With him on the brief was Terrall & Associates.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.

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146 Or App 555> In this workers' compensation case, claimant seeks review of an order of the Workers' Compensation Board denying him compensation for medical services associated with a herniated disc. We affirm.

In the early 1980's, claimant was employed as a warehouseman by West Coast Grocery. His job required that he lift and stack cases of grocery products. He sustained compensable shoulder and low back injuries in June 1983 and March and May 1984. The claim was closed in 1988 and claimant was awarded 30 percent unscheduled permanent partial disability. The notice of closure anticipated that claimant would experience waxing and waning of his symptoms.

In 1992, claimant sought treatment for low back pain. An MRI scan revealed a disc bulge that was diagnosed as a herniated disc. Claimant's treating physician, Dr. Stevens, concluded that the herniated disc was causally linked to his on-the-job injuries. Claimant submitted a claim for medical services with employer for his herniated disc. At the employer's request, claimant was examined by a panel of medical consultants who concluded that claimant's condition was not the result of his earlier on-the-job injuries but, instead, was the result of a naturally occurring degenerative process. On the strength of that medical examination, employer denied the claim. Claimant later had surgery on his lumbar spine in 1994.

Claimant challenged employer's denial. The administrative law judge (ALJ) adopted Stevens' conclusion that claimant's compensable injuries "remain a material cause of his 1994 disability and need for treatment" and set aside the denial.

On review, the Board reversed. Looking at the evidence, the Board first found that claimant's herniated disc was not directly caused by his earlier on-the-job injuries but that it was a consequential condition:

> "Our first task is to ascertain the correct legal standard. One option is ORS 656.005(7)(a)(B) [the combined condition <146 Or App 555/556> statute]. There is, however, no persuasive evidence that claimant had any low back condition that preexisted his 1983-84 work injuries or that any such condition combined with those injuries to result in this current disability or need for treatment. * * *
>
> "Another option is ORS 656.005(7)(a). In view of the series of intervening events that resulted in low back pain between 1984 and the present and Dr. Stevens' conclusion regarding the progressive nature of claimant's low back condition, we find that there is insufficient evidence to establish that claimant's current low back condition was the direct result of his work injuries over a decade ago.
>
> "That leaves ORS 656.005(7)(a)(A), the consequential condition statute." (Footnote omitted.)

The Board concluded that the consequential condition statute, ORS 656.005(7)(a)(A),[1] applied and held that claimant had failed to carry his burden of proof in showing that his earlier on-the-job injuries were the "major contributing factor" of the condition for which he sought medical treatment.

On judicial review, claimant assigns error to the Board's order on two grounds: (1) The board erred in holding claimant to the "major contributing cause" standard regarding the burden of proof concerning causation and should have applied the "material contributing cause"[2] standard because his current condition was caused directly, although belatedly, by his on-the-job injury, *see Albany General Hospital v.* **<146 Or App 556/557>** *Gasperino,* 113 Or App 411, 833 P2d 1292 (1992); and (2) that the Board erred in rejecting his treating physician's evidence. Employer responds that the Board's analysis is correct.

This case turns on the efficacy of claimant's evidence, which consisted solely of the opinion and conclusions of his treating physician, whose opinion was that the 1983-84 injuries were a material cause of claimant's need for treatment.

The Board articulated reasons for finding that Stevens' reasoning and conclusions were unpersuasive.[3] The other medical examiners found that claimant's current need for treatment was unrelated to his on-the-job injury and that it was the result of a naturally occurring degenerative process. In short, the Board's finding that claimant did not prove that his work was even a material contributing cause of his current need for treatment is supported by substantial evidence.

We therefore need not address claimant's other assignment of error.

Affirmed.

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[1] ORS 656.005(7)(a)(A) provides:

> "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."

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

> "A 'compensable injury' is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings * * *."

ORS 656.245(1) provides, in part:

> "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires * * *."

[3] The Board pointed to "the series of intervening events [chopping wood, lifting weights and helping a friend move] that resulted in [claimant experiencing] low back pain between 1984 and present" and claimant's treating physician's conclusion "regarding the progressive nature of claimant's low back condition" as evidence that claimant's condition was not directly caused by his on-the-job injuries.

Cite as 146 Or App 604 (1997) March 5, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dennis L. Keller, Claimant.
Dennis L. KELLER, *Petitioner,*
v.
WARN INDUSTRIES, INC., SAIF Corporation, Providence Medical Center and Aetna Casualty Company, *Respondents.*
(WCB Nos. 93-11978; 93-07002; CA A92833)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 16, 1996.

Robert Wollheim argued the cause for petitioner. With him on the brief was Welch, Bruun, Green & Wollheim.

Michael O. Whitty argued the cause, and filed the brief for respondents SAIF Corporation and Warn Industries, Inc.

Vera Langer waived appearance for respondents Providence Medical Center and Aetna Casualty Company.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

RIGGS, P. J.

Reversed and remanded for acceptance of claimant's degenerative back condition.

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146 Or App 606> Claimant seeks review of an order of the Workers' Compensation Board holding that SAIF is not precluded by a determination order from denying a claim for medical services for claimant's degenerative back condition. We reverse the Board.

Claimant injured his back in 1980, while working for SAIF's insured, Warn Industries, Inc. SAIF accepted the claim by an unexplained code; it did not specify what condition was being accepted. A July 1984 determination order awarded claimant 35 percent permanent partial disability. Following claimant's completion of an authorized training program, the claim was closed again without an additional award of compensation for permanent disability. SAIF did not challenge the award. The Board has found that the award included benefits for symptoms of a preexisting degenerative spinal condition, although that condition had not been accepted by SAIF.

In 1991, claimant sustained a nondisabling back and leg injury while working for Providence Medical Center, then insured by Standard Fire Insurance Company and now by Aetna Casualty Company. Standard accepted a claim for nondisabling low back strain and right leg contusions, and claimant was declared to be medically stationary in 1991. In 1993, claimant sought treatment and was diagnosed with back pain, muscle strain, chronic mild lumbar subluxation sprain and sprain complex, and degenerative spinal disease. SAIF denied the compensability of the condition and its responsibility for claimant's current condition. Standard also denied its responsibility for the condition. Claimant requested a hearing, and an administrative law judge (ALJ) concluded that in 1980, SAIF had accepted claimant's degenerative back condition and that claimant had established that his current need for medical treatment was related to that earlier accepted condition. The Board affirmed the ALJ's order, relying on our opinion in *Messmer v. Deluxe Cabinet Works,* 130 Or App 254, 881 P2d 180, *rev den* 320 Or 507 (1995) (*Messmer I*). It held that, because SAIF had failed to challenge two determination orders in July 1984 and August **<146 Or App 606/607>** 1986, that had included awards for claimant's noncompensable degenerative back condition, it was precluded from denying that claimant's condition was a part of his 1980 accepted back claim.

SAIF sought judicial review, and the parties thereafter jointly moved to remand the case to the Board for reconsideration in the light of intervening 1995 amendments to ORS 656.262(10). On remand, the Board concluded that the 1995 amendments essentially overruled *Messmer I* and permit an insurer to contest the compensability of a condition rated by a closure order, so long as the carrier has not formally accepted that condition.

When it decided this case, the Board did not have before it our opinion in *Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 915 P2d 1053, *rev den* 324 Or 305 (1996) (*Messmer II*). There, we held that the 1995 amendment to ORS 656.262(10) did not affect our holding in *Messmer I,* and that an employer's

failure to challenge a determination order precludes the insurer from subsequently contesting the compensability of a condition rated therein. Claimant contends that *Messmer II* controls here, that the Board erred and that SAIF's denial should be set aside.

We agree with claimant. *Messmer I* and *Messmer II* require that the Board's order be reversed and the case be remanded for acceptance of the claim. In a supplemental authority filed after oral argument, SAIF asks us to consider the effect of *Barrett v. D & H Drywall*, 300 Or 325, 309 P2d 1083 (1985), *on recon* 300 Or 553, 715 P2d 90 (1986), on the rule in *Messmer I*. SAIF's argument was not made below, and we decline to consider it.[1]

Reversed and remanded for acceptance of claimant's degenerative back condition.

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[1] SAIF contends that if the case is to be remanded to the Board, it should be for the limited purpose of permitting the Board to reconsider whether the 1986 determination order reasonably could be understood to have awarded benefits for the degenerative condition. The Board found that the award included benefits for that condition, and SAIF does not cross-petition from the Board's order.

Cite as 146 Or App 768 (1997) March 5, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James R. Counts, Claimant.
James R. COUNTS, *Petitioner*,
v.
INTERNATIONAL PAPER COMPANY, *Respondent*.
(WCB 94-11842; CA A91834)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 7, 1996.
Jon C. Correll argued the cause and filed the brief for petitioner.
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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146 Or App 770> Claimant seeks judicial review of an order of the Workers' Compensation Board denying the compensability of diagnostic medical services for a noncompensable condition. We review for errors of law, ORS 656.298(6), ORS 183.482(8), and affirm.[1]

Self-insured employer accepted a claim for a "left chest wall soft tissue injury" for an injury that claimant sustained on the job. A month later, claimant checked into a hospital to have a series of diagnostic tests done to determine whether the chest pain that he was then suffering was caused by coronary heart disease or a myocardial infarction. Employer subsequently issued a partial denial of claimant's "multiple cardiac risk factors" and refused to pay for the diagnostic tests. The Board concluded after a hearing that the diagnostic tests were not compensable. Claimant sought judicial review.

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[1] Claimant's first assignment of error asserts that "there is no evidence that claimant's heart symptoms began only after his chest wall discomfort improved." We review that assignment for substantial evidence, ORS 656.298(6), ORS 183.482(8), and conclude that there is substantial evidence to support the inference that claimant's heart symptoms began only after his chest wall discomfort had improved. Claimant does not question any other factual findings made by the Board.

The Workers' Compensation Law is intended to compensate employees injured on the job. ORS 656.012(2). To qualify for coverage under the law, claimant must prove that he suffered a compensable injury, as defined by ORS 656.005(7)(a). Claimant met that burden in this case. Once claimant established that he had suffered such an injury, he was entitled to "medical services for conditions *caused in material part* by the injury." ORS 656.245(1)(a) (emphasis supplied). Thus, for the diagnostic services at issue to be compensable, claimant had to show that his compensable injury made those tests necessary.

Generally, when the diagnostic services are related to noncompensable conditions, such a showing is impossible. The exception to that proposition is illustrated by *Brooks v. D & R Timber*, 55 Or App 688, 692, 639 P2d 700 (1982). In *Brooks*, the claimant suffered a compensable left knee injury **<146 Or App 770/771>** while at work. *Id.* at 691. The claimant's doctor believed that the injury might have produced a tear in the meniscus of claimant's knee. *Id.* at 692. Therefore, the doctor ordered exploratory surgery of the knee. *Id.* During the exploratory surgery, the doctor discovered that the claimant's knee condition was not a torn meniscus but a nonwork-related condition. *Id.* We held that, although the exploratory surgery ultimately served only to discover the existence of a noncompensable condition, it was still compensable because the surgery was initially performed because of the work-related, compensable injury. *Id.* at 692. Thus, if diagnostic services are necessary to determine the cause or extent of a compensable injury, the tests are compensate whether or not the condition that is discovered as a result of them is compensable.

Here, the Board considered the record and concluded that the diagnostic procedures were initially conducted because of claimant's high risk of heart disease, not because the doctors were concerned that claimant's compensable injury had caused a myocardial infarction or coronary heart disease. Thus, the Board concluded that claimant had failed to meet the *Brooks* standard; it therefore denied the compensability of those services.

Claimant does not argue that the Board lacked substantial evidence in the record to find that he had failed to meet the *Brooks* standard. Instead, claimant argues that that standard is too narrowly drawn. He asserts that diagnostic services related to a noncompensable condition should be compensable if those services, by eliminating or confirming a noncompensable condition, help determine whether a claimant's symptoms are actually related to the compensable injury. Claimant does not, however, offer any explanation as to how that standard can be reconciled with the current Workers' Compensation Law, which only requires employers to pay for "medical services for conditions caused in material part by the injury." ORS 656.245(1)(a). Thus, we conclude that the Board applied the proper legal standard, and we affirm its order denying the compensability of the diagnostic services.

Affirmed.

Cite as 147 Or App 26 (1997) March 12, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dale R. Shipley, Claimant.
SAIF CORPORATION and Great Shakes, Inc., *Petitioners,*
v.
Dale R. SHIPLEY, *Respondent.*
(WCB No. 95-02156; CA A92310)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1996.
Julene M. Quinn, Appellate Counsel, argued the cause for petitioners.
Scott M. McNutt, Sr. argued the cause for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Reversed and remanded.

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147 Or App 28> SAIF seeks review of an order of the Workers' Compensation Board, contending that the Board erred in assuming jurisdiction over the matter, which involved only a claim for medical benefits on a previously accepted claim. We agree with SAIF that the Director of the Department of Consumer and Business Services has exclusive jurisdiction.

With regard to the review of medical services disputes, 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."

Subsection 6 was added to ORS 656.245 by Oregon Laws 1995, chapter 332, section 25, and became effective on June 7, 1995. It applies to this case. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995).

The Board, in affirming the administrative law judge (ALJ), made the following findings, which are not challenged. Claimant suffered a compensable knee injury at work in 1989. The claim was closed with an award of temporary and permanent partial disability. In 1994, claimant experienced an off-thejob injury to the same knee and began receiving treatment. His physician took him off work, but claimant did not seek benefits for time-loss. The record shows that SAIF sent claimant a letter denying that claimant had experienced a worsening of his compensable condition and also denying a request to reopen the claim; however, it did not deny the compensability of the original 1989 injury.

Pursuant to ORS 656.245(6), disputes that concern only the compensability of medical services are subject to review by the Director of the Department of Business and Consumer Services. *Liberty Northwest Ins. Corp. v. Yon,* 137 Or App 413, 904 P2d 645 (1995). Claimant contends that **<147 Or App 28/29>** because SAIF denied the compensability of his current condition and need for treatment, it denied the compensability of the "underlying claim," as described in ORS 656.245(6), and that this therefore is not a case that concerns only the compensability of medical services. We reject the contention. 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 656.240 because it is materially related to the 1989 compensable 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.

Reversed and remanded.

Cite as 147 Or App 81 (1997) March 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William K. Bowler, Claimant.
STONE FOREST INDUSTRIES, INC., *Petitioner,*
v.
William K. BOWLER, *Respondent.*
(95-04253; CA A91876)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 13, 1996.
A. E. Bud Bailey argued the cause for petitioner. With him on the brief was Bailey & Associates, P.C.
James S. Coon argued the cause for respondent. With him on the brief was Swanson, Thomas & Coon.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.

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147 Or App 83> Employer Stone Forest Industries seeks review of an order of the Workers' Compensation Board in which the Board held that claimant is entitled to temporary disability payments[1] for the period beginning when Stone, as part of a plant closure, terminated his modified duty employment and ending when it ceased making payments to him related to the Worker Adjustment and Retraining Notification Act (WARN). 29 USC §§ 2101,2109. Stone argues that its WARN payments constitute wages for the purposes of the Workers' Compensation Law and that claimant, therefore, was not entitled to temporary disability payments during the time that he received them. The Board rejected that argument, and we affirm.

Claimant compensably injured his knee on August 5, 1994, while working for Stone at its lumber mill in Albany. He had surgery for the injury on September 5. Stone accepted the claim and paid temporary total disability from September 5 through September 18. On September 19, claimant was released for modified work and began working at a modified job at his pre-injury pay rate. On September 26, Stone notified claimant and its other employees that it intended to close the mill permanently. The last day of work was September 28. Stone paid its employees, including claimant, amounts equal to their regular wages and benefits through November 26, 1994.

Stone did not resume paying temporary disability benefits to claimant after the closure. Claimant did not receive unemployment benefits for this period, because he had previously exhausted his eligibility. On October 17, claimant began a light-duty job in computer sales that paid $1,000 per month, which is less than he had received while working for Stone.

Claimant was not medically stationary at the time of the hearing in May 1995. Stone conceded at the hearing that **<147 Or App 83/84>** claimant was entitled to temporary partial disability after November 26, 1994, when the WARN payments ended, but it disputed his right to temporary disability payments between the time when he stopped actually performing services and the end of the WARN payments. The administrative law judge and the Board both found in favor of claimant.

An injured worker is entitled to temporary total disability payments during the period of total disability. The amount of those payments is based on the worker's wages. ORS 656.210(1); ORS 656.211. The Workers' Compensation Law defines "wages" as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident[.]" ORS 656.005(29).

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[1] We use "temporary disability payments" to refer both to the temporary total disability payments that claimant seeks for the period before October 17, when he began his new job, and the temporary partial disability payments that he seeks thereafter.

When a worker returns to regular or modified employment, the employer may terminate temporary total disability payments. ORS 656.268(3)(a). However, if the worker remains partially disabled, the employer must make temporary partial disability payments, whose amount is based on the relationship between the worker's wages at the new job and the amount of temporary total disability payments. If the worker earns wages equal to the wages used to calculate temporary total disability, the temporary partial disability payments will be zero. ORS 656.212; OAR 436-60-030(10). Under these provisions, claimant was not entitled to temporary disability payments while he was actually performing modified work at his pre-injury pay rate.

When an injured worker returns to modified work at the pre-injury wage rate, but the employer thereafter withdraws the job offer or the job no longer exists, the "worker is entitled to temporary total disability compensation as of the date the job no longer is available." This rule applies to situations that include, but are not limited to, "termination of temporary employment, layoff or plant closure." OAR 436-60-030(11)(b);[2] *see Safeway Stores, Inc. v. Hanks*, 122 Or App 582, 857 P2d 911, *rev den* 318 Or 60 (1993) (the employer had to resume temporary total disability payments when, as part **<147 Or App 84/85>** of a labor dispute, it locked the claimant out of her modified employment).

In this case, soon after claimant returned to work and his light to temporary disability payments ended, Stone closed the plant and terminated his employment and that of all other workers in the mill. His modified job no longer existed, at least in the common meaning of the term, as of September 29. Under OAR 436-60-030(11)(b), he was entitled to temporary disability payments beginning on that date unless, as Stone argues, its payments of amounts equal to his wages and benefits were in fact "wages." We look first at the status of the payments under WARN and then at their status under the Workers' Compensation Law. We conclude that the payments were not wages, either for WARN or workers' compensation purposes.[3]

In WARN, Congress required larger employers to give employees and other affected entities specified notice of a plant closing or mass layoff. An affected employer that closes a plant without having given 60 days notice violates the Act, 29 USC § 2102, and affected employees have a right to compensatory damages. 29 USC § 2104. Under 29 USC § 2104(a)(1), the employees are entitled to damages equal to each employee's back pay and benefits, at the higher of the employee's average regular rate over the previous three years or the employee's final regular rate, for each day of the violation, to a maximum of 60 days. However, 29 USC § 2104(a)(2) permits the employer to take a credit against that liability for three kinds of payments: (1) wages that the employer paid for the period of the violation; (2) any voluntary and unconditional payment to the employee that is not legally required; and (3) any payment to a third party (such as a health and benefit trust) that is attributable to the employee.

Although employers appear to treat their WARN obligations as alternative--either to give notice or to pay the statutory amounts during the notice period--that is not how **<147 Or App 85/86>** the statute defines them. Rather, under the Act an employer, to comply, must give 60 days notice before closing the plant or engaging in a mass layoff. The payments described in 29 USC § 2104 are not an alternative way to comply with the notice requirement but are damages for failing to comply. The payments mentioned in 29 USC § 2104(a)(2) do not excuse the employer's noncompliance but limit its liability for damages.

Although Stone appears to assume that its payments were wages under 29 USC § 2104(a)(2)(A), the federal courts that have considered the issue have limited the term to payments for work actually performed. Thus, in *United Steelworkers v. North Star Steel*, 809 F Supp 5, 9 (MD Pa 1992), *affd in part and rev in part* 5 F3d 39 (3rd Cir 1993), *cert den* 560 US 1114 (1994), the employer instituted a mass layoff without providing the WARN notice. The court allowed the employer to deduct from the back pay damages under 29 USC § 2104(a)(1) the amounts that seven employees had earned after being recalled

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[2] All references to administrative rules are to the rules in effect at the time of the hearing in this case. No party asserts that any changes since then affect the issues on review.

[3] Because of our conclusion, we do not need to consider whether, assuming that the payments were "wages," the job "existed" or was "available" when his employer did not require him to do any work.

to work during the 60-day period after the layoff. Those amounts were wages. In *Washington v. Aircap Industries, Inc.*, 860 F Supp 307 (DSC 1994), 16 employees worked during the 60 days following the violation date, and the court deducted the wages that they earned from the employer's WARN liability. 860 F Supp at 313-15. Under the approach that these courts adopted, on September 26 Stone became liable to claimant for 60 days back pay damages but was entitled to deduct from that liability the wages that he earned on September 27 and 28.[4]

It thus appears that Stone's payments were not "wages" under WARN. They were not something that Stone could deduct from its liability for damages under 29 USC § 2104(1)(a). Rather, they were the payment of that liability, which consisted of 60 days compensation plus benefits, less **<147 Or App 86/87>** any wages that it paid claimant for work that he actually performed during the 60-day period.[5]

We turn to whether Stone's payments are "wages" under the Workers' Compensation Law. No court has directly discussed this issue, although one federal court has held that workers' compensation payments received during the 60-day WARN period do not reduce the employer's liability for back pay, because the payments are not within the Act's apparently exhaustive list of excludable amounts. *United Steelworkers*, 809 F Supp at 9.

Several courts have discussed whether the payments are "wages" under unemployment compensation laws, which often define the term in a similar fashion to workers' compensation laws. Most courts hold that WARN payments are not wages for unemployment compensation purposes. **"[M]erely because wage amounts form the basis for the formula by which to calculate the WARN payments, those payments are not lost wages; they are damages owed for violation of WARN's notice requirements."** *Georgia-Pacific v. Unemp. Comp. Bd.*, 630 A2d 948, 957 (Pa Cmwlth 1993) (boldface in original). As that court emphasized earlier in its opinion,

> "The WARN payment is not intended as a means of replacing lost wages; rather, it is 'to provide an incentive and a mechanism for employers to satisfy their obligations to their employees in the event they fail to provide 60 days advance notice [of plant closure] to their employees.' " 630 A2d at 956, *quoting* HR Rep No 576, 100th Cong, 2nd Sess at 1053 (1988), *reprinted in* 1988 US Code Cong & Admin News 2078,2086.

Thus, "WARN payments are in the nature of compensatory * * * damages." 630 A2d at 956 n 16. Because WARN payments are damages rather than recompense for services actually rendered, they are not wages and do not disqualify an employee from receiving unemployment compensation. **<147 Or App 87/88>** 630 A2d at 959. *See also Capitol Castings v. Dept. of Economic Sec.*, 171 Ariz 57, 828 P2d 781 (App 1992); *Westinghouse v. Callahan*, 105 Md App 25, 658 A2d 1112 (1995).[6]

No Oregon court has discussed the status of WARN payments in any context. However, in *Employment Div. v. Ring*, 104 Or App 713, 803 P2d 766 (1990), *rev den* 311 Or 432 (1991), we considered a related issue concerning what constitutes "wages" for the purposes of unemployment compensation.

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[4] As Stone points out, bankruptcy courts have treated WARN back pay liability as wages for the purposes of determining priorities under the Bankruptcy Code. *See, e.g., In re Hanlin Group, Inc.*, 176 BR 329, 333 (Bkrtcy DNJ 1995); *In re Cargo, Inc.*, 138 BR 923 (Bkrtcy ND Iowa 1992). They do so by treating the payments as severance pay, which the Bankruptcy Code includes in its definition of priority wages. *See* 11 USC § 507(a)(3). In both of these cases, the amounts in issue were the back pay damages created in 29 USC § 2104(a)(1); the employer had made no payments that could constitute credits against those damages under 29 USC § 2104(a)(2). The meaning of "wages" under WARN, thus, was not at issue.

[5] The conclusion that the payments were not wages under WARN resources Stone's argument that the reference in 29 USC § 2104(a)(2) to "any wages" preempts any state definition of "wages" for other purposes. Federal law does not purport to deal with the issue that we must decide under state law.

[6] One state holds, to the contrary, that WARN payments are wages because they are compensation for past services and, therefore, disqualify an employee from unemployment compensation. *Division of Emp. Sec. v. Labor & Indus.*, 884 SW2 399 (Mo App 1994); *LIRC v. Division of Employment Security*, 856 SW2 376 (Mo App 1993). These cases do not sufficiently consider that WARN payments are Congressionally imposed damages, not contractual compensation for services, past or present.

The question in *Ring* was whether an employee was required to repay unemployment compensation benefits after she recovered back pay damages attributable to the weeks during which she received benefits. We noted that the applicable law defined wages as "remuneration for employment" and that it defined employment as "service for an employer, * * * performed for remuneration or under any contract of hire * * *." We concluded from those definitions that "one does not receive 'remuneration' unless one actually performs a *service*." 104 Or App at 715-16 (emphasis in original). Because the claimant did not perform services during the weeks for which she received back pay damages, the payments were not wages. Therefore, she did not have to repay the unemployment compensation benefits. In reaching this conclusion we held that an Employment Division rule that called for a different result was invalid because it conflicted with the statute.

The issues in *Ring* are close to the issues in this case. Under the applicable rule, Stone could avoid making temporary disability payments to claimant only if his job was "available" during the period after Stone terminated his employment. Stone's argument that the job was "available" depends on its assertion that the payments that he received were "wages." However, the Workers' Compensation Law defines "wages" as the rate at which "service rendered" is "recompensed under the contract of hire." ORS 656.005(29). **<147 Or App 88/89>** That is essentially identical to the definitions that we considered in *Ring*. Thus, as with *Ring*, there are no wages unless the employee renders services. Claimant's job was not "available"; he provided no services for Stone during or attributable to the period that he received WARN payments. Those payments are not attributable to any period for which he did provide services.

Thus, even accepting Stone's premise that claimant's job was "available" if the payments were "wages," its argument fails. The WARN payments were damages for Stone's failure to give the notice of plant closure that the Act required. Although the WARN payments resulted from claimant's prior employment, they were not contractual compensation for his services. Under the reasoning of *Ring*, they were not wages for purposes of the Workers' Compensation Law and do not affect his right to temporary disability payments. Claimant was otherwise eligible for temporary disability payments, and the Board correctly ordered Stone to pay them.[7]

Affirmed.

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[7] Stone suggests that this result may be a windfall to claimant. As claimant and the Board point out, however, noninjured workers were able to obtain alternative employment without affecting their WARN payments. Claimant, because of his compensable injury, was limited in the employment that he could perform and the amount that he could earn. Temporary disability payments, thus, would simply place him in the same position that noninjured workers already occupied. That is not a windfall.

Cite as 147 Or App 157 (1997) March 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ricky L. Robinson, Claimant.
Ricky L. ROBINSON, *Petitioner*,
v.
SAIF CORPORATION and Parsons Pine Products, *Respondents*.
(95-06096; CA A92231)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 20, 1996.
Bruce D. Smith argued the cause and filed the brief for petitioner.
Steve Cotton argued the cause and filed the brief for respondents.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Affirmed.

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147 Or App 159> Claimant seeks review of an order of the Worker's Compensation Board upholding SAIF's denial of his claim for compensation for a hernia. We review for substantial evidence, ORS 183.482(7) and (8); ORS 656.298(6), and affirm.

Claimant began working for employer in September 1984. In April 1995, he was lifting two stacks of boards down from a shelf when he felt an immediate sharp pain in his left side. After a brief rest, he returned to work and felt a burning sensation in his left groin. However, claimant continued to work for several days until he had to leave work because of groin pain. He then sought medical treatment and was referred to Dr. Scharpf who diagnosed a symptomatic left inguinal hernia, an occult[1] right inguinal hernia, and an asymptomatic epigastric hernia. Scharpf performed surgery to repair both inguinal hernias.

Claimant asserted a claim for the inguinal hernias. SAIF, on behalf of employer, denied compensability, and claimant requested a hearing. At the hearing, claimant conceded that he had not established the compensability of the right inguinal hernia and sought compensation only for the left inguinal hernia. The administrative law judge (ALJ) upheld SAIF's denial of the left inguinal hernia, finding that claimant had a preexisting condition and that he had failed to prove that his work injury was the major contributing cause for his condition or need for treatment. The Board adopted the ALJ's findings of fact and upheld the denial on essentially the same grounds.

Claimant first argues that substantial evidence does not support the Board's finding that he had a preexisting left inguinal hernia condition. Consequently, the Board erred in applying the major contributing cause standard under ORS 656.005(7)(a)(B), rather than the material cause standard usually applied to injuries.

Scharpf, claimant's treating physician, provided the only medical expert opinion. He stated that, based on the fact **<147 Or App 159/160>** that claimant had bilateral inguinal hernias, his condition "was probably there for some time, but didn't become symptomatic until recently." The presence of bilateral hernias also suggested a preexisting congenital groin weakness. He later stated that claimant probably had a predisposition for hernias and that claimant "had some weakness in the groin area and possibly and probably some--the beginning of a hernia forming in his groin area on both sides." Although Scharpf could not say "for sure" that claimant had a preexisting condition, the Board concluded that, based on the record as a whole, the preponderance of evidence[2] showed that claimant had a preexisting left inguinal hernia condition.

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[1] Here, "occult" refers to something that is hidden or concealed. *Stedman's Medical Dictionary* 972 (illus 23rd ed 1976).

[2] ORS 656.266 provides that "[t]he burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability" is on the worker. The question of which party bears the burden of proving a preexisting condition was not raised by either party or the Board. Because the Board found that a preponderance of evidence showed a preexisting condition, we do not need to address that issue.

ORS 656.005(24) defines a preexisting condition as

> "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to a disability or need for treatment and that precedes the onset of an initial claim for an injury[.]"

Claimant insists that "Dr. Scharpf's statements on [claimant's preexisting condition] are equivocal, basically amounting to speculation; and, in any event, there is no objective evidence of a preexisting condition." We disagree. Although Scharpf could not say for certain that claimant had a preexisting condition, medical certainty is not required. Instead, a preponderance of evidence may be shown by medical probability. *Gormley v. SAIF*, 52 Or App 1055, 1060, 630 P2d 407 (1981). Here, Scharpf was able to state that claimant probably had a predisposition to developing hernias and probably had the beginning of hernias on both sides. That is sufficient to make it more likely than not that claimant had a preexisting condition. Further, Scharpf's opinion was based on his observation of bilateral hernias and thus is supported by objective findings. *See* ORS 656.005(19). Finally, even though some of the doctor's statements could be considered equivocal, the Board was entitled to consider Scharpf's statements **<147 Or App 160/161>** in the context of the whole record. That record supports the Board's finding.

Claimant next argues that, even if the Board was correct in finding that he had a preexisting condition, it erred in finding that he failed to establish that his work injury was the major contributing cause of his left inguinal hernia. 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."[3]

The Board summarized Scharpf's testimony regarding the major cause of claimant's hernia as follows:

> "Dr. Scharpf initially said that it was impossible to identify the cause of claimant's hernia. In deposition, Scharpf concluded that claimant's work injury was 'the cause that brought him to [Scharpf's] office.' Scharpf then said that he could not 'say what the major cause of [claimant's] groin weakness and hernia formation would be.' Thereafter, however, Dr. Scharpf agreed that the major cause of 'the symptoms and the problems' was claimant's work activity." (References to exhibits omitted; brackets in original.)

Two of the three Board members then concluded:

> "Taken together, Dr. Scharpf's opinions fail to establish a compensable claim under amended ORS 656.005(7)(a)(B). At most, his opinions establish that claimant's work injury was the precipitating cause of his left inguinal hernia. * * * We agree with the ALJ that, as a whole, Dr. Scharpf's opinions fail to establish that claimant's work injury was the major contributing cause of his left inguinal hernia."[4]

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[3] ORS 656.005(7)(a)(B) was amended by Oregon Laws 1995, chapter 332, section 1. Although claimant's injury occurred before the effective date of the 1995 act (June 7, 1995), his claim had no final decision as of that date, and the amended version of the statute applies. Or Laws 1995, ch 332, § 66; *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

[4] One Board member dissented. That member would have found that Scharpf's opinion that claimant's work activity was the major cause of his "symptoms" and "problems" was sufficient to establish that his work injury was also the major contributing cause of his hernia.

147 Or App 162> Claimant argues that the Board erred because it disregarded the language in the statute that provides that an injury that combines with a preexisting condition is compensable if it is the "major contributing cause for claimant's *need for treatment* of the 'combined' (symptomatic hernia) condition." (Emphasis supplied.) He also contends that "undisputed medical evidence proves that the major contributing cause of the need for surgical repair of claimant's left-sided hernia was the work activity."

Although the Board recited the provisions of ORS 656.005(7)(a)(B) early in its order, its ultimate conclusion was not expressed using the exact terms of the statute. The Board did not specifically address the major contributing cause of either "the disability of the combined condition" or "the need for treatment of the combined condition." Instead, it focused on the major cause of the combined condition itself, the symptomatic left inguinal hernia. Claimant does not explain why the major contributing cause of the need for treatment in this case should be different from the major cause of the hernia itself. Although 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.

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. The fact that a work injury caused or precipitated a claimant's condition does not necessarily mean that that injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401, 882 P2d 618 (1994), *rev dismissed* 321 Or 416 (1995). Instead, "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." *Id.* (emphasis in original). Also, 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.[5]

147 Or App 163> Here, Scharpf could not say what was the major cause of claimant's hernia. He was only able to agree that claimant's work activity was the major cause of claimant's "symptoms and problems," that it was what brought him to Scharpf's office, and that it was the major cause of claimant going from an asymptomatic state to a one that was symptomatic. That testimony shows that claimant's work injury precipitated his need for treatment. However, it does not ineluctably establish that claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment of his combined condition. The Board did not err in finding that claimant failed to meet his burden of proof.

Affirmed.

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[5] Before the amendments by Oregon Laws 1995, chapter 332, section 1, ORS 656.005(7)(a)(B) read:

"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."

Cite as 147 Or App 164 (1997) March 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Larry J. DAVIS, *Appellant,*
v.
UNITED STATES EMPLOYERS COUNCIL, INC.,
dba Sharp Management Services, Barbara Sharp, *Defendants,*
and LANPHERE ENTERPRISES, INC., dba Beaverton Honda, *Respondent.*
(9304-02342; CA A85584)

Appeal from Circuit Court, Multnomah County.
Joseph F. Ceniceros, Judge.
Argued and submitted September 25, 1996.
James S. Coon argued the cause for appellant. With him on the briefs was Swanson, Thomas & Coon.
Stephen P. Rickles argued the cause for respondent. With him on the brief was Holmes & Rickles.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Affirmed.
Deits, P. J., dissenting.

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147 Or App 166> Plaintiff appeals from an adverse judgment, which was entered after allowance of an involuntary dismissal, in an action for workplace personal injury. The trial court concluded that the exclusive remedy provision of the workers' compensation law, ORS 656.018, barred plaintiff's claim, because plaintiff's proof was legally insufficient to establish that that his injury resulted "from the deliberate intention of the employer * * * to produce such injury." ORS 656.156(2).

The trial court granted the defendant[1] employer's motion for involuntary dismissal based on its assessment of plaintiffs proof after plaintiff's opening statement. *See Sadler v. Sisters of Charity,* 247 Or 50, 426 P2d 747 (1967) (describing procedure). We review that ruling as we would the granting of a directed verdict for defendant and, thus, view the evidence described in plaintiffs opening statement and all reasonable collateral inferences in the light most favorable to plaintiff. *See Palmer v. Murdock et al,* 233 Or 334, 343, 378 P2d 271 (1963). So viewed, the record discloses the following material facts:

From 1982 until 1991, plaintiff worked as an automobile painter in defendant's Beaverton Honda body shop. Over that time, plaintiff was regularly exposed to excessive levels of toxic paint fumes and, as a result, suffered regular and increasingly severe symptoms of a respiratory nature, headaches, eye irritation, lightheartedness, and memory loss. Other workers in the body shop experienced similar problems. Plaintiff and his coworkers repeatedly complained to defendant's management about the paint fumes, the lack of adequate ventilation, and their symptoms.

Defendant knew that the conditions in the body shop were hazardous and that its employees, including plaintiff, were being injured because of those conditions. Defendant's choice as to the physical layout and surrounding areas, types of paint and painting methods used, and the inadequacy or **<147 Or App 166/167>** absence of protective equipment and other safeguards materially contributed to the neurological problems plaintiff experienced. Although defendant undertook some remedial measures, it refused to undertake others, including providing enclosed spray paint booths and air-supplied respirators. Defendant knew that its remedial methods were inadequate and, in at least some respects, did not satisfy regulatory requirements. Indeed, on at least two occasions, defendant's managers lied and actively concealed safety/ventilation violations from occupational safety inspectors.

Defendant's sole reason for refusing to undertake adequate safety measures was to save money.

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[1] "Defendant," as used in this opinion, refers exclusively to plaintiff's employer, defendant Lanphere Enterprises, Inc.

Plaintiff's symptoms became increasingly severe but were transient and did not completely incapacitate him until June 4, 1991, when, as a result of an accident, he was suddenly exposed to extreme levels of toxic fumes. On June 11, 1991, plaintiff consulted his physician, who, in turn, referred him to an occupational medical specialist. On July 20, that specialist diagnosed plaintiff as having chronic toxic encephalopathy, with organic brain damage. Plaintiffs condition was caused by excessive exposure to toxic paint fumes.

On April 12, 1993, plaintiff brought this action, alleging that defendant acted with deliberate intention to produce injury to plaintiff in that it refused to provide adequate safety equipment and to undertake other remedial measures, notwithstanding its knowledge that plaintiff and others were suffering substantial ongoing harm as a result of excessive exposure to toxic fumes. Plaintiff alleged, *inter alia,* that the exposure for the entire period of his employment, from 1982 onward, constituted a "continuing tort."

Thereafter, defendant moved for summary judgment, arguing that plaintiff's claim was time barred under the general two-year statute of limitations for personal injury actions. ORS 12.110(1). The trial court allowed partial summary judgment, holding that plaintiff could not recover for defendant's conduct before April 12, 1991 (more than two years before the filing of the action) but that the statute of limitations did not bar claimant's claims to the extent they were based on the employer's conduct after April 12, 1991.

147 Or App 168> The parties proceeded to trial on that aspect of plaintiff's claims pertaining to conduct after April 12, 1991. Employing the procedure described in *Sadler,* plaintiff submitted a written opening statement, detailing his proof of defendant's alleged "deliberate intention" to produce the injury, which would avoid workers' compensation exclusivity. *See* ORS 656.156(2). Defendant moved for an involuntary nonsuit, asserting that plaintiff's proof was legally insufficient to establish the requisite "deliberate intention." The trial court agreed and entered judgment for defendant.

On appeal, plaintiff raises two assignments of error. First, the trial court erred in concluding that plaintiff's proof was legally insufficient to establish "deliberate intention * * * to produce such injury," within the meaning of ORS 656.156(2). Second, the trial court erred in applying the two-year statute of limitations, ORS 12.110(1), to bar plaintiff from recovering for employer's conduct before April 12, 1991. The first assignment of error is, potentially, completely dispositive. That is, if we agree with the trial court that plaintiff cannot demonstrate "deliberate intention," his claims against the defendant employer are barred by workers' compensation exclusivity, regardless of the statute of limitations.[2]

We conclude, as amplified below, that plaintiff's proof of "deliberate intention" was legally insufficient. *See Kilminster v. Day Management Corp.,* 323 Or 618, 919 P2d 474 (1996); *Lusk v. Monaco Motor Homes,* Inc., 97 Or App 182, 775 P2d 891 (1989). Thus, ORS 656.018 bars plaintiff's claims against his employer.

ORS 656.018 provides, in part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the **<147 Or App 168/169>** course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter."

ORS 656.156(2) embodies an exception to that exclusivity provision:

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[2] Plaintiff's proffered proof pertaining to defendant's "deliberate intention" encompassed the entire period of his employment, from 1982 to 1991. Thus, if that proof was insufficient to establish "deliberate intention" for any period of plaintiff's employment, the statute of limitations becomes immaterial.

> *"If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death,* the worker, the widow, widower, child or dependent of the worker may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes." (Emphasis supplied.)

Plaintiff argues that, because defendant knew that plaintiff and other employees were being harmed, and would continue to be harmed, by its refusal to implement adequate safety measures, that profit-driven refusal evinced "deliberate intention":

> "[I]t makes no difference that defendant's primary motive was to make more money. Where defendant harms plaintiff as a necessary means to the motivating end, the law holds defendant to intend the harm to plaintiff."

Defendant counters that, to prove "deliberate intention," plaintiff must show that defendant "wished" to injure plaintiff. Defendant further asserts that plaintiff's opening statement identified no proof of such a "wish" or "desire" to injure. We agree.

Assuming the truth of plaintiff's evidence, as outlined in his opening statement, plaintiff could prove that: (1) Defendant knew that plaintiff and other employees were suffering severe respiratory symptoms because of their exposure to paint fumes. (2) Defendant further knew that, unless it provided better safety equipment, plaintiff or some other similarly situated employee was certain to suffer severe **<147 Or App 169/170>** injury. (3) Notwithstanding that certainty of injury, defendant did not provide better protective equipment or undertake other related safety measures. (4) Defendant did not provide the necessary equipment and chose, instead, to expose its employees to the certainty of serious injury, *because it wanted to save money.*

The last point bears reiteration because it is the *sine qua non* of the analysis that follows: Plaintiff acknowledges that the defendant employer, at worst, acted from a desire to save money and not from an affirmative desire to injure plaintiff or his coworkers. At oral argument, plaintiff's counsel was explicit in that regard:

> "I do want to make clear this concession. I will tell you that we cannot prove, * * * we will not be able to prove that they hated Larry Davis and that their motive was to hurt him. We are not hoping for a decision that says, well, 'you knew that it would [hurt him] so it's possible to infer' * * *. We're not able to prove that so it would waste everybody's time to find that there wasn't a concession [that defendant had no desire to hurt plaintiff]."[3]

That acknowledgment--that plaintiff cannot prove that his employer withheld safety equipment because it wished to injure him--precludes plaintiff's tort claims. *See Kilminster; Lusk.*

In *Lusk,* we considered whether workers' compensation exclusivity barred a claim arising from circumstances similar to those presented here. There, the plaintiff was employed as a painter for the defendant mobile-home construction company. The plaintiff worked in a painting booth without adequate ventilation and was exposed to paint vapors that can cause respiratory problems. The plaintiff began to suffer headaches, nausea, irritability, and memory loss. He complained to his supervisor, who, in turn, asked defendant to furnish the painters with supplied-air respirators. The defendant refused to buy the respirators because it did not wish to spend the necessary $2,000 per unit. The **<147 Or App 170/171>** plaintiff became permanently disabled as a result of the paint-vapor exposure.

The plaintiff subsequently brought a personal injury action against his employer, alleging that the defendant had deliberately intended to injure him. The defendant moved for summary judgment, asserting that the plaintiff's action was barred by workers' compensation exclusivity. The plaintiff contested summary judgment, asserting, *inter alia,* that there was, at least, a factual issue as to whether the defendant acted with a "deliberate intention" to produce plaintiff's injury. ORS 656.156(2). The trial court concluded that there was no evidence from which a jury could infer the requisite "deliberate intention" and granted summary judgment.

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[3] Plaintiff echoes that acknowledgment in his brief: "[D]efendant Lanphere had no desire to injure plaintiff or his co-workers; his desire was to make more money."

On appeal, the plaintiff argued that

> "a jury could find that defendant knew that the paint fumes were injuring him and that it made a conscious decision to continue to expose him to the hazard with that knowledge [and that] from those facts * * * a jury could infer that defendant deliberately intended to injure him." 97 Or App at 186.

In so arguing, the plaintiff referred to the presumption in OEC 311(1)(a) that a "person intends the ordinary consequences of a voluntary act." He also invoked *Restatement (Second) of Torts,* section 8A, which defines "intention" as "desir[ing] to cause [the] consequences of [one's] act, or * * * believ[ing] that the consequences are substantially certain to result from it."[4] Thus, the plaintiff in *Lusk* "assume[d] that the statutory phrase 'deliberate intention * * * to produce such injury' establishes the same standard as does the term 'intent' in the common law of intentional torts." 97 Or App at 186.

We rejected that argument, holding that the test of "deliberate intention" in ORS 656.156(2) was distinct from concepts of "intentionality" expressed in either OEC 311(1)(a) or the *Restatement:*

> **147 Or App 172>** "If [plaintiff] were correct, we would have no difficulty in holding that he has shown enough to defeat defendant's motion for summary judgment. However, plaintiff wrongly interprets the statutory standard.
>
> "* * * * *
>
> "* * * The statutory exemption applies only if the injury results 'from the deliberate intention of the employer of the worker to produce such injury * * *.' That phrase requires, *in addition to the intent that will normally suffice to prove an intentional tort,* that the injury be 'deliberate,' in the sense that the employer has had an opportunity to weigh the consequences and to make a conscious choice among possible courses of action, *and also that the employer specifically intends 'to produce * * * injury' to someone, although not necessarily to the particular employe who was injured.* An employe does not satisfy those requirements by showing that the employer refused to provide safety equipment, even if injury is the necessary result of that failure. *It is not enough for the employer to act with conscious indifference* to whether its actions will produce injury; it must intend to produce injury." *Id.* at 186-88 (emphasis supplied; original emphasis deleted).

Thus, under *Lusk,* a plaintiff who relies on ORS 656.156(2) to avoid the workers' compensation exclusivity bar of ORS 656.018 must prove both that the employer acted deliberately and that the employer acted with a specific intent to produce injury to the plaintiff or someone similarly situated. In so holding, the *Lusk* majority explicitly disapproved the analysis expressed in a special concurrence. *See* 97 Or App at 190 (Riggs, J., specially concurring). The special concurrence asserted that requiring proof of both "deliberation" and "specific intent" to produce injury was erroneous and, indeed, "disingenuous":

> "Plaintiff alleges that defendant was aware of the consequences of its actions, was aware of the existence of alternative courses of action and deliberately chose to inflict injury on plaintiff rather than adopt a different course. Neither statute nor policy requires that an employer be provided with an exemption from tort liability for having made such a choice." *Id.* (citations omitted).

The majority rejected that approach:

> **147 Or App 173>** "The special concurrence focuses on the 'certainty' of injury, that is, **whether** the employe will be hurt, rather than on the intent behind the injury, that is, **why** the employe will be hurt. An injury can result 'certainly' from negligence or conscious indifference and thus not meet the statutory standard. Conversely, an employer can have the specific intent to produce an injury that was not 'certain'to result from its acts, as in *Weis v. Allen*[, 147 Or 670, 35 P2d 478 (1934)]. The special concurrence would read the word 'deliberate' out of the statute. *Moreover, it fails to address the other (and, in this case, more difficult) requirement of the statute: the specific intent 'to produce [the] injury.'* " 97 Or App at 188 n 4 (original emphasis in boldface; other emphasis supplied).

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[4] Plaintiff here similarly invokes *Restatement* section 8A as support for his argument that defendant's actions demonstrated "intent" to injure.

We then proceeded to assess the sufficiency of the plaintiff's proof with respect to the two conjunctive requirements. The "deliberate" quality of the employer's conduct was straight-forward:

> "A jury could find that defendant knew that plaintiff was suffering injury from the paint, knew that he would continue to do so as long as he worked without a supplied-air respirator and, after deliberation, consciously decided not to provide such a respirator. It could, therefore, find that I defendant's acts were 'deliberate.' " *Id.* at 188.

Finally, we addressed "the more difficult question" of whether the defendant specifically intended to produce an injury:

> *"The affidavits suggest that defendant failed to provide the respirator because of the cost. Such a reason, while perhaps not laudable, is not a specific intent to produce an injury.* However, the trial court on summary judgment, like a jury, need not accept defendant's proffered reason in isolation. Specific intent to injure may be inferred from the circumstances.
>
> "Here, a jury could infer, from all of the circumstances, that defendant failed to provide the respirator **because** *it wished to injure plaintiff.* Defendant knew that the paint was highly toxic and that plaintiff's resulting injury was substantial and continuing; it did not follow the warnings of the paint manufacturer and the urging of its insurer to furnish a supplied-air respirator; plaintiff and his supervisor had complained about the problem repeatedly; and the cost **<147 Or App 173/174>** of proper, available equipment (which defendant knew would soon be required by the state) was not prohibitive. 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 (original emphasis in boldface; other emphasis supplied).

Thus, because there was a triable issue of fact in *Lusk* as to whether the employer specifically intended to produce the injury, we reversed and remanded for trial.

Lusk yields three pertinent principles: *First,* to prove "deliberate intention" within the meaning of ORS 656.156(2), a plaintiff must prove that a defendant employer acted as it did "**because** *it wished to injure* plaintiff." 97 Or App at 189 (original emphasis in boldface; other emphasis supplied).

Second, where an employer fails to undertake safety measures solely because of cost, that failure, even when the employer knows injury is certain to occur, is not actionable under ORS 656.156(2). "Such a reason, while perhaps not laudable, is not a specific intent to produce an injury." *Id.* at 189.

Third, where a plaintiff proves that a defendant employer deliberately failed to undertake safety measures knowing that injury was certain to result, that failure may, but need not, support an inference that the employer specifically intended to produce an injury. That is, even if a plaintiff proves deliberation and certainty of injury, the jury can, nevertheless, return a defense verdict because the requisite specific intent is only one of several permissible inferences the jury can draw. *Id.*

Under principles of *stare decisis, Lusk* controls unless intervening changes in the law, including decisions of the Supreme Court, repudiate or substantially call into question our analysis and holding. *Kilminster* was decided after *Lusk.* However, nothing in *Kilminster* alters our fidelity to *Lusk.*

In *Kilminster,* the court, after addressing the identical authority we discussed in *Lusk,*[5] endorsed and reiterated **<147 Or App 174/175>** *Lusk*'s operative principle: To invoke ORS 656.156(2), a plaintiff must prove that a defendant employer acted as it did "because it *wished* to injure or kill" the plaintiff. *Kilminster,* 323 Or at 633 (emphasis supplied).

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[5] *See, e.g., Duk Hwan Chung v. Fred Meyer, Inc.,* 276 Or 809, 556 P2d 683 (1976); *Bakker v. Bazar, Inc.,* 275 Or 245, 551 P2d 1269 (1976); *Caline v. Maede,* 239 Or 239, 396 P2d 694 (1964); *Weis v. Allen,* 147 Or 670, 35 P2d 478 (1934); *Heikkila v. Ewen Transfer Co.,* 135 Or 631, 297 P 373 (1931); *Jenkins v. Carman Mfg. Co.,* 79 Or 448, 155 P 703 (1916).

The circumstances in *Kilminster* closely parallel those in *Lusk*. The plaintiffs alleged that: (1) The decedent employee had frequently complained to the defendant employer about unsafe conditions and, particularly, the lack of safety equipment, in climbing a radio tower; (2) the defendant deliberately refused to undertake necessary safety measures, including providing legally required safety equipment; (3) the defendant knew that if it did not undertake the requisite safety measures, a worker would fall and suffer serious injury or death; and (4) the defendant ordered the decedent to climb the tower or lose his job. 323 Or at 621-22. Thus, in *Kilminster*, as in *Lusk*, the plaintiffs alleged that the employer deliberately refused to undertake safety measures notwithstanding the certainty of serious injury or death.

Although *Kilminster* does not cite *Lusk*, substantial portions of *Kilminster* reproduce *Lusk*'s analysis verbatim, or virtually so. *Compare, e.g., Kilminster*, 323 Or at 629-32 *with Lusk*, 97 Or App at 186-88. In particular, in *Kilminster*, as in *Lusk*, the court held that, to prove "deliberate intent," a plaintiff must show that the employer "wished to injure or kill" the employee and that, even if a plaintiff proves that the defendant employer acted deliberately, knowing that injury was certain to result, the jury need not infer "deliberate intention":

> "Reading all the allegations together, in the light most favorable to plaintiff, a finder of fact reasonably could infer that DMC determined to injure an employee, that is, specifically intended 'to produce [decedent's] injury or death.' The *underlying facts pleaded by plaintiff do not describe when or how DMC determined to injure decedent. However, a specific intent, to produce an injury* **may** be inferred from the circumstances. Taking all the allegations of the second claim **<147 Or App 175/176>** together, plaintiff alleges more than gross negligence, carelessness, recklessness or conscious indifference to a substantial risk of injury. Plaintiff alleges that serious injury to or death of a worker was certain to occur, that DMC failed to take requisite safety precautions or buy requisite safety equipment, and that DMC instructed decedent to climb the tower while knowing that a worker who climbed the tower would fall and be hurt. *A reasonable finder of fact* **could** infer that DMC acted as it did because it wished to injure or kill decedent. A specific intent to injure or kill decedent certainly is not the only state of mind that could be inferred, but it is a permissible inference. We need not consider whether plaintiff can prove that defendants had the alleged specific intent to injure or kill decedent; in the procedural posture of this case, we consider only the sufficiency of the complaint." 323 Or at 632-33 (emphasis and boldface supplied; emphasis in original deleted; citation omitted).

Kilminster's use of the same "wish to injure" formulation announced in *Lusk* was not casual or accidental. The use of identical language, assessing the application of ORS 656.156(2) to closely analogous circumstances, can only be regarded as deliberate.

The necessary consequence of the *Kilminster/Lusk* formulation is that, where a plaintiff acknowledges that he or she cannot prove that a defendant employer "wished to injure" the employee or someone similarly situated, ORS 656.156(2) is not available and the plaintiff's claim is barred as a matter of law by ORS 656.018. That is so, regardless of whether the employer acted in a calculated fashion to maximize its profits in utter disregard of the certainty of injury to its employees.

The dissent asserts that *Kilminster* does not mean what it says--and contends, particularly, that *Kilminster* is more restrictive than *Lusk*. Significantly, the dissent does not argue that *Lusk* was wrongly decided. In particular, it does not contend that Lusk misconstrued or misapplied Supreme Court authority--the same authority that underlies *Kilminster*. Rather, the dissent asserts that *Kilminster* represented not only a repudiation of *Lusk*, but also, implicitly, a retrenchment from the 80-plus years of Supreme Court **<147 Or App 176/177>** precedent on which *Lusk* relied.[6] In the dissent's view, the Supreme Court achieved that repudiation *sub silentio* through the curious--indeed, ironic--device of employing the same formulation *Lusk* announced.[7]

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[6] *See* note 5 above.

[7] We note, parenthetically, that Judge Graber wrote both *Lusk* and *Kilminster*.

The dissent's criticism flows from a false first premise, *i.e.*, that the facts alleged in *Kilminster*, if proved, would conclusively establish the defendant employer's "deliberate intention" to injure the decedent. *Kilminster* does not so hold. Rather, the court held that, if proved, the facts alleged by plaintiffs were sufficient to *permit* a jury to infer the necessary, actionable state of mind:

> "A reasonable finder of fact *could* infer that DMC acted as it did because it wished to injure or kill decedent. A specific intent to injure or kill decedent certainly is not the only state of mind that could be inferred, but it is a permissible inference. We need not consider whether plaintiff can prove that defendants had the alleged specific intent to injure or kill decedent; in the procedural posture of this case, we consider only the sufficiency of the complaint." 323 Or at 633 (emphasis supplied; emphasis in original deleted).

Thus, the court did not hold that the plaintiffs' allegations, if proved, compelled a finding of liability. That is, the *Kilminster* court understood and expressly acknowledged that, even if the plaintiffs were able to prove that the employer deliberately withheld safety measures despite the certainty of injury, those facts would not automatically establish "deliberate intention," because the requisite "wish to injure" was just one of a range of mental states the jury could infer from those facts. Among the range of other reasonably inferable, but nonactionable, mental states, is that the employer acted as it did not because it wished to injure the defendant but merely because it wanted to save money.

In *Kilminster*, as in *Lusk*--and in this case--the "wish to injure" is the *sine qua non* of "deliberate intention." We agree with the dissent that this case and *Kilminster* (and *Lusk*) are legally indistinguishable. *See* 147 Or App at 180. **147 Or App 178>** The conclusive point, however, is that this case is *factually* distinguishable from the other two. Only in this case has plaintiff stipulated that he cannot prove what he must prove, that his employer withheld safety measures because it wished to injure him. But for that admission, this case would be materially indistinguishable from *Lusk* and *Kilminster* and remand would be required.

Finally, the dissent erects, and pummels, a straw man:[8]

> "If the majority correctly reads that statement in *Lusk* to mean that an employer's conduct that is motivated by cost savings or other financial motives cannot also and simultaneously entail a specific intent to injure, then in my view, *Lusk* is wrong and is inconsistent with *Kilminster*. * * * I note that the majority's proposition would make proof of intent difficult or impossible in cases of murder for hire." 147 Or App at 182-83.

Nothing in this opinion or, indeed, in *Lusk* or *Kilminster* sanctions such a result. Indeed, they state the opposite. Clearly, a profit motive and a wish to injure can coexist--the two are not necessarily mutually exclusive--and, if they do, ORS 656.156 applies.

We fully appreciate that, in some cases, the "wish to injure" formulation may produce seemingly cold-blooded results. Nevertheless, that formulation is the product of the statute's language and of over 90 years of case law, including, most recently, *Kilminster* and *Lusk*. The choice of whether such calculated conduct should be shielded from the full force of tort law is ultimately a matter of policy.[9] Statutory amendment is committed to the legislature, not to this court.

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[8] Or, in the dissent's preferred metaphor, a "dead horse."

[9] *See, e.g.*, Guido Calabresi, *The Decision for Accidents: An Approach to Nonfault Allocation of Costs*, 78 Harv L Rev 713, 716 (1965):

> "Our society is not committed to preserving life at any cost. In its broadest sense, this rather unpleasant notion should be obvious. * * * But what is more interesting to the study of accident law, though perhaps equally obvious, is that lives are used up when the *quid pro quo* is not some great moral principle but 'convenience.' Ventures are undertaken that, statistically at least, are certain to cost lives. Thus, we build a tunnel under Mont Blanc because it is essential to the Common Market and cuts down the traveling time from Rome to Paris, though we know that about a man per kilometer of tunnel will die. We take planes and cars rather than safer, slower means of travel. And perhaps most telling, we use relatively safe equipment rather than the safest imaginable because--and it is not a bad reason--the safest costs too much."

In all events, the availability of tort remedies is not the exclusive mechanism for regulating and deterring employer conduct that deliberately sacrifices employee health in order to maximize profits. Such conduct may also be subject to criminal sanctions, *see, e.g.*, ORS 163.118 (manslaughter in the first degree); ORS 163.175 (assault in the second degree); ORS 163.195 (recklessly endangering another person), and administrative/occupational safety penalties. *See* ORS 654.001 *et seq* (the Oregon Safe Employment Act, which provides civil penalties for workplace safety violations).

147 Or App 179> 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.

Affirmed.

DEITS, P. J., dissenting.

In this case, as in *Kilminster v. Day Management Corp.*, 323 Or 618, 919 P2d 474 (1996), the plaintiffs' proffered allegations or evidence, if proven, would permit findings that the defendant employers created unduly dangerous work conditions or instrumentalities, failed to take available or required safety or curative measures, and compelled the injured employees and similarly situated persons to work under the conditions despite the employers' knowledge that injury or death was certain to result.

The Supreme Court held in *Kilminster* that those asserted facts gave rise to a permissible inference that the employer acted with a deliberate intention to injure and, therefore, gave rise to an actionable tort claim under ORS 656.156(2). After an exhaustive analysis of its earlier decisions construing and applying that statute, the court stated:

> "The meaning of the provision at issue in this case is clear from this court's prior interpretations. In order for a worker to show that an injury that occurred during the course and scope of the worker's employment 'result[ed] * * * from the deliberate intention of the employer * * * to produce' that injury, the worker must show that the employer determined to injure an employee, that is, had a specific intent to injure an employee; that the employer **<147 Or App 179/180>** acted on that intent; and that the worker was, in fact, injured as a result of the employer's actions." *Id.* at 631.

The court then proceeded to apply that legal standard to the plaintiff's allegations in *Kilminster:*

> "In this case, plaintiff has alleged facts sufficient to meet the foregoing standard for deliberate intention to injure or kill. Plaintiff alleges that [the employer] DMC knew that decedent or someone who did the same work as decedent would be injured from a fall from the tower; that DMC decided to forego taking safety procedures, knowing that, by so doing, serious injury or death would result; and that DMC told decedent to climb the tower or lose his job.
>
> " * * * * *
>
> "Reading all the allegations together, in the light most favorable to plaintiff, a finder of fact reasonably could infer that DMC determined to injure an employee, that is, specifically intended 'to produce [decedent's] injury or death.' The underlying facts pleaded by plaintiff do not describe when or how DMC determined to injure decedent. However, a specific intent to produce an injury may be inferred from the circumstances. * * * Plaintiff alleges that serious injury to or death of a worker was *certain to occur,* that DMC failed to take requisite safety precautions or buy requisite safety equipment, and that DMC instructed decedent to climb the tower while *knowing* that a worker who climbed the tower *would* fall and be hurt. A reasonable finder of fact could infer that DMC acted as it did because it wished to injure or kill decedent. A specific intent to injure or kill decedent certainly is not the only state of mind that could be inferred, but it is a permissible inference." *Id.* at 632-33. (Emphasis in original; citation omitted.)

In my view, this case does not differ from *Kilminster* in any dispositionally significant way. The majority agrees "that this case and *Kilminster* * * * are legally indistinguishable," but asserts that the cases are "factually distinguishable" because, in this case, "plaintiff [has] stipulated that he cannot prove" that defendant acted as it did "because it wished to injure him." 147 Or App at 177-78 (emphasis in original). The majority rejects plaintiffs argument that that "stipulation" is not consequential because, plaintiff asserts, the test of liability under ORS 656.156(2) that *Kilminster* and **<147 Or App 180/181>**

earlier Supreme Court opinions establish is whether the employer "specifically intended" the employee's injury or death, not whether it had the affirmative motive to produce injury that the majority understands the word "wished" to connote. I agree with plaintiff's argument, and I do not agree that the majority succeeds in drawing a tenable distinction between this case and *Kilminster.*

Contrary to its characterization, the majority's distinction between the two cases is not a factual one but, rather, rests on its understanding that an employer's "wish" to injure or kill is the "sina qua non" of the legal standard that *Kilminster* establishes or endorses as the test for liability under ORS 656.156(2). However, as shown by the passages that I have quoted from *Kilminster,* the word "wished" appears only once in the relevant portion of the Supreme Court's opinion and appears there seemingly as a random word choice; by contrast, the phrase "specific intent," along with the phrase "determined to injure" that the court expressly treated as synonymous with "specific intent," appear repeatedly in *Kilminster* and are expressly identified by the court as defining the showing that a plaintiff must make to establish a deliberate intention to injure within the meaning of the statute. Similarly, phrases such as "specific intent" and "determined to injure" also appear repeatedly--and the word "wished" does not appear--in the Supreme Court's earlier decisions construing the statute, which it discusses and quotes at length in *Kilminster.*

The words "wish" and "intend" have many possible meanings and, under some of the definitional variations, the two words are effectively synonymous. It is apparent that the majority does not read the words in that synonymous sense, or else it could not regard the absence of a potentially provable "wish" in this case and the potential presence of one in *Kilminster* to be the sole basis for opposite results in the two cases. It is equally apparent, however, that the court in *Kilminster did* use the two words synonymously. As noted, the court's repeated references to "specific intent to injure" and its repeated quotations of the "specific intent" test from its earlier cases would, without more, make it highly improbable that the court's single use of the word "wished" was meant to establish a different legal test. That conclusion is **<147 Or App 181/182>** further supported by the fact that the quotations of the specific intent standard from the earlier cases are preceded in *Kilminster* by the court's reiteration of the principle that a "prior interpretation of a statute by [the Supreme] [C]ourt becomes part of the statute itself." *Id.* at 629. That is not a point that the court likely would have emphasized had its opinion been meant to change the basic test of actionability under ORS 656.156(2) that the earlier cases established.

The majority suggests in a different connection that this dissent "pummels a straw man." I note parenthetically that it is not always easy to tell the difference between a straw man and a dead horse. At the expense of beating one or the other, however, I think that there is a problem with the majority's analysis over and above the specifics of how it reads the language in *Kilminster*: The majority would ascribe a fundamental change in the law to the single appearance of a new word in a Supreme Court opinion that repeatedly reiterates the critical phrasing which was developed in the court's earlier cases and with which the new word can be read completely synonymously. The law is simply not as ephemeral as the majority would have it be.

Although my principal disagreement with the majority concerns our different understandings of the test of liability in *Kilminster,* a number of premises that underlie the majority's view require some discussion. First, the majority maintains that the requisite deliberate intention to injure cannot be present in situations where the employer's actions will necessarily result in a worker's injury, but where the employer acts "from a desire to save money and not from an affirmative desire to injure [the] plaintiff or his coworkers." 147 Or App at 170. The majority relies for that proposition on our statement in *Lusk v. Monaco Motor Homes, Inc.,* 97 Or App 182, 189, 775 P2d 891 (1989), that "[s]uch a reason, while perhaps not laudable, is not a specific intent to produce an injury."[1]

147 Or App 183> If the majority correctly reads that statement in *Lusk* to mean that an employer's conduct that is motivated by cost savings or other financial motives cannot also and simultaneously entail a specific intent to injure, then in my view, *Lusk* is wrong and is inconsistent with

[1] For reasons that will appear as the discussion progresses, I find it unnecessary to decide whether the majority is correct in this or anything else that it ascribes to *Lusk.* I note only that this and the other statements in *Lusk* on which the majority relies may not accord with the majority's understanding of them when the context in which they appear is considered.

Kilminster. A specific intent to injure can be inferred, even where the employer has no "affirmative desire" to injure but is instead motivated by a desire to produce profits or to achieve some other objective, if an intervening injury is a certain byproduct of the other objective's achievement. While I intend no analogy between the actors or the acts, I note that the majority's proposition would make proof of intent difficult or impossible in cases of murder for hire. It is a truism that an actor can deliberately intend more than one consequence through a single course of conduct. To say that one result is the primary objective does not mean that the other is unintended, at least as a matter of law. The majority arrives at its contrary understanding by confusing motive and intent. However, there is no such confusion in ORS 656.156(2). Nothing in the statute supports the view that the existence or inferability of a deliberate intention to injure depends on the reasons--financial or other--*why* the intention was formed.

As I have indicated, the majority bases its thesis that injurious intent cannot be subsumed within economically-motivated conduct, at least in part, on the sentence it quotes from *Lusk.* However, that is far from the only inventive use that the majority makes of *Lusk;* indeed, the majority essentially treats our 1989 decision in that case, more than the Supreme Court's 1996 *Kilminster* decision or any of its others, as the linchpin of ORS 656.156 jurisprudence. The uses that the majority makes of *Lusk* are of two kinds: first, it says that *Lusk* is controlling on us in itself unless it has been "repudiate[d] or substantially call[ed] into question" by *Kilminster* or other "intervening changes in the law," 147 Or App at 174. Second, the majority appears to regard *Kilminster* as little more than a clone of *Lusk,* because of general similarities in their facts and specific similarities in their language which, according to the majority, "can only be regarded as deliberate." 147 Or App at 176.

If *Lusk* says what the majority understands it to say, I do not agree that it remains controlling after *Kilminster.* **<147 Or App 183/184>** The central premise of the majority's reasoning and its holding is that *Lusk* and, in turn, *Kilminster* adopted an "affirmative wish" standard of liability under ORS 656.156(2). As I have discussed, *Kilminster* does no such thing but, rather, reiterates and adheres to the specific intent standard established in the Supreme Court's earlier cases. If the majority is right in regarding *Lusk* as holding otherwise, then, without more, *Kilminster* and *Lusk* are not consistent.

The same example also illustrates why the majority's reliance on certain common language and usages in the two opinions does not succeed. The fact that the word "wished" can be found in both opinions adds nothing to its clear lack of substantive weight in *Kilminster*--whatever importance we might or might not have attributed to it in *Lusk.* More generally, the majority's focus on language here is not an effective analytical tool, because isolated and random words are an empty vessel when they are emphasized at the expense of context and substance. Most of the linguistic usages or similarities that the majority finds in the two cases are anecdotal: It is by no means surprising that two opinions, which interpret the same statute and apply the same Supreme Court precedent, would use some similar language. However, the majority attempts to elevate that coincidence into substance.

The majority recognizes that "*Kilminster* does not cite *Lusk,*" but regards that fact as fully compatible with its theme that the Supreme Court's later opinion was meant to be little more than a republication of our decision in *Lusk.* With due respect, it defies belief that a judicial opinion can be understood to deliberately reiterate and, in effect, adopt the substance of another that it does not even cite.[2] The inherent improbability of that understanding becomes more graphic when it is remembered that *Kilminster does* cite and discuss each of the Supreme Court's previous decisions interpreting ORS 656.156(2), and *does* repeat their language with attribution.

147 Or App 185> At least as noteworthy as the fact that the linguistic similarities between the two opinions are random and lack any apparent substantive nexus is the fact that there are linguistic differences between the two that do reflect differences in substance. The majority points out that our prevailing opinion in *Lusk* forcefully disputed the significance of "certainty of injury" as a factor in the analysis under ORS 656.156(2), and expressly took issue with the specially concurring opinion's focus on that factor. However, as illustrated in the passages that I have quoted from *Kilminster,* the Supreme Court clearly reiterated the point from *its* earlier cases that "certainty of injury" is very much a part of the appropriate analysis and can be pivotal to the chain of inferences from which liability under ORS 656.156(2) can be found.

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[2] The majority notes that *Lusk* and *Kilminster* were written by the same judge during her respective tours of duty on the two courts. That fact makes it all the more astounding that *Kilminster* does not cite *Lusk* if, as the majority hypothesizes, the former was intended to duplicate the judge's earlier opinion.

In sum, the majority's view of what *Kilminster* means is not strengthened by the fact that some of the isolated language that the majority emphasizes in that opinion has analogs in *Lusk*. For purposes of my analysis in this *dissenting* opinion, it is unnecessary for me to express a view about whether the majority is or is not correct in the way it reads *Lusk*. It suffices to say that, if the majority is right in that regard, *but see* note 1, *Lusk* as well as the majority's decision here are in conflict with the Supreme Court's decision in *Kilminster*, and the latter controls.

The majority makes one further point, which I will quote at length, rather than attempt to paraphrase:

> "The dissent's criticism flows from a false first premise, i.e., that the facts alleged in *Kilminster*, if proved, would conclusively establish the defendant employer's 'deliberate intention' to injure the decedent. *Kilminster* does not so hold. Rather, the court held that, if proved, the facts alleged by plaintiffs were sufficient to *permit* a jury to infer the necessary, actionable state of mind:
>
> " 'A reasonable finder of fact *could* infer that DMC acted as it did because it wished to injure or kill decedent. A specific intent to injure or kill decedent certainly is not the only state of mind that could be inferred, but it is a permissible inference. We need not consider whether plaintiff can prove that defendants had the alleged specific intent to injure or kill decedent; in the **<147 Or App 185/186>** procedural posture of this case, we consider only the sufficiency of the complaint.' 323 Or at 633 (emphasis supplied; emphasis in original deleted).
>
> "Thus, the court did not hold the plaintiffs' allegations, if proved, *compelled* a finding of liability. That is, the *Kilminster* court understood and expressly acknowledged that, even if the plaintiffs were able to prove that the employer deliberately withheld safety measures despite the certainty of injury, those facts would not automatically establish 'deliberate intention,' because the requisite 'wish to injure' was just one of a range of mental states the jury could infer from those facts. Among the range of other reasonably inferable, but nonactionable, mental states, is that the employer acted as it did not because it wished to injure the defendant but merely because it wanted to save money." 147 Or App at 177. (Emphasis in original.)

The "first premise" that the majority attributes to this opinion is simply not here. As the majority indicates, and I agree, it is basic and blackletter law that questions of the mental state that accompany a party's actions are almost invariably for the factfinder to decide, and the factfinder is not *required* to infer a particular mental state even when the predicate facts are present to *permit* the inference to be drawn. However, the relevant question here is not what a factfinder must find but what it may find. In this case, as in *Kilminster*, the issue is whether there is a permissible inference of deliberate intention to injure that a trier of fact may draw. The answer is yes, and that is why the trial court erred and why the majority errs in affirming the directed verdict.

For all of the above reasons, I respectfully dissent.

Cite as 147 Or App 197 (1997) March 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rodney V. Boqua, Claimant.
ROSEBURG FOREST PRODUCTS, *Petitioner,*
v.
Rodney V. BOQUA, *Respondent.*
(95-04209; CA A92333)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 19, 1996.
Michael G. Bostwick argued the cause for petitioner. On the brief were Richard D. Barber, Jr., and Bostwick, Sheridan and Bronstein.
J. Michael Casey argued the cause and filed the brief for respondent.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Affirmed.

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147 Or App 199> Employer petitions this court for reversal of an order of the Workers' Compensation Board that, *inter alia,* granted claimant attorney fees for "prevailing" at the hearing before the administrative law judge (ALJ) as to one of the multiple disability awards granted claimant, even though the ALJ reduced claimant's overall compensation. We affirm.

Employer raises two assignments of error. We reject, without further discussion, the first assignment, which challenges the Board's refusal to set aside the notice of closure.

Employer's second assignment of error challenges the Board's award of attorney fees pursuant to ORS 656.382(2). The facts material to that assignment are as follows: Claimant filed claims for carpal tunnel syndrome in both wrists and for pain in his right shoulder, all of which employer accepted and eventually closed, awarding four percent scheduled permanent partial disability (PPD) for claimant's right wrist and four percent scheduled PPD for his left wrist. Claimant sought reconsideration of that determination from the Department of Consumer & Business Services, which increased the awards for claimant's left wrist and for the right wrist. Claimant also received unscheduled PPD for the injury to his right shoulder.

Employer sought a hearing, and the ALJ reduced the award for the right shoulder condition and also reduced the award for the left wrist condition. However, the ALJ did not reduce the award for the right wrist condition.

Claimant moved for reconsideration, arguing that the ALJ incorrectly reduced the award for his left wrist condition. Claimant also argued that he was entitled to an assessed attorney fee pursuant to ORS 656.382(2), because, although the awards for his right shoulder and left wrist had been reduced--thus reducing the total amount of compensation--the award for the right wrist had not been reduced. Thus, claimant reasoned, he was entitled to recover reasonable fees incurred in litigating the degree of disability of the right wrist. The ALJ issued an order on reconsideration denying claimant's requests. With respect to attorney fees, the ALJ concluded:

> **147 Or App 200>** "Inasmuch as claimant's 'compensation' was reduced, I conclude that he is not entitled to an assessed fee. * * * I decline claimant's invitation to parcel out scheduled body parts for the purposes of granting an assessed fee under OAR 438-15-065."

On review, the Workers' Compensation Board affirmed the ALJ's order with regard to the disability awards, but it reversed the ALJ's ruling regarding claimant's request for attorney fees:

> "When conditions are considered separately for purposes of rating permanent disability, the carrier appeals the compensation awarded for every condition, and the compensation

> for at least one condition is not reduced, we award an assessed attorney fee for the claimant's counsel's efforts with regard to that condition. We take this approach even though compensation for the other conditions is reduced, because claimant must defend each condition's award separately.
>
> "In this case, claimant's compensable left wrist, right wrist, and right shoulder conditions are considered separately for purposes of rating permanent disability. The employer sought reduction in claimant's awards for all three conditions at hearing. The ALJ reduced the awards for the left wrist and right shoulder, but did not disturb the award for the right wrist. Under these circumstances, claimant is entitled to an assessed attorney fee under ORS 656.382(2) for successfully defending against the employer's challenge to the right wrist award." (Citations omitted.)

The Board then determined that claimant's reasonable attorney fees for "services at hearing regarding [his] scheduled disability award for his right wrist is $500."[1]

Employer's challenge to the attorney fee award turns on the meaning and application of ORS 656.382(2). That statute provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds **<147 Or App 200/201>** that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Employer argues that "compensation" in ORS 656.382(2) means *overall* compensation for an injury, and that, because claimant's total compensation was reduced in this case, he was not entitled to attorney fees. Claimant counters that (as the Board held), although his overall compensation was reduced by the ALJ's order, he was entitled to fees reasonably incurred in litigating the award for the right wrist condition because he succeeded in defending employer's challenge to that award. Claimant is correct. *Shoulders v. SAIF*, 300 Or 606, 716 P2d 751 (1986).

In *Shoulders*, the court addressed a similar issue. There, the claimant suffered a compensable injury to his leg and developed four different conditions in conjunction with that injury-phlebitis, tinnitus, vertigo, and thrombophlebitis. SAIF denied the claims for each condition, and the claimant requested a hearing as to those denials. The referee determined that all four conditions were compensable, and SAIF sought review of that order before the Board. The Board affirmed the referee's determination as to the phlebitis and thrombophlebitis but reversed as to the tinnitus and vertigo. The Board did not award the claimant any attorney fees.

On appeal, the claimant argued that, under the then-applicable version of ORS 656.382(2),[2] he was entitled to attorney fees. The court agreed. It first explained that, although the issue before the Board was the *compensability* **<147 Or App 201/202>** of the four conditions, because a compensability determination would result in compensation,[3] 0RS 656.382(2) applied. *Shoulders*, 300 Or at 609-10. The court then concluded that, although the Board's determination had the effect of reducing the claimant's "overall compensation," "each condition must be considered separately." *Id.* at 610. Thus:

---

[1] The Board assessed fees by reference to the criteria set out in OAR 438-015-0010(4).

[2] ORS 656.382(2), at that time, provided:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney for the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

[3] ORS 656.005(9) defined "compensation" as including "medical services." The court noted that the Board's finding of compensability would also involve an award of medical services and, therefore, an award of compensation.

> "Because the phlebitis and thrombophlebitis conditions were held to be compensable, compensation was not reduced in relation to them. Therefore, claimant is entitled to reasonable attorney fees for successfully defending against reduction of compqnsation for those two conditions. Claimant, however, is not entitled to attorney fees for time spent defending against reduction of compensation for tinnitus and vertigo." *Id.*

Under *Shoulders,* when an employer 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.

Shoulders controls this case.[4] Here, as in *Shoulders,* claimant had multiple conditions that, based on the issues that employer raised at the hearing, were considered separately.[5] Claimant defeated employer's attempt at the hearing to reduce the compensation of one of those conditions. Consequently, claimant was entitled to fees reasonably incurred in that effort.[6]

Affirmed.

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[4] As noted, see note 2 above, current ORS 656.382(2) has not been materially altered since *Shoulders.*

[5] Employer contends that *Shoulders* is inapposite because that case involved separately denied conditions and this case did not. We find that distinction unremarkable. Regardless of how employer first treated the claimed conditions, when it sought review of the disability awards before the ALJ, it treated--and challenged--each condition separately.

[6] Employer does not argue that the award of $500 in attorney fees exceeded the amount of time claimant's attorney spent on the issue regarding the right wrist condition.

Cite as 147 Or App 234 (1997) March 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James D. Johnson, Claimant.

James D. JOHNSON, *Petitioner*,
v.
BEAVER COACHES, INC., and Liberty Northwest Insurance Corporation,
Respondents.
(WCB 94-05835; CA A92230)

Judicial Review from Workers' Compensation Board.
Argued and submitted August 7, 1996.
Janet H. Breyer argued the cause for petitioner. With her on the brief was Philip H. Garrow.
Jerald P. Keene argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
PER CURIAM
Affirmed.
Armstrong, J., dissenting.

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147 Or App 235> Claimant seeks review of an order of the Workers' Compensation Board that upheld the denial of his left knee injury claim on the grounds that he failed to carry his burden of proof by showing that his injury "arose out of" his employment. We affirm.

Claimant worked on a production assembly line. On the day of his injury, claimant retrieved a part from the parts bin and then stopped to speak with a coworker about a work-related subject. When claimant took a step to return to his task, his left knee buckled and audibly "popped." The shop floor is level and there was no evidence that claimant slipped, twisted, or tripped over anything on the floor. Subsequently, claimant was diagnosed with a left medial meniscus tear.

The Board concluded that claimant failed to show that his left-knee condition arose out of his employment because he had failed to establish any causal connection between the injury and his work activities other than the mere fact that the step occurred at work. *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 867 P2d 1373 (1994). That conclusion is supported by substantial evidence.

Affirmed.

ARMSTRONG, J., dissenting.

The majority holds that the Board's conclusion that "claimant failed to show that his left-knee condition arose out of his employment" was supported by substantial evidence. 147 Or App at 235. Because the Board did not apply the proper analysis in reaching its conclusion, I respectfully dissent from the majority's decision.

According to ORS 656.005(7)(a), a " 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services." The "requirement that the injury 'arise out of' the employment tests the causal connection between the injury and the employment." *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994). "The [claimant] must show a causal link between the occurrence of the injury and a risk **<147 Or App 235/236>** connected with his or her employment." *Id.* at 368-69 (citation omitted).

Claimant was injured when, after standing still, he took a step. Thus, the risk causing claimant's injury was taking steps, *i.e.*, walking. As a preliminary matter, then, in determining whether claimant's injury arose out of his employment, the Board had to assess what type of risk walking is in those circumstances. The Board failed to do that. As a result, the Board could not properly determine whether claimant had established that his left-knee condition arose out of his employment.

In *Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 338, 874 P2d 76 (1994), we quoted Professor Larson on the identification of risk and stated:

> " 'All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and neutral risks--*i.e.*, risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance.' "

(Quoting 1 Arthur Larson, *Workmen's Compensation Law* § 7.00, at 3-14 (1996)).

As we said in *SAIF v. Marin*, 139 Or App 518, 524, 913 P2d 336 (1995), *rev den* 323 Or 535 (1996):

> "[E]mployment-related risks are those that are inherent to the claimant's job and that either produce injury while the claimant is engaged in his or her usual employment or that became manifest later in the form of occupational diseases."

" '[P]ersonal risks' are risks of injury that arise from idiopathic conditions that the claimant may have[.]" *Id.* at 52324. They are "origins of harm so clearly personal that, even if they take effect while the employee is on the job, they could not possibly be attributed to the employment." Larson, **<147 Or App 236/237>** 1 *Workmen's Compensation Law* § 7.20, at 3-15 (1996). Neutral risks are neither distinctly employment related nor distinctly personal in character. If walking, under these circumstances, is categorized as a neutral risk, then "claimant's injury is compensable only if his work conditions caused him to be in a position to be injured" by the neutral risk. *Marin*, 139 Or App at 524-25.

Because the Board failed to determine whether the risk that led to claimant's injury was employment related, neutral or personal, it could not properly determine whether claimant's injury arose out of his employment. If, applying the proper legal analysis, the Board concludes that the step was part of a risk connected to claimant's employment, either an employment-related risk or a neutral risk that his employment put him in a position to be injured by, then claimant's injury is compensable if he demonstrates that his torn medial meniscus was caused by the step that he took at work.

The order of the Board should be reversed and remanded so that the Board can apply the proper legal analysis to determine whether claimant's injury "arose out of his" employment. The majority errs in concluding otherwise.

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OREGON RULES OF CIVIL PROCEDURE CITATIONS

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Cite as 49 Van Natta ___ (1997)

* Appealed to courts (through 2/28/97)