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

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

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CITE AS

49 Van Natta ____ (1997)

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

Claimant requests reconsideration of our November 3, 1995 Own Motion Order, as republished on April 16, 1997, in which we declined to reopen his 1982 injury claim for the payment of temporary disability compensation because he failed to establish he was in the work force when his compensable condition worsened requiring surgery.

On April 21, 1997, we abated our April 16, 1997 order, and allowed SAIF 14 days in which to file a response to the motion. Claimant has submitted additional information regarding the work force issue. SAIF has not responded to claimant's motion, or to his new evidence. On reconsideration, we withdraw our prior order and issue the following order in place of our prior order.

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

In our prior orders, we concluded that claimant's compensable condition worsened requiring surgery as he underwent L4-5 disc excision surgery on March 27, 1995. See Brad D. Linnell, 49 Van Natta 493 (1997).

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

Claimant contends that he qualifies for temporary disability compensation because he continued working until his compensable condition worsened requiring surgery. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was working at the time of his 1995 disability.

Claimant provided a copy of Dr. Dunn's February 28, 1995 chart note, in which his physician noted that "[claimant] has continued to work but is doing no physical work, only administrative work." Furthermore, in a May 16, 1995 chart note, Dr. Dunn reported that "[claimant] is working full time and taking no medication." Although Dr. Dunn's May 1995 chart note issued after claimant underwent surgery, the documentation supports claimant's contention that he continued to work around that time period, and, apparently, returned to work after surgery. See Jon O. Norstadt, 49 Van Natta 168 (1997) (the claimant established he was working at the time of disability where chart notes from his physician indicated that he returned back to work after surgery). Finally, there is no rebuttal evidence which might indicate that claimant was not working prior to his surgery.

On this record, we are persuaded that claimant has established that he was working until the time of his surgery in March of 1995.

Accordingly, we authorize the reopening of claimant's claim for SAIF to provide temporary disability compensation beginning March 27, 1995, 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
YEKATERINA DREVENCHUK, Claimant
WCB Case No. 96-08070
ORDER DENYING MOTION TO DISMISS
Stoel, Rives, et al, Defense Attorneys

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Lipton's order that dismissed her request for hearing. Contending that claimant neglected to timely serve notice of her appeal on its attorney, the self-insured employer has moved the Board for an order dismissing claimant's request for review. We deny the motion.

FINDINGS OF FACT

The ALJ's order issued on May 6, 1997. The order recited that copies had been mailed to claimant, her attorney, the employer, its claim administrator, and its attorney.

On June 6, 1997, the Board received claimant's June 3, 1997 request for review of the ALJ's order. The request, which was contained in an envelope bearing a postmark date of June 4, 1997, stated that "[t]he copies of such request mailed to all other parties to this proceeding."

On June 9, 1997, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for review. Receipt of this acknowledgment was the employer's counsel's first notice of claimant's appeal.

CONCLUSION 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 the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656. 295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance 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 (1992). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, the 30th day after the ALJ's May 6, 1997 order was June 5, 1997. The Board did not receive claimant's request for review until June 6, 1997. Nevertheless, the envelope which contained claimant's request bears a postmark date of June 4, 1997. Since this date is within 30 days of the ALJ's May 6, 1997 order, we conclude that the request was timely filed. ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(a); David S. Livesay, 48 Van Natta 1732 (1996).

We turn to the employer's contention that claimant neglected to provide timely notice of her appeal to the other parties to the proceeding. Although the employer's counsel was apparently not served with a copy of claimant's appeal, no such contention has been made by the employer or its claims processor. In light of such circumstances, the present record does not rebut claimant's representation in her June 3, 1997 request for review that copies of her request were mailed "to all other parties" to the proceeding. See David S. Livesay, 48 Van Natta at 1732; Harold E. Smith, 47 Van Natta 703 (1995). Inasmuch as June 3, 1997 is within 30 days of the ALJ's May 6, 1997 order, we are persuaded that claimant provided timely notice of her appeal to the other parties to this proceeding. See ORS 656.295(2).

Accordingly, we deny the motion to dismiss. In light of these circumstances, the briefing schedule shall be revised as follows. Claimant's appellant's brief (her written argument explaining why she disagrees with the ALJ's decision and what action she wants the Board to take) must be filed within 21 days from the date of this order. (A copy of her brief should also be mailed to the employer's

attorney.) The employer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

July 3, 1997 Cite as 49 Van Natta 1017 (1997)

In the Matter of the Compensation of
GREGORY A. BARRELL, Claimant
WCB Case No. C701399
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Martin L. Alvey, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On June 4, 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 his compensable injury. We approve the proposed disposition.

The CDA, as originally submitted, provided for "costs" of $306.71 to be deducted from the CDA proceeds. We have previously disapproved a CDA that provided for payment of costs to claimant's counsel. Debbie K. Ziebert, 44 Van Natta 51 (1992). In Ziebert, we held that costs incurred by an attorney are not included in the fees paid to an attorney. See OAR 438-015-0005(6). We further reasoned that ORS 656.234 prohibits assignment by an injured worker or beneficiary of any moneys payable under chapter 656 prior to their receipt. See OAR 438-015-0005(6).

On June 12, 1997, the Board's staff requested that the parties submit an addendum to the CDA to amend the reference to "costs." On June 23, 1997, the Board received the parties' addendum to the CDA. The addendum provides for a total consideration of $20,000, ($17,693.29 payable to claimant and $2,306.71 payable to claimant's counsel as an attorney fee). The summary page of the agreement continues to provide for deduction of "attorney fees and costs" from the CDA proceeds. However, after the deduction of the $2,306.71 attorney fee from the total consideration of $20,000, the remainder to claimant equals $17,693.29. Consequently, the "costs" are, in effect, equal to zero. Under such circumstances, despite the CDA's continuing reference to "costs," no costs have actually been deducted from the CDA proceeds. Therefore, we do not consider the "costs" reference to be, in effect, contrary to ORS 656.234 and our Ziebert holding.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $2,306.71, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUDITH K. NIX, Claimant
WCB Case No. 95-02805
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's June 5, 1997 order, this case has been remanded for further proceedings in light of the Nix v. Freightliner, 145 Or App 560 (1997).

On May 30, 1997, in response to the court's Nix decision, we issued our Second Order on Remand. (WCB Case No. 93-02704). We held that the self-insured employer was required to pay all of an "out-of-compensation" attorney fee (25 percent of the "increased" 12 percent unscheduled permanent disability award) directly to claimant's counsel. In addition, we authorized the employer to offset any overpayments created by our directive against claimant's future compensation.

This case arises from claimant's hearing request which was filed after our initial order in WCB Case No. 93-02704 which had granted the "increased" permanent disability award. Consistent with our initial order in WCB Case No. 93-02704, we previously affirmed the Administrative Law Judge's (ALJ's) order that determined that the employer was under no obligation to directly pay the "out-of-compensation" attorney fee directly to claimant's counsel.

In accordance with the Nix holding that our initial decision in WCB Case No. 93-02704 violated OAR 438-015-0085(2), our May 30, 1997 Second Order on Remand in WCB Case 93-02704 directed the employer to pay all of the "out-of-compensation" attorney fee payable from claimant's "increased" unscheduled permanent disability award directly to claimant's counsel. Because this case pertains to the "enforcement" of our decision in WCB Case No. 93-02704, the employer is required to comply with our May 30, 1997 order.

Accordingly, on reconsideration of our March 8, 1996 order, we reverse the ALJ's June 14, 1995 order. The employer is directed to pay claimant's counsel's "out-of-compensation" attorney fee in the manner prescribed in our May 30, 1997 Second Order on Remand in WCB Case No. 93-02704.

IT IS SO ORDERED.

In the Matter of the Compensation of
JORGE PEDRAZA, Claimant
WCB Case No. 96-07084
ORDER ON RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our June 5, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order affirming an Order on Reconsideration award of 21 percent (67.2 degrees) unscheduled permanent disability for claimant's low back condition.

On reconsideration, claimant argues that, under de novo review, a discussion of our conclusions is required. Consequently, claimant argues that, rather than adopting and affirming the order of the ALJ, our Order on Review should have supplied an explanation regarding why we adopted the ALJ's order.

The court has held that a Board order need not set forth its own findings of fact and conclusions if it affirms or adopts a referee's (ALJ's) order that is itself sufficient for substantial evidence review. George v. Richard's Food Center, 90 Or App 639 (1988). Accordingly, by adopting the ALJ's order, we have found it sufficient for appellate review and the facts and conclusions in that order express our opinion of the case.

In other words, although claimant argues that the physical capacities evaluation (PCE) is dispositive with respect to his restrictions, the ALJ addressed the issue and found that a subsequent chartnote from the treating doctor found only a lifting limit and "no other restrictions." (Ex. 29). We agree with the ALJ's reasoning that the evidence shows that the treating doctor imposed no further limitations on claimant. Consequently, contrary to claimant's argument on review that there is no reason to discount or ignore the PCE findings, the ALJ found, and we agree that, based on the subsequent report from the treating doctor which undermines the PCE findings, the PCE is not persuasive and claimant has failed to meet his burden of proof with respect to an increased award.

Accordingly, we withdraw our June 5, 1997 Order on Review. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. BREWSTER, Claimant
WCB Case No. 96-06817
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's claim for a neck, back and left arm injury. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 7, 1996 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

Board Member Moller dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant's cervical and thoracic strain injury is compensable. In light of claimant's disputed description of the work incident and his failure to appear at hearing in order to substantiate his own description of the incident, combined with his prior history of injuries and treatment, I do not agree that the medical record is sufficient to sustain his burden of proving compensability.

Claimant had worked for the employer for 2 days at the time of the June 11, 1996 incident. (Ex. 17). Previously, in August 1995, claimant experienced an on-the-job injury with a prior employer. He began treatment with Kent Wilcox, chiropractor. Wilcox noted in his intake examination that claimant "relates a number of prior on-the-job injuries to his neck and lower back." (Ex. 2-1). Following the earlier August 1995 incident, claimant completed a pain diagram indicating low back, upper back and neck pain, which he rated nearly excruciating. (Ex. 1).

Subsequently, in October 1995, claimant reported severe right shoulder pain following a period of work activities. (Ex. 4). Claimant's claim for a right shoulder strain was denied. As the result of a disputed claim settlement, claimant's right shoulder claim remained denied. (Ex. 13). Claimant was subsequently fired from his employment.

On June 11, 1996, the incident that gave rise to this dispute occurred. In describing the injury on the "827" form, claimant wrote: "On 6-11-96 at approximately 1:25 p.m. I was blowing out a parking lot with back pack blower, and was hit by a vehicle pulling into a parking space." (Ex. 16). In the "801" form signed June 12, 1996, claimant wrote:

> "I was blowing out parking lot with a back pack type blower when I was struck by a moving vehicle. The person driving said after the accident that she saw me move towards the right, thought I was finished with that space, and pulled in. I felt pain to my upper back, left shoulder, neck and left arm within 2 or 3 minutes." (Ex. 17).

Claimant returned to Dr. Wilcox for treatment on the day of the injury. Claimant completed a new pain diagram indicating head pain, neck and upper back pain, left shoulder and arm pain, right shoulder pain, midback pain, low back pain, and pain in the buttocks. (Ex. 14). Again, claimant indicated the pain was nearly excruciating. (Id.). Wilcox reported that claimant

> "was walking slightly backwards into the left side, when he was suddenly struck by a vehicle that was pulling into the parking spot. He was jolted and twisted and nearly fell, however, he did not fall. He reports that he was essentially stunned for three to four minutes and then began experiencing neck and upper back pain with pain extending into his shoulder and left arm." (Ex. 15).

He diagnosed cervical and thoracic strain, and left arm paresthesia. (Id.) Dr. Wilcox subsequently opined that the June 11, 1996 incident was the "material major contributing cause" for claimant's cervicothoracic strain and need for treatment. (Ex. 23).

However, claimant's descriptions of the injury on the "801" and "827" forms, as well as Dr. Wilcox's understanding of the injury based on claimant's report, are not supported by other evidence in the record. Although claimant indicated on the "801" and "827" forms that he was hit by a moving vehicle, the driver of the car testified under oath that her car was stationary at the time claimant backed into her car. Ms. Van Domelen, who was driving the car, testified that, after she had pulled into the parking lot,

> "I noticed a man with a blower blowing dirt out of the parking lot. And he was right in the middle of an open parking space. And I stopped and waited, and he moved to my right into the next space in front of a car that was already parked there, so I assumed that he was finished in that spot. I proceeded to pull into that parking space. As I was pulling in, I noticed him backing up. So I stopped my car and he backed up into the passenger's side front fender of my car." (Ex. 22-5).

Van Domelen testified that when claimant backed into her car,

> "[H]e was startled like anybody that would back into something that he wasn't expecting to be there. He jumped a little bit, but he did not fall down and he did not stagger around or stumble or anything. He hit the fender of the car and jumped and stopped and turned around and looked at me. Obviously, he was surprised and so was I." (Ex. 22-8).

Van Domelen said that claimant came around to the driver's side window and she apologized and told him she thought he had been finished in that space. (Ex. 22-6). Claimant did not appear to be injured and did not have any sort of limp or any problem moving. (Ex. 22-7). Van Domelen did not think claimant was hurt and he did not indicate to her that he was hurt. (Ex. 22-21).

Although Dr. Wilcox reported that claimant was "jolted and twisted and nearly fell" (Ex. 15), Van Domelen did not agree with the characterization that she struck claimant, jolted him, caused him to twist and nearly knocked him down. (Ex. 22-9). She said: "My car was stopped and he backed into my car. I did not strike him. And he jumped but he did not fall down. It didn't appear to me that he was even close to falling down." (Id.) She did not recall any twisting by claimant. (Id.)

In light of her testimony, claimant's statements to Dr. Wilcox are unreliable. Claimant did not appear at the hearing or testify regarding the circumstances of the June 11, 1996 incident. See Zurita v. Canby Nursery, 115 Or App 330, 334 (1992), rev den 315 Or 443 (1993) (a claimant who opts not to testify personally or present witnesses concerning the circumstances of his injury runs the risk that the statements contained in the medical reports may not be sufficient to carry the burden of proof on work-connectedness).

In a later report, Dr. Wilcox said:

> "Given a similar scenario, [claimant] carrying a blower back pack, wearing ear muffs, walking slightly backwards, slightly bend [sic] forward, backing into a stationary car or any other stationary object could of [sic] jolted him, causing him to twist and nearly fall while trying to keep his balance carrying the back pack blower. This type of mechanism would be consistent with an injury to the neck and upper back." (Ex. 24; emphasis added).

Dr. Wilcox's amended opinion does not establish compensability. As discussed above, Ms. Van Domelen testified that claimant was not jolted, did not twist and did not nearly fall. (Ex. 22-9). Rather, claimant merely bumped into her car and jumped a little bit. Because Dr. Wilcox's amended opinion was based on inaccurate information, it is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977). Further, claimant's report of left arm pain is unexplained by the mechanism of his injury. To the contrary, Wilcox's explanation regarding causation confusingly states that the "[claimant's] on-the-job incident while blowing out a parking lot on 6/11/96 are [sic] consistent with a mechanism of injury that one would incur if jarred from behind while carrying a back pack blower." (Ex. 23).

Inasmuch as the only evidence that relates claimant's medical treatment to his work activities is his statement in his physician's report, which is not persuasive, I would conclude that there is insufficient evidence to establish that claimant sustained a cervical and thoracic low back strain at work on June 11, 1996 that caused either disability or a need for medical treatment. Therefore, I would reverse the ALJ's order and reinstate the employer's denial.

In the Matter of the Compensation of
MICHAEL A. CRAUSE, Claimant
WCB Case No. 96-02150
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial insofar as it pertains to claimant's chronic pain syndrome. Claimant also submits a copy of a page from a DSM-IV manual and a "post-ALJ's order" opinion letter from claimant's clinical psychologist. We treat such submissions as a request to take administrative notice and a motion to remand. In its respondent's brief, SAIF contests that portion of the ALJ's order that set aside its denial insofar as it concerned claimant's L4-5 fusion condition. SAIF also moves to strike a portion of claimant's reply brief that addresses the ALJ's attorney fee award. On review, the issues are the procedural motions, remand and compensability. We deny the procedural and remand motions. With respect to the compensability issues, the ALJ's order is affirmed in part and reversed in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

On review, SAIF moves to strike that portion of claimant's reply brief which discussed the ALJ's attorney fee award. SAIF argues that the reply brief raises a new issue which was not raised in claimant's opening brief.

After reviewing claimant's reply brief, we decline to strike that portion of the brief. Although claimant refers to the ALJ's attorney fee award, claimant has not asked for an increased fee. Rather, claimant has responded to SAIF's challenge to the ALJ's decision that found the L4-5 fusion to be compensable. Accordingly, we conclude that the reply brief does not raise a new issue. SAIF's motion is therefore denied.

Remand

On review, claimant has submitted a letter from Dr. Goldmann, psychologist, which was not previously admitted at the hearing. We treat such submissions as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). We may remand a case to the ALJ for further evidence taking if we

find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, we find no compelling basis to remand. Specifically, we find that a medical opinion from Dr. Goldmann already exists in the record. Consequently, we do not find that Dr. Goldmann's latest submission is reasonably likely to affect the outcome of the case. Moreover, we find no explanation why the latest report was not obtainable with due diligence at the time of hearing. Accordingly, claimant's motion to remand is denied.

Administrative Notice

On review, claimant has submitted an excerpt from a "currently used DSM-IV" manual. Claimant has referenced the excerpt in his appellant's brief and has asked us to take "judicial notice" of the attachment. We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985).

Here, we decline to take judicial notice of the medical journal or treatise referenced by claimant. In Bend Millwork v. Dept. of Revenue, 285 Or 577 (1977), the Court approved of special dictionaries which gave the "true significations" of words described as being "scientific," especially in the mathematical sciences. 285 Or at 583. However, outside those fields, the Court recommended the exercise of "self-restraint...in order to avoid the taking of evidence from a source not subject to confrontation and cross-examination." 285 Or at 584.

Consequently, because claimant's submission from the DSM-IV manual is taken from a source not subject to confrontation and cross-examination, we decline to take judicial notice in this case. See Richard H. Olsen, 41 Van Natta 1300 (1989) (On review, the Board did not have authority to consider the most recent version of a medical treatise where the evidence was not admitted at the hearing and not a part of the record).

Compensability/Chronic Pain Syndrome

We adopt and affirm the ALJ's "Conclusions and Opinion" on the issue of compensability of claimant's chronic pain syndrome, with the exception of the ALJ's discussion regarding the DSM-IV.

On review, claimant acknowledges that the ALJ was asked to review claimant's chronic pain diagnosis in the manual. Nevertheless, claimant disagrees with the ALJ's conclusion that there was no separate DSM-IV diagnosis for claimant's chronic pain syndrome. Claimant further contends that the ALJ misread the diagnostic text and instead, substituted his own opinion. SAIF, on the other hand, argues that the ALJ erred in relying on evidence not in the record.

We have previously held that an ALJ should not have taken administrative notice of a portion of a DSM treatise which was not specifically discussed by a doctor and where the treatise had not been admitted into evidence. See Fidela O. Durgan, 39 Van Natta 316 (1987). Rather, we concluded, the ALJ should have decided the case from evidence contained in the record. 39 Van Natta at 318.

Similarly, in the present case, we conclude that, because the DSM was not discussed or interpreted by a doctor and was not admitted at the hearing, the ALJ should not have relied on the treatise. However, we parenthetically note that, even after considering the manual, the ALJ was not persuaded that claimant's compensable low back condition was the major contributing cause of his chronic pain syndrome.

Finally, we agree with the ALJ that the opinions supporting compensability (Drs. Goldmann and Irvine) are not persuasive as they are not based on an accurate history. Accordingly, we affirm the ALJ's conclusion that claimant has failed to establish compensability of his chronic pain syndrome.

Compensability/L4-5 Fusion

The ALJ concluded that claimant's compensable L5-S1 injury was the major contributing cause of his need for surgery at L4-5. ORS 656.005(7)(a)(A). On review, SAIF argues that a "consequential condition" analysis, pursuant to ORS 656.005(7)(a)(A), rather than a "combined condition" analysis, is the appropriate standard. However, we conclude that, under either standard, claimant has failed to prove that his compensable L5-S1 injury is the major cause of the L4-5 condition.

Here, as noted by the ALJ, SAIF had previously denied claimant's L4-5 disc bulge. Furthermore, because claimant did not appeal the denial, it became final by operation of law. As such, the denied L4-5 disc bulge cannot be considered as a work-related cause of claimant's current condition.

In determining whether the "major contributing cause" standard has been met, a persuasive medical opinion must weigh the relative contribution of different causes. See Dietz v. Ramuda, 130 Or App 397 (1994); Alec E. Snyder, 47 Van Natta 838 (1995). In the present case, only Dr. Misko has provided an opinion regarding causation of claimant's current L4-5 condition. Dr. Misko reported that, had it not been for the injury to the L5-S1 disc requiring surgery at that level, claimant would not have had to be treated at the L4-5 level. Consequently, Dr. Misko concluded that the injury was "a major contributing cause" for the need to extend the fusion to the L4-5 level. (Ex. 53).

In reaching his conclusion, Dr. Misko has not discussed claimant's prior L4-5 condition, nor has he weighed any possible contribution from the noncompensable L4-5 disc bulge. In light of the fact that claimant's current need for surgery is at the same level, we conclude that Dr. Misko's opinion is not persuasive, due to its lack of acknowledgment or discussion of the disc bulge.[1] Additionally, without more, we are unable to determine whether Dr. Misko meant to say that the compensable L5-S1 injury was "a major" factor or "the major" contributing cause of claimant's need for surgery at L4-5. See James S. Modesitt, 48 Van Natta 2542 (1996) (Physician's report was found to be unclear where we were unable to find whether the injury was "a" major contributing factor or "the" major contributing cause of the condition). Consequently, for the aforementioned reasons, we find that Dr. Misko's opinion is not persuasive.

Because there are no other expert medical opinions which discuss compensability, we conclude that claimant has failed to meet his burden of proof. Accordingly, we reverse the ALJ's opinion on the issue of compensability of the L4-5 condition. The ALJ's attorney fee award is also reversed.

ORDER

The ALJ's order dated January 9, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which set aside the SAIF Corporation's denial of the L4-5 fusion claim is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award of $1,500 is also reversed. The remainder of the ALJ's order is affirmed.

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[1] In SAIF v. Nehl, 148 Or App 101 (1997), the court found that the immediate cause of the claimant's need for treatment was an on-the-job accident, and accordingly, the treatment was compensable. However, we have subsequently reasoned that Nehl does not overturn the major contributing cause standard discussed in Dietz; i.e., the requirement that determination of major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause. See Gregory C. Noble, 49 Van Natta 764 (1997).

In Noble, we concluded that Nehl stands for the proposition that a claimant is not required to prove a work injury is the major contributing cause of the entire combined condition. Instead, the claimant must prove that the work injury is the major contributing cause of the need for treatment of the combined condition. In reaching that compensability determination, the standard for proving major contributing cause, as articulated by Dietz, remains unchanged. Noble, 49 Van Natta at 767. Here, we do not find that the opinion expressed by Dr. Misko meets the compensability standard set forth in Dietz.

In the Matter of the Compensation of
SHARON D. DAN, Claimant
WCB Case No. 96-09032
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of her injury claim for a low back condition, including a herniated disc at L4-5. Contending that claimant's reply brief raises new issues for the first time on review, the employer moves to strike the reply brief. On review, the issues are motion to strike and compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. On page 2, we change the date in the seventh full paragraph to "August 20, 1996." We do not adopt the ALJ's findings of ultimate fact.

The employer moves to strike claimant's reply brief on the ground that she raises new issues. The employer asserts that claimant raises the standard of causation and a constitutional argument for the first time in her reply brief.

The ALJ found claimant had preexisting low back conditions that combined with her industrial injury and, therefore, that she had to prove her industrial injury was the major contributing cause of the disability or need for treatment of the combined condition. In her reply brief, claimant contends that the medical record does not support a finding that she had a preexisting degenerative disc condition. She asserts that there was nothing about her "preexisting condition" that caused her any symptoms or disability.

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995)). In light of such circumstances, we reject the employer's objections to claimant's reply brief insofar as claimant addresses the appropriate legal standard to apply to this compensability issue.

Our first inquiry is whether claimant had any preexisting conditions that contributed or predisposed her to disability or a need for treatment. See ORS 656.005(24) ("preexisting condition" is "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment * * *").

On June 3, 1996, Dr. Matthew Gambee reported that claimant's lumbar spine films demonstrated degenerative disc disease at L4-5 and L5-S1 with significant facet arthrosis at both levels. (Ex. 6A). He diagnosed lumbar radiculopathy, right lower extremity.

Dr. Phaon Gambee examined claimant on July 24, 1996. He noted that claimant, who is five feet three and one-half inches, weighed 140 pounds more than recommended at 268 pounds. (Ex. 12-5). He diagnosed morbid obesity and "sciatica, causally related to her morbid obesity and the obvious degenerative changes that must exist in her low back." (Id.) He felt that the major contributing cause of claimant's need for treatment of her back condition was her preexisting osteoarthritis, degenerative disc disease and morbid obesity. (Ex. 12-6).

A lumbar myelogram and CT scan on July 26, 1996 showed a right-sided disc protrusion at L4-5, moderate bilateral L4-5 facet degenerative change, L5-S1 disc bulges and marked bilateral L5-S1 facet degenerative change, L3-4 disc bulges and marked anterior osteophytic change at the T-12 to L1 level. (Ex. 12A). Dr. Matthew Gambee diagnosed a disc herniation at L4-5 with radiculopathy. (Ex. 12C).

In his October 3, 1996 report, Dr. Hummel acknowledged that claimant had degenerative changes (Ex. 18), although he did not specifically comment whether or not they preexisted the April 20, 1996 injury.

Based on Dr. Phaon Gambee's reports, we conclude that claimant's osteoarthritis, degenerative disc disease and obesity preexisted her April 20, 1996 injury and contributed to or predisposed her to disability or a need for treatment for a low back condition. The reports from Drs. Hummel and Matthew Gambee are not to the contrary. Consequently, we conclude that the osteoarthritis, degenerative disc disease and obesity constituted preexisting conditions as defined in ORS 656.005(24).

In determining whether ORS 656.005(7)(a)(B) applies, we must determine whether claimant's preexisting conditions "combined" with her April 1996 injury to cause disability or a need for medical treatment. Although Dr. Hummel commented that claimant's disc herniation was not related to "degenerative changes only" (Ex. 18), we interpret his opinion to mean that claimant's degenerative changes contributed, at least in part, to her disability or need for treatment and, therefore, "combined" with the April 1996 injury. In addition, we interpret Dr. Phaon Gambee's July 24, 1996 report to mean that claimant's April 20, 1996 injury combined with her preexisting osteoarthritis and degenerative disc disease. Dr. Phaon Gambee believed that claimant's April 20, 1996 injury was the major contributing cause of her knee condition and he felt that the altered gait from claimant's knee condition impacted her low back condition to some extent. (Ex. 12-6).

Dr. Phaon Gambee also concluded that claimant's morbid obesity contributed to her disability or need for treatment. (Exs. 12-5, -6). Both Drs. Matthew Gambee and Hummel encouraged claimant to lose weight in order to treat her back condition. (Exs. 19, 21). Dr. Hummel reported that claimant was a "very bad surgical candidate" because of her size in terms of accomplishing the surgery and chances of recurrent herniations. (Ex. 14A).

Based on the aforementioned medical reports, we conclude that claimant's April 1996 injury "combined" with her preexisting osteoarthritis, degenerative disc disease and obesity to cause her disability and/or need for treatment. We agree with the ALJ that ORS 656.005(7)(a)(B) applies and claimant must prove that her April 1996 injury was the major contributing cause of the disability or the need for treatment of the "combined condition."

We agree with the ALJ's analysis of the medical opinions. For the reasons stated by the ALJ, we conclude that, based on Dr. Phaon Gambee's well-reasoned opinion, claimant's April 20, 1996 injury was not the major contributing cause of the disability or the need for treatment of the combined condition. Consequently, claimant has failed to prove that her low back condition, including a herniated disc at L4-5, is compensable.

In her reply brief, claimant cites Article 1, sections 1 and 20, of the Oregon Constitution, and argues that the law does not tolerate a denial of rights to someone simply because she is vulnerable.

Claimant did not raise any constitutional arguments at hearing. In previous cases, we have held that a constitutional challenge must be raised at the hearings level before it can be argued on review. See, e.g., Gary L. Doty, 48 Van Natta 148 (1996). Because this constitutional argument is not adequately developed for our review, we decline to address the issue.

ORDER

The ALJ's order dated January 17, 1997 is affirmed.

Board Chair Hall specially concurring.

Although I agree that claimant has failed to prove that her low back condition is compensable, I write separately to address my concerns about the consideration of claimant's "obesity" as a "preexisting condition."

The lead opinion concludes that claimant's obesity constitutes a preexisting condition. I do not believe it is factually necessary to address that issue. Moreover, the consideration of obesity as a preexisting condition raises legal questions. ORS 656.005(24) defines a "preexisting condition" as "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

In Muriel D. Nelson, 48 Van Natta 1596 (1996), we were not persuaded that the claimant's "being female and slightly overweight" constituted preexisting conditions. We concluded that being "slightly overweight but not a lot," without further explanation, did not fit within the definition of a preexisting condition because it was not an "injury, disease, congenital abnormality, personality disorder or similar condition." 48 Van Natta at 1597. Here, I am not persuaded that claimant's obesity constitutes an "injury, disease, congenital abnormality, personality disorder or similar condition."

Nevertheless, I agree that claimant had other preexisting conditions that combined with her April 1996 injury to cause disability or a need for treatment. I also agree that claimant's April 20, 1996 injury was not the major contributing cause of her low back condition. For those reasons, I concur in the result.

In the Matter of the Compensation of
RONALD R. DART, Claimant
WCB Case No. 96-03619
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's right knee 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.

On March 14, 1996, while on duty in his job as a janitor, claimant used the urinal. When claimant flushed the urinal, he noticed that it flushed forcefully, with a lot of water pressure. (Tr. 8-9, 20). When turning to leave, claimant slipped, his feet came out from underneath him, and he fell. He did not feel his right knee give out before he fell; instead, he slipped on the floor. (Tr. 8-9, 21). During this fall, claimant twisted his right knee and dislocated his kneecap. The fall was caused by claimant slipping on water splashed on the floor from the urinal.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to meet his burden of proving the compensability of one or more of the right knee conditions diagnosed subsequent to his March 14, 1996 fall. Claimant argues that he has established that he injured his right knee in the course and scope of his employment. We agree with claimant.

Claimant had previously injured his right knee in 1980 and 1986. In March 1996, claimant worked as a janitor for the insured. Early in his shift on March 14, 1996, claimant used the urinal on one of the floors on which he was working. When he flushed the urinal, claimant noticed that it flushed forcefully, with a lot of water pressure. When he turned from the urinal, he felt his foot slip and he fell, twisting his right knee and dislocating his kneecap. He was unable to straighten his leg or get up. Sometime thereafter, his supervisor discovered him. Subsequently, another supervisor, Mr. Mosin, was called and came from about two blocks away. An ambulance was called and it arrived approximately 45 to 60 minutes after claimant's fall.

Claimant was transported by ambulance to the Emergency Room where he was sedated and his right patellar dislocation was reduced. (Ex. 2). He was referred to Dr. Wells, orthopedist, who became his attending physician. Dr. Wells first saw claimant on March 15, 1996, the day after the work incident, and followed claimant's right knee condition since that date. When claimant's knee condition did not improve, Dr. Wells ordered an MRI, which showed a tear of the medial collateral and anterior

cruciate ligaments. (Exs. 10, 11). On April 2, 1996, the insurer denied claimant's claim for his right knee conditions, contending, in part, that claimant's injury did not arise out of and in the course of his employment. (Ex. 12). On May 7, 1996, Dr. Wells performed an arthroscopy of the right knee with debridement of the lateral femoral condyle. (Ex. 13).

"A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services[.]" ORS 656.005(7)(a). In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Supreme Court re-examined the work-connection standard under ORS 656.005(7)(a) and clarified the proper analytical framework. The Court reiterated that, to establish the compensability of an injury, the claimant must show that the injury: (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Id. at 366. However, the Court explained that neither element is dispositive; rather, one must consider "all the circumstances" to determine if the claimant has satisfied the work-connection test. Id. at 366, 369. Although adopting a unitary "work-connection" test, the Court has also held that both elements of the test, "arising out of" and "in the course of," must be met in some degree for an injury to be compensable. Krushwitz v. McDonald's Restaurants of Oregon, Inc., 323 Or 520, 531 (1996).

In Torkko v. SAIF, 147 Or App 678 (1997), the court interpreted the "arising out of" standard outlined in Norpac Foods. In Torkko, the court reversed a Board's order finding a school teacher's injury, which occurred when she struck her head on a coworker's van's side mirror while walking from her employer's parking lot to the school, did not arise out of her employment. Citing SAIF v. Marin, 139 Or App 516, 522, rev den 323 Or 535 (1996), the court reiterated that, "under the 'arising out of' standard in Norpac Foods., the Board should not focus on individual factors, like control, but rather on 'the totality of the events that gave rise to [the] claimant's injury.'" 147 Or App at 682. The court reasoned that the Board had improperly focused on whether the employer controlled the instrumentality that caused the claimant's injury. Id. The court concluded that the proper focus was on whether the claimant's injury was causally connected with her employment, given that the injury was caused when she struck her head on an object in her employer's parking lot while taking school materials from her car to her classroom. Id.

Finally, medical and legal causation are requirements for every workers' compensation claim. Legal causation requires the existence of an on-the-job injury. Medical causation requires evidence connecting the accidental injury and the condition for which medical benefits are being claimed. Claimant carries the burden to establish each of these elements by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979).

Although primarily focusing its argument on the "arising out of employment" element, the insurer also contends that it is questionable that the "course of employment" element is met here, due to the circumstances of the injury, which occurred while claimant was using the restroom. In this regard, the insurer argues that, while going to the bathroom was not prohibited, neither was it part of claimant's employment. We do not find that fact to be dispositive.

Because the employer controls its premises, injuries that occur on the employer's premises typically arise out of and are in the course of a worker's employment, unless an exception applies. Cope v. West American Ins. Co., 309 Or 232, 238 (1990). One exception is the "personal comfort" doctrine. Under that doctrine, the work connection of an on-premises injury is severed if the injury resulted from a personal comfort activity that was not expressly or impliedly allowed by the employer. Clark v. U.S. Plywood, 288 Or 255, 266 (1980).

Here, the employer at least impliedly allowed claimant to use the restroom during working hours. Therefore, the work connection was not severed when claimant used the restroom. We find that claimant's injury occurred in the course of employment in that it occurred at work while claimant was on duty.

We also find that claimant has established a sufficient causal connection between his injury and his employment. In this regard, we find that claimant's testimony persuasively establishes that his fall was caused by water on the floor. Claimant acknowledged injuring his right knee in 1980 and 1986; however, he testified that he had had no recent problems with his right knee. This testimony is supported by the lack of any evidence of medical treatment in recent years. He also testified that he did not feel his knee give out; instead, he felt his foot slip. Given the fact that the urinal flushed with a lot of water pressure, claimant inferred that his foot slipped on water on the floor.

The insurer argues that claimant has not established that there was water on the floor causing claimant to slip. In support of this argument, the insurer relies on claimant's admission that he did not see any water on the floor and the testimony of Mr. Mosin, a supervisor, and Mr. Bremer, the paramedic who treated claimant at the scene. Although claimant testified that he did not see any water on the floor, he said he felt his foot slip before he fell and, given the fact that the urinal had just forcefully flushed, he inferred he slipped on water on the floor. In addition, Mr. Mosin was not the supervisor who found claimant. Instead, Mr. Mosin was called after claimant was discovered. Moreover, Mr. Mosin had to travel a couple of blocks to get to the scene. Furthermore, Mr. Bremer arrived even later, after the ambulance was called. Therefore, it is not unreasonable that there was no longer any water on the floor by the time Mr. Mosin and Mr. Bremer arrived. Under these circumstances, we infer that there was water on the floor causing claimant to slip and fall. Thus, examining the totality of the events that gave rise to claimant's injury, i.e., the wet floor causing claimant to slip and fall, we conclude that claimant's injury arose out of his employment.[1] Accordingly, claimant has established legal causation of his slip and fall injury.

In reaching this decision, we note that the ALJ and the insurer relied on James D. Johnson, 48 Van Natta 303 (1996), aff'd Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997). However, we find Johnson distinguishable in that, there, the claimant failed to show that his knee condition arose out of his employment because he failed to establish any causal connection between the injury and his work activities other than the fact that the injury occurred at work. Here, claimant has established a causal connection -- the slippery floor that caused him to slip and fall.

In addition, we find that the persuasive medical evidence establishes medical causation. Given claimant's previous right knee injuries, medical causation is a complex medical issue that requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967). Two physicians rendered opinions regarding medical causation. Both physicians had a correct history of the March 14, 1996 slip and fall on the wet floor and claimant's prior history of right knee injuries. (Exs. 14A, 14AA).

Dr. Tesar, orthopedist, examined claimant on behalf of the insurer. He opined that claimant sustained a lateral patellar dislocation at the time of the March 14, 1996 injury. (Ex. 14AA-6). He opined that the major contributing cause of the patellar dislocation was the incident at work. Id. However, he opined that claimant's ligament injuries and chondromalacia were all preexisting. (Ex. 14AA7).

Dr. Wells also indicated that claimant sustained a dislocated patella as a result of the March 14, 1996 injury. In addition, he opined that claimant had "pre-existing condition with laxity of the medial collateral, anterior and posterior cruciate ligaments, and some damage to the lateral femoral condyle and lateral tibial plateau." (Ex. 14A-3). He opined that the described March 1996 injury "associated with" the preexisting condition, resulting in the injury of March 14, 1996. Finally, he opined that the major cause for treatment and subsequent medical care, including the arthroscopy, was the March 14, 1996 injury. Id.

We generally give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are no persuasive reasons not to defer to the opinion of Dr. Wells. He is in an advantageous position, as claimant's treating surgeon, to evaluate claimant's condition. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Moreover, he had an accurate history of claimant's previous right knee injuries and considered this preexisting condition in rendering his causation opinion.

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[1] Even if we did not conclude that there was water on the floor, the fact remains that claimant's foot slipped on the floor. Thus, the condition of the slippery floor, whether that slippery condition was caused by water, wax, or some other substance, was a condition at work that caused claimant to slip and fall. Therefore, we would continue to find claimant's injury arose out of his employment based on the slippery condition of the floor, even if we did not find that there was water on the floor.

In addition, in determining whether a causal connection exists between the injury and the employment, we consider whether what occurred was an anticipated risk of employment, i.e., whether the conditions of claimant's employment put him in a position to be injured. Henderson v. S.D. Deacon Corp., 127 Or App 333, 338-39 (1994). Here, claimant slipped on a slippery floor while using the urinal at work. As addressed above, the employer at least impliedly allowed claimant to use the restroom during working hours. Therefore, injury due to slippery floors while using the restroom was an anticipated risk of employment.

When a preexisting disease or condition combines with a compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the combined condition. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).

Here, there is no dispute that claimant has preexisting right knee conditions. Moreover, we find that Dr. Wells' opinion establishes that the preexisting right knee conditions combined with a compensable injury and the compensable injury is the major contributing cause of the combined condition. Therefore, claimant has established compensability of his right knee injury pursuant to ORS 656.005(7)(a)(B).

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

ORDER

The ALJ's order dated October 18, 1996 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's right knee injury claim is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded a fee of $3,000, payable by the insurer.

In the Matter of the Compensation of
JOSE L. HERNANDEZ, Claimant
WCB Case No. 96-04633
CORRECTED ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker's order that increased claimant's unscheduled permanent disability for a gastrointestinal condition from 25 percent (80 degrees), as awarded by an Order on Reconsideration, to 37 percent (118.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

As part of claimant's compensable left arm injury, SAIF accepted "peptic duodenal ulcer disease secondary to the use of NSAIDS." A Notice of Closure awarded 9 percent scheduled permanent disability for the left arm and 18 percent unscheduled permanent disability for the left shoulder. An Order on Reconsideration increased the unscheduled permanent disability award to 25 percent and otherwise affirmed the Notice of Closure. The increase in part was based on the finding that claimant was entitled to 3 percent impairment for his peptic ulcer disease.

Claimant requested a hearing, asserting that he was entitled to additional impairment for his ulcer condition. The ALJ agreed and increased claimant's unscheduled permanent disability award. SAIF challenges the ALJ's order, contending that claimant did not prove additional impairment under the standards.

Impairment of the upper digestive tract, including the duodenum, is valued according to four classes. OAR 436-035-0420(2). Class 1 provides:

> "Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; and
>
> "Continuous treatment is not required; and
>
> "Weight can be maintained at the desirable level; or
>
> "There are no sequelae after surgical procedures."

Class 2 provides:

> "Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and
>
> "Appropriate dietary restrictions and drugs are required for control of symptoms, signs and/or nutritional deficiency; and
>
> "Loss of weight below the 'desirable weight' [provided in the standards] does not exceed 10%."[1]

Claimant's treating physician, Dr. Garcia, reported to claimant's attorney that claimant was "having ongoing problems with his peptic ulcer disease" and he needed "ongoing medical care and dietary instruction along with continuation of his current medications." (Ex. 16). Dr. Garcia then concurred with a "check-the-box" report from SAIF's attorney stating that claimant needed to "follow appropriate dietary restrictions and use prescription medication to control the symptoms of his peptic ulcer disease[.]" (Ex. 17).

During reconsideration, the appellate review specialist asked Dr. Garcia to examine the standards "regarding impairment to the upper digestive tract and note what Class, if any, the claimant's condition would fall into." (Ex. 20-2). Dr. Garcia responded that claimant "will need continued treatment for the peptic ulcer disease, including medications and dietary restrictions" and classified his condition "as Class I." (Ex. 7).

The ALJ found that Class 2 impairment did not require weight loss. Because there was medical evidence of dietary restrictions and medication, the ALJ concluded that impairment should be valued according to Class 2.

We disagree with the ALJ's construction of the rule. First, Class 2 impairment lists as a requirement that "[l]oss of weight below the 'desirable weight' does not exceed 10%." Based on the plain meaning of such terms, we find there must be proof of weight loss. Furthermore, Class 1 impairment provides that "[w]eight can be maintained at the desirable level." Because Class 1 refers to the maintenance of weight and Class 2 instead provides for loss of weight, we find additional support for our construction of the rule. This construction is further confirmed by provisions in Class 3 and Class 4 impairments referring to additional percentages of weight loss. Thus, we conclude that, in order to prove entitlement to Class 2 impairment, claimant also must show loss of weight that did not exceed 10 percent of his desirable weight.

According to claimant, he satisfied such a showing. We agree. In December 1993, claimant weighed 145 pounds. (Ex. 5A). By April 1995, claimant's weight was down to 137 pounds.[2] (Ex. 8-4).

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[1] Class 3 impairment is the same as Class 2 except it requires a "10-20% loss of weight below the 'desirable weight' which is ascribable to a disorder of the upper digestive tract." Class 4 in part requires that upper digestive tract symptoms cannot be controlled by treatment or "greater than a 20% loss of weight below the 'desirable weight.'"

[2] We consider the subsequent statement in the report that claimant's "weight has been stable at 146 pounds," (Ex. 8-10), to be unreliable. The weight of 137 pounds was recorded by examining neurologist, Dr. Brooks, during the "Neurologic Examination," indicating that claimant was actually weighed during the examination. The latter statement referring to 146 pounds was recorded by examining surgeon Dr. Swangard and appears under "Current Symptoms" where the information appears to have been provided from claimant himself. For this reason, we consider the weight of 137 pounds, rather than 146 pounds, to be most accurate.

Dr. Garcia's indication that claimant fell within Class 1 does not rebut the evidence of weight loss. In providing such information, Dr. Garcia was asked to "review the enclosed standards" and classify claimant's impairment. (Ex. 20-2). Thus, Dr. Garcia's opinion was based only on his own interpretation of the rule's requirements. In responding to the request, Dr. Garcia did not refer to weight loss or otherwise indicate that he had considered whether claimant sustained a weight loss. Consequently, we conclude that Dr. Garcia's opinion does not relate to the weight loss issue.

According to Dr. Garcia, claimant continued to experience symptoms from his peptic ulcer disease and was required to follow dietary restrictions and use prescription medication to control the symptoms. (Exs. 7, 16, 17). Furthermore, as discussed above, claimant experienced a weight loss below his "desirable weight."[3] Thus, claimant is entitled to Class 2, or 15 percent, impairment. Former OAR 436-035-0420(2).

The parties do not disagree with the Order on Reconsideration finding entitlement to 2 percent impairment for the shoulder condition; this impairment, combined with 15 percent, results in 16 percent impairment. The parties also do not contest the values of 5 for age and education and 4 for adaptability. Multiplying the age and education values with adaptability results in a value of 20 percent. Former OAR 436-035-0280(6). Adding that value to the impairment value of 16 results in 36 percent. Former OAR 436-035-0280(7). Thus, claimant is entitled to an award of 36 percent unscheduled permanent disability. Accordingly, we reduce claimant's 37 percent award as granted by the ALJ's order.

ORDER

The ALJ's order dated September 20, 1996 is modified. In lieu of the ALJ's order, and in addition to the Order on Reconsideration's award of 25 percent (80 degrees) unscheduled permanent disability, claimant is awarded 11 percent (35.2 degrees), for a total of 36 percent (115.2 degrees) unscheduled permanent disability. Claimant's "out-of-compensation" attorney fee is modified accordingly.

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[3] Because claimant is 68 inches tall, (Ex. 8-4), the least "desirable weight" under the standards is 140 pounds. Former OAR 436-035-0420. Inasmuch as claimant weighed 137 pounds, he had a loss of weight below the "desirable weight."

Board Member Haynes dissenting.

Although I agree with the majority's interpretation of OAR 436-035-0420(2) as requiring proof of weight loss, I disagree with the majority's application in this case. First, there is inconsistent evidence concerning claimant's weight. In the same report that indicates claimant's weight is 137 pounds, the physicians note that his "weight has been stable at 146 pounds." (Ex. 8). Moreover, claimant's physician found that claimant's impairment came under Class 1, which additionally supports the finding that claimant did not sustain weight loss.

More importantly, the majority's discussion concerning the issue of "desirable weight" is inadequate and misleading. The rule includes a desirable weight table, which is based on the worker's sex, height and body build. Because claimant is 68 inches tall, his desirable weight is 140 to 148 pounds if he has a small frame; 145 to 157 pounds if he has a medium frame; and 152 to 172 pounds if he has a large frame. The majority would be correct that, if claimant's weight was 137 pounds and he has a small frame, weight loss would not exceed 10 percent below the "desirable weight." The problem with this finding is that there is a complete absence of evidence concerning claimant's body build. If claimant has a medium or large frame, then weight loss would exceed 10 percent below the "desirable weight" and he would not qualify for a value under Class 2. He also would not be entitled to impairment under Class 3 and Class 4 since both provisions require that the weight loss "is ascribable to a disorder of the upper digestive tract" and there is no proof, assuming claimant sustained a weight loss, concerning its cause.

Finally, the record shows that, by September 1995 (subsequent to the report putting his weight at 137 pounds), claimant weighed 142 pounds. (Ex. 9A-1). In November 1995, claimant weighed 151 pounds. (Id. at 2). Consequently, when SAIF closed the claim in December 1995, claimant had sustained a weight gain. Because impairment is to be rated as of the date the Order on Reconsideration issues, ORS 656.283(7), and claimant did not have a loss of weight as of that date, claimant is not entitled to a value under the rule.

For these reasons, I would find that, at most, claimant is entitled to a value for Class 1 under OAR 436-035-0420(2).

In the Matter of the Compensation of
BONNIE C. THOMAS, Claimant
WCB Case No. 96-06742
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of claimant's claim for a consequential left knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings," except for the last sentence.

CONCLUSIONS OF LAW AND OPINION

Based on the medical evidence, the ALJ concluded that claimant failed to prove that her compensable 1985 knee injury is the major contributing cause of her current degenerative arthritic left knee condition. The ALJ also reasoned that the employer was not precluded from denying the claim, because no previous permanent disability had been awarded for claimant's left knee chondromalacia or degenerative arthritis. We disagree.

Under Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), a carrier is precluded from denying a condition which was the basis for a prior final permanent disability award.

In this case, Dr. Neufeld, former treating surgeon, unequivocally diagnosed claimant's 1987 condition as "chondromalacia of the knee, with more severe degenerative changes in the medial compartment." (Ex. 19-2, see Ex. 20). Dr. Farris performed a closing examination on April 19, 1988 and recorded his impression that claimant had chondromalacia. (Ex. 25-4). Dr. Farris also stated, "There is nothing in the history, the physical examination or the medical record to indicate that the patient's symptoms are due to anything other than the industrial injury of 12/12/85." (Id.) A final June 9, 1988 Determination Order awarded claimant 20 percent scheduled permanent disability for her left knee condition (with ratings for lost range of motion and disabling pain). (Ex. 26). Based on the Determination Order's award and the unequivocal contemporaneous medical evidence, we find that the 1988 Determination Order awarded permanent disability for chondromalacia/degeneration.

The medical evidence concerning claimant's current left knee condition is provided by Drs. Vessely, Gripekoven, Zimmerman, and Griffin. In August 1996, Dr. Vessely, orthopedist, reviewed claimant's records and stated, "Everyone has concurred that this lady has had tri-compartmental chondromalacia." (Ex. 99-2). He also referred to claimant's current condition as "advanced arthritis" and associated claimant's chondromalacia with "degenerative process." (Exs. 99-2, 99-4). Drs. Gripekoven and Zimmerman describe claimant's current left knee problems as arthritis and degeneration. (Exs. 95, 99B, 101). Dr. Griffin, claimant's longtime treating physician, believes that claimant's current left knee condition represents a more advanced stage of the condition which was present at the time of the prior claim closure. He explained that the 1985 knee injury caused osteoarthritis which ultimately caused widespread joint failure. (Ex. 100; see Ex. 99A-3). Based on these opinions, we find that claimant currently suffers from the same chondromalacia/arthritis/degenerative left knee condition for which she received a permanent disability award in 1988. Under these circumstances, the employer is precluded from contending that claimant's left knee condition is not part of her compensable condition. See Deluxe Cabinet Works, 140 Or App 548; Carolyn A. Morrison, 48 Van Natta 1690 (1986).

Moreover, assuming for the sake of argument that the employer's denial of claimant's left knee condition is not precluded, we would reach the same result based on the medical evidence, as explained below.

To prove entitlement to compensation for her current left knee condition, claimant would be required to prove that her 1985 work injury is the major contributing cause of her consequential condition. ORS 656.005(7)(a)(A).

Drs. Vessely, Zimmerman, and Gripekoven opined that claimant's current tri-compartmental left knee degeneration results from natural progression of degenerative disease (rather than the 1985 injury), largely because there is no evidence that the 1985 injury affected more than one knee compartment and she did not have a meniscus tear in 1985. (Exs. 96, 99, 101).

Dr. Griffin, on the other hand, persuasively described the specific mechanism of injury which led indirectly to claimant's current condition: The 1985 injury caused direct damage to the cartilage and subsequent swelling and damage to the tendons surrounding the joint which led to disturbance of normal joint function, which, in turn, led to more damage. (Ex. 100). In other words, the work injury caused claimant's current widespread left knee problems indirectly. Dr. Griffin also ruled out causes other than the work injury, noting that claimant has no apparent genetic predisposition for degenerative disease. Considering Dr. Griffin's advantage as claimant's longtime treating physician and his well-reasoned opinion (based on an accurate history), we find his conclusions regarding causation persuasive. See Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, based on Dr. Griffin's opinion, we would conclude that claimant's current consequential left knee condition is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). We consider the amount of claimant's counsel's attorney fee by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issues in this case were of above average medical and legal complexity. The hearing lasted less than an hour and claimant was the only witness. The record includes over 100 exhibits, with at least two generated by claimant's counsel. The value of the interest involved and the benefit secured for claimant were substantial, particularly in light of the medical services involved. In addition, considering the complicated nature of the case, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the aforementioned factors, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $6,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs[1]), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 31, 1996 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $6,000 attorney fee, payable by the employer.

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[1] We note that, although claimant sought an attorney fee of $8,000 and listed some of the factors recited in OAR 438-015-0010(4), her counsel did not file a request describing in detail the manner in which the relevant factors applied to this case. See OAR 438-015-0029(2)(b). In light of such circumstances, although we have considered claimant's request, we have not found it particularly probative in reaching our determination of a reasonable attorney fee. Consequently, in rendering our decision, we have primarily relied on the factors expressed above as supported by the record.

In the Matter of the Compensation of
KENNETH D. LEGORE, Claimant
WCB Case No. 94-14696
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Moller, Bock, and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) declined to direct the employer to disclose to claimant surveillance videotapes; and (2) reinstated her prior (November 7, 1995) Opinion and Order which had been vacated by the Board.[1] In that order, the ALJ: (1) found that claimant's left rotator cuff disruption had not been accepted by the employer; (2) upheld the self-insured employer's denial of claimant's claim for a left rotator cuff disruption; (3) set aside the employer's denial of claimant's headache condition; (4) admitted Exhibits 44 and 45 over claimant's objection; and (5) declined to order the employer to turn over to claimant surveillance videotapes. On review, the issues are discovery, evidence, scope of acceptance and compensability.[2] We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 49 at the time of hearing, was working as a truck driver when, on November 27, 1993, he was involved in a motor vehicle accident on icy roads. Claimant's truck was rear-ended by an automobile. The impact caused claimant's head to hit the back of the cab, then fall forward. Claimant also hit his left shoulder against the side of the cab or the shoulder harness. He sustained a bump on his head and bruises on his face, neck, and chest.

On his return home, claimant sought treatment complaining of soreness and stiffness in his neck, head and left shoulder. He continued treating with his family physician, Dr. Gray, for a cervical, thoracic and left shoulder girdle strain, head contusions and TMJ dysfunction.

On March 1, 1994, the employer accepted claimant's condition as "Contusion - Head (Lt. Occipital Region), Strain - Cervical, Thoracic & Lt. Shoulder, Bruise - Rt. Hip, TMJ Dysfunction." (Ex. 74). On November 10, 1994, the employer issued a partial denial, denying that various other conditions, including a left rotator cuff disruption, were associated with his compensable injuries.[3] On February 8, 1995, the employer issued another partial denial, contending that claimant's headache condition was not compensably related to the November 1993 accident. Claimant requested a hearing challenging the denials.

The first day of hearing occurred on February 24, 1995. The matter was then continued until May 24, 1995. During this second day of hearing, claimant demanded copies of all documents in the claim examiner's file that were not produced prior to hearing, including the examiner's running notes and status reports. The employer agreed to turn over all documents not previously produced, except

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[1] In remanding the case to the ALJ for further proceedings with regard to the discovery issue, we did not address the other issues (i.e., evidence, scope of acceptance and compensability) raised by the parties on review. See Kenneth D. Legore, 48 Van Natta 1577 (1996).

[2] Previously (in addition to challenging the ALJ's ruling on the discovery issue), claimant requested review of those portions of the ALJ's November 5, 1995 order that upheld the employer's denial of his left rotator cuff condition, admitted exhibits 44 and 45 and found that claimant's left rotator cuff condition had not been accepted. The employer cross-requested review of that portion of the order that set aside its denial of claimant's headache condition. See Kenneth D. Legore, supra.

[3] The other conditions addressed in the employer's partial denial are not at issue on review.

those that were privileged and those it believed to be impeachment evidence.[4] The ALJ deferred ruling on the "impeachment evidence" disclosure issue, allowing the parties to brief the discoverability of certain evidence, specifically surveillance videotapes of claimant recorded in late 1994 and early 1995.[5] On July 25, 1995, the ALJ issued an interim order finding the videotapes not discoverable under amended ORS 656.283(7). On October 27, 1995, the hearing reconvened for closing argument. Prior to hearing the closing argument, the ALJ clarified the remaining issues to be resolved (compensability, penalties and attorney fees) and admitted an additional exhibit.

On review, we vacated the ALJ's order and remanded on the discovery issue. We directed the ALJ to view the videotapes to determine whether they constituted "impeachment evidence" only or were relevant and material for other purposes. Kenneth D. Legore, supra. On remand, after reviewing the videotapes, the ALJ ruled that the evidence was not discoverable.

CONCLUSIONS OF LAW AND OPINION

Discovery

After reviewing the surveillance videotapes in camera after the hearing, the ALJ determined that the videotapes had no bearing on the compensability issues and therefore did not constitute "impeachment evidence" in this hearing. The ALJ found, however, that the videotapes could have impeachment value in another proceeding arising out of the same claim, and concluded that the evidence was not discoverable under ORS 656.283(7).

Claimant seeks review, contending that the videotapes should be disclosed and that he should have the opportunity to determine whether he wishes to present them as evidence. As a result of events which transpired at a subsequent proceeding, we need not resolve claimant's contention.

The later proceeding concerned claimant's hearing request regarding an Order on Reconsideration. WCB Case No. 95-12687. He sought increases in his unscheduled permanent disability and temporary disability awards. At that hearing, the videotapes were neither admitted into the record nor disclosed to claimant. The ALJ's order in that case (which increased claimant's unscheduled permanent disability award for a cervical and thoracic spine injury from 17 percent to 21 percent and declined to award additional temporary disability) has not been appealed and has become final by operation of law. ORS 656.289(3).[6]

The insurer's failure to present impeachment evidence at the subsequent hearing in WCB Case No. 95-12687 arguably contradicts its position in this case that the videotapes should not be disclosed. Nonetheless, we need not resolve the ALJ's evidentiary ruling because, even if it was erroneous, the question remains whether remand would be warranted for admission of the videotapes into the record.

After reviewing the videotapes, we agree with the ALJ's assessment that its contents have no relevance to the substantive issues in dispute. In other words, the depiction of claimant walking around a commercial establishment is of no assistance to us in determining whether claimant's left rotator cuff disruption had been accepted and whether that condition and claimant's headaches were compensable. In light of such circumstances, we find that the admission of the videotapes is not reasonably likely to affect the outcome of this case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Samantha L. Spencer, 49 Van Natta 280 (1997). (Remand to ALJ for credibility finding not warranted because, in absence of persuasive medical evidence establishing compensability of claim, such a finding was not reasonably likely to affect the outcome.) Consequently, there is no compelling reason to remand for the introduction of these videotapes. Id.

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[4] In cross-examination, the claims examiner testified that she obtained the surveillance videotapes at the request of defense counsel in anticipation of litigation regarding the extent of claimant's permanent disability. The claims examiner further testified that these videotapes and the surveillance reports were removed from the claims file not disclosed to claimant because they were withheld for impeachment purposes in future litigation. (Tr. 188-193).

[5] The surveillance videotapes were not presented as evidence at the hearing.

[6] We may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned." Rodney J. Thurman, 44 Van Natta 1572 (1992). Here, we find that the subsequent ALJ's Opinion and Order satisfies that criteria.

Evidence

At the hearing, the ALJ overruled claimant's relevancy objection and admitted a prior Opinion and Order (Ex. 44) and Order on Review (Ex. 45) issued in connection with claimant's 1989 claim for injuries to his right shoulder and elbow, while working for another employer. On review, claimant argues that the probative value of this evidence is outweighed by the danger of unfair prejudice, and that it was an abuse of discretion for the ALJ to admit these prior orders, which found the injuries noncompensable and claimant lacking in credibility. We disagree.

ALJ's are not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ has broad discretion in determinations concerning the admissibility of evidence. See e.g. Brown v. SAIF, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. See Thomas E. Andrews, 47 Van Natta 2247 (1995).

As a general rule, an ALJ may properly take administrative notice of prior orders involving the same claimant. See e.g. Gary L. Goodeagle, 47 Van Natta 628 (1995). Furthermore, although the ALJ relied on the previous orders to some extent in concluding that claimant is not a truthful witness, our holding in this case does not turn on the ALJ's credibility finding. In other words, our decision regarding the merits of claimant's claims would be the same even if we disregarded the prior administrative orders.

Scope of Acceptance

In another interim order, the ALJ found that the employer's March 1, 1994 notice of acceptance, which included acceptance of a left shoulder strain, did not accept a rotator cuff tear. The ALJ therefore held that the employer's later denial of a rotator cuff disruption did not constitute a "back up" denial and the burden of proof did not shift to the employer pursuant to ORS 656.262(6).

Claimant maintains on review that the employer's March 1, 1994 acceptance encompassed the rotator cuff tear and that the burden should shift to the employer to prove the condition was noncompensable. We disagree.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). For purposes of adjudicating a back-up denial, acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. SAIF v. Allen, 320 Or 192, 215 (1994); Johnson v. Spectra Physics, 303 Or 49 (1987). Here, the employer accepted a number of specific conditions, including a "strain" of the left shoulder. (Ex. 74). The medical evidence establishes that claimant's left shoulder strain was a distinct, separate diagnosis from his rotator cuff tear, and is not a symptom of the latter. (See e.g. Exs. 74B, 92, 113 and Tr. 2 at 79). Therefore, we agree with the ALJ that the employer did not accept claimant's left rotator cuff, and that claimant retains the burden of proving the compensability of this condition. See ORS 656.266.

Compensability - Left Rotator Cuff Disruption

Relying on the opinion and testimony of Dr. Bald and the opinions of Drs. Barth and Thompson, the ALJ found that claimant's November 1993 industrial accident was not the major contributing cause of his left rotator cuff tear.[7] Drs. Bald, Barth and Thompson attributed claimant's rotator cuff tear to his longstanding preexisting degenerative arthritis and a preexisting acromial spur rather than any injury sustained during the truck accident.

On review, claimant argues, in essence, that the opinions of Drs. Bald, Barth and Thompson are unpersuasive because these physicians did not have an accurate account of the accident and mechanism of injury. In addition, claimant urges us to give greater weight to the opinions of his treating doctor,

[7] Claimant does not dispute that he had a preexisting degenerative left shoulder condition and that ORS 656.005(7)(a)(B) is applicable to this claim.

Dr. Gray, and consulting specialist, Dr. Switlyk, who reported that the November 1993 accident caused his rotator cuff tear.[8]

Because of the preexisting conditions, the causation of claimant's left rotator tear presents a complex medical question, the resolution of which largely turns on an analysis of the medical evidence. See 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).

Dr. Gray initially opined that claimant's left rotator cuff tear was related to the motor vehicle accident because the impact caused claimant to hit his left shoulder against the side of the cab with his arms outstretched. (See Ex. 105C). He later explained that the accident was the cause because: (1) claimant had a seat belt bruise across his left shoulder and chest for two weeks following the accident; and (2) claimant could no longer do heavy lifting with his left arm and shoulder. (See e.g. Exs. 109A, 114, 127A). This latter assessment was based on claimant's report that he had no left shoulder pain prior to the accident and was able to lift 100 pounds with his left upper extremity without difficulty. (Ex. 127A).

Like the ALJ, we find Dr. Gray's opinion unpersuasive for a number of reasons. First, Dr. Gray did not explain how a direct blow to the left shoulder could result in a rotator cuff tear. Dr. Bald, an expert on shoulder injuries, testified that the impact of claimant's shoulder against the side of the cab would not produce a rotator cuff tear, because it would not supply the necessary muscle trauma, and this testimony has not been rebutted.[9] Second, Dr. Gray did not address the functional element to claimant's symptoms reported by the other examining doctors, nor did he explain how a relatively minor rotator cuff tear could result in such severe pain and significant loss of motion.[10] Third, Dr. Gray's opinion apparently assumes that claimant's left shoulder was totally asymptomatic prior to the accident and that he "routinely" lifted in excess of 100 pounds (see Ex. 127A). Yet claimant admitted at hearing that he experienced aching in his left shoulder prior to the accident and that he did not do much heavy lifting by himself. (Tr. 1 at 79). Finally, although Dr. Gray identified the accident as the major contributing cause of the rotator cuff tear, it is not clear that his analysis includes a comparison of the relative contribution of the preexisting conditions (degenerative arthritis and acromial spur) and the work-related incident, as required by Dietz v. Ramuda, 130 Or App 397 (1994) ("major contributing cause" analysis involves evaluating the relative contribution of different cause of an injury or disease and deciding which is the *primary* cause). Because Dr. Gray's opinion is lacking in explanation and analysis and is based on a questionable history, we give it little weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion); Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (doctors' opinions based on an inaccurate history entitled to little or no weight).

We also find Dr. Switlyk's opinion on causation insufficient to sustain claimant's burden on compensability. Dr. Switlyk agreed that the November 1993 accident was the major contributing cause of claimant's rotator cuff tear, in a "check the box" report devoid of any explanation. (Ex. 118).

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[8] Notwithstanding claimant's argument, the record indicates that claimant's treating doctors were operating with essentially the same understanding of the nature of the motor vehicle accident (a rear-end collision) and the mechanism of claimant's shoulder injury (being thrown against the shoulder harness or side of the cab) as were Drs. Bald, Barth and Thompson. (See e.g. Exs. 57, 77).

[9] Dr. Bald explained that a rotator cuff tear "is only achieved in a traumatic sense with sudden high stress applied to the arm with the elbow away from the side and the arm outstretched." (Tr. 2 at 94). Although claimant now contends that he could have sustained the rotator cuff tear when he jerked on the steering wheel while trying to right the jack-knifing truck, this scenario is not supported by the evidence. Claimant reported to his treating and examining physicians that the mechanism of injury was being thrown forward against the shoulder harness or hitting his shoulder against the side of the cab on impact. (See, e.g. Exs. 54A, 77-1, 86-3, 88, 105C). He did not report, nor did he specifically testify at hearing, that he had to violently jerk on the steering wheel.

[10] Both Dr. Switlyk, who examined claimant on referral from Dr. Gray, and Dr. Thompson, who examined claimant at the insurer's request, found that claimant's subjective complaints far exceeded the objective findings. (Exs. 77, 84, 88-7). Both doctors had difficulty associating claimant's symptoms with the rotator cuff tear, and Dr. Switlyk reported that he was pessimistic that claimant's symptoms would improve with a surgical repair of the rotator cuff. (Ex. 84-1).

Because this opinion is so conclusory, we decline to give it any probative weight. See Marta I. Gomez, 46 Van Natta 1654 (1994) (the persuasiveness of a "check the box" opinion depends upon the persuasiveness of the foundation upon which the opinion is based). Further, as noted above, in his prior reports concerning claimant's shoulder injury, Dr. Switlyk found exaggerated pain behavior and questioned whether claimant's reported left shoulder pain was even associated with the rotator cuff tear, since an anesthetic injection into the subacromial space did not provide any relief.[11] (Exs. 77-4, 84).

Accordingly, even if we were to reject the medical opinions of Drs. Bald, Barth and Thompson as claimant urges us to do, we would find the evidence concerning the compensability of claimant's rotator cuff tear insufficient to carry claimant's burden of proof.[12]

Compensability - Headache Condition

The employer issued a partial denial of claimant's headaches on February 8, 1995, contending that his ongoing headaches were not compensably related to his accepted injuries. The ALJ found that claimant's ongoing headaches were a compensable consequence of his accepted contused head and cervical, thoracic and left shoulder strain.[13] On review, the employer argues that, given claimant's history of stress-related headaches prior to the November 1993 accident, the lack of objective findings and the lack of a physical explanation for the continuing pain, there is insufficient evidence linking his reported headaches to the accepted injuries. We agree.

When examined by Drs. Bald and Barth on October 4, 1994, claimant reported headaches occurring every two weeks since the November 1993 accident. Although they related the headaches by history to claimant's cervical strain and bilateral upper trapezius muscle discomfort, Drs. Bald and Barth found "no objective evidence of organic basis for [claimant's] continued complaint of headache." (Ex. 107-8). At that time, neither doctor was aware of claimant's history of tension headaches associated with stress beginning in 1984 and lasting through at least August 1987. (See, e.g., Exs. 9, 20-4, 24-4). When presented with this history, Dr. Bald reported, based on the absence of any physical findings indicating some organic basis for the headaches, that claimant's subjective complaint of headaches was not associated with the November 1993 accident. (Ex. 113, Tr. 2 at 108-09). Moreover, at hearing, Dr. Bald explained that when he examined claimant, he found no evidence of palpable muscle tightness, spasm or fibrosis that is generally associated with post-traumatic muscle tension headaches. (Tr. 2 at 117).

Dr. Gray, on the other hand, reported in May 1995 that claimant was still suffering from headaches which are "related to the muscular contraction in the neck and shoulder girdle" and are a "consequence" of the November 1993 neck and shoulder strains sustained in motor vehicle accident. (Ex. 127A). In making this assessment, however, Dr. Gray did not document any objective physical

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[11] Like Dr. Switlyk, Dr. Bald also opined that claimant's left shoulder symptoms did not relate to his rotator cuff tear. (Tr. 2 at 77-79, 101-105). Dr. Bald testified that claimant's left rotator cuff tear is probably the result of his preexisting degenerative process and acromial spur. He explained that, in addition to an acute traumatic event, a rotator cuff tear can occur gradually and progressively over time with repetitive use of the upper extremity. Dr. Bald concluded that claimant's left torn rotator cuff probably preexisted the November 1993 accident and is not the cause of claimant's symptoms. (Tr. 2 at 96-102).

[12] Claimant also argues on review that the employer did not sustain its burden of proving that his rotator cuff tear is not compensable as an occupational disease. First, as discussed above, the employer does not bear the burden of proof in this case. The burden rests with claimant. ORS 656.266. Second, we find no evidence that the occupational disease theory was raised at hearing. Third, even assuming claimant had timely raised the occupational disease theory, he has failed to sustain his burden under ORS 656.802(2). There is no persuasive evidence establishing that claimant's work activity is the major contributing cause of his rotator cuff tear.

[13] We reject claimant's contention that the ALJ erred in applying the major contributing cause standard to the headache condition. Claimant does not contend (and the ALJ did not find) that the November 1993 accident itself directly caused his headaches, but that the headaches result from the compensable neck and back injuries sustained in the accident. Therefore, even if we do not consider claimant's prior headaches a preexisting condition for purposes of ORS 656.005(7)(a)(B), his current, ongoing headaches are properly analyzed as a consequential condition under ORS 656.005(7)(a)(A). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

findings of muscle tension associated with these continuing headaches.[14] In addition, unlike Dr. Bald, Dr. Gray did not address or acknowledge claimant's previous history of stress-related headaches, or his history of functional overlay.

Where the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). On this record, we find Dr. Bald's well-explained opinion regarding the nature of claimant's continuing headaches to be more persuasive than the opinion of Dr. Gray. Although Dr. Gray has been claimant's physician since 1987, his opinion is incomplete and conclusory. We therefore give it little probative value. See Miller v. Granite Construction Co., supra. Accordingly, we conclude that claimant has not established the compensability of his headache condition by a preponderance of the evidence.

ORDER

The ALJ's order dated November 7, 1995 is affirmed in part and reversed in part. That part of the order setting aside the employer's February 8, 1995 partial denial is reversed, and the denial of claimant's headache condition is reinstated and upheld. The $2,000 attorney fee award is also reversed. The remainder of the order is affirmed.

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[14] In the months following claimant's accident, Dr. Gray found spasms in claimant's neck and reported on several occasions that claimant complained of muscle-related headaches. (See e.g. Exs. 68,70A, 71, 76). In September 1994, Dr. Gray reported that claimant was medically stationary. Thereafter, Dr. Gray's chart notes do not document any physical findings (i.e. muscle contractions) associated with claimant's complaints of continuing headaches.

Board Chair Hall specially concurring.

I agree with my fellow members' conclusions regarding the compensability of claimant's left rotator cuff and headache conditions. I also concur that, because consideration of the withheld videotape would not affect the outcome of this case, remand is not appropriate. Nonetheless, I write separately to emphasize that the videotape was not "impeachment evidence" and, thus, it should have been disclosed.

ORS 656.283(7) addresses "impeachment evidence." The statute provides that only "impeachment evidence" may be withheld. To state the obvious, if it is not impeachment evidence, it must be disclosed. See OAR 438-007-0015; OAR 438-007-0017. In light of these statutory and administrative regulations, a party cannot withhold otherwise discoverable evidence based on the assertion that the evidence may have potential impeachment value at some future date.

Here, the employer does not contest the ALJ's finding that the videotape did not constitute "impeachment evidence" regarding this "compensability" hearing. Under such circumstances, the videotape is subject to disclosure under OAR 438-007-0015(2) and (5).

In reaching this conclusion, I construe ORS 656.283(7) as applying only to "impeachment evidence" in the particular hearing before the ALJ, and not claim-related evidence that may have impeachment value in some potential future hearing. ORS 656.283(7) provides that impeachment evidence may be withheld "until the party's case in chief has been presented," indicating that the statute's application is limited to the one hearing at hand.[1] Therefore, even though the videotape may have had impeachment value in a future hearing, the videotape is not "impeachment evidence" within the meaning of ORS 656.283(7).

Notwithstanding the employer's violation of the Board's discovery rules, I agree with the majority's reasoning that remanding this case to the ALJ for "substantive" consideration of this withheld evidence would have no impact on the compensability issues which are in dispute. Consequently, I concur in my fellow members' decision not to remand in this particular case.

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[1] I find nothing in Representative Mannix's testimony concerning the amendments to ORS 656.283(7) to indicate otherwise. His scenario was limited to the withholding of "impeachment evidence" pertinent to the one hearing at issue.

In the Matter of the Compensation of
ANTHONY J. McKENNA, Claimant
WCB Case Nos. 95-07570, 95-02480 & 94-07262
ORDER DENYING RECONSIDERATION
Jerome P. Larkin (Saif), Claimant Attorney
Bottini, et al, Defense Attorneys

On May 27, 1997, we corrected our May 2, 1997 order that had republished our January 31, 1997 Order on Review that: (1) directed Safeco to accept claimant's injury claim for an "L4-5 disc derangement/bulge" condition; (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition; (3) upheld Safeco's denials of claimant's aggravation and occupational disease claims for the same condition; (4) denied claimant's motions to remand and strike Safeco's Cross-Reply Brief; and (5) declined to award interim compensation or assess penalties or sanctions. Asserting that the September 13, 1995 hearing transcript contains a typographical error, claimant seeks correction of the record for purposes of his judicial appeal.

More than 30 days has elapsed since our May 27, 1997 Second Order on Reconsideration. Under such circumstances, our authority under ORS 656.295(8) to withdraw or reconsider our prior order has expired. See SAIF v. Fisher, 100 Or App 288 (1990). Although jurisdiction over this case presently resides with the court, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed purposes of reconsideration provided that we follow the procedures set forth in ORAP 4.35. See ORS 183.482(6); Glen D. Roles, 43 Van Natta 278 (1991). We rarely exercise this authority. See Carole A. Vanlanen, 45 Van Natta 178 (1993).

Claimant contends that the hearing transcript should be corrected to confirm that Safeco's counsel admitted that claimant's L4-5 disc bulge claim had been accepted, albeit by error. Claimant maintains that such a correction will provide further support for his argument that Safeco unreasonably attempted to revoke its acceptance of the L4-5 disc bulge condition.

To begin, in support of his request for correction of the transcript, claimant relies on ORAP 3.40. Because this rule is expressly applicable to trial courts, it is questionable whether the rule applies to an administrative agency. In any event, even assuming that the rule is applicable, we are not in a position to determine whether the cited portion of the hearing transcript is inaccurate. Rather, because the Administrative Law Judge (ALJ) conducted the hearing in question, the ALJ would be the appropriate arbiter for such a decision.

In order for us to return the case to the ALJ, it must be determined that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, in our previous orders, we determined that Safeco was precluded from denying claimant's L4-5 disc bulge condition because it had not appealed a Determination Order permanent disability award which had been partially based on that condition. In light of such circumstances, we found it unnecessary to address claimant's contention that Safeco had accepted the condition. Finally, in the absence of amounts then due, we held that, even if Safeco's conduct had been unreasonable, a penalty was not warranted.

Based on these previous findings and reasoning, a determination regarding whether Safeco's counsel admitted that the L4-5 disc bulge claim had been accepted in error would have no effect on the outcome of this case. In other words, even if this "correction" was made, we would adhere to our prior conclusion that Safeco's denial was precluded and that there were no amounts then due on which to

base a penalty. Consequently, remand for consideration of claimant's correction request is not justified.[1]

Accordingly, we deny claimant's motion for correction of the record. The issuance of this order neither "stays" our previous orders nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 545 (1985).

IT IS SO ORDERED.

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[1] In reaching this conclusion, we acknowledge that, in response to Safeco's motion, we corrected a clerical error in a prior order. Because the circumstances surrounding the two requests are significantly different, our refusal to grant claimant's motion for correction should not be interpreted as according Safeco preferential treatment. First, unlike claimant's current motion, Safeco's motion was filed prior to the expiration of our authority to withdraw or reconsider our order without first seeking court approval. See ORS 656.295(8); Fisher v. SAIF. Under such circumstances, reconsideration based on a motion filed within 30 days of the previous order does not necessitate consideration of the possible disruption to appellate procedures and case precedents caused by seeking court permission for withdrawal of an appealed order. Moreover, Safeco's motion pertained to a matter directly within our control; i.e., a clerical error in our prior order. In contrast, claimant's motion involves the proposed "correction" of a hearing transcript; a matter that requires examination of whether the case should be remanded to the ALJ. For the reasons expressed above, we have determined that remand would serve no useful purpose because the ultimate outcome of the disputed issues would remain unchanged.

July 9, 1997 Cite as 49 Van Natta 1042 (1997)

In the Matter of the Compensation of
JOHN C. PEERSON, Claimant
WCB Case Nos. 96-03026 & 96-00765
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney
David J. Lefkowitz, Defense Attorney

Reviewed by Board Members Hall and Haynes.

Alexsis Risk Management Service (Alexsis) requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its current condition and "back-up" denials of a low back condition; and (2) upheld the SAIF Corporation's denial of an aggravation claim for the same condition. On review, the issues are the propriety of Alexsis' "back-up" and current condition denials and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. In December 1994, while performing his duties as a utility clerk, claimant turned in his chair, stood up and felt his back pop. He felt immediate back pain and sought treatment with Dr. Howison on December 20, 1994. (Exs. 9-2, 16B-3).

Alexsis did not close claimant's accepted disabling lumbosacral sprain claim before issuing a current condition denial on November 27, 1995. (Exs. 18, 26).

CONCLUSIONS OF LAW AND OPINION

"Back-up" Denial

The ALJ found that Alexis did not meet its burden of proving a proper "back-up" denial under ORS 656.262(6)(a). We adopt the ALJ's reasoning and conclusions regarding this issue with the following supplementation.

In October 1986, SAIF accepted claimant's claim for an acute low back strain/sprain. (Ex. 2A). Subsequently, claimant began working as a utility clerk for the employer. In December 1994, while working, claimant turned in his chair, stood up and felt his back pop. He felt immediate back pain and sought treatment with Dr. Howison on December 20, 1994. (Exs. 9-2, 16B-3). Dr. Howison diagnosed "[l]umbosacral strain, chronic" and noted that claimant had a history of a work-related injury with back problems dating back to 1986. (Ex. 9-2). Within a few days, claimant's back pain had largely resolved and he returned to his regular work.

On March 9, 1995, claimant experienced a recurrence of low back pain following a similar incident at work of twisting in his chair while attempting to stand. (Exs. 11-1, 16B-3). In March 1995, claimant again sought treatment from Dr. Howison, who diagnosed "[a]cute exacerbation of chronic condition" and "[c]hronic back pain" with a history of herniation. (Ex. 11-1). In April 1995, claimant was examined by Drs. Snodgrass, neurologist, and Fuller, orthopedist, on behalf of SAIF, and by Drs. Brooks, neurologist, and Smith, orthopedist, on behalf of Alexsis. (Exs. 16, 16B).

Drs. Brooks and Smith noted that an April 1, 1995 MRI showed degenerative changes with posterior bulging at L3-4 and L4-5. They noted claimant's history of a 1986 work injury and that claimant "has experienced intermittent attacks of low back pain, each of which have responded quite well to conservative measures (particularly to manipulative treatment) until his present episode." (Ex. 16B-2, -6). In addition, they noted that, since the initial injury, claimant had given up some activities because of back pain, but that claimant still fished and could do some yard work when his back was not "out." (Ex. 16B-5). However, they noted that he currently was unable to do any of these activities. Id. They diagnosed "[s]prain of lumbosacral spine, occurring on March 9, 1995, with exacerbation of pre-existing back pain." (Ex. 16B-6).

On April 28, 1995, Alexsis accepted a disabling lumbosacral sprain, identifying the date of injury as March 9, 1995. (Ex. 18). On April 19, 1996, Alexsis issued a "back-up" denial of the March 9, 1995 injury.

Under ORS 656.262(6)(a), if an employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and "later obtains evidence that the claim is not compensable" the employer may revoke the claim acceptance and issue a formal denial of the claim, as long as the denial is issued within two years of the date of the initial acceptance. In this case, the pivotal question is whether Alexsis' April 19, 1996 "back-up" denial was based on "later obtain[ed] evidence" that the claim was not compensable.

To constitute "later obtain[ed] evidence," the statute requires that there be something other than evidence the insurer or employer had at the time of initial acceptance. As the ALJ points out, a reevaluation of known evidence does not constitute later obtained evidence. See CNA Ins. Co. v. Magnuson, 119 Or App 282 (1993) (the legislature intended that evidence warranting the retroactive denial "come about" after the insurer's original acceptance); see also Ralph E. Murphy, 45 Van Natta 725 (1993) ("back-up" denial set aside where the employer knew at the time of acceptance that the claimant was not an Oregon subject worker).

On review, Alexsis argues that its "back-up" denial was proper, contending that it was based on later obtained evidence because Drs. Snodgrass and Fuller did not have an accurate history regarding claimant's preexisting condition until after the claim was accepted. (Exs. 16, 31). Even assuming that this contention is correct, Drs. Brooks and Smith, who examined claimant on Alexsis' behalf, had an accurate history of claimant's preexisting condition, as described above. (Ex. 16B). Furthermore, Alexsis does not contend that it did not receive the April 21, 1995 report from Drs. Brooks and Smith before issuing its acceptance on April 28, 1995. Therefore, the information provided by Drs. Snodgrass and Fuller is simply a re-evaluation of evidence present at the time of claim acceptance and, as such, does not support the "back-up" denial.[1]

[1] The same reasoning applies to the opinion of Drs. Maukonen, neurologist, and Gambee, orthopedist, who examined claimant on behalf of Alexsis following its claim acceptance. (Ex. 25).

Alexsis also contends that the "fact" that claimant's condition did not resolve as quickly as anticipated by Drs. Brooks and Smith represents later obtained evidence that supports the "back-up" denial. We disagree. Such a "fact" is not evidence that, in the first instance, the claim is not compensable or Alexsis is not responsible for the claim. ORS 656.262(6)(a).

Finally, Alexsis argues that Dr. Howison's May 30, 1996 opinion and "post-hearing" deposition provide "later obtain[ed] evidence" that support its "back-up" denial.[2] (Exs. 32, 33). Even if we found that Dr. Howison's opinions supported the procedural validity of the "back-up" denial, because we find those opinions unpersuasive, they do not support the denial on the merits.

As discussed above, ORS 656.262(6)(a) provides that an employer may, under certain circumstances, revoke claim acceptance and issue a "back-up" denial. However, if the worker requests a hearing on such a revocation of acceptance and denial, the carrier must prove, by a preponderance of the evidence, that the claim is not compensable or the carrier is not responsible for the claim. Id. The persuasive medical evidence does not establish that claimant did not sustain a compensable lumbar strain injury while working for the employer on March 9, 1997.

Prior to Alexsis' acceptance of the disabling lumbosacral strain, Dr. Howison offered no opinion as to the cause of this condition. However, Dr. Howison subsequently reported that the March 9, 1995 incident "caused a sprain." (Ex. 28-1). Without explanation, he later indicated that the March 9, 1995 incident "was not and never had been, the major cause of [claimant's] condition, disability or need for treatment." (Ex. 32-1). He stated that claimant had a "preexisting back condition as a result of prior trauma, which caused him to be out of condition," and this preexisting back condition is the major cause of claimant's disability and need for treatment. Id.

In his deposition, Dr. Howison again changed his opinion without explanation. At that time, he opined that the major cause of claimant's disability and need for treatment following the March 9, 1995 incident was claimant's obesity and deconditioning, which preexisted both the 1986 and 1995 incidents. (Ex. 33-4, -6). He could not allocate the contribution of the 1986 injury to claimant's deconditioning. (Ex. 33-6).

Absent persuasive reasons to the contrary, generally we defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). We find persuasive reasons in this case not to defer to Dr. Howison's opinion. In particular, Dr. Howison offers no explanation for his several changes of opinion. We give little deference to such an unexplained change of opinion. See Kelso v. City of Salem, 87 Or App 630 (1987). Instead, we find the well-reasoned opinion of Drs. Brooks and Smith persuasive evidence that claimant sustained a compensable lumbosacral strain on March 9, 1997. (Ex. 16B). Accordingly, Alexsis did not carry its burden of proof and we set aside its "back-up" denial.

Responsibility

The ALJ found that responsibility remains with Alexsis. We adopt the ALJ's reasoning and conclusions on this issue with the following supplementation.

ORS 656.308(1)[3] applies if a worker sustains a "new compensable injury" involving the same condition as that previously processed as part of an accepted claim. See SAIF v. Yokum, 132 Or App 18 (1994). Responsibility is then assigned to the carrier with the most recent accepted claim for that condition. Smurfit Newsprint v. De Rosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45

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[2] Claimant and SAIF argue that because this evidence was obtained after issuance of the "back-up" denial, it necessarily cannot support that denial. Since we find Dr. Howison's opinion unpersuasive, as explained in the body of our order, we need not address this argument.

[3] 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."

Van Natta 1058 (1993). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or treatment involves a condition different than that which has already been processed as part of a compensable claim. See Armand J. DeRosset, 45 Van Natta at 1059.

Here, SAIF accepted "acute low back strain/sprain."[4] (Ex. 2A). Claimant subsequently sustained a new injury involving the same condition, which Alexsis accepted as "lumbosacral sprain." (Exs. 16B, 18). In addition, we find that claimant's further disability or treatment involves the same condition that has already been processed as part of a compensable claim. In this regard, claimant's current condition is diagnosed as "chronic lumbosacral strain" or "chronic back strain." (Exs. 25-5, 26A). No medical evidence attributes claimant's current condition to any degenerative condition. Nor is there any medical evidence that makes a distinction between lumbar sprain/strain and "chronic" lumbar sprain/strain. Therefore, we find that ORS 656.308 applies to this claim. Thus, as no subsequent injury has occurred that could transfer responsibility, responsibility is assigned to Alexsis, the carrier with the most recent accepted claim for the low back sprain condition.

Moreover, even if claimant's current low back condition did not involve the "same condition," but only the same body part, we would still find Alexsis responsible under the analysis in Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), as applied by the ALJ. Kearns created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "Kearns presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. Id. at 587. The carrier with the last accepted injury can rebut the Kearns presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. Id. at 588.

As the ALJ found, because it is the last carrier with an accepted claim for the low back, Alexsis is presumptively responsible for claimant's current low back condition. Id. Furthermore, as the ALJ found, Alexsis failed to rebut the "Kearns presumption." In this regard, persuasive medical evidence establishes there is some contribution to claimant's current condition by the 1995 work injury, the last accepted injury. (Ex. 25-6). Accordingly, Alexsis remains responsible.

Current Condition Denial

Without first closing its accepted claim for disabling lumbosacral sprain, Alexsis issued a current condition denial, contending that the major contributing cause of claimant's current condition was the "pre-existing chronic lumbosacral strain." (Exs. 18, 26). For the following reasons, we agree with the ALJ that this denial should be set aside.

As a preliminary matter, we note that compensability was not raised at hearing. (Tr. 3). Therefore, it is questionable whether Alexsis can contest compensability of the current condition on review. Nevertheless, even if Alexsis could contest compensability, we find that, under the facts of this case, Alexsis' current condition denial is not supportable.

ORS 656.262(6)(c) provides:

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

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[4] Citing Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), Alexsis argues that SAIF also accepted preexisting degenerative back conditions by virtue of the permanent disability awarded by an August 14, 1989 Determination Order and a December 7, 1989 Opinion and Order. (Exs. 3A, 5). We disagree. As the ALJ found, there is no evidence that claimant's permanent disability award was based on impairment for any condition other than SAIF's accepted low back strain/sprain condition. Thus, the reasoning in Messmer does not apply.

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."

In Elizabeth B. Berntsen, 48 Van Natta 1219 (1996), we interpreted these statutes as meaning that a "pre-closure" denial of a current condition is invalid when that condition is neither a "combined" nor a "consequential" condition, provided the condition is for the same condition previously accepted. Thus, we found that the rationale expressed in Roller v. Weyerhaeuser Co., 67 Or App 743, amplified 68 Or App 743, rev den 297 Or 601 (1984), precluding pre-closure denials of a previously accepted condition, remained viable under these circumstances despite enactment of amended ORS 656.262(6)(c) and (7)(b). In addition, by its terms, ORS 656.262(6)(c) requires an "acceptance of a combined or consequential condition under ORS 656.005(7)" before it applies.

Here, Alexsis did not accept a combined or consequential condition; instead, it accepted claimant's disabling lumbosacral sprain. (Ex. 18). Furthermore, as discussed above, the condition Alexsis attempts to deny in its pre-closure current condition denial is the same condition that it previously accepted. Such a pre-closure denial is not permitted under ORS 656.262(6)(c) and (7)(b) and Roller. Berntsen, 48 Van Natta at 1221-22.

Finally, Alexsis' current condition denial attempts to circumvent the assignment of responsibility pursuant to ORS 656.308 and Kearns. In this regard, as explained above, under either ORS 656.308 or Kearns, responsibility is assigned to Alexsis as the last carrier to accept the lumbar sprain condition. However, Alexsis' current condition denial alleges claimant's condition is due to claimant's preexisting lumbosacral strain, which occurred at SAIF's insured, a prior employer.

Accordingly, we find that Alexsis' current condition denial is improper and set it aside. Responsibility remains with Alexsis.

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 Alexsis. 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, an the value of the interest involved.

ORDER

The ALJ's order dated December 23, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by Alexsis.

In the Matter of the Compensation of
JANICE M. HAWKINS, Claimant
WCB Case No. 95-07634
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Hall, Bock, and Moller.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for left shoulder tendinitis. Claimant cross-requests review of that portion of the ALJ's order that upheld the employer's denial of her aggravation/current condition claim for a right knee condition. Claimant also contends that the ALJ should have set aside the employer's denial of her occupational disease claim for a left shoulder impingement condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

Claimant slipped and fell at work on March 12, 1992. The employer accepted a right leg/knee strain, multiple bruises and twisted right hip. (Ex. 9G). Claimant was examined two weeks after the injury, complaining of hip and sacral pain, but she did not mention any knee pain. (Ex. 9I).

On August 23, 1995, claimant was examined by Dr. Gargaro for complaints of right knee pain. (Ex. 41A). Claimant told Dr. Gargaro about her 1992 injury at work and "stated that really her knee has never been quite right." (Id.) Claimant said that it took quite awhile to get over the acute injury, but she was eventually able to work with minimal problems. However, in the last few months, claimant's knee pain progressively increased. (Id.) An MRI showed a tear of the posterior horn of the medial meniscus. (Exs. 41A, 41B).

Claimant was examined by Dr. Bald on behalf of the employer. Dr. Bald diagnosed a degenerative medial meniscal tear of the right knee. (Ex. 44-6). Dr. Bald concluded that claimant's current right knee symptoms had no relationship to her March 1992 injury. (Id.)

In August 1993, claimant filed a claim for pain in her left shoulder, neck, back and arm. (Exs. 13, 15). Claimant indicated that her condition was caused by reaching and carrying heavy trays at work. (Id.) On November 12, 1993, the self-insured employer accepted a left shoulder strain. (Ex. 19).

Claimant was later treated for her shoulder condition by Dr. Balme, who diagnosed subacromial bursitis, left shoulder, with calcific peritendinitis and AC joint arthritis. (Ex. 30). Dr. Balme recommended surgery or a job change. (Ex. 34).

On March 18, 1995, claimant was examined by Drs. Watson and Martens regarding her bilateral arm and shoulder pain. They diagnosed bilateral shoulder discomfort with diminished range of motion, x-ray evidence of degenerative AC joint changes, calcific tendinitis (left), obesity, deconditioning and depression. (Ex. 37). They doubted that a surgical procedure would accomplish significant symptomatic improvement and they found no evidence that the major contributing need for shoulder surgery was related to work. (Id.) Dr. Balme agreed with their report. (Exs. 36, 38).

Claimant was also examined by Dr. Bald regarding her arm and shoulder condition. Dr. Bald diagnosed impingement syndrome, left shoulder, secondary to calcific tendinitis and osteoarthritis of the glenohumeral and AC joints. (Ex. 44).

On May 3, 1995, the employer issued a partial denial of bilateral shoulder discomfort with degenerative arthritic changes and calcific tendinitis (left), obesity, deconditioning and depression.[1] (Ex. 40A). On May 15, 1996, the employer issued an aggravation and current condition denial of claimant's current right knee condition, including a meniscus tear. (Ex. 47). On the same date, the employer issued a partial denial of left shoulder impingement syndrome. (Ex. 48). Claimant requested a hearing on the denials.

[1] Claimant does not take issue with the employer's denials of obesity, deconditioning and depression.

CONCLUSIONS OF LAW AND OPINION

Left Shoulder

We briefly review claimant's medical treatment for her shoulder problems. Claimant, a waitress, has worked for the employer for approximately 28 years. In 1993, claimant filed a claim for left shoulder strain, asserting that it was related to carrying trays. (Ex. 13). On November 12, 1993, the employer accepted a nondisabling left shoulder strain. (Ex. 19).

On September 15, 1994, Dr. Balme reported that claimant had neck pain and shoulder pain primarily in the left side. (Ex. 30). Claimant was unable to work because of the discomfort. Dr. Balme noted that claimant's job required her to carry trays that weighed up to 20 pounds with her left hand. (Id.) Dr. Balme diagnosed subacromial bursitis, left shoulder, with calcific peritendinitis and AC joint arthritis. (Id.) Claimant continued to have shoulder pain while performing modified work. (Ex. 32).

On January 27, 1995, Dr. Balme reported that claimant had bilateral shoulder pain, left greater than right. (Ex. 34). Claimant had calcific peritendinitis in the left shoulder, as well as left AC joint arthritis. (Id.) Dr. Balme thought claimant's shoulder pain was related to subacromial impingement, tendinitis and arthritis. He took claimant off work to give her shoulders a complete rest from her waitress job.

On February 27, 1995, Dr. Balme reported that claimant had left shoulder pain with hyperextension of her cervical spine. (Ex. 33). Dr. Balme said he was "probably dealing now with chronic shoulder pain related to her AC joint arthritis." (Id.)

Dr. Balme commented on March 8, 1995 that "[i]t is possible that [claimant's] AC joint arthritis is the cause of a great deal of her discomfort," and he felt she might need surgery. (Ex. 36).

On May 3, 1995, Dr. Balme wrote to the employer that claimant would probably need a "distal claviculectomy in treatment for her AC joint arthritis" unless job modification provided significant relief. (Ex. 39).

On May 3, 1995, the employer issued a partial denial of claimant's bilateral shoulder discomfort with degenerative arthritic changes and calcific tendinitis (left), obesity, deconditioning and depression. (Ex. 40A). On May 15, 1996, the employer issued a supplemental partial denial of left impingement syndrome. (Ex. 48).

The ALJ set aside the employer's denial of claimant's occupational disease claim for left shoulder tendinitis, but upheld the denial of claimant's AC joint arthritis.

Left Shoulder Impingement

Claimant asserts that the ALJ failed to address her left shoulder impingement condition and she argues that the ALJ should have set aside the employer's denial of that condition. Claimant contends we should defer to the opinion of her treating physician, Dr. Balme, to establish that her work activities were the major contributing cause of her left shoulder impingement condition.

The employer contends that claimant has not established that her work activity was the major contributing cause of her impingement syndrome.[2] The employer relies on Dr. Bald's opinion that claimant's moderately severe AC joint arthritis was the major contributing cause of her impingement syndrome. (Ex. 46-32, -33).

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[2] The employer also argues that claimant's degenerative changes and configuration of the acromion constitute "preexisting conditions," and, therefore, she must establish that her work activities were the major contributing cause of her combined condition and a pathological worsening of the underlying degenerative disease pursuant to ORS 656.802(2)(b). We need not decide whether ORS 656.802(2)(a) or ORS 656.802(2)(b) applies to claimant's shoulder condition, however, because we do not find the left shoulder impingement condition compensable under either standard.

When the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We generally defer to the treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to defer to Dr. Balme's opinion regarding the causation of the impingement syndrome.

On October 27, 1995, Dr. Balme said that claimant's anterior impingement and "degenerative changes" in the soft tissues of the shoulder were probably caused by her work activities. (Ex. 45A). He commented that claimant's AC joint arthritis was "possibly caused" by her work. (Id.) Dr. Balme also said that the proposed surgery was directed at claimant's work-related condition. (Ex. 45A-3). He did not believe claimant still had a left shoulder strain, because that usually heals within a short time. Dr. Balme's conclusion that claimant's impingement and degenerative changes were caused by her work activities is inconsistent with his earlier reports.

On March 18, 1995, claimant was examined by Drs. Watson and Martens regarding her shoulder pain. They diagnosed bilateral shoulder discomfort with diminished range of motion, x-ray evidence of degenerative AC joint changes, calcific tendinitis (left), obesity, deconditioning and depression. (Ex. 37). Drs. Watson and Martens doubted that a surgical procedure would accomplish significant symptomatic improvement and they found no evidence that the major contributing need for shoulder surgery was related to work. (Id.) In April 1995, Dr. Balme agreed with their report. (Exs. 36, 38).

Thus, although Dr. Balme initially agreed that there was no evidence that the major contributing need for claimant's shoulder surgery was related to work, he subsequently opined that the proposed surgery was directed at a work-related condition and her anterior impingement and "degenerative changes" in the shoulder were probably caused by her work activities. Because Dr. Balme did not explain his apparent change of opinion regarding causation and the need for surgery for claimant's left shoulder condition, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987).

We are more persuaded by the opinion of Dr. Bald because it is better-reasoned. On September 29, 1995, Dr. Bald diagnosed impingement syndrome, left shoulder, secondary to calcific tendinitis and osteoarthritis of the glenohumeral and AC joints. (Ex. 44). Dr. Bald explained that the impingement syndrome was a result of a degenerative condition, which was not related directly or indirectly to her work activities. (Ex. 44-7). In a deposition, Dr. Bald testified that claimant's AC joint arthritis was the major contributing cause of her impingement syndrome. (Ex. 46-32, -33).

We conclude that claimant's occupational disease claim for left shoulder impingement syndrome is not compensable.

Left Shoulder Tendinitis

The employer argues that the ALJ erred by finding claimant's tendinitis compensable, asserting that claimant waived the right to separately establish compensability of tendinitis. The employer refers to claimant's attorney's statements at hearing to argue that claimant agreed that the tendinitis was not a separate condition and combined with other underlying conditions to result in the impingement syndrome.

Claimant responds that the employer originally identified calcific tendinitis as a separate condition in its May 3, 1995 partial denial. She contends that the ALJ correctly set aside the employer's denial of her left shoulder tendinitis condition.

The employer's May 3, 1995 partial denial referred to claimant's bilateral shoulder discomfort with degenerative arthritic changes and calcific tendinitis (left), obesity, deconditioning and depression. (Ex. 40A). In opening statement at hearing, claimant's counsel said:

> "What [claimant's] going to say is that her shoulder has remained symptomatic since its onset in that summer of '93. She's gone back to Balme. I think in September of '94, he diagnosed what I would term as an impingement syndrome. I'm not sure he really used those words, but be that as it may --

"* * * * *

"Yeah -- well, I don't know what he said in September of '94. I mean, I think he used bursitis/tendinitis/a.c. arthritis, but it's all part and parcel, I think, in this record at least of what can be called an impingement syndrome." (Tr. 5, 6).

Claimant's attorney subsequently referred to Dr. Balme's opinion that claimant's bursitis/tendinitis was probably caused by her work activities. (Tr. 8). Claimant's attorney said that he thought "both of the opining doctors agree that the tendinitis that she's experiencing is caused in major part by her work activity." (Tr. 9).

Waiver is "the intentional relinquishment of a known right." Wright Schuchart Harbor v. Johnson, 133 Or App 680, 685 (1995) (quoting Drews v. EBI Companies, 310 Or 134, 150 (1990)). Waiver must be plainly and unequivocally manifested, either "in terms or by such conduct as clearly indicates an intention to renounce a known privilege or power." Id. at 685-86 (quoting Great American Ins. v. General Ins., 257 Or 62, 72 (1970)). A waiver may be explicit or implied from a party's conduct. Id. at 686.

Here, although claimant's attorney said that claimant's "bursitis/tendinitis/a.c. arthritis" was "all part and parcel" of an impingement syndrome, his later statements indicated he was relying on medical opinions that said claimant's tendinitis was caused in major part by her work activity. Under these circumstances, claimant's attorney's statements were equivocal, and do not constitute a waiver. We are not persuaded claimant waived the right to separately establish compensability of left shoulder tendinitis.

The employer contends that tendinitis is an inseparable component of the noncompensable impingement syndrome. We disagree.

Dr. Balme explained that tendinitis is the inflammation of the tendons of the rotator cuff. (Ex. 45A-2). He agreed that tendinitis was basically mechanical irritation of the tendons and soft tissue of the rotator cuff caused in major part by claimant's work activities. (Id.) When asked how claimant's work activities caused the calcific tendinitis, Dr. Balme said:

"With the positioning of the shoulder - or the arm at shoulder height, you cause the narrowing of the space between the acromion and the head of the humerus putting some impingement on the soft tissues that occupy that space and that real soft tissue is by the rotator cuff and it's with that impingement - the pinching over time can go and develop the degenerative changes." (Id.)

Dr. Balme explained that calcific deposits occasionally occur in degenerative tissue, particularly in the shoulder area. (Id.)

The employer relies on Dr. Bald's opinion to argue that claimant's tendinitis condition is an inseparable component of the impingement syndrome. Dr. Bald explained that claimant's left shoulder impingement syndrome was a "combination effect" of a calcific tendinitis of the rotator cuff tendon, as well as moderately severe degenerative osteoarthritis of the AC joint and, to a lesser degree, of the glenohumeral joint of the left shoulder. (Ex. 44-7). In a deposition, Dr. Bald acknowledged that the kind of work activities claimant performed frequently result in chronic rotator cuff tendinitis, bursitis and calcific tendinitis of the rotator cuff tendon. (Ex. 46-29).

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland, 64 Or App at 814. Here, finding no persuasive reasons to do otherwise, we rely on the opinion of Dr. Balme that claimant's tendinitis condition was caused in major part by her work activity. In reaching this conclusion, we note Dr. Bald's acknowledgment that work activities like those performed by claimant frequently resulted in chronic tendinitis. Accordingly, we agree with the ALJ that claimant's left shoulder tendinitis condition is compensable.

Claimant's attorney is entitled to an assessed fee for services on review regarding the left shoulder tendinitis condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services

on review regarding the left shoulder tendinitis condition is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Right Knee Condition

Claimant compensably injured her knee on March 12, 1992. The employer accepted a right leg/knee strain, multiple bruises and twisted right hip. (Ex. 9G).

On May 15, 1996, the employer denied claimant's aggravation claim on the basis that her right knee strain had not worsened. (Ex. 47). The employer also denied claimant's current right knee condition on the basis that it was not compensably related to her previous right knee strain or her employment. (Id.)

The ALJ held that claimant had to prove that the March 1992 injury was a material cause of the medial meniscus tear that was first treated in 1995. The ALJ rejected Dr. Gargaro's opinion because it was based on a twisting injury in 1992 that was not supported by the contemporaneous medical record or by claimant's testimony. The ALJ concluded that claimant failed to prove that her right medial meniscus tear was compensable.

Claimant argues that her right knee medial meniscus tear was an aggravation of her March 1992 injury. Claimant contends that the ALJ made incorrect assumptions about the mechanism of injury.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Gloria T. Olson, 47 Van Natta 2348 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

We begin our aggravation analysis with a determination of whether claimant's current right knee condition is compensable. Claimant's compensable March 1992 injury was accepted as a right leg/knee strain, multiple bruises and twisted right hip. (Ex. 9G). Her current condition has been diagnosed as a complex tear of the medial meniscus. (Exs. 41A, 41B). Claimant's right medial meniscus tear is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish the medial meniscus tear is a compensable condition. See Gloria T. Olson, 47 Van Natta at 2348.

The employer contends that claimant has to prove that her 1992 injury was the major contributing cause of her current right knee condition, either under ORS 656.005(7)(a)(B) or ORS 656.005(7)(a)(A). We find that, whether under a material or major cause standard, claimant has failed to prove the compensability of her current right knee condition.

Claimant relies on the opinion of Dr. Gargaro. She contends that Dr. Gargaro correctly concluded that she sustained an injury to her meniscus in 1992 that constitutes the major reason for her need for care in 1995. We disagree.

Claimant injured her knee on March 12, 1992. Her "827" form indicated that she slipped and fell at work, injuring her right knee and twisting her right hip. (Ex. 9A). Claimant was diagnosed with a strain of quadriceps and gluteus muscles. (Ex. 9E). Her knee exam showed a negative McMurray test. (Id.) X-rays of her right hip and right knee were normal. (Ex. 9C). The employer accepted a right leg/knee strain, multiple bruises and twisted right hip. (Ex. 9G).

Claimant was released to regular work on March 16, 1992. (Ex. 9H). On April 2, 1992, claimant sought medical treatment, complaining of back pain. (Ex. 9I). The chart note indicates claimant's right knee and hip injury had slowly improved and were 50 percent better. (Id.) However, claimant had continuing pain in the sacral area, occasionally radiating to her right hip. The physician felt claimant had a "little muscle pull." (Id.)

Claimant was examined by Drs. Potter and Kho on December 18, 1993. In reporting claimant's previous injuries, they said: "Knee and back were injured at work about a year ago, completely resolved with no residual." (Ex. 22-1). Although claimant sought treatment for other conditions after 1992, there is no indication in the record of further knee problems until 1995, when she sought treatment from Dr. Gargaro.

On August 23, 1995, Dr. Gargaro reported that claimant said that, after the 1992 knee injury, "her knee has never been quite right." (Ex. 41A). She said she had no x-ray in 1992. Claimant told Dr. Gargaro that it took quite awhile to get over the acute injury, but she was then able to work with minimal problems. Claimant reported that her pain had been progressively worse over the last few months. Dr. Gargaro ordered an MRI, which showed a complex tear of the posterior horn of the medial meniscus. (Exs. 41A, 41B). Dr. Gargaro recommended surgery.

Dr. Bald examined claimant on September 29, 1995. Dr. Bald indicated claimant said she fell in 1992 and landed directly on the front part of her right knee and shin. (Ex. 44-1). She was off work for 3 to 4 days in 1992 and went back to regular work. Claimant said she was given a referral for follow-up, but did not see any other physicians for the knee problem. (Ex. 44-2). Claimant told Dr. Bald that her knee "never got back to normal" and continued to bother her, although she was able to perform her regular work. (Id.) Dr. Bald diagnosed a degenerative medial meniscal tear of the right knee. (Ex. 44-6). Dr. Bald felt that the mechanism of injury in 1992 was not consistent with a meniscal tear nor was it reasonable to think that claimant could have been asymptomatic or presented with minimal or no symptoms for several years before becoming symptomatic as a result of the 1992 injury. (Id.) Dr. Bald concluded that claimant's current right knee symptoms were degenerative and were not related to her March 12, 1992 injury or her work activities.

Dr. Gargaro subsequently discussed claimant's 1992 injury:

> "She says she slipped; that could have caused a twisting motion that could have caused a small tear that has never really healed and yes, over the course of three years, that tear may have gotten larger and now is more symptomatic, and I think that without documentable objective evidence to the contrary she could certainly have had a meniscal injury at that time." (Ex. 45B-1; emphasis added).

Dr. Gargaro agreed that it was probable that claimant tore the meniscus in 1992 and it gradually worsened over time. (Id.)

At a deposition, Dr. Bald testified that claimant did not describe symptoms that he usually associates with a meniscal injury, such as catching, feelings of instability, giveaway, difficulty squatting and kneeling, in relation to her 1992 injury. (Ex. 46-39). Although claimant continued to have some knee complaints after 1992, the meniscal symptoms appeared to start long after the 1992 injury. (Ex. 46-39, -40). Dr. Bald said that meniscal injuries typically come from "twisting type" injuries. (Ex. 46-43). In contrast, falling on the front of the knee does not typically result in a meniscal tear. (Ex. 46-44, -45). Dr. Bald agreed that claimant could have twisted her knee in 1992, but he said that, if she had, he would expect her to have different symptoms in 1992 than those she described. (Ex. 46-43). Dr. Bald testified that the fact that claimant had a negative McMurray's in 1992 supported his conclusion that she probably did not have even a small meniscal tear at that time. (Ex. 46-51, -52). Dr. Bald explained that the McMurray's maneuver is used specifically to detect meniscal injuries. (Ex. 46-52). In sum, Dr. Bald disagreed with Dr. Gargaro's conclusion that claimant sustained a meniscal tear in 1992.

At hearing, claimant testified that she remembered falling, but she did not remember exactly what happened to her knee. (Tr. 18). She remembered twisting her right hip, but did not remember twisting her right knee. (Tr. 25, 26).

Although Dr. Gargaro opined that when claimant slipped, that "could have caused a twisting motion that could have caused a small tear" (Ex. 45B), we agree with the ALJ that Dr. Gargaro's opinion that claimant twisted her knee in 1992 is not supported by the contemporaneous medical record or by claimant's testimony. Because Dr. Gargaro's conclusions were based on a twisting injury, we conclude that his opinion was based on an inaccurate history and is therefore afforded little persuasive weight. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Furthermore, Dr. Gargaro's opinion

establishes, at most, the possibility, not the probability, of a causal connection between claimant's 1992 injury and her medial meniscus tear. See Miller v. SAIF, 60 Or App 557 (1982); Gormley v. SAIF, 52 Or App 1055 (1981). Dr. Gargaro also failed to explain the initial absence of clinical signs of a meniscal tear and the continuing absence of such symptoms for almost three years after the March 1992 injury.

We conclude that claimant has failed to establish the compensability of her current right knee condition under a material or major cause standard.

ORDER

The ALJ's order dated June 18, 1996 is affirmed. For services on review regarding the left shoulder tendinitis condition, claimant's attorney is awarded $1,000, payable by the self-insured employer.

Board Member Moller concurring in part and dissenting in part.

Although I agree that claimant's right knee condition and left shoulder impingement condition are not compensable, I disagree with that portion of the majority's order that concluded that claimant's left shoulder tendinitis condition is compensable.

To begin, the majority reasons that claimant did not "waive" her right to separately establish compensability of left shoulder tendinitis. The majority puts the cart before the horse. In her brief, claimant asserts that she "never sought to establish tendinitis as a separable compensable condition[.]" (Claimant's brief at 17). Claimant contends that the employer's May 3, 1995 denial identified "Calcific Tendinitis, Left" as an element of bilateral shoulder discomfort. (Ex. 40A). Because claimant never made a claim for the tendinitis condition, the employer's denial of that condition is premature. See Vicki L. Davis, 49 Van Natta 603 (1997) (carrier's precautionary partial denial of lumbar degenerative conditions was premature because the claimant had not filed a "new medical condition" for the conditions); Ramona E. Hamilton, 48 Van Natta 2438 (1996). Since a denial issued in the absence of a claim is a nullity, the employer's denial of the tendinitis condition has no legal effect. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Vicky L. Davis, 49 Van Natta at 604.

Furthermore, even if it is necessary to reach the merits, the majority incorrectly analyzes the medical evidence. The employer correctly asserts that the persuasive medical evidence establishes that claimant's tendinitis and the other left shoulder conditions combined and were inseparable components of her impingement syndrome. There is no medical evidence to the contrary. On this record, claimant's tendinitis symptoms cannot be separated from her impingement syndrome. See, e.g., Mary F. Krieger, 48 Van Natta 948 (1996) (rejecting the claimant's argument that her various strain and tendinitis conditions were separately compensable, aside from her degenerative osteoarthritis condition); Anselmo Perez, 48 Van Natta 71 (1996) (back strain and muscle spasm could not be separated from the preexisting disc condition; Daniel S. Field, 47 Van Natta 1457 (1995). Under these circumstances, the majority erred by concluding that the tendinitis condition is a separable component of the noncompensable impingement syndrome.

Dr. Bald reported that claimant's left shoulder impingement syndrome was a "combination effect" of a calcific tendinitis of the rotator cuff tendon, as well as moderately severe degenerative osteoarthritis of the AC joint and, to a lesser degree, of the glenohumeral joint of the left shoulder. (Ex. 44-7). Dr. Bald opined that the impingement syndrome was the result of a degenerative condition that was idiopathic and was not related directly or indirectly to her work activities. (Id.)

In a deposition, Dr. Bald explained that claimant had bony abnormalities, which included arthritis in the AC joint and the glenohumeral joint, as well as "soft tissue" things, such as tendinitis, bursitis and calcific deposits. (Ex. 46-27). Dr. Bald testified that claimant's arthritic changes were not a result of her work activities. (Ex. 46-28). On the other hand, he said that "soft tissue" problems could be related to work activities. (Ex. 46-29). Dr. Bald testified that the kind of work activities claimant performed can frequently result in chronic rotator cuff tendinitis, bursitis and calcific tendinitis of the rotator cuff tendon. (Id.) Dr. Bald explained that impingement syndrome is the "end stage." (Ex. 46-30). Dr. Bald said that impingement syndrome could result strictly from "soft tissue" things, i.e., a chronic inflammatory response. (Ex. 46-30, 31). In claimant's case, however, Dr. Bald said that there was more than one factor contributing because claimant did not have a normal AC joint with no osteophyte. (Ex. 46-32). Dr. Bald testified that claimant's impingement syndrome was a combination of

both the chronic rotator cuff tendinitis and AC joint arthritis. (Ex. 46-33). Dr. Bald believed that claimant's moderately severe AC joint arthritis was the major cause of her impingement syndrome. (Exs. 46-32, -33). Dr. Bald said that his opinion would be different if claimant's x-rays were normal or not so prominently abnormal. (Ex. 46-34).

Dr. Bald's opinion is persuasive because it is well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). Based on his opinion, I would conclude that claimant's tendinitis condition is an inseparable component of the impingement syndrome.

Although the majority "defers" to Dr. Balme's opinion, his opinion does not support the conclusion that claimant's tendinitis is a separable component of the impingement syndrome.

Dr. Bald and Dr. Balme classified claimant's "soft tissue" problems differently. Although Dr. Bald referred to claimant's tendinitis, bursitis and calcific deposits as "soft tissue" conditions (Ex. 46-27), Dr. Balme referred to claimant's anterior impingement, degenerative changes and calcific tendinitis as "soft tissue problems." (Ex. 45A). Dr. Balme said that claimant's "soft tissue problems, that is, the anterior impingement and the degenerative changes we see in the soft tissues of the shoulder, are probably caused by her work for the already stated reasons." (Id.) Dr. Balme said that would include calcific tendinitis. When asked how claimant's work activities caused the calcific tendinitis, he said:

> "With the positioning of the shoulder - or the arm at shoulder height, you cause the narrowing of the space between the acromion and the head of the humerus putting some impingement on the soft tissues that occupy that space and that real soft tissue is by the rotator cuff and it's with that impingement - the pinching over time can go and develop the degenerative changes." (Id.; emphasis added).

Because Dr. Balme's description of how claimant's work activities caused the tendinitis condition includes a discussion of the left shoulder impingement, his opinion supports a conclusion that claimant's tendinitis condition is an inseparable component of the impingement syndrome.

In any event, however, Dr. Balme's opinion is not persuasive because it is inconsistent. Although Dr. Balme originally agreed with Drs. Watson and Martens that there was no evidence that the major contributing need for claimant's shoulder surgery was related to work (Exs. 36, 37, 38), he subsequently reported that claimant's proposed surgery was directed at a work-related condition and her soft tissue problems, which included anterior impingement, degenerative changes and calcific tendinitis, were probably caused by her work activities. (Ex. 45A). Since Dr. Balme did not explain his apparent change of opinion, I would attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987).

Furthermore, Dr. Balme said on October 27, 1995 that claimant's "degenerative changes" were "probably" caused by her work activities, whereas her AC joint arthritis was only "possibly" caused by her work activities. (Ex. 45A). Because Dr. Balme had indicated in earlier reports that claimant's AC joint arthritis was a "degenerative change," his opinions are inconsistent and confusing.[1] Moreover, Dr. Balme's earlier reports indicated that claimant's left AC joint arthritis was a significant cause of her left shoulder pain, rather than her tendinitis.[2]

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[1] Dr. Balme's earlier reports indicated that claimant's "degenerative changes" included the AC joint arthritis. On September 15, 1994, Dr. Balme reported that claimant's left shoulder x-rays showed "calcifications in the soft tissues about the rotator cuff, as well as some degenerative change of the AC joint" and he diagnosed subacromial bursitis, left shoulder, with calcific peritendinitis and AC joint arthritis. (Ex. 30). In April 1995, Dr. Balme agreed with Drs. Watson's and Martens' report, which included a diagnosis of "degenerative AC joint changes." (Exs. 36, 37, 38).

[2] On September 15, 1994, Dr. Balme diagnosed subacromial bursitis, left shoulder, with calcific peritendinitis and AC joint arthritis. (Ex. 30). On January 27, 1995, Dr. Balme reported that claimant had calcific peritendinitis in the left shoulder, as well as "significant" left AC joint arthritis. (Ex. 34). On February 27, 1995, Dr. Balme said he was "probably dealing now with chronic shoulder pain related to her AC joint arthritis." (Ex. 33). Dr. Balme commented on March 8, 1995 that "[i]t is possible that [claimant's] AC joint arthritis is the cause of a great deal of her discomfort." (Ex. 36). Finally, on May 3, 1995, Dr. Balme reported to the employer that claimant would probably need a distal claviculectomy "in treatment for her AC joint arthritis." (Ex. 39). By referring to claimant's left AC joint arthritis as "significant" (Ex. 34), commenting that claimant's chronic shoulder pain was "related to her AC joint arthritis" (Ex. 33), and opining that claimant would need surgery "in treatment for her AC joint arthritis" (Ex. 39), Dr. Balme's reports indicate that claimant's left AC joint arthritis was a significant part of her left shoulder pain.

In summary, claimant never made a claim for the tendinitis condition and, therefore, the employer's denial of that condition is premature. Even if it were appropriate to reach the merits, the majority errs by relying on Dr. Balme's opinion to conclude that the tendinitis condition is a separable component of the noncompensable impingement syndrome.

In the Matter of the Compensation of
CINDY L. KEEN, Claimant
WCB Case No. 96-02120
ORDER ON REVIEW
Max Rae, Claimant Attorney
Cummins, Goodman, 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) found that the insurer's denial of claimant's current low back condition was not precluded by a prior permanent disability award; (2) upheld the insurer's denial of an aggravation claim for claimant's current low back condition; and (3) rejected claimant's constitutional and Americans with Disabilities Act (ADA) challenges to the 1995 amendments to the workers' compensation laws. On review, the issues are compensability, aggravation and constitutionality.

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

Claimant, age 36 at the time of hearing, compensably injured her back on July 26, 1993 while lifting countertops at work. Shortly thereafter, the insurer accepted a "low back strain." An MRI indicated that claimant also had degenerative disc disease at L1-2, L2-3, L5 and S1. The claim was initially closed by Determination Order on June 8, 1994, which awarded no permanent disability.

Claimant experienced intermittent pain following the initial closure. Her symptoms increased in January 1995, and she was taken off work. Claimant continued to seek treatment for chronic lumbar and SI joint pain. In April 1995, claimant was examined by Dr. Hunt at the insurer's request, who diagnosed preexisting degenerative disc disease, recurrent overuse of the back superimposed on the preexisting degenerative changes and possible pathological changes due to work activities. Dr. Hunt found that claimant had some permanent impairment (loss of motion) in her low back, half of which he attributed to her work activities and half of which he attributed to her preexisting degenerative condition. Claimant's attending physician, Dr. Molloy, concurred with Dr. Hunt's findings.

Claimant's claim was closed a second time by a May 24, 1995 Determination Order which awarded 6 percent unscheduled permanent disability. This 6 percent permanent disability award represented the one-half of claimant's impairment that was due to her work injury.

On November 27, 1995, claimant returned to Dr. Molloy complaining of progressive back pain that suddenly worsened while she was at home the previous Saturday. She filed an aggravation claim alleging that her current symptoms were an exacerbation of her previous injury. Dr. Molloy reported that claimant had lumbar pain and degenerative disc disease.

In February 1996, claimant was examined by Drs. Scheinberg and Zivin at the insurer's request. Drs. Scheinberg and Zivin diagnosed chronic low back strain and lower extremity pain secondary to musculoligamentous strain superimposed on her preexisting degenerative arthritis and degenerative disc disease. Drs. Scheinberg and Zivin also reported, among other things, that claimant was experiencing a waxing and waning consistent with her prior unscheduled permanent disability award, that she was predisposed to injury because of the degenerative changes in her back, and that the major contributing cause of her current symptoms was her preexisting degenerative condition. Dr. Molloy concurred with these findings.

In upholding the insurer's current condition/aggravation denial, the ALJ found that claimant failed to prove that her accepted low back strain was the major contributing cause of her current combined low back condition. The ALJ further found that the Hearings Division lacked jurisdiction to consider claimant's federal preemption and constitutional challenges to the workers' compensation law.

On review, claimant asserts that her current condition is compensable and that she has shown an actual worsening of her condition entitling her to reopening of the claim. With regard to compensability, claimant raises the same arguments she raised at hearing, specifically that: (1) her prior permanent disability award bars the insurer's current condition denial; (2) the preexisting degenerative condition in her back is not a "preexisting condition" under ORS 656.005(24); (3) her preexisting degenerative condition is not a "cause" of her current condition; and (4) the 1995 amendments to the workers' compensation law violate the ADA. We conclude that the ALJ properly disposed of each contention.

As the ALJ found, the medical evidence overwhelmingly establishes that claimant's current condition involves a *combination* of her accepted low back strain and her preexisting, underlying degenerative disc disease. The insurer is not precluded from denying the compensability of claimant's current condition under the rule of Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996),[1] because the permanent disability awarded by the prior Determination Order was expressly limited to impairment caused by the accepted injury and did not include an award for her noncompensable degenerative condition.

Second, contrary to claimant's contention, her underlying degenerative condition constitutes a "preexisting condition" and is properly considered a contributory factor in determining the major cause of her current condition. Pursuant to ORS 656.005(24), a "preexisting condition" means "any injury, disease, congenital abnormality or similar condition that contributes or predisposes a worker to disability or need for treatment" and that precedes the claim. (Emphasis added). Pursuant to ORS 656.005(7)(a)(B), a "combined condition" is an otherwise compensable injury that has combined with a preexisting condition to cause or prolong disability or need for treatment.[2] Notwithstanding claimant's characterization of disc degeneration as part of the normal aging process, the medical evidence in this case persuasively establishes that, prior to her July 1993 compensable injury, claimant had degenerative disc *disease* which not only *predisposed* her to low back injury but also *contributed* to her current condition and need for treatment. (See, e.g., Exs. 50-6, 56, 57, 59-18, 60-10). Therefore, the ALJ did not err in treating claimant's degenerative condition as a cause and evaluating the compensability of her current condition under ORS 656.005(7)(a)(B).

Finally, we have repeatedly held that the Board is not the proper forum for a claimant's ADA challenge to the workers' compensation laws. See, e.g., Rex Brink, 48 Van Natta 916 (1996), aff mem 146 Or App 777 (1997); Gary W. Benson, 48 Van Natta 1161 (1996); Sandra J. Way, 45 Van Natta 876 (1993), aff'd on other grounds Way v. Fred Meyer, Inc., 126 Or App 343 (1994).

Because claimant has not established the compensability of her current condition, she cannot prove an aggravation under ORS 656.273(1). See Gloria T. Olson, 47 Van Natta 2348 (1995) (ORS 656.273(1) "requires proof of two specific elements to establish a worsened condition: (1) "actual worsening"; and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury."). Furthermore, because claimant has failed to satisfy the "compensable condition" element of ORS 656.273(1), we need not address her constitutional challenges to the actual worsening standard and ORS 656.214(7).[3] See, e.g., Jackson v. Fred Meyer, Inc., 139 Or App 222 (1996) (recognizing the fundamental rule that a case shall not be decided upon constitutional grounds unless absolutely necessary to determination of the issue before it).

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[1] In Messmer, the court affirmed its prior decision, Messmer v. Deluxe Cabinet Works, 130 Or App 54 (1994), rev den 320 Or 507 (1995), which held that unless the employer objects to a Determination Order which has awarded permanent disability based, in part, on impairment resulting from a noncompensable condition, the employer will later be precluded from contending that condition rated was not part of the compensable claim.

[2] ORS 656.005(7)(a)(B) further provides that "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] This section, which was added by the 1995 amendments, provides, in pertinent part, that "[a]ll permanent disability contemplates future waxing and waning of symptoms of the condition."

ORDER

The ALJ's order dated February 7, 1997 is affirmed.

In the Matter of the Compensation of
LORENZA MELENDEZ, Claimant
WCB Case No. 96-08571
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that awarded 29 percent (92.8 degrees) unscheduled permanent disability whereas an Order on Reconsideration awarded no unscheduled permanent disability. On review, the issue is unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

We summarize the relevant facts. Claimant was compensably injured on September 27, 1995. The claim was accepted for lumbar, cervical and thoracic strains. Claimant's claim was closed by a Notice of Closure dated May 31, 1996, which awarded temporary disability but awarded no permanent disability. Claimant requested reconsideration and an Order on Reconsideration issued on September 6, 1996 which awarded no permanent disability. Claimant requested a hearing seeking an award of unscheduled permanent disability.

Relying on OAR 436-035-0007(27) and the medical arbiter's report, the ALJ awarded claimant 29 percent unscheduled permanent disability. SAIF has appealed the ALJ's order and argues that the medical evidence does not establish that claimant has objective findings of impairment. Claimant contends that there are objective findings of impairment and seeks to have the ALJ's order affirmed.

Claimant was examined on behalf of SAIF by Dr. Klein, psychiatrist, Dr. Duff, an orthopedist and Dr. Gardner, a neurologist. Drs. Duff and Gardner opined that claimant was medically stationary and reported:

> "No permanent impairment is noted today. There is some self-imposed restriction of spinal range of motion due to discomfort. There are also significant non-organic pain signs, including generalized non-anatomic tenderness, give-way weakness in the extremities, that suggests a significant psychological overlay."

Duff and Gardner also indicated that subjective complaints considerably outweighed objective findings. These physicians further indicated that claimant could return to her regular work without restrictions.

In a separate report, Dr. Klein indicated that claimant did appear to be an individual who is somewhat over-focused in the physical realm and spends a long time making sure that she is recovered before undertaking an active life schedule. Dr. Klein indicated that this appeared to be a personality style and choice rather than a significant mental illness. Dr. Klein opined that claimant did not have any psychiatric disability and could be released to work without any restrictions.

Claimant's attending physician, Dr. Nordal, agreed that claimant was medically stationary without impairment.

Claimant requested reconsideration of a May 31, 1996 Notice of Closure which awarded no unscheduled permanent disability. Dr. Neumann performed a medical arbiter examination. In his medical arbiter report, Dr. Neumann indicated that claimant showed significant functional behavior throughout the examination. With regard to claimant's lumbar range of motion findings, Dr. Neumann reported that claimant's readings were very inconsistent. Dr. Neumann also reported that claimant failed to meet the criteria for the straight leg raising validity test. After recording claimant's cervical and thoracic range of motion findings, Dr. Neumann indicated that, on casual observation, claimant's flexion noted throughout other parameters of testing appeared to exceed the range of motion demonstrated. Dr. Neumann noted remarkable functional overlay with subjective complaints far outweighing objective findings. In the "Discussion and Recommendations" section of his report, Dr. Neumann opined: "I feel the findings are invalid in regards to her meeting the criteria for the straight leg raising validity test. Also, range of motion studies are inconsistent and invalid for reasons as noted in the physical examination above."

Based on Dr. Neumann's report, the Order on Reconsideration awarded no permanent disability.

In awarding claimant 29 percent unscheduled permanent disability, the ALJ relied on OAR 436-035-0007(27) which provides:

> "Validity shall be established for findings of impairment according to the criterion noted in the **AMA guides to the evaluation of Permanent Impairment, 3rd Ed., Rev., 1990,** unless the validity criterion for a particular finding is not addressed in this reference or is not pertinent to these rules. 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. When findings are determined invalid, the findings shall receive a value of zero." (Bold in original, underlining added).

The ALJ reasoned that Dr. Neumann's "casual observation and nothing more is not as I view it, an explanation based on sound medical principles as to why findings that otherwise meet validity criteria would be invalid." On this basis, the ALJ relied on Dr. Neumann's impairment findings to rate claimant's permanent disability.

OAR 436-035-0007(27) does require the reviewer, who is likely to be a lay person, to make a determination regarding whether the physician's explanation why the findings are invalid is "based on sound medical principles." In this case, Dr. Neumann, an orthopedic surgeon, has given a written explanation regarding why he believes the range of motion findings are invalid. He has explained that the findings are inconsistent and that, on casual observation, claimant appeared to exceed the ranges of motion demonstrated on testing. There is no medical evidence from Dr. Neumann or from any other physician which indicates that a physician's observation of the patient demonstrating range of motion which exceeds that observed on formal testing is not a sound medical basis for invalidating the range of motion findings. Dr. Neumann also stated that the findings were "inconsistent." There is likewise no evidence that this basis for discounting the findings is not based on "sound medical principles." The record contains no evidence that Dr. Neumann's explanation for invalidating the findings is not based on "sound medical principles." Under such circumstances, in the absence of contrary information, we conclude that Dr. Neumann's explanation is based on "sound medical principles."

In reaching this decision, we distinguish Justeen L. Parker, 49 Van Natta 334 (1997). In Parker, the medical arbiter stated that range of motion 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 range of motion measurements did not meet validity standards. Thus, we concluded that the arbiter's range of motion findings must be rated as impairment.

Here, unlike the arbiter in Parker, Dr. Neumann provided a written explanation for determining that the range of motion findings were invalid. As stated above, he indicated that the findings were inconsistent and that he observed claimant demonstrating greater range of motion on casual observation

than she did in formal testing. Dr. Neumann also noted "remarkable functional overlay." Under such circumstances, we find that Dr. Neumann satisfied the written explanation requirement of OAR 436-035-0007(27).[1]

Because the findings have been determined to be invalid, OAR 436-035-0007(27) requires that the findings receive a value of zero. Inasmuch as there is no evidence of permanent impairment in the record, we affirm the Order on Reconsideration.

ORDER

The ALJ's order dated December 31, 1996 is reversed. The September 6, 1996 Order on Reconsideration is reinstated and affirmed.

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[1] Moreover, in Parker, we discussed other cases in which physicians offered satisfactory explanations for the physician's conclusion that range of motion findings were invalid. For instance, in Harvey Clark, 47 Van Natta 136 (1995), the medical arbiter found functional interference which caused the range of motion findings to be considered invalid. In Christopher R. Garza, 47 Van Natta 99 (1995), the physician provided a satisfactory explanation by stating that the range of motion findings were an "underestimate" of the claimant's true ability. As in Clark and Garza, we find Dr. Neumann's explanation for concluding that the range of motion findings were invalid to be sufficient.

In the Matter of the Compensation of
SAUNDRA A. MILLER, Claimant
WCB Case No. 96-10032
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Charles L. Lisle, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that increased claimant's scheduled permanent disability award for loss of use and function of the right forearm from 6 percent (9 degrees), as awarded by an Order on Reconsideration, to 14 percent (21 degrees). On review, the issue is extent of scheduled permanent disability.

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

Relying on the medical arbiter's report, the ALJ found that claimant's 4/5 loss of strength in the right upper extremity was related to the compensable injury. In rating the loss of strength, the ALJ rejected the employer's argument that the loss of strength was a result of a 1982 noncompensable incident in which claimant was assaulted with a knife and suffered an injury to her ulnar nerve.

On review, the employer asserts that the ALJ inappropriately relied on medical treatises or journals, which were cited in claimant's written argument to the ALJ, but were not part of the evidentiary record. The treatises apparently were cited to establish that median nerve weakness is a common consequence of the carpal tunnel release surgery claimant underwent as a result of the compensable injury.

First, the ALJ's only reference to the disputed treatises is in a summary of claimant's argument. Thus, we are not persuaded that the ALJ relied on the extra-record treatises in reaching his decision. In any case, because we find, based solely on the evidentiary record, that the 4/5 loss of strength in the right upper extremity is "due to" the compensable injury, it is unnecessary to address the employer's contention that the ALJ relied inappropriately on extra-record medical treatises or journals.

Prior to listing claimant's impairment findings, the medical arbiter indicated that the "[e]xamination is confined to both upper extremities and is directed toward responding to the accepted

condition of right wrist strain/sprain with secondary carpal tunnel of the right wrist." At the conclusion of his report, the medical arbiter addressed questions regarding claimant's "accepted condition" and indicated that muscle strength was recorded in the body of the report. (Ex. 24-4). In the body of his report, the arbiter reported that muscle strength testing of the right upper extremity was graded as 4/5. (Ex. 24-3). Although the arbiter was aware of claimant's prior noncompensable assault, he did not attribute the loss of strength to the assault. Based on his report, we are persuaded that the arbiter considered the loss of strength to be "due to" the compensable injury. See ORS 656.214(2) (the criteria for the rating of scheduled disability is the permanent loss of use or function of the injured member due to the compensable injury); SAIF v. Danboise, 147 Or App 550 (1997). Accordingly, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated February 19, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
JOSEPH E. BRIDWELL, Claimant
WCB Case No. 96-07849
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that dismissed claimant's request for hearing concerning claims for interim compensation and penalties. On review, the issues are jurisdiction, interim compensation, and penalties. We reverse.

FINDINGS OF FACT

On August 5, 1996, claimant was injured when the truck he drove for the self-insured employer overturned. That day, claimant sought emergency room treatment for a cervical strain and scalp abrasions. (Ex. 2). Dr. Collins prescribed conservative treatment and released claimant to return to work as of August 10, 1996. (Exs. 2, 4).

On August 6, 1996, claimant reported for work with a full duty work release which he had obtained that day from a physician's assistant. (Ex. 6). The employer advised claimant that he was suspended from work pending investigation of the accident and sent him home. (Tr. 11, 42, 64). On August 7, 1996, the employer provided written notice of the suspension. (Ex. 6A).

On August 8, 1996, Dr. Rabie examined claimant and diagnosed strains of the neck, mid, and low back, scalp contusions and abrasions, and a possible capsular tear of the left shoulder. Dr. Rabie prescribed conservative treatment and imposed work restrictions for the period from August 8, 1996 through August 28, 1996. (Exs. 7-3, 9).

On August 12, 1996, the employer notified claimant that he was terminated as of that date, due to two preventable accidents and a previous two-day suspension for excessive speeding. (Ex. 11A).

On August 13, 1996, the employer received Dr. Rabie's work restrictions for the period from August 8, 1996 through August 28, 1996. (See Exs. 9, 10).

By letter dated August 14, 1996, the employer notified claimant that his injury claim had been placed in deferred status. (Ex. 13). By letter dated August 20, 1996, the employer notified claimant that it would not be paying interim compensation on the ground that claimant was not available for modified work due to his suspended status. (Ex. 14).

On August 29, 1996, claimant requested a hearing, raising issues of temporary disability, penalties, and attorney fees.

On September 20, 1996, Dr. Collins indicated that claimant had been released from work August 5, 1996 through August 7, 1996. (Ex. 17).

On November 15, 1996, three days before the scheduled hearing, the employer accepted claimant's injury claim as nondisabling. (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

The ALJ granted the employer's motion to dismiss on jurisdictional grounds, citing Jay Pitman, 45 Van Natta 1782, 1783 (1993). In Pitman, the issue was whether the compensable injury, which was accepted as nondisabling, had become disabling within one year of the injury. Noting that interim compensation was not at issue, we held that the Hearings Division lacks original jurisdiction to address the classification question. Id.; see Debra A. Canterberry, 46 Van Natta 1859 (1994) (Board had jurisdiction to address a claimant's entitlement to interim compensation benefits under a claim that had been accepted as nondisabling); Ralph E. Fritz, 44 Van Natta 1168 (1992) (same); Christine A. Degrauw, 44 Van Natta 91 (1992), rev'd on other grounds, Degrauw v. Columbia Knit, Inc., 118 Or App 227 (1993).

Unlike Pitman, the issue here is claimant's procedural entitlement to interim compensation.[1] In a decision issued subsequent to the ALJ's order, we clarified our jurisdiction to address procedural temporary disability issues. See Alfredo Martinez, 49 Van Natta 67 (1997) (Original jurisdiction over disputes regarding procedural entitlement to temporary disability benefits rests with the Hearings Division). Accordingly, we reinstate claimant's hearing request and proceed to the merits. See Gary G. Koker, 47 Van Natta 1513, 1514 (1995).

Claimant seeks interim compensation for the period from the August 5, 1996 injury until the November 18, 1996 hearing. The employer argues that claimant has not established, by competent medical evidence, that he is entitled to interim compensation. The employer further argues that claimant is not entitled to interim compensation because he was unavailable for modified work for reasons unrelated to his work injury (i.e., because he had been fired).[2]

"The term 'interim compensation' * * * refers to temporary disability payments which ORS 656.262 requires be made to a claimant who is off work as a result of an injury for the time between the employer's notice of the injury and acceptance or denial of the claim." Nix v. SAIF, 80 Or App 656, 658 n.1 (1986) (citing Jones v. Emanuel Hospital, 280 Or 147 (1977)). In order to establish entitlement to interim compensation, claimant must prove: (1) a claim (medically verified inability to work resulting from the compensable injury); and (2) notice or knowledge of the claim by the employer or insurer. Avalos v. Bowyer, 89 Or App 546, 549-51 (1988).

Since "the policy behind interim compensation is to compensate an injured worker for having to leave work[,]" it need not be paid when a worker fails to demonstrate absence from work due to the compensable injury. Weyerhaeuser Co. v. Bergstrom, 77 Or App 425, 427 (1986). However, a claimant who has been fired from work, but otherwise is in the work force, is entitled to interim compensation if he or she "left work," i.e., was either absent from work due to the work injury or sustained diminished earning power attributable to the injury. RSG Forest Products v. Jensen, 127 Or App 247 (1994); see Jerilyn Hendrickson, 46 Van Natta 1888 (1994) (Where work restrictions placed on the claimant prior to the denial resulted in diminished earning power, the claimant was entitled to interim compensation even though fired for reasons unrelated to the injury).

In this case, Dr. Collins treated claimant the morning of the injury and released him from work at least for August 5, 1996 through August 7, 1996. (Exs. 4, 17). On August 8, 1996, Dr. Rabie became claimant's attending physician and released him to modified work for the period from August 8, 1996 through August 28, 1996. (Exs. 7-3, 8, 9, 10). The employer was notified of these releases long before the claim was accepted. Thus, even though claimant was fired on August 12, 1996 (after he became disabled), the employer was obligated to pay interim compensation upon notice of claimant's "pre-termination" disability. In other words, based on the attending physicians' work releases and restrictions (which were effective before claimant was fired), we find that claimant experienced injury-related diminished earning capacity[3] from August 5, 1996 through August 28, 1996.[4] Consequently, he is entitled to interim compensation for that period. See Nix, 80 Or App at 656; Hendrickson, 46 Van Natta at 1888; see also David A. Matthews, 47 Van Natta 257 (1995) (Because claimant remained disabled from performing his regular work at the time of his termination, he was entitled to temporary disability benefits, regardless of the reason for his termination).

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[1] Resolution of this "pre-acceptance/denial-interim compensation" dispute does not depend on the claim's classification as disabling or nondisabling or the accuracy of the classification. See Darlene L. Vanover, 47 Van Natta 672, 674 (1995) (Entitlement to interim compensation established even though claim had been accepted as nondisabling).

[2] The employer concedes that ORS 656.325(5)(b) does not apply to this case, because claimant did not refuse employment. In the absence of attending physician approval of a modified job (which would have been offered if claimant had remained employed), we agree that the statute does not apply.

[3] In reaching this conclusion, we note evidence indicating that claimant was looking for work during this time. (See Tr. 58-60).

[4] The employer appears to argue that the physician's assistant's August 6, 1996 "full duty" work release means that claimant's absence from work that day (and thereafter) was not injury related. (See Exs. 5A, 6). However, even assuming that a physician's assistant could be an attending physician for purposes of ORS 656.262(4), we would not find this release to be persuasive evidence of claimant's medical ability to work because it apparently issued solely in response to claimant's request, rather than in response to his medical condition. (See Ex. 5A).

Claimant requests a penalty based on the employer's allegedly unreasonable failure to pay interim compensation.

A penalty may be assessed for unreasonable delay or refusal to pay compensation under ORS 656.262(11)(a). In this case, the employer received notice of claimant's work releases for the period from August 5, 1996 through August 28, 1996 on or before September 24, 1996. (See Exs. 4, 7-3, 9, 17). Claimant's first payment of interim compensation was therefore due on or before October 8, 1996. See ORS 656.262(4)(a). No such compensation had been paid as of the November 18, 1996 hearing.

The employer offers no explanation for its failure to pay interim compensation upon receipt of claimant's work releases beyond its assertion that claimant's time loss resulted from being fired rather than from his injury. However, considering the caselaw holding that interim compensation is due when a worker becomes disabled before termination, we find that the employer had no legitimate doubt regarding its interim compensation liability in this case. See, e.g., David A. Matthews, 47 Van Natta at 258. In the absence of such doubt, we conclude that the employer's failure to pay interim compensation was unreasonable in this case. See Stephen M. Snyder, 47 Van Natta 1956 (1996) (Considering the established caselaw concerning interim compensation and the fact that the employer had notice that the claimant left work due to the work injury, failure to pay interim compensation constituted unreasonable refusal to pay compensation under ORS 656.262(11)). Consequently, we assess a penalty of 25 percent of amounts due under this order. See Lisa R. Angstadt, 47 Van Natta 981, 983 (1996) ("Refusal to pay interim compensation is a claims processing decision that necessarily assumes the risk of assessed penalties and attorney fees if that decision is later found to have been unreasonable."); Hendrickson, 46 Van Natta 1888.

ORDER

The ALJ's order dated December 18, 1996 is reversed. Claimant's hearing request is reinstated. The self-insured employer is directed to pay interim compensation to claimant for the period from August 5, 1996 through August 28, 1996. The employer is directed to pay a penalty of 25 percent of amounts due under this order, to be shared equally between claimant and claimant's attorney. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

July 14, 1997 Cite as 49 Van Natta 1063 (1997)

In the Matter of the Compensation of
KENNETH C. QUICK, Claimant
WCB Case Nos. 96-09224 & 96-06240
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's occupational disease claim for a right shoulder degenerative arthritis condition. On review, the issues are compensability and responsibility.

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

Claimant contends the ALJ erred by concluding that claimant's degenerative arthritis was a preexisting condition and that claimant had to meet the additional requirements of ORS 656.802(2)(b) to establish compensability. However, even if claimant had no preexisting condition, in order to establish compensability of his degenerative arthritis of the right shoulder as an occupational disease, he must still prove that employment conditions were the major contributing cause of the disease. ORS 656.802(a). No physician opines that claimant's work activities are the major contributing cause of his degenerative arthritis. Rather, all three physicians who address the question opine that claimant's degenerative arthritis is idiopathic and that the work activities are not the major contributing cause. Under such circumstances, even if claimant's degenerative arthritis did not constitute a preexisting condition, he has failed to meet his burden of proof.

ORDER

The ALJ's order dated January 14, 1997 is affirmed.

In the Matter of the Compensation of
RICHARD L. SHORT, Claimant
WCB Case No. 96-05658
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the insurer's denial of his current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured his right arm and shoulder, low back and right hip and leg on March 13, 1995 when he fell off a ladder. The insurer accepted a nondisabling lumbosacral strain, right shoulder and right hip contusion. The claim was later reclassified as disabling pursuant to a June 7, 1996 Order on Reconsideration.

Meanwhile, on April 15, 1996, the insurer issued a partial denial of claimant's current low back condition.

Prior to his compensable injury, claimant had injured his low back in a 1972 accident while he was in the military. He received permanent disability benefits as a result of this injury. Claimant also sought treatment for low back pain in 1981 and 1982.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant failed to prove that his compensable back injury is the major contributing cause of his current combined low back condition or need for treatment of that condition. On review, claimant urges us to rely on the opinion of his treating physician, Dr. Poulson, and conclude that his current low back condition is compensable.

Where, as here, the medical evidence is divided, we rely on the opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Poulson, who began treating claimant shortly after his March 1995 injury, acknowledged that claimant had a preexisting degenerative condition and reported that the compensable injury aggravated this condition and probably increased the rate of degeneration of the L5 disc. (Ex. 42) Dr. Poulson also stated that claimant's compensable injury was "additive," meaning that it left his back weaker and more vulnerable to recurrent injury than it had been prior to the accident. (Exs. 42, 43). Dr. Poulson further opined that the compensable injury was the major contributing cause of his current condition. (Ex. 43).

On the other hand, Drs. Scheinberg and Dordevich, who examined claimant one time at the request of the insurer, opined that claimant's compensable injury had become medically stationary and that the major contributing cause of his ongoing symptoms and need for treatment was his preexisting degenerative disc disease. (Ex. 33-5).

After considering the medical evidence, we find no persuasive reason not to rely on the opinion of Dr. Poulson. He had an complete and accurate understanding of claimant's previous injuries and preexisting condition as well as the nature of the compensable injury. (See, e.g. Ex. 7). As noted above, Dr. Poulson explained that claimant had been asymptomatic for years prior to his work injury, but that the compensable injury increased the rate of disc degeneration and left claimant's low back symptomatic and more vulnerable to recurrent injury. Unlike the ALJ, we are persuaded that in identifying the compensable injury as the major cause of claimant's current condition, Dr. Poulson weighed the relative contribution of his previous injury and his degenerative condition. See Dietz v. Ramuda, 130 Or App 397 (1994) (determining the "major contributing cause" involves evaluating the relative contributions of different causes; the precipitating cause of symptoms is not necessarily the major cause of those symptoms). Consequently, we conclude that claimant has shown by a preponderance of the evidence that his current combined condition is compensably related to his accepted low back injury. See ORS 656.005(7)(a)(B).

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

ORDER

The ALJ's order dated September 20, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for further processing according to law. For services at hearing and on review, claimant's counsel is awarded $4,000, to be paid by the insurer.

Board Member Moller dissenting.

At issue in this case is whether claimant's current low back condition results primarily from his March 13, 1995 accepted lumbosacral strain or from his prior low back injury and preexisting degenerative disc disease. Because I believe that claimant has failed to prove that his current condition is compensably related to his March 1995 strain, I respectfully dissent.

The majority found no persuasive reason not to rely on the opinion of claimant's treating doctor, Dr. Poulson. I find several. First, unlike the majority, I am not persuaded that Dr. Poulson weighed the relative contribution of the various causes of claimant's low back condition, as required by Dietz v. Ramuda, 130 Or App 397 (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). Although he may have been advised of claimant's history, Dr. Poulson did not discuss claimant's previously diagnosed chronic back pain or his degenerative disc disease in addressing the cause of claimant's ongoing symptoms. Rather, Dr. Poulson simply reasoned that claimant's compensable injury was the major cause of his current condition because his back was asymptomatic before the accident. I believe that such a "but for" or precipitating cause analysis is insufficient to sustain claimant's burden of proof under the major contributing cause standard. See, e.g. Alec E. Snyder, 47 Van Natta 838 (1995); Cody L. Lambert, 48 Van Natta 115 (1996).

Second, although he used the magic words, I am unpersuaded by Dr. Poulson's opinion because it is so conclusory. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). Dr. Poulson initially described claimant's compensable injury as "additive," as in adding to or aggravating his prior back problem. He later concluded that the compensable injury was the major cause of claimant's combined condition without explaining how or why the injury resulted in a worsening of his preexisting degenerative disc disease.

Third, although the contrary opinion of Drs. Scheinberg and Dordevich is also conclusory, it is evident that their report is based on a complete and accurate history of claimant's low back problems. Drs. Scheinberg and Dordevich concluded that the major contributing cause of claimant's current condition was his preexisting degenerative disc disease. They reported that although claimant's need for low back treatment following his March 1995 injury was directly related to that injury, he had since

become medically stationary from that injury and therefore his current and future need for treatment would relate to his preexisting condition, rather than the accepted strain. Unlike Dr. Poulson, Drs. Scheinberg and Dordevich did not believe that claimant's compensable injury caused a permanent worsening of his preexisting degenerative disc disease.

Considering the divided medical evidence and the lack of any persuasive reason to rely on Dr. Poulson's opinion over that of Drs. Scheinberg and Dordevich, I would agree with the ALJ's determination that claimant has not sustained his burden of proof under ORS 656.005(7)(a)(B) and 656.266.

In the Matter of the Compensation of
PABLO A. SOLORIO, Claimant
WCB Case No. 96-03390
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) found that claimant's major depressive disorder was compensable; (2) found that an Order on Reconsideration prematurely closed claimant's accepted claim for various facial injuries; and (3) awarded an assessed attorney fee. In its reply brief, the insurer moves to strike claimant's respondent's brief as untimely filed. On review, the issues are the insurer's motion to strike, compensability, premature claim closure, extent of permanent disability, 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

Preliminary Issue

The insurer first moves to strike claimant's respondent's brief because it was not timely filed. The file shows that, after being granted an extension, claimant's respondent's brief was due on March 6, 1997. Claimant did not mail his brief, however, until March 12, 1997 and provides no explanation for the late filing. Consequently, we grant the insurer's motion and do not consider claimant's respondent's brief on review. See OAR 438-011-0020, 438-011-0030.

Compensability

On December 21, 1994, claimant was injured when a chainsaw "bucked" and hit him in the face. The insurer eventually accepted "laceration right forehead, fracture of frontal bone, disruptive wound right upper eyelid and right lower lid, wound of right cheek and wound of right upper lip." (Ex. 15). On June 3, 1996, a Determination Order issued awarding no permanent disability. (Ex. 41). An October 8, 1996 Order on Reconsideration affirmed the Determination Order. (Id.)

After issuance of the Notice of Acceptance but before claim closure, claimant's attorney wrote to the insurer requesting that it accept numerous additional conditions, including depression and headaches. (Ex. 27). At hearing, claimant continued to assert the compensability of these conditions and the ALJ agreed that claimant proved compensability for major depressive disorder and chronic headache pain.[1] The insurer challenges that portion of the order finding claimant's depression compensable.

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[1] The ALJ further found that the insurer was not required to accept the conditions of severed nerves, severed or fractured facial bones, cuts, contusions, concussion, post-traumatic stress disorder, anxiety, vision problems, eye injury, chronic pain, neck and back sprain and strains, and scarring. Those conditions are not at issue on review.

The diagnosis of major depressive disorder was made by Dr. Lerner, psychiatrist, who saw claimant on two occasions at his attorney's request. (Ex. 35). In relating the condition to claimant's injury, Dr. Lerner stated only that the "information presented by [claimant] and his wife clearly link the onset of a change in his personality and mood with the chain saw injury." (Id. at 2).

In evaluating medical opinions, we find most persuasive those opinions that are well-reasoned and rely on an accurate history. Somers v. SAIF, 77 Or App 259 (1986). Dr. Lerner essentially provides no reasoning for why claimant's depressive episode was caused by his accident. We find such an absence particularly fatal in view of the fact that other medical providers and examiners did not diagnose claimant with depression. (Exs. 24, 35B, 38). Although claimant's treating physician, Dr. Kooiker, agreed with Dr. Lerner's diagnoses, (Ex. 35A), he also had previously concurred with examining psychiatrist, Dr. Klecan, who found that claimant had no mental or emotional disorder, (Ex. 25). Thus, having provided contradictory concurrences, we give little credence to evidence from Dr. Kooiker.

In sum, because Dr. Lerner's diagnosis of major depressive episode is not supported by any reasoning or by the remaining opinions, we find it inadequate to establish compensability of major depressive episode. ORS 656.005(7)(a), 656.005(7)(a)(A).

Premature Claim Closure

After finding that claimant proved the compensability of major depressive disorder and chronic headache pain, the ALJ also concluded that such conditions were not medically stationary and, consequently, the accepted claim was prematurely closed.

A carrier's "post-hearing" acceptance of a condition different from those originally accepted does not automatically mean that the accepted claim was prematurely closed. E.g., Anthony J. Telesmanich, 49 Van Natta 49 (1997); Rodney V. Boqua, 48 Van Natta 357 (1996). Rather, a "post-hearing" acceptance requires the carrier to process the newly accepted condition as required by law, including payment of any compensation to which the claimant would be entitled as a result of such condition. Id.

Here, consistent with the reasoning expressed in Telesmanich and Boqua, the insurer is required to process claimant's headache condition, including the payment of any compensation to which claimant may be entitled. Nonetheless, such a conclusion does not mean that claimant's claim was prematurely closed. To the contrary, finding no persuasive evidence that claimant's accepted conditions were not medically stationary at claim closure, we reverse the ALJ's decision to set aside the claim closure as premature.

Permanent Disability

We turn to a review of claimant's permanent disability for his right eye vision loss and cranial nerve. Claimant's attending physician concurred in findings from examining physicians that do not support permanent impairment beyond that granted by the Determination Order. In light of such circumstances, we affirm the Order on Reconsideration that affirmed the Determination Order award of 18 percent unscheduled permanent disability and 5 percent scheduled permanent disability for right eye vision loss.

Attorney Fee at Hearing for Headache Condition

The insurer asserts that, because the headache condition was part of those conditions it initially accepted, there was no "de facto" denial of such condition and, thus, claimant is not entitled to an attorney fee at hearing.

As explained above, the insurer accepted "laceration right forehead, fracture of frontal bone, disruptive wound right upper eyelid and right lower lid, wound of right cheek and wound of right upper lip." According to examining neurologist, Dr. Brown, claimant's headaches were from "traumatic neuropathy" and were not conventional headaches but "more of a neuralgic pain." (Ex. 23-5). Based on this report, we understand claimant's headache pain as due to a nerve injury. Because the insurer's claim acceptance made no reference to any injury to a nerve, we find that the insurer's acceptance did not include traumatic neuropathy.

A reasonable attorney fee is allowed at hearing when a claimant prevails finally over a denied claim. ORS 656.386(1). A "denied claim" is a claim for compensation which a 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 any compensation." Id. We have construed the provision as requiring evidence that the carrier refused to pay compensation by expressly questioning causation. E.g., Michael J. Galbraith, 48 Van Natta 351 (1996).

Although claimant's attorney in this case requested before hearing that the insurer accept the headache condition, the insurer did not revise the acceptance or "make other written clarification in response." See ORS 656.262(6)(d). The insurer's response to claimant's hearing request, however, expressly denied that claimant "sustained a work-related accidental injury or occupational disease." Such evidence is sufficient to show that the insurer expressly questioned causation. See Emily J. Bowman, 48 Van Natta 1199 (1996), aff'd Kimberly Quality Care v. Bowman, 148 Or App 292 (1997). Thus, we conclude that there was a "denied claim" for the headache condition over which claimant prevailed at hearing, warranting the assessment of an attorney fee for services at hearing.

The ALJ awarded an assessed fee of $3,500 for claimant's attorney's services in prevailing over the denials of the psychological condition and the headache condition. Because we reversed that portion of the ALJ's order concerning the psychological condition, claimant is entitled to a fee only for services at hearing concerning the headache condition. The amount of an assessed fee is based on the factors set forth in OAR 438-015-0010(4). After considering such factors, we find that a reasonable attorney fee is $2,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant's attorney is not entitled to a fee on review concerning the attorney fee issue.

ORDER

The ALJ's order dated November 14, 1996 is reversed in part and modified in part. The insurer's denial of claimant's major depression claim is reinstated and upheld. That portion of the ALJ's order finding the accepted claim prematurely closed is reversed. The Order on Reconsideration is affirmed. Claimant's headache condition claim shall be processed according to law. For services at hearing, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the insurer.

In the Matter of the Compensation of
DEAN A. STUBBS, Claimant
WCB Case No. 96-07689
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order which directed it to recalculate claimant's temporary disability rate. On review, the issue is rate of temporary disability benefits and offset. We modify.

FINDINGS OF FACT

We adopt the ALJ's finding of fact with the following correction and supplementation. The first sentence of the third paragraph of the ALJ's findings of fact is corrected to indicate that claimant returned to work for SAIF's insured on September 12, 1995.

Claimant worked as a truck driver for SAIF's insured. His last day of work in this position was before July 4, 1995. (Tr. 15). Claimant was laid off from SAIF's insured. During the period from after the July 4, 1995 weekend until he was rehired by SAIF's insured on September 12, 1995, claimant worked for Claremont as a truck driver. (Tr. 15-16). While employed at Claremont, claimant worked

over 60 hours per week and could not have performed his truck driving job at SAIF's insured due to the workload at Claremont. (Tr. 17). When claimant was rehired by SAIF's insured on September 12, 1995, he was under the same pay agreement as when he last worked for this employer. (Tr. 19). Claimant was under this same pay agreement when he compensably injured his low back on September 14, 1995.

CONCLUSIONS OF LAW AND OPINION

Applying former OAR 436-60-025(5)(a),[1] WCD Admin. Order 94-055, the ALJ determined that this case involved the proper interpretation of the second sentence of OAR 436-60-025(5)(a) dealing with "extended gaps." Opinion and Order, page 2. Relying on the language of the rule and Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), which determined that the Board's interpretation of "extended gaps" under a prior version of the rule impermissibly added a requirement that there be a change in the employment relationship before an extended gap could be found, the ALJ determined that claimant's rate of temporary disability compensation should be calculated on the basis of the 30.5 weeks claimant actually worked for SAIF's insured during the period prior to his injury. Thus, the ALJ determined that the period from before July 4, 1995, when claimant last worked for SAIF's insured, to September 12, 1995, when claimant returned to work for SAIF's insured, should not be included in determining the rate of temporary disability.

For the following reasons, we find that claimant's temporary disability rate should be calculated based on the intent of the most recent wage earning agreement. Former OAR 436-60-025(5)(a).

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 14, 1995. Thus, the ALJ correctly determined that the rules contained in Workers' Compensation Order No. 94-055 apply to this claim.

On review, SAIF argues that, although claimant was "on-call" and had no earnings with SAIF's insured from just before July 4, 1995 until he returned to work at SAIF's insured on September 12, 1995, he continued to be employed by SAIF's insured during this period. Therefore, SAIF argues that this July 4, 1995 to September 12, 1995 time period is included in the "actual weeks of employment" under former OAR 436-60-025(5)(a). Consequently, SAIF argues, it properly calculated claimant's temporary disability rate using the entire 41.8 weeks of employment. In making this argument, SAIF contends that Thomas J. Kollen, 48 Van Natta 127 (1997), a case issued after the ALJ's order, is distinguishable. We disagree with both SAIF's argument and its contention regarding Kollen.

In Thomas J. Kollen, 48 Van Natta 2454 (1996), recon 49 Van Natta 127, recon 49 Van Natta 554 (1997), the claimant, a carpenter, began working for the employer on October 2, 1995, at a wage of $10 per hour. He worked until November 27, 1995, when he was laid off due to a lack of work. While laid off, the claimant looked for other work; however, he was not able to find other employment and collected unemployment benefits during this period. The claimant returned to work for the employer on January 2, 1996 at the same wage. On January 3, 1996, the claimant compensably injured his right leg. Subsequently, a dispute arose over the insurer's calculation of the claimant's time loss rate. The Director issued an order affirming the insurer's recalculation of the time loss rate including the period of time the claimant was laid off. The claimant requested a hearing. The ALJ determined that the period during which the claimant was laid off constituted an "extended gap," which was not to be included in determining the claimant's average weekly wage.

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[1] Former OAR 436-60-025(5) provides, in part:

"(5) 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."

The carrier requested review, ultimately arguing that the phrase "actual weeks of employment" in former OAR 436-60-025(5)(a) was ambiguous and could include those weeks during which the claimant was on the job and actually worked or the phrase could refer to the total period of employment, regardless of whether the claimant actually performed any work during a particular week. The carrier asserted the second interpretation was correct.

However, we did not find it necessary to address the carrier's argument regarding its interpretation of the phrase "actual weeks of employment" because, applying former OAR 436-60-025(5)(a) (WCD Admin. Order 94-055), we ultimately concluded that the claimant had been "rehired" on January 2, 1996. Thomas J. Kollen, 49 Van Natta at 555. Therefore, since the claimant had been employed for less than four weeks after his rehire date before he was injured on January 3, 1996, we determined that the provision in former OAR 436-60-025(5)(a) which provides that "[f]or 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" applied to the claimant's case. Based on the "801" form filled out by the employer and the testimony at hearing, we concluded that the parties' intent at the time of claimant's rehire was for the claimant to work an average of 40 hours per week at the rate of $10 per hour.

SAIF argues that Kollen is distinguishable because, here, claimant was not laid off and rehired but, instead, remained employed by SAIF's insured, although on-call and earning no wages during the period in question. As discussed above, in Kollen we concluded that the claimant was "rehired" when he returned to work for the employer. For the following reasons, we reach the same conclusion in the present case.

Mr. Brown, the employer's office manager, testified that the employer's business of selling ornamental and bedding plants was a heavily seasonal business. (Tr. 9, 11). He testified that, in the past, claimant had resigned when sales slowed and was eligible for rehire. (Tr. 10, Ex. 2). However, he testified that there was not a similar resignation in July 1995 and rehiring in September 1995. (Tr. 10). Instead, claimant was placed on "on-call" status as sales waned in July 1995 and there was no demand for claimant's services. (Tr. 9). During this "on-call" status, time sheets indicated "no time - on call." (Tr. 9, Ex. 9A). This "on-call" status continued until claimant returned to work for the employer in September 1995, when claimant began to have earnings again. (Tr. 9-10). However, Mr. Brown testified that this was not a rehire because there was no termination of employment documented when claimant was placed on "on-call" status. (Tr. 10).

In contrast to Mr. Brown's description of claimant's employment relationship, claimant testified that his understanding was that, following the last day of work with the employer, the workers were "released to draw unemployment or go find other work," so he always considered himself laid off at that point and that is why he went to work elsewhere. (Tr. 17). He testified that he could not have worked for the employer while employed by Claremont because he was kept too busy there working over 60 hours per week. (Tr. 16-17). When he met with his supervisor at SAIF's insured in September 1995, she offered his position back, telling him that he would be "coming back full time, that under the new system they don't believe in lay offs, so they can keep me busy full time and wanted me to come back to work." Id. Claimant testified that he was under the same pay agreement when he returned to work for the employer in September 1995. (Tr. 19).

We find that claimant's testimony of full-time work for another employer persuasively rebuts the employer's representative's testimony and SAIF's argument that claimant was on "on-call" status from before July 4, 1995 until his return to work for the employer on September 12, 1995. There is no evidence that claimant was notified about being on "on-call" status or any change in treatment of the period of time when the employer had no work for claimant. Claimant persuasively testified that, as in the past, he considered the current lack of work with the employer to constitute a lay off and he was released to draw unemployment or find other employment, which he did. Furthermore, claimant persuasively testified that, when he met with his supervisor prior to returning to work for the employer, he was told that the employer wanted him to return to work and, under the new system, lay offs would not occur. Under these circumstances, we find that claimant was laid off when he last worked for the employer before July 4, 1995. Claimant was rehired by the employer on September 12, 1995.

Given these findings, we conclude that our final reasoning in Kollen applies to this case. In other words, because claimant was rehired on September 12, 1995 and was injured on September 14,

1995, he was employed less than four weeks at the time of his injury. Therefore, "the intent of the most recent wage earning agreement as confirmed by the employer and the worker" is used to determine claimant's temporary disability rate. Former OAR 436-60-025(5)(a). We determine the parties' intent of the most recent wage earning agreement by reviewing the information provided by the employer on the "801" form and the testimony at hearing. See Qualified Contractors v. Smith, 126 Or App 131 (1994); Ralph L. Keller, 48 Van Natta 146 (1996).

Here, the "801" form completed by the employer stated that claimant worked five days per week, 10 to 18 hours per shift (on a 70 hour, eight day log book), at $10 per hour. (Ex. 10). When claimant was rehired in September 1995, he understood that he was still under this "old system," although the pay agreement apparently changed in 1996. (Tr. 14, 19). The employer does not dispute that the wage agreement remained the same when claimant was rehired in September 1995.

Based on the "801" form filled out by the employer and the testimony at hearing, we conclude that the parties' intent at the time of claimant's rehire on September 12, 1995 was for claimant to work five days per week, 10 to 18 hours per day, at $10 per hour. Therefore, SAIF is ordered to recalculate claimant's temporary disability on this basis.

To the extent that this recalculation results in any increased compensation, claimant's attorney is awarded 25 percent of such increased compensation, provided that the total out-of-compensation attorney fees awarded by the ALJ and this order do not to exceed $3,800. OAR 438-015-0055.

On review, SAIF requests that, if we find that it improperly calculated the temporary disability rate, we should direct it to recalculate the overpayment using 30.5 weeks of wages. In making this request, SAIF contends that the ALJ's order language can be interpreted to essentially nullify the entire overpayment rather than directing it to recalculate the overpayment. SAIF notes that the overpayment was based in part on an incorrect time loss rate and in part on an incorrect prorating of temporary partial disability after claimant had returned to modified work. (Exs. 22, 25).

Because we have found claimant entitled to a time loss rate calculated on a different basis than that found by the ALJ, it necessarily follows that recalculation of the time loss rate pursuant to our order may result in an adjustment of any overpayment. To the extent that this recalculation results in an adjustment of any overpayment of temporary disability, SAIF shall adjust any overpayment accordingly.

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

ORDER

The ALJ's order dated December 12, 1996 is affirmed in part and modified in part. In lieu of that portion of the ALJ's order that directed the SAIF Corporation to calculate claimant's time rate loss on the basis of 30.5 actual weeks of wages earned during the period prior to his injury, SAIF is directed to calculate claimant's time loss rate based on the parties' intent that claimant work five days per week, 10 to 18 hours per day, at $10 per hour. To the extent that this recalculation results in any increased compensation, claimant's attorney is awarded 25 percent of such increased compensation, payable directly to claimant's attorney, provided that the total out-of-compensation attorney fees awarded by the ALJ and this order do not to exceed $3,800. This attorney fee is not subject to any offset based upon any prior overpayment of compensation. OAR 438-015-0085(2). To the extent that this recalculation of claimant's temporary disability rate results in an adjustment of any overpayment of temporary disability, SAIF shall adjust any overpayment accordingly. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $500, payable by the SAIF Corporation.

In the Matter of the Compensation of
MARK R. WOODS, Claimant
Own Motion No. 66-0442M
OWN MOTION ORDER
Pozzi, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On April 30, 1997, the SAIF Corporation submitted claimant's request for medical benefits for treatment of his bilateral shoulder osteoarthritis. SAIF has accepted claimant's right shoulder dislocation condition as compensable to his 1964 injury claim. SAIF recommended that the Board disallow the payment of the requested medical treatment, contending that claimant's current bilateral shoulder osteoarthritis condition is not causally related to the compensable injury.

FINDINGS OF FACT

On May 15, 1964, claimant sustained a compensable right shoulder dislocation injury with SAIF's insured. On November 17, 1967, claimant sustained another injury with a different employer / insurer. As a result of the 1967 injury, claimant is paraplegic and was declared permanently and totally disabled. Claimant has been confined to a wheelchair since the 1967 injury, and is required to propel his wheelchair with his arms. Claimant has had bilateral shoulder pain for several years for which he now seeks medical attention. Claimant's current condition is diagnosed as bilateral shoulder osteoarthritis.

CONCLUSIONS OF LAW AND OPINION

Inasmuch as claimant sustained his compensable shoulder industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, the Board 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).

In a December 3, 1996 medical report, Dr. Deetjen, claimant's treating physician, opined that claimant has "severe bilateral shoulder osteoarthritis which is severely limiting his activity." Dr. Deetjen reported that he injected both of claimant's shoulders in an attempt to give him some relief. Finally, Dr. Deetjen opined that, at some point, claimant "may need bilateral total shoulders to relieve the pain and continue to give him ability to propel his wheel chair."

On May 8, 1997, the Board requested the parties' positions regarding the compensability of claimant's current bilateral shoulder condition. We further requested that the parties submit any medical evidence used to determine their positions. Finally, we requested that the parties advise the Board whether surgery was currently recommended for claimant's current condition.

In a May 16, 1997 response, SAIF contended that Dr. Deetjen's December 3, 1996 report established that claimant's bilateral shoulder condition was related to his "years of propelling a wheelchair with his arms." SAIF further contended that claimant's current bilateral shoulder condition is the responsibility of the 1967 injury with another insurer.

On June 11, 1997, the Board sent claimant's attorney copies of its May 8, 1997 letter requesting positions in this claim, as well as SAIF's May 16, 1997 response to that letter. On June 20, 1997, claimant's counsel forwarded a May 28, 1997 letter from Dr. Deetjen. In that letter, Dr. Deetjen opined that:

> "Since I saw [claimant] in December of 1996 his shoulder pain has not improved nor has it significantly worsened. The injection into the joint helped for only a few days. The discomfort that he has in his shoulder is likely to very slowly worsen and at that point will limit his use in propelling his wheel chair. At this point [claimant] is functioning adequately and is able to propel himself as needed to fulfill his daily functions[. H]owever, it is very hard to predict how long [claimant] will be able to maintain this level of activity."

Although it appears that Dr. Deetjen limited his May 28, 1997 opinion to the condition and / or worsening of claimant's right shoulder, on December 3, 1996, he opined that the gradual worsening of both of claimant's shoulders affected his ability to continue to propel his wheelchair.[1] SAIF has not accepted claimant's left shoulder condition, nor has it accepted his paraplegic condition. Furthermore, on December 3, 1996, Dr. Deetjen opined that claimant's current condition is bilateral shoulder osteoarthritis, which is a different condition than his original shoulder dislocation injury.

Dr. Deetjen related claimant's worsened bilateral shoulder condition to his years of propelling his wheelchair, in which he is confined due to another injury. Nowhere in the record does a physician relate claimant's current condition to his 1964 right shoulder injury. Rather, the medical record persuades us that claimant's current shoulder condition is a result of his daily use of his arms to propel a wheelchair which was necessitated by his paraplegic condition. In fact, the only statement which relates claimant's current condition to any previous condition or injury is Dr. Deetjen's December 3, 1996 report that claimant "sustained an injury from a fall in the 1960's working construction which resulted in paraplegia" and wheelchair use, which requires him to use him arms. The injury which resulted in claimant's paraplegic condition occurred after claimant sustained his right shoulder injury. Claimant's injury which resulted in paraplegia is not the responsibility of SAIF under claimant's 1964 injury claim. Dr. Deetjen's unrebutted opinion appears to relate claimant's current condition to his 1967 injury. Thus, we do not find sufficient medical evidence in the record to establish that the requested medical treatment for claimant's bilateral shoulder osteoarthritis condition is reasonable and necessary and causally related to claimant's 1964 compensable injury with SAIF.

Finally, because claimant has not established the compensability of his current bilateral shoulder condition to his 1964 injury claim, we need not address whether claimant's current condition requires surgery or hospitalization, and, thus, whether claimant is entitled to temporary disability compensation at this time.[2]

Accordingly, we decline to authorize payment of medical treatment and / or temporary disability compensation for claimant's current bilateral shoulder osteoarthritis condition.

IT IS SO ORDERED.

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[1] We have previously found that no worsening of a compensable injury is required for authorization of medical services in pre-1966 injury claims. Gerald S. Gaage, 42 Van Natta at 2722; Donald B. Karstetter, 42 Van Natta at 156. However, in order to be entitled to medical services, the burden of proof falls upon the claimant to establish that the current condition is causally related to the compensable injury and that the requested medical services are reasonable and necessary for the compensable injury.

[2] In any event, in his May 28, 1997 report, Dr. Deetjen opined that claimant is currently functioning adequately. In his December 6, 1996 report, Dr. Deetjen opined that both of claimant's shoulders may need surgery at some point in the future so that he may continue to propel his wheelchair. Thus, even if claimant's current condition was compensably related to his 1964 injury claim, barring a current recommendation for surgery by a physician, claimant would not qualify for TTD under ORS 656.278 at this time.

In the Matter of the Compensation of
JODY CROMPTON, Claimant
Own Motion No. 95-0287M
OWN MOTION ORDER OF ABATEMENT
Carney, et al, Claimant Attorneys
Garrett, et al, Defense Attorneys

The self-insured employer requests reconsideration of our June 18, 1997 Own Motion Order, in which we directed the employer to pay temporary disability compensation pursuant to our June 12, 1996 order (including an approved attorney fee), and assessed a 25 percent penalty under ORS 656.262(11)(a) of the amounts "then due" claimant beginning the date she underwent surgery, payable in equal shares to claimant and her attorney. Contending that claimant's alleged "double recovery" of sick leave and temporary disability compensation should not be allowed, the employer moves the Board to reconsider its decision to enforce its June 12, 1996 order "because it creates an imbalance in fairness against the self-

insured employer, who is responsible for the payment of both sick leave benefits as well as temporary disability benefits."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROD M. HOPKINS, Claimant
WCB Case No. 96-06822
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that: (1) upheld the insurer's denial of claimant's claim for a thoracic injury; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

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

On review, claimant argues that it is "common knowledge" that twisting while lifting heavy objects can cause sprains, strains and disc herniations, even among healthy individuals. Claimant argues that there is nothing complicated about his injuries in this case. We disagree.

As noted by the ALJ, expert medical evidence is necessary when a case is complex. Whether expert medical evidence of causation is required depends on: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. Uris v. Compensation Dept., 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993).

Here, claimant apparently felt symptoms immediately following a lifting incident at work on June 3, 1996. Although the insurer disputes that claimant promptly reported the occurrence to a superior that day, the employer did discuss a back injury with claimant the following evening. (Ex. 9A-1).

Notwithstanding the above conclusions, we agree with the ALJ's reasoning that this is a complicated situation. Although there is no specific opinion that the lifting event could not have been the cause of the injury, films taken after the injury revealed numerous thoracic conditions, including: (1) nodes at three thoracic levels with vertebral wedging "believed to represent residuals from Scheuermann's disease or posttraumatic epiphysitis"; (2) "mild accentuated thoracic kyphosis"; (3) "mild levo-cervicothoracic scoliosis"; and (4) "right paracentral disc protrusion at T7-8." (Exs. 7, 8, 10).

Additionally, we agree with the ALJ that this is a complex causation issue in light of the fact that claimant previously experienced thoracic problems, including an on-the-job injury in 1993 which required medication and physical therapy. (Ex. B-29). Moreover, at the time of the 1993 injury, claimant reported a prior fracture of a thoracic vertebrae. (Ex. B-6).

Accordingly, we conclude that expert medical evidence of causation is required. Although claimant contends that the emergency room report and the reports of Drs. Johnson and Slack[1] support

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[1] Although the ALJ found that claimant was referred to Dr. Slack for evaluation and treatment, and claimant contends that Dr. Slack's opinion supports his claim, we find no report containing a causation opinion by Dr. Slack in the record.

compensability, we are unable to find any discussion regarding claimant's prior thoracic injuries or the recent MRI findings. Consequently, we agree with the ALJ that the medical opinions in the record are neither complete nor accurate. See Miller v. Granite Construction, 28 Or App 473 (1977). Therefore, we do not find such opinions to be persuasive evidence of causation, and we conclude that claimant has failed to meet his burden of proof.

ORDER

The ALJ's order dated February 19, 1997 is affirmed.

In the Matter of the Compensation of
JIM D. HOWERTON, Claimant
WCB Case No. 96-09143
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that: (1) found that the parties were litigating the compensability of a "combined condition;" and (2) set aside the insurer's partial denial of claimant's "combined" degenerative cervical condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Following a May 15, 1996 incident at work, the insurer accepted claimant's acute cervical strain condition. On July 23, 1996, claimant's treating doctor, Dr. Kitchel, diagnosed musculoligamentous injury of the cervical spine, multiple level cervical degenerative disc disease, and radiculitis at C-7, right.

On September 17, 1996, claimant was examined by Drs. Tesar and Farris, on behalf of the insurer. The doctors diagnosed a cervical strain/sprain syndrome and unrelated preexisting degenerative disc disease.

On October 21, 1996, the insurer issued a partial denial, which denied claimant's "cervical degenerative disk disease treatment, impairment or disability related to this condition." Claimant requested a hearing on the insurer's denial.

CONCLUSIONS OF LAW AND OPINION

On review, the insurer[1] contends that the ALJ erred in finding that claimant had established compensability of a "combined condition," where claimant was making a claim for an "independent condition" comprised solely of the degenerative condition. The insurer contends that claimant chose to litigate only the degenerative cervical condition, as opposed to a combined condition, and the ALJ should not have addressed an issue that had not been raised. For the following reasons, we agree that a combined condition was not at issue at the time of hearing.

Following the examiner's report which found that: (1) claimant's neck injury was a cervical strain/sprain which should have resolved, and; (2) claimant had degenerative disc disease unrelated to the injury, the insurer issued a partial denial. The denial provided that the insurer denied claimant's "cervical degenerative disk disease treatment, impairment or disability related to this condition." (Ex. 35-1).

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[1] We change the ALJ's reference on page 3 of the Opinion and Order from "Liberty Northwest" to "the insurer."

At hearing, claimant and the insurer agreed that claimant was appealing the insurer's denial, which claimant's counsel described as a "partial denial and it denies the compensability of a cervical degenerative disc disease." (Tr. 2). Accordingly, based on the parties' statements regarding the issues, we find that the sole issue was the insurer's denial. Although claimant contends, on review, that the denial could also be interpreted to deny a "combined condition," we find no language in the denial regarding a combined condition which would lead us to agree with such a conclusion.

Claimant also argues that we have previously held that parties may litigate an issue by implicit agreement, even where the issue was not a ground relied upon by the insurer in its denial. See Michael A. Beall, 48 Van Natta 487 (1996). Here, claimant contends that, in opening statements, claimant's counsel argued that the case was a "contest between what the IME docs say and Dr. Kitchel, his treating orthopedic surgeon." (Tr. 3). On review, claimant argues that, because Dr. Kitchel's opinion discussed a "combined condition," and the insurer did not object or respond during opening comments, the parties tried the issue by implicit agreement.

We conclude that, under the facts of this case, claimant's counsel's summary that the case was based on the persuasiveness of the respective doctors does not constitute an agreement to litigate the compensability of a combined condition. Our conclusion is based on the lack of any comments or discussion regarding the issue, in addition to the fact that claimant did not identify the claim or the denial as involving a combined condition. Under these circumstances, we agree with the insurer that the ALJ should not have addressed an issue which was not raised by the parties.[2] See, e.g., Kenneth L. Devi, 48 Van Natta 2349 (1996), on recon 49 Van Natta 108 (1997) (Board declined to address a preclusion argument or theory where the claimant's case had been litigated only on the merits and the claimant had not properly raised a preclusion theory at hearing).

Turning to the issue of the insurer's denial of claimant's degenerative condition, we agree with the ALJ's decision to set aside the denial. However, we set aside the denial based on different reasoning.

We find that there has been no "claim" for a separate degenerative condition. In order for claimant to have made a "new medical condition" claim pursuant to ORS 656.262(7)(a), claimant must clearly request formal written acceptance of the condition.

Here, claimant made no "clear request" that his degenerative condition be accepted. Thus, we find that no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Because a denial issued in the absence of a claim is a nullity, the insurer's denial has no legal effect. See Ramona E. Hamilton, 48 Van Natta 2438 (1996); Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995). Accordingly, we conclude that the insurer's denial was premature.

Finally, claimant will not receive any benefits as a result of our holding that the insurer's denial was premature and, therefore, a "nullity." Thus, we conclude that claimant has not "prevailed" over a denied claim and is not entitled to an attorney fee under ORS 656.386(1). Hamilton, 48 Van Natta at 2440; William C. Becker, 47 Van Natta 1933 (1995).

ORDER

The ALJ's order dated January 31, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial is affirmed, but the denial is set aside as premature. The ALJ's attorney fee award is reversed.

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[2] Our order should not be construed as a commentary or decision on the merits of a combined condition, based on our conclusion that the ALJ should not have reached the issue. Rather, we have merely decided that procedurally, the issue was not before the ALJ in this proceeding.

In the Matter of the Compensation of
SUSAN V. LUNDGREN, Claimant
WCB Case No. 96-05423
ORDER ON REVIEW
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Galton's order that upheld the insurer's denial of her claim for a low back condition. In its respondent's brief, the insurer contends that claimant's claim was not timely filed. On review, the issues are timeliness and compensability.

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

We agree with the ALJ that, whether analyzed as an injury or an occupational disease, claimant's burden of proof is major contributing cause. Under an accidental injury theory, ORS 656.005(7)(a)(B) applies, as claimant's preexisting spondylolisthesis has combined with her lumbar strain, which makes it necessary for claimant to prove that the "injury" was the major contributing cause of her combined condition. Under an occupational disease theory, claimant must show that employment conditions were the major contributing cause of a pathological worsening of her preexisting low back condition. ORS 656.802(2)(a),(b).

On review, claimant argues that the ALJ erred by relying on the opinion of Dr. Kaesche, her initial orthopedist, rather than the opinion of Dr. Flemming, her most recent orthopedic physician. However, for the following reasons, we agree with the ALJ that Dr. Flemming's opinion does not meet claimant's burden of proof.

In order to meet her burden of establishing a compensable occupational disease, claimant must prove a pathological, rather than just a symptomatic, worsening of her preexisting low back condition. ORS 656.802(2)(b). However, Dr. Flemming found only that claimant's preexisting spondylolisthesis appeared to have become more "symptomatic" following her work activities or exposures. (Ex. 12). When discussing a pathological worsening, Dr. Flemming could only make a "theoretical argument" that there was a pathological change. (Ex. 12). Accordingly, we agree with the ALJ that Dr. Flemming's opinion does not meet claimant's burden of proof pursuant to ORS 656.802. See Gormley v. SAIF, 52 Or App 1055 (1981); Horst Zunker, 48 Van Natta 2433 (1996) (Doctor's opinion expressed in terms of possibility, rather than probability, was found to be insufficient to establish the claimant's burden of proof under either an occupational disease or an industrial injury theory of compensability).

Finally, we conclude that Dr. Flemming's opinion is not sufficient to meet claimant's burden of proof under ORS 656.005(7)(a)(B). Dr. Flemming acknowledged that claimant had a preexisting spondylolisthesis condition. When asked to identify when claimant's herniated or bulging disc first appeared, Dr. Flemming replied that the disc was probably associated with the slippage resulting from the preexisting condition, "so it's been there all along." (Ex. 12-9). Dr. Flemming further stated that "you couldn't really tell" what occurred to irritate the L-5 nerve root. (Ex. 12-10). Finally, Dr. Flemming attributed his opinion that claimant's condition was work related to his belief that claimant had not experienced prior hip, buttock or leg pain. (Ex. 12-30). Dr. Flemming agreed that the "proverbial straw that broke the camel's back," or the incident or activity which took claimant's condition over the line between asymptomatic and symptomatic was her position of sitting on her chair at work. (Ex. 12-49).

We find that Dr. Flemming's opinion is essentially premised on his conclusion that the work exposure is the major cause because it was the precipitating cause. However, without weighing the contributions from claimant's preexisting condition, and her prior injuries or exposures which caused back problems, we do not find his opinion to be persuasive. See Dietz v. Ramuda, 130 Or App 397, 401 (1994). In light of his prior concession that the disc had probably been there all along and that it was not possible to tell what irritated claimant's nerve root, we are also not persuaded by a conclusory opinion that work was the major cause of claimant's combined condition.

Furthermore, at hearing, claimant testified that after buying a Nordic Track and using it steadily for a few weeks in January 1995 (prior to beginning work for the employer), she had experienced slight hip pain while on the machine. (Tr. 18). Accordingly, because Dr. Flemming was not aware or did not

acknowledge claimant's prior hip pain, we are unable to find that he had a complete or accurate history. Therefore, for this additional reason, we find Dr. Flemming's opinion to be unpersuasive. Miller v. Granite Construction, 28 Or App 473 (1977).

Because Dr. Flemming's opinion is the only opinion on causation that could be argued to support claimant's claim, we agree with the ALJ that claimant has failed to meet her burden of proof on the issue of compensability.[1]

ORDER

The ALJ's order dated January 22, 1997 is affirmed.

[1] We also agree with the ALJ that, because claimant has failed to prove her case on the merits, it is not necessary to address the insurer's timeliness arguments.

In the Matter of the Compensation of
WILLIAM R. WALLACE, Claimant
WCB Case No. 95-11039
ORDER ON REVIEW
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) found that claimant's toxic exposure claim was precluded by a prior litigation order; and (2) dismissed claimant's hearing request from the insurer's denial of the claim. On review, claimant seeks a new hearing to relitigate the compensability of his previously denied claim based on "post-order" evidence.

We adopt and affirm the ALJ's order regarding the preclusion issue. See David R. Sills, 48 Van Natta 1621 (1996) (Where the issue is the same as previously litigated, a party may not rely on new evidentiary facts to avoid the prior final determination).

In addition, we offer the following supplementation concerning claimant's request for a new hearing.

Our review must be based on the record developed at the hearing before the ALJ. See ORS 656.295(5). Consequently, we treat claimant's request for a new hearing, which is based on "post-order" evidence, as a request for remand to the ALJ for further evidence taking. See 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 clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988). Although evidence that is not generated until after the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. Compton, 301 Or at 648-49 (Neither erroneous factual foundation nor change of opinion creates unobtainable evidence; thus, even though certain medical reports were not available at the time of hearing, the substance of the reports was obtainable); Myrna J. Talbert, 47 Van Natta 353 (1995); Felicitas Deleon, 46 Van Natta 1109, 2210 (1994); James E. Gore, 45 Van Natta 1652 (1993) ("[E]vidence is not newly discovered merely because it was generated after the hearing.").

In this case, claimant argues that his early doctors' misdiagnoses and his lack of access to a law library made it impossible for him to obtain evidence supporting the claim before the hearing. We disagree.

First, we do not see how earlier access to a law library would have affected the pre-hearing medical opinions. Second, we are not persuaded by claimant's contention that the "post-order" medical opinions offered on review were previously unobtainable. See Karen P. Wagner, 46 Van Natta 453, 454 (1994) (Although post-hearing medical report was not available it was obtainable at the time of hearing). Compton, 301 Or at 648-49; Gore, 45 Van Natta at 1652. On the contrary, because information regarding the efficacy of the respirator he wore at the time of his work exposure was obtainable prior to hearing, medical opinions based on such information were similarly obtainable. See Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986) (Where a new medical report was based on information available before the hearing, it was merely an attempt to explain a changed opinion and there was no compelling reason to remand). Moreover, a new hearing based on claimant's new evidence would not change the result on the merits because, as the ALJ explained, claimant may not collaterally attack the prior final judgment. See Sills, 48 Van Natta 1621.

Accordingly, after considering the ALJ's order and the record,[1] we conclude that the record in this case has not been improperly, incompletely or otherwise insufficiently developed and there is no compelling reason to remand. See Lyster, 79 Or App at 420. Consequently, claimant's request for remand is denied.

ORDER

The ALJ's order dated February 7, 1997 is affirmed.

[1] We consider the proffered "post-order" evidence for the purpose of ruling on claimant's motion for remand/request for a new hearing.

In the Matter of the Compensation of
BONNIE L. PRATHER, Claimant
WCB Case No. 96-04284
ORDER ON REVIEW
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of that portion of Administrative Law Judge (ALJ) Neal's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for an L5-S1 hernated disc condition. On review, the issue is compensability.

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

We first note the absence of evidence supporting claimant's assertion that Dr. Rosenbaum is "known to be a SAIF doctor." In any event, Dr. Rosenbaum is the physician who performed claimant's surgery and is in the best position to determine the cause of the disc herniation. We find no reason to reject Dr. Rosenbaum's opinion that the disc is idiopathic in origin. In contrast with the opinion of Dr. Rosenbaum, Dr. Grewe provides little explanation of his opinion. Under such circumstances, we affirm the ALJ's opinion.

ORDER

The ALJ's order dated February 7, 1997, as corrected on February 19, 1997, is affirmed.

In the Matter of the Compensation of
GARY M. EMMERSON, Claimant
WCB Case No. 96-06224
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order which: (1) admitted a report from a forensic scientist; (2) found that the employer had not established that alcohol consumption was the major contributing cause of claimant's left foot and ankle injury; and (3) set aside the employer's denial of claimant's left foot and ankle injury claim. On review, the issues are the ALJ's evidentiary ruling and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, but offer the following brief summary of the relevant facts.

The night before his alleged injury, claimant, a maintenance mechanic, consumed several drinks, consisting of vodka and cranberry juice. Claimant did not drink alcohol the next morning (April 29, 1996) before going to work.

Claimant alleged that he injured his left foot and ankle stepping off a loader, a piece of heavy equipment he parked over a shallow V-shaped depression in an area of gravel and dirt. According to claimant, he suffered immediate pain in his left foot and ankle as his left foot left the last step of the loader and entered the V-shaped depression.

A company manager transported claimant back to the shop, where claimant's supervisor took him to an immediate care center. X-rays revealed a left heel (calcaneous) fracture and a left ankle sprain. Dr. Holmboe, claimant's personal physician, provided follow-up treatment.

Approximately 45 minutes after the injury, claimant submitted to urinalysis required by his employer. Testing revealed a blood alcohol content of .048. On May 9, 1996, the employer issued a denial based on two grounds: (1) that claimant's injury occurred outside the course and scope of his employment because of his use of alcohol; and (2) that use of alcohol was the major contributing cause of his injury. (Ex. 11). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, concluding that claimant's injuries arose out of and in the course of his employment. The ALJ reasoned that, despite the presence of alcohol in claimant's bloodstream, the work claimant was performing was within the boundaries of his ultimate work. The ALJ then determined that the employer failed to prove that claimant's consumption of alcohol was the major contributing cause of his injury. In reaching this conclusion, the ALJ relied on the report of a forensic scientist, Mr. Bigelow, who concluded that claimant was not under the influence of intoxicants when injured, and whose report the ALJ admitted over the employer's objection that it was not an admissible "medical report" under ORS 656.310(2).

On review, the employer reiterates its objection to the admission of Mr. Bigelow's report. The employer further asserts that the ALJ incorrectly concluded that consumption of alcohol was not the major contributing cause of claimant's injury and that, pursuant to David Bottom, 46 Van Natta 1485 (1994), aff'd mem Liberty Northwest v. Bottom, 133 Or App 449 (1995), claimant was not in the course and scope of his employment when injured. Finally, the employer argues that claimant failed to prove legal and medical causation. Claimant responds that the ALJ correctly decided all contested issues and that, since the employer's denial did not raise causation as a defense, our review should be limited to a determination of the "course and scope/alcohol consumption" issues.

For the following reasons, we find that legal and medical causation were raised as issues at the hearing and that claimant's injury claim fails for lack of legal and medical causation. Given our disposition of the case, we need not address the evidentiary, course-and-scope, and alcohol-consumption issues.

Scope of Denial

The basis for the employer's denial was limited to allegations that claimant's injury occurred outside the course and scope of his employment and that alcohol consumption was the major contributing cause of his injuries. No "causation" issue was 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). Here, we find that the parties implicitly agreed to try a causation issue.

Prior to taking testimony, the parties discussed the issues to be litigated. Claimant's attorney described the issue as whether an injury occurred in the course and scope of employment. (Tr. 18). The employer's attorney agreed but, when asked if there was a question as to whether the injury occurred on the job, the attorney replied that, "I think we have to leave that open at this point." (Tr. 19). The employer's attorney then stated: "As to whether [the injury] occurred at the work place, I think we'll have to listen to all the evidence." Id. At another point in "pre-testimony" discussions, the employer's attorney emphasized that claimant's description of the mechanism of his injuries was inconsistent with the usual manner in which such injuries occur as noted in the medical evidence. (Tr. 22-23). Claimant did not contend that the employer was attempting to impermissibly expand its denial.

After completion of testimony, a discussion occurred between the ALJ and the parties concerning the necessity of depositions of Dr. Holmboe and Mr. Bigelow. When claimant's attorney requested a stipulation from the employer's attorney that the fractured heel occurred when claimant was stepping off the loader, the employer's attorney replied: " I can't stipulate that the thing occurred the way [claimant] said it did, because the medical evidence indicates that the mechanism is different from what is described in this case." (Tr. 85). The employer's attorney then declined to stipulate that claimant's injury occurred at the time and place claimant testified to after the ALJ inquired regarding the possibility of such a stipulation. Id. Claimant did not assert that the employer was precluded from taking such a position.

After claimant provided additional brief testimony, both parties agreed that depositions would not be necessary. (Tr. 89-90). No further discussions occurred regarding the disputed issues. The hearing then adjourned.

From our review of the extensive discussions of the issues, we are persuaded that the employer's counsel did not concede legal or medical causation. Although the employer's denial did not raise medical causation as an issue, claimant's counsel did not object to the employer's "at-hearing" amendment of the denial to include causation as a defense.[1] Accordingly, we find that the parties at least implicitly agreed to try a causation issue. See Alan T. Spaeth, 48 Van Natta 1585, 1588 n. 1 (1996) (Given the lack of objection to a carrier's attempt to raise a compensability defense, an implied agreement existed to try a compensability issue); Michael A. Beall, 48 Van Natta 487, 487 (1996) (where the parties tried the issue of whether the claimant's injury occurred in the course of his employment by implicit agreement, i.e., without objection, the issue was properly before the ALJ). We, therefore, proceed to a consideration of whether claimant proved a causal relationship between the alleged incident and his left foot and ankle injury.

Causation

To establish a compensable injury, claimant must prove medical and legal causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618 (1981). Legal causation is established by showing that claimant engaged in potentially causal work activities; whether those work activities did cause claimant's

[1] Claimant argues that he would be significantly prejudiced if we address the issue of medical causation on review, alleging that he did not depose Dr. Holmboe because the employer did not raise an issue of causation at the hearing. However, our review of the transcript persuades us that, without objection from claimant, the employer did raise causation as an issue. Moreover, we are convinced that the employer's unwillingness to concede causation was sufficiently apparent at the conclusion of the hearing so that claimant bears the responsibility for any "prejudice" that may have resulted from his failure to depose Dr. Holmboe.

condition is a question of medical causation. Id. at 621. Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

Here, two physicians commented on the issue of whether the alleged incident on April 29, 1996 caused claimant's left foot and ankle injuries: Dr. Burton, a physician who reviewed records pertaining to the claim on behalf of the employer and issued a report on September 25, 1996, and Dr. Holmboe, claimant's attending physician. Dr. Burton opined that the injury sustained was not compatible with stepping off a tractor, stating that a calcaneal fracture requires significant deceleration energy. (Ex. 23-2). According to Dr. Burton, such a fracture requires a fall from a significant height, i.e., from a ladder, roof or perhaps a tractor cab. Id.

Dr. Holmboe initially reported that claimant's injury is one that occurs from direct compression such as a fall from a height, a motor vehicle accident, or any type of activity that may suddenly cause an overload to the heel bone. (Ex. 22-1). Dr. Holmboe commented: "I do believe that [claimant's] injury was caused by a fall or a stepping down from a significant height, usually 2-4 [feet], and that this action alone, landing on a firm surface or on a rock or on some gravel combined with rotational stresses through the foot could have caused [claimant's] injury." (Ex. 22-2).

Dr. Holmboe later agreed with a summary of a conversation with counsel for the employer. The summary stated that the kind of fracture claimant sustained involved a significant amount of force usually caused by a "direct free fall" with a person coming down with all his weight directly on the heel. Although a twisting motion might be involved, Dr. Holmboe agreed that the pressure from a "free fall" comes directly on the heel, driving the talus into the calcaneus like a "wedge splitting wood." Finally, Dr. Holmboe agreed that a description of "stepping off" a tractor did not, within a reasonable degree of medical probability, correlate with the type of fracture that occurred. (Ex. 26-1).

Claimant testified that there was nothing unusual about the way he stepped off the loader. (Tr. 66). Claimant also testified that he measured the distance from the last step of the loader to a level surface as 21 inches. (Tr. 87). However, claimant further testified that the distance between the bottom step and the surface of the V-shaped depression would have been "quite a bit greater," but that he could not determine the actual distance because the surface of the alleged injury site had been altered since the incident. (Trs. 87, 88).

While claimant's testimony is compatible with Dr. Holmboe's initial opinion that stepping down from a height of 2-4 feet could have caused his injuries, claimant also testified that he held on to the rails of the loader as he descended. (Tr. 88). When specifically asked if there was a "free fall" to the ground, claimant testified: "If I did, it was for a very short distance. No, I didn't." (Tr. 89, emphasis added). Claimant emphatically ruled out the possibility that he jumped off the loader. Id.

In summary, it appears from claimant's testimony that his descent from the loader was controlled. Considering Dr. Holmboe's opinion that a "free fall" from a significant height would be necessary to cause claimant's injury, and Dr. Burton's opinion that a calcaneal fracture requires significant deceleration energy, we find that claimant failed to establish legal causation, i.e., that the alleged incident could have caused his injury. See Harris, 53 Or App at 622-23. Moreover, even if we were to conclude that legal causation had been established, we would also conclude that claimant had failed to establish medical causation in light of the medical opinions of Drs. Burton and Holmboe, who opined that the alleged mechanism of injury did not correlate with the type of fracture sustained.[2]

Accordingly, we conclude that claimant failed to prove that he sustained a compensable injury, even if he was in the course and scope of employment when allegedly injured, and even if alcohol played no role in causing his injuries. Therefore, we reverse.

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[2] Citing Samuel J. Adams, 46 Van Natta 914 (1994), claimant argues that he established medical causation. We disagree. Relying on Barnett v. SAIF, 122 Or App 279 (1993) (expert medical evidence not required to prove causation in uncomplicated cases), we concluded in Adams that, considering the lack of factual complexity, the claimant's injury occurred as alleged. Specifically, we noted in Adams that there was no evidence that the alleged injury event could not have caused the claimant's medical problems. 46 Van Natta at 915. In contrast to Adams, there is medical evidence in this case from Drs. Burton and Holmboe that the alleged injury event (as described by claimant) could not have caused claimant's injuries. Thus, claimant in this case was required to adduce persuasive medical evidence to prove medical causation. For the reasons previously mentioned, claimant has not satisfied his burden of proving medical causation in this case, even if we found that he proved legal causation.

ORDER

The ALJ's order dated November 27, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

Based on its evaluation of the parties' discussions of the issues, the majority concludes that there was an implicit agreement to try a causation issue. Because I find such a conclusion unwarranted, and, further, because such a conclusion unfairly prejudices claimant, I must respectfully dissent.

At the outset, there is no question that the basis for the employer's denial was limited to allegations that claimant's injury occurred outside the course and scope of employment and that alcohol was the major contributing cause of his injuries. Even the majority concedes that the employer's denial did not raise a "causation" issue.

The issue then becomes whether the parties implicitly agreed to try a causation issue. See Weyerhaeuser Co. v. Bryant, 102 Or App 432 (1990). It is at this point that I part company with the majority.

I first note that the employer agreed with claimant's counsel's description of the issue to be litigated as whether claimant's injury occurred in the course and scope of employment. (Tr. 18, 19). While the majority points to employer's counsel's unwillingness to stipulate that claimant's injury occurred on the job (Tr. 19), I would find the employer's counsel's representations ambiguous as to whether causation was being raised as defense.

Moreover, to the extent that the employer's counsel's statements could be construed as orally amending the denial, I would find that allowing such an amendment has caused significant prejudice to claimant. Because the employer did not clearly raise medical causation as an issue, claimant declined to depose Dr. Holmboe at the conclusion of the hearing. (Tr. 90). Since the majority relies substantially on Dr. Holmboe's opinion in finding that claimant failed to establish medical and legal causation, the damage to claimant's case is obvious.

Therefore, in contrast to the majority, I would find that the employer was precluded from raising a causation defense. Moreover, because I agree with the ALJ's evidentiary ruling and compensability analysis, I would find claimant's injuries to be compensable and affirm the ALJ's decision setting aside the employer's denial.

July 17, 1997 Cite as 49 Van Natta 1083 (1997)

In the Matter of the Compensation of
KENNETH A. HERDINA, Claimant
WCB Case Nos. 96-08104 & 96-01185
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) upheld Willamette Industries' denial of claimant's current low back condition; and (2) upheld Freightliner Corporation's denial of claimant's current low back condition. On review, the issues are compensability, and potentially, responsibility.

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

On review, claimant contends that the ALJ should have relied on the opinion of Dr. Misko, his treating surgeon. Claimant disagrees with the ALJ's conclusion that Dr. Misko's opinion is inconsistent because Dr. Misko initially found that the 1991 injury was the major cause of claimant's current condition, and then found that the 1994 injury was the major contributing cause. Regardless of whether or not Dr. Misko's opinion is consistent, however, we find his opinion nonpersuasive for the following reasons.

Numerous doctors who have submitted opinions on the causation issue in this case have attributed claimant's current condition to his preexisting degenerative disc disease.[1] Although claimant's treating doctor, Dr. Flemming, eventually reported that he was unable to determine the major cause of claimant's condition, Dr. Flemming at one time also believed that the preexisting degenerative condition was the major cause. (Ex. 72).

Despite the MRI findings and the opinions set forth by the other doctors in the record regarding a degenerative disc disease, Dr. Misko has not discussed the potential contribution from that condition. Under the circumstances, because it lacks any discussion of claimant's preexisting degenerative disc condition[2], we find Dr. Misko's opinion to be less than persuasive. See Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995) (Determining the compensability of a "combined condition" requires a comparison of the relative contribution to the worker's need for treatment of the preexisting condition and the compensable injury).

We therefore agree with the ALJ that claimant has failed to establish compensability of his current condition.

ORDER

The ALJ's order dated February 12, 1997, as corrected February 19, 1997, is affirmed.

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[1] Claimant argues that the degenerative disc disease had not been identified by the time he saw Dr. Flemming in November 1994, and it was not until a February 1995 MRI that degenerative changes were shown. However, claimant was diagnosed with disc degeneration at three levels as early as 1991. (Ex. 13-2).

[2] As noted by the ALJ, Dr. Misko's reference to a "preexisting" condition does not clarify whether Dr. Misko was referring to (and considering) the degenerative disc disease condition, the prior work injury, or both.

In the Matter of the Compensation of
PATRICIA M. JOHNSON, Claimant
WCB Case No. 96-08889
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) increased claimant's unscheduled permanent disability for a right shoulder condition from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to 20 percent (64 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of both arms from 1 percent (1.92 degrees) for each arm, as awarded by an Order on Reconsideration, to 5 percent (7.5 degrees) for each arm. On review, the issues are extent of unscheduled and scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Partial Disability

The September 23, 1996 Order on Reconsideration awarded claimant 1 percent (1.92 degrees) scheduled permanent disability for loss of use or function of each arm. (Ex. 21). The worksheet attached to the Order on Reconsideration indicated that the award was for minimally reduced arm motion (pronation) bilaterally. (Ex. 20-2). See OAR 436-035-0100(4).

At hearing, claimant argued she was entitled to a chronic loss of use of each wrist, rather than range of motion impairment. Based on Dr. Rand's opinion, the ALJ concluded that claimant was entitled to a 5 percent award for chronic loss of use of each arm.

The employer argues that the ALJ erred by awarding an additional scheduled award for chronic loss of use of both arms. The employer contends that Dr. Rand's opinion is not sufficient to establish a chronic loss of use.

The extent of claimant's permanent disability is determined by an application of the "standards." The claim was closed by a Determination Order dated May 9, 1996. (Ex. 17). Accordingly, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 96-051 and 96-068 apply to claimant's claim. OAR 436-035-0010(5) provides, in part:

> "A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following four body parts:
>
> "* * * * *
>
> "(c) Forearm (below elbow/hand/wrist); and/or
>
> "(d) Arm (elbow and above)."

Dr. Rand, medical arbiter, reported:

> "The worker may find some limitation in repetitive forceful grip, or prolonged grip of both wrists, but would be able to repetitively use both hands and wrists within these limitations." (Ex. 19-5).

Claimant argues that Dr. Rand's opinion establishes that she is entitled to a chronic condition award. We disagree.

The medical arbiter indicated that claimant "may find some limitation in repetitive forceful grip, or prolonged grip of both wrists[.]" (Ex. 19-5; emphasis added). The indication of a possible limitation of repetitive use of the wrists is not sufficient to establish that claimant is "significantly" limited in the repetitive use of her wrists. See Gormley v. SAIF, 52 Or App 1055 (1981) (physician's opinion framed in terms of possibility, rather than probability, found unpersuasive); Boyd K. Belden, 49 Van Natta 59 (1997) (arbiter indicated only that the claimant "may have some limitations in his ability to repetitively use his left knee"; no chronic condition impairment). We are not persuaded that claimant is "significantly limited in the repetitive use" of her wrists pursuant to OAR 436-035-0010(5). Therefore, claimant has failed to establish chronic condition impairment.

The employer also argues that claimant has no impairment resulting from the carpal tunnel condition. According to the employer, claimant's treating physician reported that she did not have any problems attributable to the carpal tunnel condition.

On August 23, 1996, Dr. Rand reported that claimant's pronation measurement for the wrists was 76 degrees on the right and 74 degrees on the left. (Ex. 19-3). Based on those findings, OAR 436-035-0100(4) provides for an award of 1 percent (1.92 degrees) scheduled permanent disability for loss of use or function of each arm.

Although Dr. Casey reported that claimant had no loss of motion in any joints of either upper extremity (Ex. 15), there is no evidence that Dr. Casey specifically measured claimant's loss of pronation.

In contrast, Dr. Rand provided specific measurements of claimant's wrist range of motion. Because Dr. Rand's examination was conducted closer in time to the reconsideration order and because his report is a thorough evaluation of claimant's impairment, we rely on Dr. Rand's findings. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment). We affirm the Order on Reconsideration award of 1 percent (1.92 degrees) scheduled permanent disability for loss of use or function of each arm.

Unscheduled Permanent Partial Disability

The Order on Reconsideration awarded 14 percent (44.8 degrees) unscheduled permanent disability for claimant's shoulder condition. (Ex. 21). The worksheet attached to the Order on Reconsideration indicated that claimant was entitled to 10 percent impairment for her two shoulder surgeries and 1 percent for decreased right shoulder abduction. (Ex. 20-2, -3). The worksheet indicated that, based on Dr. Rand's opinion, claimant's residual functional capacity (RFC) was "Light (M/L with restrictions)." (Ex. 20-3). Claimant's age and education factors were 3.

At hearing, the ALJ noted that neither party disagreed with the 10 percent award for claimant's surgical impairment or with the age and education factors of 3. The ALJ relied on Dr. Rand's range of motion measurements to determine claimant's right shoulder impairment and relied on Dr. Casey's opinion to determine that claimant's RFC was sedentary, rather than light. The ALJ concluded that claimant was entitled to 20 percent (64 degrees) unscheduled permanent disability for her right shoulder condition.

According to the employer, claimant's attending physician reported normal ranges of motion in her right shoulder, as did the report from Drs. Stanford and Watson. (Exs. C-2, C-3, 6, 15, D-4).

On the other hand, Dr. Rand provided specific measurements of claimant's shoulder range of motion. Dr. Rand's abduction measurement was 140 degrees for the right shoulder and 166 degrees for the left. (Ex. 19-3). See OAR 436-035-0330(5). For the same reasons noted above with respect to claimant's wrist range of motion measurements, we are most persuaded by Dr. Rand's specific range of motion measurements for claimant's right shoulder. Because Dr. Rand's examination was conducted closer in time to the reconsideration order and because his report is a thorough evaluation of claimant's range of motion measurements, we rely on Dr. Rand's findings. We also agree that claimant is entitled to 1 percent impairment for decreased right shoulder abduction.

The employer also argues that the ALJ erred in finding that claimant's RFC is "sedentary." The employer contends that Dr. Casey's reports of claimant's RFC are not persuasive.

Adaptability is measured by comparing base functional capacity (BFC) to the worker's maximum RFC at the time of becoming medically stationary. OAR 436-035-0310(2). RFC refers to "an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition." OAR 436-035-0310(3)(b).

Claimant's BFC is "light." Dr. Casey performed claimant's two right shoulder surgeries, the most recent one in June 1995. On January 10, 1996, Dr. Casey reported that claimant was unable to perform the lifting required to continue work as a waitress because the job required significant lifting at shoulder level or above. (Ex. 12). Dr. Casey felt that claimant was medically stationary and he thought she should be retrained for a lighter form of work. (Id.) Claimant was restricted from lifting to the shoulder level and above on the right side on a regular basis with weights more than 5 pounds. (Id.)

On January 23, 1996, Dr. Casey indicated that claimant could occasionally lift and carry up to 50 pounds, and could frequently lift and carry up to 25 pounds. (Ex. 14-1). The report did not distinguish between lifting/carrying with the right or left arm. On the second page of the report, however, Dr. Casey reported that claimant "should do no significant lifting above waist level with her right arm." (Ex. 14-2). We interpret Dr. Casey's report to mean that, although claimant is able to occasionally lift and carry up to 50 pounds, she should not do any significant lifting if it is above the waist level with the right arm.

In a later report in April 1996, Dr. Casey clarified that claimant should be limited to doing no significant lifting above the shoulder level, and no lifting of greater than 5 pounds up to the waist level. (Ex. 15). When read as a whole, Dr. Casey's reports indicate that claimant's RFC is "sedentary."

Dr. Rand examined claimant on only one occasion. Dr. Rand reported that claimant was restricted to occasional lifting over 30 pounds over her shoulder and she could frequently lift less than 20 to 30 pounds. (Ex. 19-6). Dr. Rand also said that claimant was precluded from constantly lifting or carrying overhead with the right shoulder. (Id.)

We conclude that the preponderance of medical opinion establishes that claimant's RFC is "sedentary." We agree with the ALJ that Dr. Casey's opinion on claimant's RFC is the most persuasive, particularly in light of his opportunity to observe claimant over time and evaluate her response to various work activities. Comparing claimant's BFC (light) to her RFC (sedentary) results in an adaptability value of 3, the value assigned by the ALJ. OAR 436-035-0310(6). We affirm the ALJ's conclusion that claimant is entitled to 20 percent (64 degrees) unscheduled permanent disability for shoulder condition.

Claimant is entitled to an assessed attorney fee for prevailing against the employer's appeal of the ALJ's unscheduled permanent disability award. See ORS 656.382(2); Roseburg Forest Products v. Boqua, 147 Or App 197 (1997); Justeen L. Parker, 49 Van Natta 334 (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 unscheduled permanent disability issue is $750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 11, 1997 is modified in part and affirmed in part. In lieu of the ALJ's award of 5 percent (7.5 degrees) scheduled permanent disability for each of arm, we reinstate and affirm the Order on Reconsideration award of 1 percent (1.92 degrees) scheduled permanent disability award for each arm. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $750, to be paid by the employer.

In the Matter of the Compensation of
KELLY A. NIELSON, Deceased, Claimant
WCB Case No. TP-97002
THIRD PARTY ORDER
Rasmussen, et al, Claimant Attorneys
David B. Hatton (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, the personal representative of the estate of Kelly Nielson, has petitioned the Board for resolution of a third party dispute concerning her entitlement to the remaining balance of the SAIF Corporation's claim reserve for the deceased worker's claim. Claimant also requests that the matter be set for hearing to allow for fact finding and discovery and that the case be set for oral argument.

As set forth below, we reject claimant's requests for a hearing and oral argument. We further conclude that SAIF may retain its unexpended claim reserve and deny claimant's petition for relief.

FINDINGS OF FACT

Kelly Nielson was compensably injured on January 22, 1992, when he fell through a building skylight while working on a roofing project. He sustained multiple serious and disabling injuries, which were accepted by SAIF.

Mr. Nielson elected to bring a third party negligence action against the owner of the premises on which he was injured.[1] On September 17, 1992, claimant, as conservator of Mr. Nielson's estate, filed a personal injury action. In October 1992, SAIF advised claimant's attorney that SAIF's lien on any third

[1] Pursuant to ORS 656.578, a worker who receives a compensable injury due to the negligence of a third party may elect to sue the third party for damages under ORS 656.154.

party settlement or judgment was $3,613,730.36.[2] This amount included incurred costs of $271,361.04, projected indemnity costs of $702,743.23 and projected future home health care and routine medical costs of $2,639,626.[3]

In November 1992, the parties agreed to settle the third party negligence action for $2,200,000. SAIF approved the settlement and agreed to accept $1,000,000 as satisfaction for its lien. SAIF also approved claimant's receipt of $500,000 as settlement for her individual loss of consortium claim against the third party.

Mr. Nielson died on June 6, 1995 as a result of complications from leukemia. On January 30, 1996, claimant's attorney wrote to SAIF, requesting an accounting of SAIF's expenditures on Mr. Nielson's claim. On February 2, 1996, claimant's attorney demanded that SAIF refund the unused balance of its third party lien recovery. SAIF declined to do so.

On July 11, 1996, claimant filed a civil action against SAIF seeking recovery of the remaining balance. The court granted SAIF's motion to dismiss, finding that the Board had exclusive jurisdiction over the third party recovery dispute. Claimant appealed the trial court judgment, then obtained an abatement of the appeal to enable her to petition the Board for relief.

As of May 23, 1997, SAIF has incurred costs of $647,121.57 on Mr. Nielson's claim,[4] leaving an unused balance of $352,878.42 on its $1,000,000 recovery.

CONCLUSIONS OF LAW AND OPINION

Request for Hearing

Claimant requests that this matter be set for hearing for fact finding and discovery, asserting that SAIF has refused to provide information concerning its current claim costs. We conclude that SAIF has provided sufficient documentation and we reject claimant's request.

Board decisions under the third party law must be made on a record sufficient to sustain judicial review. Blackman v. SAIF, 60 Or App 446, 448 (1982). While referring a "third-party" dispute to a fact-finding hearing is not unprecedented, see Nova Y. Knutzen, 40 Van Natta 1825 (1988), we conclude that the record has been sufficiently developed so that we can decide the issues presented for resolution. See Kenneth D. Legore, 49 Van Natta 736 (1997); Kim J. Hayes, 48 Van Natta 1635 (1996).

The issue in dispute is whether claimant may recover the remaining balance of the $1,000,000 paid to SAIF in satisfaction of its lien due to Mr. Nielson's untimely death. This is a legal issue that is not dependent upon the actual amount of SAIF's current claim costs. Furthermore, although SAIF maintains that claimant is not entitled to recover the unexpended balance of the claim reserve, it has submitted an accounting of its claim expenditures as of May 27, 1997. (Ex. 101). Because the actual claim costs are irrelevant to the legal issue before us and SAIF has nevertheless provided the information claimant seeks, there is no need for a fact-finding hearing.

Request for Oral Argument

Claimant also asserts that the case be set for oral argument because her petition involves an issue of first impression. We will not ordinarily entertain oral argument. OAR 438-011-0015(2). We may allow oral argument, however, where the case presents an issue of first impression that could have a substantial impact on the workers' compensation system. See OAR 438-011-0031(2); Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996); Jeffrey B. Trevitts, 46 Van Natta 1767 (1994). The decision to grant such a request is solely within our discretion. OAR 438-011-0031(3).

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[2] Pursuant to ORS 656.580(2), the paying agency has a lien against the worker's cause of action, which is preferred to all claims except the cost of recovering such damages.

[3] There is no evidence in the record that claimant disputed the amount of SAIF's lien.

[4] This amount includes payments for Mr. Nielson's medical care and treatment, permanent total disability benefits and spousal benefits paid to claimant. (Ex. 101).

While this case does present a novel issue, we conclude that the parties have, through the evidence submitted and legal argument presented in their briefs, adequately addressed the issue before the Board. We are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. See, e.g. Tim L. Besheone, 48 Van Natta 2337, n. 2 (1996).

Third Party Dispute

Claimant asserts that, pursuant to ORS 656.593(1)(c),[5] she is entitled to recover the unexpended balance of the $1,000,000 paid to SAIF in satisfaction of its lien. Specifically, claimant argues that SAIF has no legal basis to retain the unused claim reserves. We disagree.

ORS 656.593 sets forth the procedure when a worker elects to bring a third party action. If the worker or beneficiaries obtain a judgment for damages in a third party action, the recovery is to be distributed pursuant to the statutory formula set forth in ORS 656.593(1).[6] If, on the other hand, the worker or beneficiaries settle the third party case with the approval of the paying agency, the settlement proceeds are to be distributed pursuant to ORS 656.593(3). See, e.g. Denton v. EBI Companies, 67 Or App 339 n.1 (1984) ("ORS 656.593(3) relates to *settlements*, as opposed to ORS 656.593(1)(c) and (d), which relate to recovery of *damages*.").

Under ORS 656.593(3), "the paying agency is authorized to accept such a share of the proceeds as may be just and proper" provided the claimant receives at least the amount to which he or she would be entitled if the proceeds were distributed under the statutory formula.[7] Thus, the amount that the agency is "authorized to accept" under ORS 656.593(3) is less precise than the amount of its lien under ORS 656.593(1)(c): "just and proper," as opposed to "its expenditures for compensation * * * and * * * the present value of its reasonably to be expected future expenditures for compensation." See Estate of Troy Vance v. Williams, 84 Or App 616 (1986).

In this case, claimant settled the third party action in November 1992 with SAIF's approval. Consequently, the third party recovery was subject to distribution under the "just and proper" standard of ORS 656.593(3) rather than the strict formula set forth in ORS 656.593(1). The parties mutually agreed that SAIF would be paid $1 million in satisfaction of its $3.3 million lien. Thus, the $1 million constituted SAIF's "just and proper" share of the proceeds.

In her petition, claimant does not contest the parties' agreement or argue that the distribution should be set aside due to misrepresentation or mutual mistake. Rather, as noted above, claimant asserts that SAIF has no right to retain the unused portion of its claim reserve because, as a result of Mr. Nielson's death, it has ceased to have any reasonably to be expected future expenditures for compensation.

In other situations, we have rejected parties' attempts to subsequently alter a mutually agreed "just and proper" distribution. For example, in Robert L. Hardt, 45 Van Natta 1487 (1993), the paying agency had approved a third party settlement based on the claimant counsel's representation that the agency would be reimbursed the full value of its lien. When the claimant later objected to the agency's entitlement to a certain portion of the lien, we declined to modify the parties' previous agreement. We

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[5] This subsection provides, in pertinent part, as follows:

"The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation * * * and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter."

[6] Under ORS 656.593(1)(a), litigation costs and attorney fees are initially disbursed. Then, the worker receives at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency is paid the balance of the recovery to the extent that it is compensated for its expenditures for compensation and for the present value of its reasonably to be expected future expenditures for compensation. See ORS 656.593(1)(c). Any remaining balance is paid to the worker. ORS 656.593(1)(d).

[7] ORS 656.593(3) further provides that "[a]ny conflict as to what may be a just and proper distribution shall be resolved by the board."

explained that "[t]o permit either party to challenge or alter any portion of a previously approved lien at a date subsequent to the third party settlement would create further instability in the negotiation process." See also Timothy J. Gheen, 43 Van Natta 1484 (1991) (where the claimant agreed to honor the paying agency's $18,000 lien in return for the agency's approval of the third party settlement, the claimant could not later object to a portion of the lien related to projected medical treatments).

Even assuming the third party distribution in this case was subject to the strict formula set forth in ORS 656.593(1)(c), nothing in that statute requires the return of unexpended claim reserves to the worker's estate. The statute requires that the paying agency "be paid and retain" the balance of the recovery to the extent it is compensated for expenditures incurred at the time of the third party recovery "and for the present value of its *reasonably to be expected future expenditures* for compensation and other costs of the worker's claim." In other words, the statute contemplates a payment to the paying agency at the time of the third party recovery based on a reasonable estimate of future expenses. The statute does not, however, provide for any "after the fact" correction or adjustment of the agency's recovery should the estimation of future costs turn out to be inaccurate.[8] Indeed, to require that the paying agency retain only those future expenditures that it actually incurs would necessitate inserting language into ORS 656.593(1)(c) that we are forbidden by law to add. See ORS 174.010; Deluxe Cabinet Works v. Messmer, 40 Or App 548, 553 (1996) ("We are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted.")

As the court explained in Schlect v. SAIF, 60 Or App 449, 456 (1982): "The [third party distribution] statutes are not aimed at maximizing recovery by claimant's in third party actions. Their objective is to allocate whatever the claimant recovers between him and the paying agency and to provide reimbursement to those responsible for statutory compensation of injured workers when damages or settlements are obtained against the persons whose acts caused the injuries."

Contrary to claimant's contention, the court's holding in Denton v. EBI Companies does not compel the return of SAIF's unexpended claim reserves. There, the court held that under ORS 656.593(1)(c), the paying agency's reserve for anticipated medical expenses must be based on the "present value" of those future expenses and not their current cost. The court explained that if the carrier was paid the current cost of its anticipated expenses without a reduction to actuarial present value, the carrier could enjoy a windfall that properly belongs to claimant. It was in this context that the court noted that "[u]nder the statutory scheme relating to the allocation of third party recoveries, the carrier is only entitled to reimbursement--not a profit." 67 Or App at 345. Thus, the "profit" or "windfall" at issue in Denton was not an unused claim reserve occasioned by a worker's unanticipated death, but rather a payment to the carrier (at the time of the third party distribution of proceeds) in excess of the amount necessary to maintain a fund to meet its reasonably anticipated future expenditures.

Although in this case SAIF's actual future expenditures on the claim are less than what was reasonably expected (and agreed upon) by the parties at the time of the third party distribution, we find no statutory nor common law justification for requiring that the agency return its unexpended reserves to claimant due to Mr. Nielson's untimely death. On the contrary, we conclude that both certainty and judicial economy are served by upholding and enforcing the parties' 1992 agreement as to a "just and proper" distribution of the settlement proceeds.

Consequently, we deny claimant's request for relief.

IT IS SO ORDERED.

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[8] For example, where the paying agency's obligations for future medical expenses exceeds the amount retained, the paying agency is liable for the excess and cannot not seek reimbursement. See SAIF v. Parker, 61 Or App 47 (1992) (even though paying agency elected not to retain a portion of the claimant's third party recovery in exchange for the claimant's assumption of all medical costs, the paying agency remained liable for all of claimant's future medical expenses under ORS 656.593(1)(c)); see also Denton v. EBI Companies, 67 Or App at 344 (the risk of underestimating the amount of the reserve fund falls on the carrier).

In the Matter of the Compensation of
ALLEN P. CROYLE, JR., Claimant
WCB Case No. 96-05703
ORDER ON REVIEW (REMANDING)
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) found that SAIF had waived the issue of claimant's failure to timely file his request for hearing from SAIF's denial of his cervical and thoracic injuries; and (2) set aside its denial insofar as it denied claimant's cervical injury claim. It its brief, SAIF contends that the ALJ erred in failing to dismiss claimant's request for hearing as untimely. On review, the issues are timeliness and compensability. We vacate the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and briefly summarize as follows.

Claimant, a carnival ride foreman, sustained a July 1994 claim for an upper back injury which was accepted by the State of Washington Labor and Industries Department. On July 5, 1995, claimant injured his back in the course and scope of his employment in Hillsboro, Oregon, and injured his back and neck on July 12, 1995, in Kent, Washington. Claimant filed a claim in Washington, requesting that his 1994 claim be reopened, which was denied on the basis that claimant was an Oregon employee.[1]

On February 26, 1996, claimant filed a claim in Oregon for his July 1995 injuries. On March 1, 1996, SAIF denied claimant's claim on the basis that claimant's neck and back conditions were not work related. (Ex. 15). On June 17, 1996, claimant, pro se, filed a request for hearing on SAIF's denial. In his request for hearing, he stated:

> "I was informed by Ms. Huss of SAIF Co. that if I did not have the financial ability to return to Oregon for a hearing that I should not file an appeal but instead apply for public asstance (welfare) I comtend that I was led to believe that without money, I had no rights of appeal.
>
> "Also, a phone worker at SAIF led me to believe that I had the option of re-submitting a new claim form with the medical evidence to dispute SAIF's contention that my injuries had any connection to my slight back strain of 1994.
>
> "I recieved the chart notes from my injury of 5/18/94 on June 5th, the day before mailing my new claim form and all other pertainant information after repetedly requesting this information since Jan./Feb. of this year.
>
> "My wife spoke today with a bene. counsler and recieved the proper process for filing an appeal and I contend that I have been misdirected in my efforts to receive my due benefits and show cause for a hearing." (Sic).

On September 11, 1996, the ALJ convened a hearing and admitted exhibits. Claimant appeared pro se. At hearing, SAIF's attorney agreed that the sole issue was compensability, and specified that he had no cross issues. (Tr. 29, 30). On October 3, 1996, the ALJ issued an Opinion and Order in which he made findings on the merits, set aside SAIF's denial of claimant's cervical injury, and upheld its denial of his thoracic injury.

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[1] Claimant initially reported his July 5, 1995 upper back injury, which was sustained in Hillsboro, Oregon, to his employer. (Ex. 4). Although the July 12, 1995 injury occurred in Kent, Washington, and claimant initially filed his claim in Washington, the parties stipulated at hearing that claimant was an Oregon worker and SAIF stipulated that he was in the course and scope of his employment at the time of both injuries. (Tr. 111).

On October 15, 1996, SAIF filed a Motion for Reconsideration on the ground that claimant's request for hearing was untimely and should be dismissed. In support of its motion, SAIF provided a copy of its June 28, 1996 Response to Issues, in which it denied that claimant timely filed his request for hearing.

In his written response to SAIF's motion, claimant argued that the Board's decision to grant a hearing was evidence that his request for hearing was valid; that SAIF compounded the confusion by sending him a new claim form with which to submit his original claim; that he was confused by filing in Washington to open his 1994 claim and having to refile in Oregon; and that, because he was residing in Pennsylvania and needed to use his tax refund money to get to a (free) Indian hospital in South Dakota, his lack of money and the distances from Pennsylvania and South Dakota to Oregon hindered his ability to pursue his claim.

CONCLUSIONS OF LAW AND OPINION

On January 17, 1997, the ALJ issued an Order on Reconsideration, in which he found that SAIF had waived the timeliness issue at hearing and was, therefore, barred from asserting the timeliness defense on reconsideration or Board review. On review, SAIF asserts that the ALJ erred in so concluding. We agree.

Here, SAIF expressly raised the timeliness issue in its written Response to Issues. Such an action is sufficient to allow the Board to address that issue on review. Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458, 460 (1991) (case remanded to the Board to address an issue raised in pleadings before hearing). We acknowledge that SAIF's attorney agreed with the ALJ's statement at hearing that the sole issue in the proceeding concerned compensability. (Tr. 29, 30). However, it is well settled that the provisions for timely request for hearing under ORS 656.319[2] are jurisdictional and cannot be waived. Sweeden v. City of Eugene, 95 Or App 577, 578 (1989); Duane Fresh, 42 Van Natta 864 (1990). Moreover, whether or not the issue is raised at hearing, it is our duty to raise a lack of jurisdiction on our own motion. Southwest Forest Industries v. Anders, 299 Or 205 (1985); Sadie Symonds, 48 Van Natta 940 (1996); see also Naught v. Gamble, Inc., 87 Or App 145 (1987). Consequently, we proceed to address the timeliness issue.

A hearing shall not be granted and the claim shall not be enforceable unless the claimant files a request for hearing no later than the 60th day after the claimant was notified of the denial, or the request is filed not later than the 180th day after notification and claimant establishes at hearing that there was good cause for failure to file the hearing request within 60 days. ORS 656.319(1), (2). Claimant has the burden to prove "good cause." Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1). See Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986). Lack of diligence does not constitute good cause. Cogswell, 74 Or App at 237.

SAIF issued its denial on March 1, 1996, which claimant received in Johnstown, Pennsylvania, on March 4, 1996. Claimant had until April 30, 1996, to file his request for hearing. Claimant's request for hearing was received on June 17, 1996, after the expiration of the 60-day timely filing period, but within 180 days of SAIF's mailing the denial. Therefore, in order for the Board to assume jurisdiction, claimant is required to establish at hearing that there was good cause for his failure to file his request by the 60th day of mailing the denial.

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[2] ORS 656.319 provides in relevant part:

"(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

In claimant's June 14, 1996 request for hearing, he alluded to an earlier conversation with Ms. Huss, a claims examiner for SAIF, asserting that he was told that, if he did not have the financial ability to return to Oregon for a hearing, he should not file an appeal but instead should apply for welfare. Claimant also asserted that, in a subsequent phone call to SAIF, another claims worker led him to believe that he had the option of resubmitting a new claim form with medical evidence to refute SAIF's contention that claimant's 1995 injury claim was related to his 1994 Washington claim. Finally, claimant asserted that, on June 14, 1996, his wife spoke to a benefits counselor, who relayed the proper information for filing an appeal. In sum, claimant contends that he was misled by SAIF's claims adjusters. Moreover, SAIF argues that claimant failed to establish at hearing, as required by ORS 656.319(1)(b), what the SAIF representative actually said to him that is the basis for his contention regarding Ms. Huss.

Because the ALJ was led to believe that the only issue before him was the merits of claimant's injury claim, claimant had no opportunity to testify at hearing regarding the good cause issue. Reliance on a misleading statement of a carrier's claims representative can constitute good cause. See Voorhies v. Wood, Tatum, Mosser, 81 Or App 336, rev den 302 Or 342 (1986) (good cause established where claims supervisor erroneously advised a claimant that mailing of a request for hearing on the 60th day would protect his rights). Thus, in this particular case, to establish good cause based on such grounds, claimant must put forth persuasive evidence that the insurer's representative misled him into believing that he should not file a request for hearing. Without such evidence, this record is insufficient to establish there was good cause for the late hearing request.

We may remand to the ALJ for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, claimant had no opportunity to testify at hearing regarding the reason he failed to timely appeal the denial. Consequently, because we are unable to determine whether good cause for failing to timely appeal the denial has been established, we find the record incompletely developed concerning the good cause issue and conclude that remand is justified. ORS 656.295(5).

We, therefore, remand this matter to ALJ Otto to conduct further proceedings to consider whether claimant established "good cause" for his hearing request to be filed more than 60 days after the issuance of SAIF's denial of his injury claim. The further proceedings may be conducted in any manner which will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order regarding this jurisdictional issue. In addition, should the ALJ find that "good cause" has been established, he is further directed to render a decision concerning the merits of the claim.

ORDER

The ALJ's order dated October 3, 1996, as reconsidered January 17, 1997, is vacated. This matter is remanded to ALJ Otto for further proceedings consistent with this order.

In the Matter of the Compensation of
CLELAND B. CARSON, SR., Claimant
WCB Case Nos. 96-09519 & 96-05995
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Corporation (Liberty) requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's "new injury" claim for low back condition; and (2) upheld the SAIF Corporation's denial of the same condition. On review, the issues are compensability and responsibility.

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

We acknowledge Liberty's contention that the ALJ erred in admitting claimant's testimony, because there is evidence that claimant currently has memory problems. However, inasmuch as the ALJ relied on claimant's contemporaneous reporting, not his recollections at the time of hearing (and we do the same on review), we need not address claimant's competency as a witness at hearing or the ALJ's decision to admit claimant's testimony.

On the merits, we agree with the ALJ that claimant suffered a compensable new injury in March 1996 and responsibility for claimant's subsequent low back condition (which involves the same condition previously accepted by SAIF) therefore shifts from SAIF to Liberty under ORS 656.308(1). See ORS 656.005(7)(a)(B).

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

ORDER

The ALJ's order dated February 13, 1997, as amended February 14, 1997 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
RICHARD J. DOUTT, Claimant
WCB Case No. 96-07752
ORDER ON REVIEW
Sara L. Gabin, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's injury or occupational disease claim for an L3-4 herniated disc. On review, the issue is compensability.

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

Because this claim is based on the cumulative effects of repetitive heavy work activities, we apply ORS 656.802. In addition, because we conclude, as did the ALJ, that claimant's work activities were the major contributing cause of his L3-4 herniated disc condition, we also conclude that the claim is compensable. Moreover, to the extent that the claim is based on a worsening of a preexisting disease or condition,[1] we further find that claimant has established that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the preexisting disease. See ORS 656.802(2)(b).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 6, 1996 is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the SAIF Corporation.

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[1] There is some evidence that claimant's prior strain injury made him vulnerable to a disc herniation. (See Ex. 11-2; see also Ex. A-1).

In the Matter of the Compensation of
SYLVIA EBERLEI, Claimant
WCB Case Nos. 96-08140 & 96-06881
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Davis's order which: (1) determined that the self-insured employer was not precluded from denying claimant's current low back and cervical condition; (2) upheld the employer's denial of claimant's current condition; and (3) decreased claimant's unscheduled permanent disability for a neck and back condition from 4 percent (12.8 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issues are claim preclusion, compensability and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant, a janitor, alleged that she sustained a compensable injury on March 1, 1994, when she experienced low back pain while bending over to remove a bag of trash from a barrel. Claimant was diagnosed with a lumbosacral strain. The employer denied the compensability of the claim on March 21, 1994.

In November 1995, an examining physician, Dr. Wilson, diagnosed a history of lower back and cervical strain related to the alleged on-the-job injury and a history of chronic lower back and left upper buttock pain unrelated to the alleged injury. (Ex. 35-6). Dr. Wilson opined that it was medically unlikely that claimant's then-present back and upper buttock pain was related to the alleged injury, explaining that a lower back strain would normally resolve in a matter of days or weeks. Id. Dr. Wilson attributed claimant's continued complaints to unspecified "nonorganic" causes unrelated to the alleged injury.

On February 7, 1996, a hearing was held to determine the compensability of claimant's alleged March 1, 1994 injury. In a March 10, 1996 order, a prior ALJ set aside the employer's denial. The ALJ concluded that the record as a whole established that claimant experienced an injury at work on March 1, 1994 that resulted in a cervical and lumbar strain requiring medical services and causing disability. (Ex. 37-4). In reaching this conclusion, the ALJ specifically referred to Dr. Wilson's medical report. (Ex. 37-3). The employer requested review of the ALJ's order, but the Board affirmed on September 13, 1996. Sylvia Eberlei, 48 Van Natta 1794 (1996) (Board Member Moller dissenting).

In the meantime, the employer closed the claim by Notice of Closure of March 26, 1996, which awarded no permanent disability. (Ex. 38). Claimant requested reconsideration. On July 8, 1996 (and October 17, 1996), the employer denied the compensability of claimant's "current condition." (Exs. 42, 46).

On July 22, 1996, Dr. Smith performed a medical arbiter's examination in connection with claimant's reconsideration request. Dr. Smith concluded that claimant's cervical and lumbar sprains were related to the compensable injury. Although finding no impairment based on muscle strength and sensation, Dr. Smith opined that claimant had some impairment based on inclinometer measurements of range of motion in the cervical and lumbar spine. (Ex. 43-6).

An Order on Reconsideration issued on August 16, 1996 and awarded claimant 4 percent unscheduled permanent disability, based on 1 percent impairment for reduced range of motion in the cervical spine and on a value of 3 for the social/vocational factors. (Ex. 44-4, 5). The employer requested a hearing, seeking elimination of the unscheduled permanent disability award.

CONCLUSIONS OF LAW AND OPINION

The ALJ rejected claimant's contention that the employer was precluded from denying her "current condition" because it could have litigated the issue at the prior hearing. The ALJ reasoned that the employer could not have been expected to issue and litigate a "current condition" denial at the prior hearing when the claim was denied in its entirety and no decision had been issued on the merits of the denial. Turning to the merits of the compensability issue, the ALJ upheld the employer's denial,

concluding that, while the evidence addressing the causation issue was sparse, Dr. Wilson's November 1995 medical opinion was more persuasive than Dr. Smith's causation opinion and, thus, it supported the employer's denial.

Finally, the ALJ found that claimant was not entitled to an award of unscheduled permanent disability given his conclusion that claimant's condition at the time of the medical arbiter's examination was not compensable. Thus, the ALJ modified the reconsideration order to eliminate claimant's unscheduled permanent disability award.

On review, claimant contends that the employer was barred from issuing its current condition denial in light of Katherine A. Wood, 48 Van Natta 2196 (1996). We agree.

The doctrine of res judicata, or "preclusion by former adjudication," is comprised of two rules: issue preclusion and claim preclusion. Issue preclusion refers to future litigation of issues that were "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. Drews v. EBI Companies, 310 Or 134, 139 (1990).

In Katherine A. Wood, the ALJ concluded that a prior ALJ's Opinion and Order in September 1994 barred the employer from denying the compensability of the claimant's current low back condition. The ALJ reasoned that the current low back condition was the same condition which was finally determined to be a compensable injury by the prior ALJ. We affirmed, finding that the issue "actually litigated and determined" in 1994 was the compensability of the claimant's then-current low back condition and resultant disability and need for treatment. Moreover, we concluded that the prior ALJ's determination that the condition was compensable was essential to his decision setting aside the employer's 1994 denial.

In determining whether issue preclusion applied, we focused on whether the claimant's current low back condition was the same condition which was actually litigated before the prior ALJ in 1994. We were persuaded that it was where the employer expressly relied on medical information indicating that claimant had been diagnosed with preexisting degenerative arthritic changes which were not caused or worsened by employment, based on imaging studies that pre-dated the prior ALJ's order and were actually considered by the prior ALJ in his final determination. Furthermore, we found no evidence of any change in the claimant's condition. The only change had been in the diagnosis of the condition. We, therefore, held that the employer was seeking to avoid the preclusive effect of the final determination in 1994 and was barred from doing so.

Like the employer in Wood, the employer here also relies on medical evidence (Dr. Wilson's November 1995 medical report) that predated the prior ALJ's order and was actually considered by the prior ALJ. The only medical evidence addressing causation produced after the prior hearing in February 1996 was Dr. Smith's medical arbiter's report, which stated that claimant's cervical and low back conditions were related to the compensable injury. Moreover, as was true in Wood, there is no evidence of any change in claimant's cervical and low back conditions. Therefore, we conclude that the employer in this case is also seeking to avoid the preclusive effect of the final determination in 1996 that claimant's low back and cervical conditions are compensable. Like the employer in Wood, it is barred from doing so.

Given our conclusion that the employer's current condition denial was improperly issued, it follows that the employer's denial should be set aside. Accordingly, we reverse the ALJ's order that upheld the denials.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the claim preclusion issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the denial issue is $3,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the denial 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.

Having determined that the employer was precluded from denying claimant's current low back and cervical condition, we now turn to the extent of disability issue. As previously noted, the reconsideration order awarded claimant 4 percent unscheduled permanent disability based on reduced range of motion in the cervical spine, as well as on social/vocational factors. However, the ALJ reduced the award to zero after determining that claimant's current condition was not compensable.

Since we have now found that the employer was precluded from denying claimant's current condition, her present cervical and low back conditions are compensable. We now proceed with our determination of whether the reconsideration order properly calculated claimant's unscheduled permanent disability.

The medical arbiter, Dr. Smith, provided range of motion findings that equal 1 percent impairment for reduced range of cervical motion. (Ex. 43-5, 44-4). Where a medical arbiter is used on reconsideration, impairment is determined by the medical arbiter, except where a preponderance of the medical evidence establishes a different level of impairment. See Silvero Frias-Molinero, 48 Van Natta 1285 (1996). Here, we conclude that a preponderance of evidence does not establish a different impairment level. Thus, we rely on the medical arbiter's impairment findings in determining claimant's unscheduled permanent disability.

Moreover, based on our de novo review of the record, we agree with the reconsideration order's calculation of claimant's social/vocational factors (3). When this figure is added to claimant's impairment value (1), claimant's unscheduled permanent disability is 4 percent. Accordingly, we reverse the ALJ's decision on the extent of disability issue and affirm the reconsideration order's permanent disability award.

Claimant's counsel is entitled to an attorney fee payable from any increased compensation created by this order. ORS 656.386(2); OAR 438-015-0055. Consequently, that award shall equal 25 percent of any increased compensation created by our order, not to exceed $3,800, payable directly to claimant's counsel. In the event that compensation resulting from this order has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994).

Inasmuch as claimant's award of compensation was not ultimately disallowed or reduced by the employer's hearing request, claimant's attorney is also entitled to an assessed fee for services at hearing. ORS 656.382(2); Patricia L. McVay, 48 Van Natta 317 (1996); Thomas R. Yon, Jr., 47 Van Natta 1475 (1995). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the extent of permanent disability issue is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 18, 1996 is reversed. The employer's denials of claimant's current low back and cervical conditions are set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,500, to be paid by the employer. That portion of the ALJ's order which reduced claimant's unscheduled permanent disability to zero is also reversed. The Order on Reconsideration is reinstated and affirmed. For services at hearing regarding the extent of permanent disability issue, claimant's counsel is awarded an assessed fee of $750, to be paid by the employer. Claimant's attorney is also awarded 25 percent of the increased compensation created by our order, not to exceed $3,800, payable directly to claimant's attorney. In the event the increased compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk.

Board Member Moller dissenting.

I disagree with that portion of the majority's opinion that concludes the employer is precluded from litigating the compensability of claimant's current low back condition by prior litigation to determine initial compensability of claimant's claim. Unlike the majority, I agree with the ALJ that the employer is not precluded from litigating claimant's current low back condition by the prior litigation. Further, I agree with the ALJ that claimant has failed to establish compensability of her current low back condition. For these reasons, I respectfully dissent.

The issue in the prior litigation was whether claimant had experienced an accidental injury arising out of and in the course of her employment on March 1, 1994 that required medical services or resulted in disability. See ORS 656.005(7). Those were the essential findings necessary for claimant to

establish a compensable initial claim. No requirement existed that claimant prove that her low back condition -- as of the date of the prior hearing -- remained compensably-related to her work accident. In other words, claimant could have established a compensable claim even if her injury-related condition had resolved long before the date of the hearing.

The work incident that gave rise to claimant's initial claim occurred in March 1994. Dr. Wilson examined claimant on November 29, 1995, more than one-and-one half years after claimant's work incident. Dr. Wilson diagnosed lower back and cervical strain injuries related to claimant's accidental injury. Dr. Wilson opined, however, that those strains had resolved prior to his examination of claimant.

Here, the ALJ relied on the opinion of Dr. Wilson to conclude that claimant failed to establish compensability of her current condition. However, the majority reasons that the employer is precluded from challenging claimant's current condition unless that condition is somehow changed from the condition found compensable in the prior litigation. The majority concludes that reliance on the report of Dr. Wilson in order to establish a change in claimant's condition is improper because Dr. Wilson's report predated the prior ALJ's order in the initial compensability proceeding and was considered by the prior ALJ.

In the process of finding Dr. Wilson's opinion unavailing to the employer, the majority loses sight of the essential finding in the prior hearing which had nothing to do with whether claimant had an ongoing compensable low back condition when examined by Dr. Wilson or at the subsequent hearing. In fact, Dr. Wilson's report lends support to the essential factual finding that claimant did experience an accidental injury on March 1, 1994 that previously resulted in a need for medical treatment and/or disability. In fact, the prior ALJ stated that Dr. Wilson "also assumed that the strain condition diagnosed in March and April 1995 was related to the reported work injury. There is no contrary medical opinion." (Ex. 37-3).

However, it is axiomatic that many injuries do resolve without permanent residuals. Dr. Wilson opined that this was such an injury and that claimant's ongoing complaints were related to nonorganic causes, including functional overlay. In other words, it is Dr. Wilson's opinion that claimant's condition did change subsequent to the compensable March 1994 incident. Considering the entire medical record, the ALJ found that opinion to be persuasive. So, too, do I.

The majority relies on our decision in Katherine A. Wood, 48 Van Natta 2196 (1996), in support of its conclusion that the employer's current condition denial is precluded by the prior litigation. The majority misinterprets Wood. In Wood, the claimant suffered degenerative spinal conditions that preexisted her work-related low back injury. The employer denied claimant's initial claim. That denial was subsequently set aside through litigation. At the time of the litigation, the existence of the preexisting conditions was established.

The employer subsequently issued a current condition denial on the basis that claimant's preexisting degenerative conditions were, in major part, the cause of her ongoing condition. We found that the employer was precluded from making this argument because the existence of claimant's preexisting degenerative conditions had been known from the outset. In other words, the preexisting conditions could have served from the outset as a defense to the claim. However, the initial claim was found compensable despite the evidence of the preexisting condition. Therefore, we concluded that "[b]y presenting new medical evidence relating claimant's low back condition to preexisting degenerative arthritic changes, the employer is seeking to avoid the preclusive effect of the final determination in [the prior litigation]." Id. at 2197.

The case before us now is legally and factually distinguishable. Dr. Wilson's opinion, upon which the employer relies, is not that claimant never had a compensable injury. Rather, it is Dr. Wilson's opinion that claimant's work-related injury subsequently resolved and has been replaced by a new, noncompensable condition. The employer is not seeking to avoid the preclusive effect of the final prior determination in the initial compensability litigation by "presenting new medical evidence." Wood does not control. Moreover, for the reasons set forth in the ALJ's order, Dr. Wilson's opinion on compensability of claimant's current condition is the most persuasive. For these reasons, I would affirm the order of the ALJ and reinstate the employer's current condition denial.

In the Matter of the Compensation of
BECKEY A. FALASCO, Claimant
WCB Case No. 96-04743
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral foot condition; and (2) did not award penalties or attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

Claimant, a cashier and attendant at a service station/convenience store, developed bilateral heel pain in March 1996 after working six ten-hour shifts pumping gasoline, which required her to stand on a concrete surface. On April 17, 1996, claimant sought treatment from Dr. Dahlin, an orthopedic surgeon, who diagnosed a heel spur syndrome. (Ex. 2).

Claimant signed a form 801 on April 26, 1996, alleging that the ten-hour shifts caused her heel spur condition. (Ex. 3). SAIF denied the claim four days later on April 30, 1996, on the ground that the evidence failed to establish that claimant's work activity was the major contributing cause of her bilateral heel spurs. (Ex. 4). The denial also stated that it had been determined that the bilateral heel spurs were a "preexisting condition." Id. Claimant requested a hearing from the denial.

Dr. Dahlin subsequently clarified that claimant's diagnosis was plantar fascitis. (Ex. 7). An examining physician, Dr. Linder, evaluated claimant's bilateral foot condition on July 18, 1996 and also diagnosed plantar fascitis.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's bilateral foot claim should be analyzed as an occupational disease. Upholding SAIF's denial, the ALJ found that the medical evidence from Dr. Dahlin and Dr. Linder did not establish that claimant's work exposure was the major contributing cause of her bilateral foot condition.

On review, claimant agrees that her claim should be viewed as an occupational disease claim, but contends that Dr. Dahlin's opinion establishes that her employment was the major contributing cause of her bilateral plantar fascitis condition. While we agree with the ALJ that claimant's bilateral foot claim is not compensable, our reasoning differs from the ALJ's.

Dr. Linder stated that claimant had a preexisting degenerative condition involving the plantar fascia of her feet. (Ex. 9-6). Dr. Dahlin opined that claimant's work activities in excess of her usual work load "combined with probable preexisting but clinically asymptomatic changes in the plantar fascia." (Ex. 15). Based on this evidence, we conclude that claimant had a preexisting degenerative condition in the plantar fascia of her feet.

Because claimant's occupational disease claim is based on a worsening of a preexisting disease, she must prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2)(b). It is no longer sufficient for a claimant to prove that work conditions were the major contributing cause of the worsening of the preexisting disease; he or she must prove that work conditions were the major contributing cause of the "combined condition." Dan D. Cone, 47 Van Natta 2220 (1995).

Here, the "combined condition" is claimant's current plantar fascitis condition, which allegedly resulted from the combination of claimant's preexisting changes in the plantar fascia and the work conditions with the employer. Claimant must prove that work conditions with the employer were the major contributing cause of the combined condition and pathological worsening of the disease. See ORS 656.802(2)(b). In addition, the worsening of the preexisting condition must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

There is no medical evidence that claimant's employment was the major contributing cause of a pathological worsening of the preexisting plantar fascitis condition. Dr. Dahlin concluded that claimant's plantar fascitis "came on directly in association with her increased workload in the spring of 1996." (Ex. 16-8). However, Dr. Dahlin's opinion does not clarify whether the increased workload pathologically worsened the preexisting plantar fascitis condition or whether claimant's current plantar fascitis represents only a symptomatic worsening of the preexisting condition.

Moreover, Dr. Linder opined that the degenerative plantar fascitis condition did not occur as a result of claimant's overtime work. (Ex. 9-6). In addition, Dr. Linder stated that any contribution by claimant's overtime work was so small as to be "unmeasureable." (Ex. 9-4). According to Dr. Linder, claimant's "symptoms" were unavoidable and the fact that they occurred at work was "more a matter of coincidence than of causation." (Ex. 9-7).

Therefore, based on our de novo review of the medical evidence, we conclude that claimant failed to prove her occupational disease claim is compensable under ORS 656.802(2)(b). Alternatively, even if claimant's occupational disease claim was not based on a worsening of preexisting plantar fascitis condition, we would still not find the claim compensable.

Pursuant to ORS 656.802(2)(a), it is claimant's burden to prove that employment conditions were the major contributing cause of the disease. Inasmuch as this case requires expert analysis as opposed to expert external observation, the opinion of claimant's attending physician, Dr. Dahlin, is not entitled to special deference. Allie v. SAIF, 79 Or App 284, 287 (1986). As previously noted, Dr. Dahlin has related claimant's condition to employment conditions, while Dr. Linder has opined that the degenerative plantar fascitis condition did not occur as result of claimant's overtime work and that the appearance of symptoms in conjunction with work was more coincidental than evidence of causation. Because the medical evidence is, at best, in equipoise, we conclude that claimant cannot satisfy her burden of proof under ORS 656.802(2)(a).

Finally, claimant contends that the insurer's denial was unreasonably issued only four days after her claim was filed. SAIF responds that the issue of unreasonable denial was not properly raised at hearing. We need not address the merits of these contentions, for, even if the issue of unreasonable denial was properly raised, and even assuming the denial was unreasonably issued, there would be no compensation due on which to base a penalty under ORS 656.262(11) because we have determined that the occupational disease claim is not compensable. Steve D. Edwards, 48 Van Natta 2162, 2163 (1996). Moreover, because no compensation was due, there can be no unreasonable resistance to the payment of compensation to support an attorney fee award under ORS 656.382(1). Id.

ORDER

The ALJ's order dated January 23, 1997 is affirmed.

In the Matter of the Compensation of
EARIN J. HADLEY, Claimant
WCB Case No. 95-01763
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Hadley v. Cody Hindman Logging, 144 Or App 157 (1996). The court reversed our order that affirmed the Administrative Law Judge's (ALJ's) order, which found that the SAIF Corporation had properly calculated the rate of claimant's temporary disability benefits. Earin J. Hadley, 48 Van Natta 216 (1995). In our prior order, we found that there were no "extended gaps" within the meaning of former OAR 436-60-025(5)(a) and we declined claimant's request to disavow our long-standing interpretation of "extended gaps" as used in that rule.

The court concluded that our interpretation of former OAR 436-60-025(5)(a) inhibited what the rule was meant to accomplish. The court determined that we had added the requirement of a "change in employment relationship" and it concluded that such a requirement disqualifies some workers from being compensated at a rate based on their wages at the time of the injury, even though there are gaps in the prior 26-week period of employment. The court has remanded to the Board for reconsideration. Having received and considered the parties' supplemental briefs, as well as a brief from the Workers' Compensation Division, on behalf of the Director of the Department of Consumer and Business Services, pursuant to ORS 656.726(3)(h), we now proceed with our reconsideration.

FINDINGS OF FACT

On November 17, 1993, claimant began working for the employer. This was a logging operation and claimant worked as a skidder operator, knot bumper. He worked varying hours and days.

Claimant did not work from December 4, 1993 to December 26, 1993. (Ex. 1). He also did not work the first three weeks in January 1994 and from February 19 to March 10, 1994, as well as between March 15 and May 6, 1994. He returned to work on May 7, 1994 and worked steadily until his June 7, 1994 compensable injury.

Claimant's injury was disabling and he became entitled to temporary disability compensation under ORS 656.210 and 656.212. SAIF relied on former OAR 436-60-025(5)(a) (WCD Admin. Order 1-1992) in determining claimant's wage rate for temporary disability compensation purposes. This rule provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

SAIF computed claimant's average weekly wage based on the 26 weeks before the injury and used this figure as the weekly wage.

CONCLUSIONS OF LAW AND OPINION

On remand, claimant contends that the Court of Appeals' decision clearly requires SAIF to recalculate his time loss based upon the last four weeks of employment. See former OAR 436-60-025(5)(a) ("[w]hen such [extended] gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average).

In Hadley, 144 Or App at 162, the court determined that, at the time of the injury, claimant "had been working more than four weeks since the end of the last layoff period and there were gaps in the previous 26 weeks of his employment." Although the court held that there were "gaps" in claimant's employment, it did not decide whether there were "extended gaps" in his employment. Furthermore, the court did not provide a definition of an "extended gap," although the court specifically rejected the Board's requirement that a change in employment must occur if the four-week rule is to be used.

SAIF argues that there were no "extended gaps" in the 26 weeks before claimant's injury and it properly calculated claimant's wage at injury. SAIF contends that we should apply former OAR 436-60-025(5)(a) as we have in the past because that is the application intended by the Director. SAIF also argues that the ALJ correctly determined that there were no extended gaps because the layoffs were seasonal, within the reasonable expectation of claimant and the employer, were not abnormally lengthy and did not occur during an irregular time.

The Director, acting through the Workers' Compensation Division, ORS 656.726(3)(h), asserts that the Court of Appeals correctly rejected the Board-imposed requirement that there be a change in the employment relationship in order to constitute an extended gap that would call for using the four-week earnings calculation approach. The Director contends that the term "extended gap" was intended to apply to periods of unemployment that were unexpected in the normal occurrence of an employment or were of unexpected duration, regardless of whether a substantial change in employment status occurred for the worker between the two or more employment periods.[1]

The parties do not dispute that claimant had "gaps" in employment pursuant to former OAR 436-60-025(5)(a). The issue in this case is whether claimant had any "extended gaps" in employment within the meaning of that rule.

Former OAR 436-60-025(5)(a) does not define "extended gaps." However, the rule recognizes that, at least in some instances, an extended gap may occur even within a four-week period. Former OAR 436-60-025(5)(a) provides, in part: "For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker." (Emphasis added).

The Director contends that the term "extended gaps" was intended to apply to periods of unemployment that were "unexpected" in the normal occurrence of an employment or were of "unexpected" duration regardless of a substantial change in employment status. Nevertheless, the Director does not explain how to determine whether periods of unemployment were "extended" or of "unexpected" duration. Moreover, the Director has not cited, nor have we found, any historical reference which would document the drafter's intention when adopting the rule in question; e.g. Orders of Adoption or documents relied on by the Director when adopting this applicable version of the rule. Lacking such history, we decline to interpret the former rule in a manner that effectively adds another requirement; i.e., to constitute an "extended gap," the worker's hiatus from employment must be "unexpected." As previously explained by the court, an analysis which requires more than a hiatus of employment and adds a requirement regarding a change in employment relationship would be improper.[2]

Having concluded that the term "extended gaps" is undefined in the rule and having dispensed with the definition proposed by SAIF and the Director, we turn to a dictionary definition for assistance. Webster's Third New Int'l Dictionary 804 (unabridged ed. 1993), defines "extended" as "drawn out in length * * * esp. in length of time[.]" Utilizing that definition, we find that a determination as to

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[1] Both SAIF and the Director refer to recent amendments to OAR 436-60-025(5)(a). However, claimant's rate of temporary disability compensation is based on his wage at the time of the injury. Because claimant was injured on June 7, 1994, the former rules apply. Former OAR 436-60-025(1) (WCD Admin. Order 1-1992). We do not address the interpretation of the new rules.

[2] The dissent asserts that we are "omitting undisputed facts" that pertain to claimant's "contemplated" layoffs during the winter season. Our lack of discussion merely reflects our reasoning that such matters are irrelevant to an application of this former version of the "extended gap" rule. Furthermore, to include the parties' intentions in an analysis of whether "extended gaps" existed in a worker's employment under the former rule inevitably necessitates an exploration of whether their employment relationship changed. Because such an evaluation is expressly contrary to the court's rationale, we decline to consider such matters.

Secondly, we disagree with the dissent's characterization of our decision as ignoring the employment relationship itself. Consistent with the court's rationale, we are confining our review to the essence of claimant's employment relationship; i.e., the periods of time he was employed and unemployed (regardless of the reason) during the 26 weeks preceding his compensable injury.

Finally, our analysis is admittedly susceptible to the dissent's charge that it "is a purely mathematical decision." Nonetheless, because such an analysis is necessitated by the language used in the rule, any such charges should be directed to the drafter of the rule, rather than to the reviewer of the rule.

whether a gap in employment is "drawn out in length" depends on the particular circumstances of each case. However, as previously instructed by the court, in determining whether there was an "extended gap," we do not consider whether a change in the work relationship occurred. Hadley, 144 Or App at 162.

We apply our understanding of the term "extended gaps" to the case at hand. Claimant began working for the employer on November 17, 1993, and he worked varying hours and days. Former OAR 436-60-025(5)(a) provides that, for workers employed with varying hours, shifts or wages, carriers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. Claimant was injured on June 7, 1994. The 26-week period before June 7, 1994 began on December 6, 1993. Thus, we examine the 26 weeks before claimant's injury, beginning on December 6, 1993, and determine whether the gaps in his employment were drawn out in length.

Claimant did not work from December 6, 1993 to December 26, 1993, a period of almost three weeks. (Ex. 1). In addition, he did not work the first three weeks in January 1994 nor the three weeks between February 19, 1994 and March 10, 1994. Finally, claimant did not work from March 15 to May 6, 1994, a period of 7 1/2 weeks.

We conclude that 16 1/2 weeks of unemployment out of the 26-week period constitutes "extended gaps." In reaching this conclusion, we believe that an unemployment period which represents some 63.4 percent of the 26-week period preceding claimant's injury is "drawn out in length." Alternatively, even if we limited our review to the 12-week period (March 15-June 7) that precedes the June 7, 1994 injury, we would likewise consider a gap of employment that lasted from March 15 to May 6 (7.5 weeks of 12 weeks) to be sufficiently "drawn out in length" to constitute an "extended gap."

Former OAR 436-60-025(5)(a) provides that, when "extended gaps" exist in the previous 26 weeks, "insurers shall use no less than the previous four weeks of employment to arrive at an average." Therefore, to comply with the rule, SAIF shall be directed to recalculate claimant's temporary disability rate by using the four weeks of employment before the June 7, 1994 injury.

Claimant's counsel is entitled to an attorney fee of 25 percent, not to exceed $3,800, of any increased compensation that results from the recomputation of his temporary total disability benefits, payable directly by SAIF to claimant's counsel. See ORS 656.386(2); OAR 438-15-055(1).

Finally, claimant seeks an attorney fee of $1,000 pursuant to ORS 656.382(2). ORS 656.382(2), provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis added).

Here, claimant appealed to the Board and to the Court of Appeals. Because neither appeal was "initiated by an employer or insurer," no attorney fee is available under ORS 656.382(2).

Accordingly, on reconsideration of our February 2, 1996 order, the ALJ's order dated May 31, 1995 is reversed. The SAIF Corporation is directed to calculate claimant's temporary disability compensation in a manner consistent with this order. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

IT IS SO ORDERED.

Board Member Haynes dissenting.

The majority omits important undisputed facts from the ALJ's findings of fact and focuses only on the duration of claimant's gaps in employment in order to determine whether "extended gaps" existed pursuant to former OAR 436-60-025(5)(a). Because I believe that the majority misconstrues and misinterprets the rule, I dissent.

In Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), the court referred to the following undisputed facts:

> "Claimant is a logger who began working for employer in November 1993. Both claimant and employer contemplated that layoffs during the winter season were likely because of inclement weather conditions and that work would be more steady once summer arrived. Claimant sustained an injury in June 1994 that made him eligible for TTD [temporary total disability] benefits. SAIF computed the TTD amount based on claimant's average wage during the 26 weeks preceding his compensable injury. That period of time included layoffs, including a time during which claimant received unemployment compensation. The last period of layoff began in March 1994 and ended in May 1994, when employer called claimant back to work." 144 Or App at 159.

The majority, in reporting the facts on remand, omits the fact that both claimant and the employer contemplated that layoffs during the winter season were likely because of inclement weather conditions. At hearing, both parties testified about the weather problems presented in logging operations. The employer testified that when it rains too much, logging can be damaging to the land. (Tr. 14). Claimant testified that most loggers are out of work in the winter and he generally does not make much money during the winter. (Tr. 5, 7). He understood when he was hired that he would not work that much in the winter or spring when it was wet, but he would work a lot of hours in the summer. (Tr. 9). In his brief to the Court of Appeals, claimant asserted that his layoff periods were necessary because weather conditions did not permit logging at the time. (Appellant's br. at 2).

According to the majority, the fact that both parties contemplated layoffs during the winter season because of inclement weather conditions is not even relevant. The majority concludes that we need only determine the length of the "gap" in employment in order to decide whether it was "extended." I do not understand how the majority can determine whether a gap in employment is "drawn out in length" without considering the circumstances of the employment relationship.

Although the majority asserts that a determination as to whether a gap in employment is "drawn out in length" depends on the particular circumstances of each case, it proceeds to completely ignore the circumstances here. Rather, the majority merely considers the cumulative length of claimant's "gaps" in employment and determines that 16 1/2 weeks of unemployment out of the 26-week period is "drawn out in length." Alternatively, the majority concludes that, even if the review is limited to the 12-week period (March 15-June 7) that precedes the June 7, 1994 injury, it would consider a gap of employment that lasted from March 15 to May 6 (7.5 weeks of 12 weeks) to be sufficiently "drawn out in length" to constitute an "extended gap."[1]

The majority does not explain when a "gap" in employment becomes "extended" or what standards we use to decide whether a gap in employment is "drawn out in length." According to the majority's analysis, this is a purely mathematical decision. We may not consider any of the circumstances of employment, i.e., whether the work is seasonal or whether the place of employment closes for a certain time period every year. We may not consider whether the gap in employment is due to claimant's illness, vacation or a personal problem or whether it is due to equipment failure. In this case, we may not consider the fact that both parties contemplated that layoffs during the winter season were likely because of inclement weather conditions. If the parties anticipated weather-related layoffs every winter, why should weather-related gaps in employment automatically be considered "drawn out in length"?

Moreover, the majority provides no explanation for lumping separate gaps of employment together and looking only at the total "gap" of employment. The language of the rule indicates that we are to look at each gap of employment separately in order to determine whether it is "extended." Former OAR 436-60-025(5)(a) provides, in part: "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist." (Emphasis added).

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[1] The majority's alternative analysis, which looks only to the 12-week period that preceded the injury, is inconsistent with former OAR 436-60-025(5)(a), which requires that "insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist."

As the Court of Appeals made clear in Hadley, 144 Or App at 160, ORS 656.210(2)(c) delegates to the Director broad authority to prescribe by rule "methods" of approximating the wage amount at the time of injury of those workers who are not regularly employed. As long as the Director prescribed a method that is within the delegation by the legislature, the Board may not substitute its own judgment regarding the method of computation. Id. Although it is clear from the court's opinion that we may not consider whether a change in the employment relationship has occurred, the court gave no indication that we are to ignore the employment relationship itself. The majority's comment that it is confining its review to the "essence of claimant's employment relationship" apparently means that we look only to when claimant did and did not work, regardless of the circumstances.

On remand, the Director, acting through the Workers' Compensation Division, ORS 656.726(3)(h), asserts that the Court of Appeals correctly rejected the Board-imposed requirement that there be a change in the employment relationship in order to constitute an extended gap that would call for using the four-week earnings calculation approach. The Director contends that the term "extended gap" was intended to apply to periods of unemployment that were unexpected in the normal occurrence of an employment or were of unexpected duration, regardless of whether a substantial change in employment status occurred for the worker between the two or more employment periods. Because the Director's interpretation is consistent with my interpretation of former OAR 436-60-025(5)(a), I would apply the Director's interpretation.[2]

Former OAR 436-60-025(5)(a) does not define "extended gaps." However, the rule recognizes that, at least in some instances, an extended gap may occur even within a four-week period. Former OAR 436-60-025(5)(a) provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

A dictionary defines "extended" as "drawn out in length * * * esp. in length of time[.]" Webster's Third New Int'l Dictionary 804 (unabridged ed. 1993). Whether or not a gap in employment is "drawn out in length" or of "unexpected" duration depends on the circumstances of each case. However, in determining whether there was an "extended gap," we do not consider whether a change in the work relationship occurred. Hadley, 144 Or App at 162.

Claimant began working for the employer on November 17, 1993, and he worked varying hours and days. Former OAR 436-60-025(5)(a) provides that, for workers employed with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. Claimant was injured on June 7, 1994. The 26-week period before June 7, 1994 began on December 6, 1993.

Claimant did not work from December 6, 1993 to December 26, 1993, a period of almost three weeks. (Ex. 1). In addition, he did not work the first three weeks in January 1994. He did not work from February 19 to March 10, 1994, another period of almost three weeks. Finally, claimant did not work from March 15 to May 6, 1994, a period of seven and 1/2 weeks. Once he returned to work on May 7, 1994, he worked on a steady basis.

As mentioned earlier, both parties contemplated that layoffs during the winter season were likely because of inclement weather conditions and that work would be more steady once summer arrived. Claimant testified that most loggers were out of work in the winter. (Tr. 5). He understood when he was hired that he would not work that much in the winter or spring when it was wet, but he would work a lot of hours in the summer. (Tr. 9).

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[2] The majority rejects the Director's interpretation of the term "extended gap" because the Director has not cited any historical reference that would document the drafter's intention when adopting former OAR 436-60-025(5)(a). According to SAIF's brief to the Court of Appeals, the Director has maintained the substance of the "extended gap" rule for many years. (SAIF's br. at 5-6). SAIF indicated that the language has existed at least since 1980 and the rule itself dates back to 1970. (Id.)

Although the parties agreed that periods of unemployment were expected in the logging industry because of inclement weather, there is no testimony as to what duration of unemployment was expected. Out of 26 weeks of employment beginning on December 6, 1993, claimant did not work for approximately 16 and 1/2 weeks. Claimant's periods of unemployment occurred in the winter and spring, as the parties anticipated. However, the record is insufficient to determine whether the periods of unemployment were "extended," i.e., drawn out in length or of an unexpected duration.

The Board may remand a case for further evidence taking if it finds that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court).

Although it is clear from the record that the parties anticipated "gaps" of employment in the winter and spring because of the weather, the record is unclear as to whether any of claimant's gaps in employment, particularly the seven and 1/2-week layoff in the spring, constituted an "extended gap" pursuant to former OAR 436-60-025(5)(a).[3] As such, I consider the record to be incompletely and insufficiently developed to determine whether an "extended gap" existed in claimant's employment. Therefore, I would find that there is a compelling reason to remand this matter for the submission of additional evidence regarding what duration of unemployment was expected or anticipated. Thus, I would remand for the parties to submit additional evidence and allow the ALJ to determine whether, in light of such evidence, any of the gaps in claimant's employment were "extended," i.e., drawn out in length or of an unexpected duration.

For the foregoing reasons, I dissent from the majority's overly simplistic conclusion that a gap in employment becomes "extended" when it reaches a yet-to-be announced percentage of the 26-week period of employment preceding the injury.

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[3] I acknowledge that the ALJ concluded that claimant's layoffs were "not abnormally lengthy." However, since there is no evidence as to what duration of unemployment the parties anticipated, I am unable to determine whether any of claimant's gaps in employment were "abnormally lengthy."

In the Matter of the Compensation of
ELVIA H. HILLNER, Claimant
WCB Case No. 96-11311
ORDER ON REVIEW
Moscato, Skopil, et al, Claimant Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Podnar's order that dismissed her request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

FINDINGS OF FACT

On June 8, 1994, claimant signed a retainer agreement employing her former attorney of record to represent her in connection with her workers' compensation claim. A provision of that retainer agreement stated that "[i]f, after reasonable investigation, my attorney finds that my claim is not well supported by facts or law, my attorney may either withdraw from representing me or dismiss the request for hearing."

On December 19, 1996, claimant, through this attorney, requested a hearing regarding an Order on Reconsideration and raised issues of premature closure, extent of scheduled and unscheduled permanent disability, penalties, and attorney fees. A hearing was scheduled for March 17, 1997.

By letter dated March 28, 1997, claimant's former attorney withdrew the hearing request, stating that the "evidence did not support additional permanent disability at this time." On April 2, 1997, the ALJ dismissed claimant's hearing request.

By letter dated April 4, 1997, and received by the Board on April 10, 1997, claimant requested Board review of the ALJ's order, noting that she was dissatisfied with the dismissal of her hearing request.

By letter dated April 18, 1997, claimant's former attorney notified the Board that claimant filed the request for review on her own and his office was not representing her on this appeal.

By letter dated April 21, 1997, claimant contended that her permanent disability had been "under evaluated" and stated that she still had difficulty fully using her hands. By letter dated April 28, 1997, claimant contended that her hearing request was withdrawn because she refused the self-insured employer's offer of $750 for a "release and waiver" of her claim.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the employer sought dismissal of claimant's request for Board review, contending that the Board was without jurisdiction to review the matter because claimant's hearing request had been withdrawn. In Elvia H. Hillner, 49 Van Natta 567, on recon 49 Van Natta 584 (1997), we denied the employer's motion to dismiss. Specifically, we found that claimant had timely requested Board review of the ALJ's decision and the employer had received proper notice of the appeal. Therefore, we concluded that, as a procedural matter, we had jurisdiction to examine the propriety of the ALJ's decision to dismiss claimant's hearing request. Id.

We proceed to address the substantive issue before us, which is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order was appropriate.

We find that the record establishes that claimant, through her former attorney, withdrew her request for hearing. Claimant does not dispute her former attorney's authority to act on her behalf, nor does she dispute the fact that the ALJ dismissed her request for hearing on this claim in response to her former attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the dismissal order. William A. Martin, 46 Van Natta 1704 (1994); Mike D. Sullivan, 45 Van Natta 900 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

The ALJ's order dated April 2, 1997 is affirmed.

In the Matter of the Compensation of
GARY W. HOLMES, Claimant
WCB Case No. 95-10941
ORDER ON REVIEW (REMANDING)
Glenn M. Feest, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's denial of his current low back condition. On review, the issues are scope of acceptance and compensability. We remand.

FINDINGS OF FACT

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

On December 27, 1974, claimant sustained a compensable low back injury removing a barrel of water from a truck. He was diagnosed with an acute strain and sprain of the lower lumbar spine with possible lower lumbar disc injury. The claim was accepted by SAIF as a nondisabling injury in December 1979.

In April 1980, claimant was diagnosed with mild lumbar syndrome, probably secondary to facet joint arthropathy. X-rays revealed considerable degeneration of the facet joints at L4, L5 level.

In January 1987, claimant saw Dr. Nash, who found, among other things, mild bilateral facet arthropathy at L4-5 and disc degeneration at L5-S1. On February 15, 1987, claimant filed an injury claim, listing the date of injury as approximately 1975. In April 1987, Dr. Nash reported that the etiology of claimant's low back condition was "somewhat clouded." In June 1987, SAIF denied claimant's claim, and claimant requested a hearing.

On January 21, 1988, SAIF wrote to claimant, advising claimant that it had "cancelled" claimant's 1987 claim (Claim No. 4830434F) because it appeared that claimant had made two claims for the same injury occurring on December 27, 1974. SAIF indicated that the records from Claim No. 4830434 would be transferred to and made a part of Claim No. 4072235A (the 1974 claim).

On March 14, 1988, a stipulation was approved that cancelled claim No. 4830434, transferred the records to the earlier claim, dismissed claimant's request for hearing and awarded an attorney fee.

Claimant began treating with Dr. Mawk on April 3, 1995. Dr. Mawk diagnosed vertebral instability, stenosis and disc herniation. On November 15, 1995, claimant underwent a decompressive laminectomy at L3, L4 and L5.

Dr. Snodgrass reviewed claimant's medical records on SAIF's request. He determined that claimant had chronic degenerative spondylosis due to the aging process. On December 19, 1995, Drs. Fuller and Reimer examined claimant at SAIF's request. They attributed claimant's condition to discopathy at L4-5 but not his 1974 compensable injury.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that, by virtue of the March 14, 1988 stipulation, SAIF had accepted the conditions identified by Dr. Nash in 1987 and that those conditions (including vertebral instability and facet arthropathy at L4-5 and disc degeneration at L5-S1) were the major contributing cause of his need for treatment in 1995. SAIF, on the other hand, argued that it had only accepted claimant's December 1974 back strain injury and not his 1987 back condition. SAIF further asserted that claimant's accepted injury was not the major contributing cause of his current low back condition. The ALJ determined that the parties' 1988 stipulation had no bearing on the compensability issue and that claimant failed to establish any causal link between his 1974 accepted strain and his current (1995) low back condition.

On review, claimant maintains that SAIF voluntarily accepted claimant's 1987 low back condition by virtue of its January 14, 1988 letter or the parties' stipulation, and that his need for treatment in 1995 is compensably related to his accepted 1987 condition. SAIF responds that claimant's 1987 condition has not been accepted, and that claimant has failed to prove the compensability of his current (1995) condition or need for treatment under ORS 656.005(7)(a)(A) or (B).

The persuasive medical evidence does not relate claimant's need for treatment in 1995 to his accepted 1974 injury.[1] Rather, a preponderance of the medical evidence establishes that claimant's current need for treatment results from a *progression* of his discopathy, instability and disc herniation at L4-5, the conditions identified by Dr. Nash in 1987. Therefore, SAIF's liability for claimant's current condition and need for treatment depends upon whether it accepted the conditions diagnosed by Dr. Nash as part of the parties' 1988 stipulation.

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[1] Although Dr. Mawk speculates that the 1974 injury may have lead to the disc herniation and instability (see Ex. 19), his opinion is not couched in terms of any medical probability. See Gormley v. SAIF, 52 Or App 1055 (1981) (physician's opinion framed in terms of possibility, rather than probability, found unpersuasive).

The parties' stipulation is a contract which implicates general principles of contract law. See Pollock v. Tri-Met, Inc., 144 Or App 431, 435 (1996). Although neither party specifically argues that the terms of the 1988 stipulation are ambiguous, we find the agreement ambiguous as a matter of law. See, e.g. Abercrombie v. Hayden Corp., 320 Or 279, 292 (1994) (whether the terms of an agreement are ambiguous is in the first instance a question of law). The stipulation provides that "the claim established under No. 4380434F is cancelled in its entirety and the records therein are transferred and made a part of claim No. 4072235A and benefits allowed as required by law."[2] The stipulation does not, however, indicate what records were transferred to the prior claim file, whether claimant's then-current condition was causally related to his accepted 1974 injury or what the parties intended to accomplish by consolidating the records into one claim file.

Because the stipulation is ambiguous, extrinsic evidence is admissible to show what the parties intended, and their intention is a question of fact. See, e.g., Sisters of St. Joseph v. Russell, 318 Or 370 (1994); Mary M. Mitchell, 47 Van Natta 300 (1995) (an incomplete or ambiguous agreement should be augmented with extrinsic evidence of the parties' intent); see also ORS 41.740; ORS 42.220. However, the record in this case contains no evidence concerning the circumstances of the 1988 stipulation or the parties' intentions in that regard. Consequently, on this record, we are unable to determine whether, in agreeing to consolidate all of the records into one claim file, SAIF intended or agreed to expand its prior acceptance to include those conditions diagnosed by Dr. Nash in 1987.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Because the record contains little or no extrinsic evidence regarding the parties' intentions, the circumstances under which the stipulation was made, or the causal relationship between claimant's 1974 injury and his low back condition in 1987, we cannot reasonably interpret the parties' agreement. We therefore find that the record is insufficiently developed and remand the matter to the ALJ with instructions to allow both parties the opportunity to submit additional evidence to explain their intent in transferring all records to claim No. 4073335A, canceling the later claim and dismissing claimant's request for hearing on SAIF's 1987 denial. The submission of this additional evidence may be accomplished in any matter that the ALJ determines achieves substantial justice.

ORDER

The ALJ's order dated December 20, 1996 is vacated. This matter is remanded to ALJ Menashe for further proceedings consistent with this order.

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[2] Although drafted by claimant's counsel, the stipulation takes its terminology from SAIF's January 21, 1988 letter to claimant.

Board Member Haynes dissenting.

The majority has elected to remand, concluding that the parties' 1988 stipulation is ambiguous and the current record is insufficient to ascertain the parties intentions and interpret their agreement. I dissent, because I do not find the stipulation ambiguous nor do I believe that it has any bearing on the compensability dispute in this case.

As set forth in the majority's opinion, the parties stipulated that claim No. 4830434F (the 1987 claim) would be "cancelled in its entirety and the records therein transferred and made a part of claim No. 4072235A and benefits allowed as required by law." The parties further stipulated that the 1987 claim was a "nullity" as were all proceedings attendant thereto, and that claimant's request for hearing would be dismissed.

I find nothing ambiguous about these terms. An ambiguity exists in a contract if the contract is capable of more than one sensible and reasonable interpretation. Deerfield Commodities v. Nerco, Inc., 72 Or App 305, 317, rev den 299 Or 314 (1985). To me, the only sensible and reasonable interpretation of the stipulation is that, after determining that claimant had made two claims for the same (1974) injury, the parties agreed to nullify the later (1987) claim and transfer the records from that file and make them a part of the 1974 claim file.

When an agreement is unambiguous in its terms, the interpretation of the agreement becomes a question of law to be decided on an examination of the terms of the agreement as a whole. Pollock v. Tri-Met, Inc., 144 Or App 431 (1996); Timberline Equipment v. St. Paul Fire and Marine Ins., 281 Or 639, 643 (1978). The construction to be given such an agreement is to render, if possible, all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. Pollock, 144 Or App at 435.

In this case, after examining the terms of the stipulation, I cannot conclude that it was intended to resolve anything other than the procedural or administrative matter it expressly addressed. I agree with the ALJ's conclusion that, because the stipulation does not refer to claimant's then-current condition or Dr. Nash's findings, it cannot be reasonably construed to have any bearing on whether SAIF accepted claimant's 1987 low back diagnoses. See, e.g., International Paper Co. v. Pearson, 106 Or App 121, 124 (1991) (holding that a settlement agreement resolved that certain medical services were compensable but did not resolve the compensability of the underlying condition because the agreement said nothing about the compensability of the underlying condition); see also Amber D. Applebee, 45 Van Natta 2270 (1993) (where the parties' stipulation provided that the carrier agreed to rescind the denial and reopen the claim but did not specify the identity of the claimant's then-current condition, the stipulation could not constitute an acceptance of claimant's specific condition at the time of the stipulation).

Whether a condition has been accepted is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. See Gene C. Dalton, 43 Van Natta 1191 (1991). Although claimant asserts that SAIF accepted his 1987 claim for vertebral instability and disc prolapse with mild facet arthropathy at L4-5 and disc degeneration at L4-5, I find no evidence establishing this fact. Like the parties' 1988 stipulation, SAIF's January 21, 1988 letter to claimant does not refer to claimant's then-current condition. The only condition for which SAIF acknowledged responsibility was "a low back injury sustained on December 27, 1974." (Ex. 12). Even if SAIF paid for claimant's medical treatment in 1987, payment of these bills does not constitute acceptance of the underlying condition. ORS 656.262(10).

In the absence of any evidence indicating that SAIF accepted responsibility for claimant's condition in 1987 and the absence of any medical evidence linking claimant's accepted 1974 injury to his need for treatment in 1995, I would find, as did the ALJ, that claimant failed to sustain his burden of proof. Because I would affirm the ALJ's order, I respectfully dissent.

In the Matter of the Compensation of
ROBERT J. LANDOLL, Claimant
WCB Case No. 96-09083
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that reduced claimant's scheduled permanent disability award for the loss of use or function of the left hand from 26 percent (39 degrees), as awarded by Order on Reconsideration, to 16 percent (24 degrees). In its respondent's brief, the SAIF Corporation contends that claimant is not entitled to any scheduled permanent disability for the compensable injury. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

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

In support of the 16 percent scheduled disability award, the ALJ relied on the impairment findings made by the medical arbiter, Dr. Fietti. On review, SAIF contends that a preponderance of the evidence establishes that claimant suffered no ratable permanent impairment due to the compensable hand laceration injury. We disagree, based on the following supplementation.

Claimant's attending physician, Dr. Brady, began treating claimant in November 1995, several months after surgery was performed to repair the laceration to the ulnar digital nerve of the left thumb and to the radial digital nerve of the left index finger. At that point, claimant's laceration injury to the left palm was well healed and he was experiencing a satisfactory recovery of sensation to the left hand. (Ex. 14). By the time of the closing examination on February 23, 1996, claimant's sensation had improved to the point of having only diminished sensation at the tips of the thumb and index finger. (Id.) Dr. Brady rated claimant's permanent impairment as grade 1 (minimal) loss of sensation on the left thumb and index finger. (Ex. 16).

The medical arbiter, Dr. Fietti, examined claimant on August 23, 1996. He found grade 3 (severe) sensation loss on the ulnar side of the left thumb and the radial side of the left index finger, which extended to the laceration scar in the thumb/index finger web space. (Exs. 21, 22).

Because of the substantial discrepancy between the impairment findings of the attending physician and those of the medical arbiter, SAIF argues that the arbiter's findings are unpersuasive because he gave no explanation for the discrepancy. In our view, however, the discrepancy can reasonably be explained as reflecting a fluctuation of claimant's condition during the six month period between Dr. Brady's closing examination and the medical arbiter's examination. Such a fluctuation would not be unexpected, given the substantial time period involved.

We are required to evaluate claimant's disability as of the issuance date of the Order on Reconsideration (September 19, 1996). See ORS 656.295(5). Because the arbiter's examination was conducted closer in time to that date, and it was a thorough and well-reasoned evaluation of claimant's impairment, we conclude that the arbiter's impairment findings best describe the extent of claimant's disability as of the issuance date of the reconsideration order. See Kenneth E. Myers, 48 Van Natta 1736 (1996). We therefore conclude that a preponderance of the evidence establishes that claimant suffered injury-related permanent impairment to the extent found by the medical arbiter.

The ALJ adopted all of the medical arbiter's impairment findings, with one exception. Although the arbiter found grade 3 (protective) loss of sensation on the left palm in the thumb/index finger web space, (Exs. 21-1, 22), the ALJ concluded that an award could not be granted for the loss because the arbiter did not indicate whether the loss involved the palmar median nerve or the palmar ulnar nerve. (O&O p 4). We modify that portion of the ALJ's conclusions and opinion.

On review, claimant argues that the medical arbiter's drawing of the palmar area where claimant sustained his sensory loss indicates that the loss involves the palmar median nerve. (Ex. 21-1). We agree. The medical arbiter's drawing shows that claimant's laceration scar and palmar sensory loss are in the thumb/index finger web space. Anatomically, that is an area innervated by the palmar median nerve. See AMA Guides to the Evaluation of Permanent Impairment 39 (3rd ed 1990). See also OAR 436-035-0007(6). Because we find that a preponderance of the medical evidence establishes that the palmar sensory loss in the thumb/index finger web space involves the palmar median nerve, claimant is entitled to an impairment value of 11 percent for that sensory loss. See former OAR 436-035-0110(1)(e).[1] Accordingly, we shall affirm the Order on Reconsideration award of 26 percent scheduled permanent disability for the left hand.

Because we have affirmed the reconsideration order, claimant's attorney is entitled to an assessed attorney fee for services at hearing and on Board review in defending against SAIF's request for reduction in claimant's award. 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 at hearing and on review in defending against a reduced award is $1,900, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the reduction issue (as represented by the hearing record and claimant's reply brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's services might have gone uncompensated.

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[1] The applicable standards for rating claimant's disability are set forth in WCD Admin. Order 96-051, as amended by WCD Admin. Order 96-068. See OAR 436-035-0003(2).

ORDER

The ALJ's order dated January 22, 1997 is reversed. The Order on Reconsideration is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $1,900, to be paid by SAIF. In addition, claimant's attorney is awarded an out-of-compensation attorney fee of 25 percent of the additional compensation created by this order, not to exceed $3,800, to be paid by SAIF directly to claimant's attorney.

In the Matter of the Compensation of
FRANCES M. McLAUGHLIN, Claimant
WCB Case No. 96-03489
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Hall, Bock, and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order which set aside its denial of claimant's bilateral elbow condition. On review, the issue is compensability.

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

The ALJ set aside the employer's denial of claimant's bilateral elbow condition, finding that claimant's work activities were the major contributing cause of a bilateral elbow "overuse" condition. On review, the employer contends that the parties agreed to litigate the compensability of an alleged bilateral epicondylitis condition, rather than a bilateral overuse condition, and that the ALJ incorrectly concluded that claimant's work activities were the major contributing cause of her bilateral upper extremity condition. While we agree that the parties agreed to litigate the compensability of a bilateral epicondylitis condition, we, nevertheless, conclude that this condition is compensable.

The employer denied claimant's bilateral upper extremity condition on February 29, 1996. (Ex. 33). The denial stated that claimant's "left epicondylitis or left elbow overuse syndrome" did not result from an incident on or about May 1, 1995. Id. However, at hearing, claimant stated that the issue was the "compensability of a epicondylitis claim, and the date of the denial is February 29, 1996, as amended at hearing today." (Tr. 2). The employer explained that it was amending its denial to include an upper back condition. (Tr. 3). The employer also stated that it was denying both "left and right epicondylitis." Id. Claimant then clarified that she was not contesting the compensability of her upper back condition. Id.

The basis for the employer's denial was that claimant's "left epicondylitis or left elbow overuse syndrome" did not result from the alleged May 1, 1995 injury. Parties to a workers' compensation proceeding may, 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). Here, the parties modified the express terms of the denial to litigate only a bilateral epicondylitis condition. Thus, we agree with the employer that the ALJ should only have addressed the compensability of that condition.

However, for the reasons the ALJ cited, claimant sustained her burden of proving that her bilateral elbow condition is compensable. That is, we agree for the reasons cited by the ALJ that the opinion of the attending physician, Dr. Daugherty is the most persuasive medical opinion in this record. Dr. Daugherty concluded that claimant's work activities were the major contributing cause of claimant's bilateral epicondylitis condition. (Ex. 42). Accordingly, we find that the ALJ correctly set aside the employer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a

reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 10, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the employer.

Board Member Moller dissenting.

The majority concludes that the parties modified the express terms of the employer's denial to litigate a bilateral epicondylitis condition. It then adopts the ALJ's reasoning that claimant sustained her burden of proof, based on the medical opinion of Dr. Daugherty, the attending physician. Because I believe both the majority and the ALJ excused too many flaws in claimant's case, I must respectfully dissent.

To begin, it is necessary to briefly recount the background of this rather complex case. Employed as a merchandise salesperson and floor clerk, claimant filed a personal injury report on May 8, 1995, alleging that she had injured her neck and right shoulder that day after she pulled back on a handcart while moving merchandise. (Ex. 2). Claimant did not file a form 801 or immediately seek medical treatment for the alleged injury, although she was apparently familiar with workers' compensation procedures, having previously filed a claim for her left shoulder. (Ex. A-3).

On August 4, 1995, claimant sought treatment from Dr. Lees, a family physician, for left arm pain. (Ex. 4). At hearing and in a recorded statement, claimant stated that she informed Dr. Lees of the May 1995 hand-cart incident, yet Dr. Lees only noted that there were left arm complaints with "no frank trauma." (Exs. 4-1, 28A-12; Tr. 17). Dr. Lees prescribed some physical therapy.

On September 14, 1995, claimant began treating with another family medicine physician, Dr. Daugherty, who stated that he was to "recheck for upper back strain and left elbow pain." (Ex. 10-1). Claimant reported not only the May 1995 hand-cart incident, but also another incident some six weeks earlier when she had to grab a hand truck with both hands when it started to slip. In addition to upper back and left elbow complaints, claimant reported aching and stiffness into her left hand. Dr. Daugherty diagnosed upper thoracic strain, lateral epicondylitis and left hand arthralgias.

Claimant again underwent physical therapy. The therapy notes indicated that claimant had discomfort in the "elbows," thoracic spine, lumbar spine and forearm. (Ex. 12).

Claimant eventually filed a claim on or about December 1, 1995. (Ex. 21). The date of injury was listed as May 1, 1995 and the form 801 referenced the hand- cart incident. Alleging that she initially hurt her "back" and "shoulder," claimant reported that subsequently her left arm, wrist and elbow started hurting. Another injury report was also completed. Claimant listed numerous body parts as the source of her pain: right neck, right upper back, low back, right shoulder, left elbow, and left forearm. (Ex. 22-1).

In a January 25, 1996 recorded statement, claimant related her left arm symptoms to the May 1995 incident. However, after speaking to her physical therapist, claimant concluded that she was favoring her right side due to the May 1995 incident, causing her to overuse the left arm. (Ex. 28A-9).

Dr. Daugherty continued to treat claimant. A consulting orthopedist, Dr. Lantz, examined claimant on February 9, 1996 at Dr. Daugherty's request. Dr. Lantz was only able to diagnose an overuse syndrome in the left elbow. (Ex. 30). On February 29, 1996, the employer denied left elbow epicondylitis or left elbow overuse syndrome.

On June 18, 1996, an examining orthopedist, Dr. Strum, evaluated claimant's complaints. According to Dr. Strum, claimant's complaints were primarily in the bilateral forearm. Dr. Strum diagnosed bilateral forearm tendonitis. (Ex. 40-6). Finding no objective evidence of injury, Dr. Strum concluded that he could not establish that claimant's work activities were the major contributing cause of her bilateral forearm condition. (Ex. 40-7).

Having summarized the factual background of this claim, it should be apparent that this is a very complex case from a factual and medical standpoint. From this complexity, however, several weaknesses in claimant's case emerge.

First, there has never been a clear, consistent diagnosis for claimant's diffuse complaints. Although she had previously filed at least one workers' compensation claim, claimant waited several months after the alleged May 1995 incident to seek medical treatment in August 1995 from Dr. Lees, who noted only left arm complaints without frank trauma. Dr. Lees initially diagnosed left elbow tendonitis and lateral epicondylitis, but that diagnosis was expanded to include left shoulder AC strain with bursitis. (Exs. 4-1, 4-3). When claimant began treatment with Dr. Daugherty on September 14, 1995, the diagnosis was upper thoracic strain, lateral epicondylitis, and left hand arthralgias. When Dr. Lantz examined claimant in February 1996, he could only diagnose an overuse syndrome.

I recognize that a claimant is not required to prove a specific diagnosis in order to establish a compensable claim. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). However, the inconsistent nature of the diagnoses applied to claimant's numerous complaints makes it much more difficult to find a work connection. I agree with the employer that work activities that might cause bilateral epicondylitis may not cause overuse syndrome or tendonitis. Without a clear and consistent diagnosis of claimant's physical condition, I am unable to make a casual connection between claimant's employment and her numerous symptoms.

Then, there is the matter of the varying histories. In her May 8, 1995 personal injury report, claimant alleged that she injured her neck and right shoulder pulling on a handcart. (Ex. 2). However, no claim was filed. In August 1995, when claimant finally sought treatment, Dr. Lees did not report the handcart incident, although claimant testified that she reported the incident to Dr. Lees. Dr. Lees only noted left arm complaints with "no frank trauma." (Ex. 4-1).

On September 14, 1995, claimant reported not only the May 1995 handcart incident to Dr. Daugherty, but also another handcart incident six weeks earlier, which would have coincided with Dr. Lees' office visit. Again, there is no mention in Dr. Lees' chart note of either incident of injury. Later, in her recorded statement on January 25, 1996, claimant alleged that her left arm complaints were due to favoring her right side.

Given the vague, incomplete and sometimes inconsistent histories claimant has provided to her physicians, I am unable to find any medical opinion persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Certainly, I have great difficulty accepting Dr. Daugherty's diagnosis of work-related bilateral epicondylitis, given the diffuse nature of claimant's symptoms, as well as the fact that two orthopedists, Drs. Lantz and Strum, could not diagnose bilateral epicondylitis.

Finally, it should be emphasized that the employer orally amended its denial at hearing to include an upper back condition. Claimant withdrew any claim for her upper back condition. Therefore, claimant's attribution of her left arm symptoms to overuse resulting from alleged right shoulder and upper back injuries does not establish compensability of the alleged consequential condition since the right shoulder and upper back conditions are preexisting noncompensable conditions for the purposes of ORS 656.802(2)(e).

In conclusion, I would find that claimant has not satisfied her burden of proving a bilateral arm condition in light of the clear deficiencies in the record. Because the majority concludes otherwise, I must respectfully dissent.

In the Matter of the Compensation of
ONALEE D. PARISH, Claimant
WCB Case Nos. 96-07037 & 96-05243
ORDER ON REVIEW
Max Rae, Claimant Attorney
Safeco Legal Department, Defense Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld Safeco's denial insofar as it denied claimant's aggravation claim for a bilateral hand/wrist condition; (2) set aside Safeco's denial insofar as it pertained to claimant's current bilateral hand/wrist condition; and (3) upheld the SAIF Corporation's denial of responsibility for the same condition. In her brief, claimant requests remand to the ALJ for the admission of additional evidence. On review, the issues are remand, aggravation and responsibility.

We deny the motion to remand, and adopt and affirm the ALJ's order with the following supplementation.

Remand

The ALJ concluded that claimant failed to prove a pathological worsening and failed to present direct medical evidence to suggest that her increase of symptoms in January 1996 represented a worsening of her compensable condition. SAIF v. Walker, 145 Or App 294 (1996). Asserting that the legal standard had changed subsequent to hearing, claimant requests remand to the ALJ for further development of the record under the "post-Walker" law. We decline to remand this case to the ALJ.

According to claimant, a compelling basis for remand exists because Dr. Elgersma's opinion was solicited at a time when the law required only a showing of medical evidence that increased symptoms represented a worsening of the compensable condition to establish an aggravation, and the ALJ, applying the more stringent Walker standard, concluded that claimant had not sustained her burden to prove that her compensable bilateral wrist condition had actually worsened. We disagree.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In order to satisfy this standard, a "compelling reason" must be shown for remanding. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

We acknowledge that, at the time of the hearing, caselaw held that a symptomatic worsening was sufficient to establish an aggravation. However, claimant argued at hearing that her bilateral wrist condition was either a new occupational disease due to her exposure at SAIF or an aggravation of her accepted Safeco claim. In order to prove a new occupational disease, claimant was required to establish that her work activities were the major contributing cause of a pathological worsening of the accepted condition. ORS 656.802(2); Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993); Shelly K. Funkhouser, 47 Van Natta 126 (1995).

The record contains medical evidence regarding claimant's worsened condition, including opinions from Dr. Elgersma, Dr. Donovan, Dr. Wilson, and Dr. Rand. Thus, claimant had the opportunity to present evidence of a pathological worsening of her condition, whether related to her exposure at SAIF or to her Safeco claim. We therefore consider the record to be properly, completely and sufficiently developed to resolve the aggravation issue. Consequently, we find no compelling reason to remand and deny claimant's motion.

In her brief, claimant also contends that the application of the "actual worsening" requirement of ORS 656.273(1), as interpreted by the court in Walker, deprived her of a remedy, in violation of Article I, Section 10 of the Oregon Constitution[1], when she was disabled from working in 1996 due to a condition that has been found compensable. Claimant asserts, therefore, that she is entitled to the reopening of her claim.

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[1] Article I, section 10 provides:

"[E]very man shall have remedy by due course of law for injury done in his person, property, or reputation."

Because claimant did not raise the constitutional issue until after Walker had issued, we conclude that claimant's objection is not to the application of the statute itself, but to the holding in Walker. In effect, then, claimant is asking us to overturn Walker on constitutional grounds. Since Walker is a decision from a higher appellate authority and remains good law, we are obliged to follow its holding. In other words, if the Walker holding is contrary to the statutory scheme, that decision is for the appellate courts, not this forum.[2]

ORDER

The ALJ's order dated January 3, 1997, is affirmed.

[2] Because we reject claimant's challenge to Walker, we need not address the insurer's arguments on this issue.

In the Matter of the Compensation of
PENNY J. SODERHOLM, Claimant
WCB Case No. 96-07759
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that reversed an Order on Reconsideration which found that claimant's back claim had been prematurely closed. In her brief, claimant contends that the ALJ erred in excluding evidence not submitted at the reconsideration proceeding. On review, the issues are evidence and premature closure.

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

On review, claimant argues that the insurer did not submit certain documents (i.e., chartnotes from her attending physician, Dr. Hill) at the time of reconsideration. Consequently, claimant contends that it was not equitable for such documents to have been excluded by the ALJ, even though ORS 656.283(7) provides that evidence not submitted at the reconsideration is not admissible at hearing.

First, we find that we are unable to consider the exhibits submitted by claimant as our review is limited to the hearing record. ORS 656.295(5). Consequently, we treat claimant's argument as a request to remand the matter to the Department for consideration and admission of the evidence pursuant to ORS 656.283(7).

Assuming, without deciding, that we have the authority to remand to the Department on such a basis, we conclude that claimant is required to show that a remand would be warranted, as the excluded evidence would be reasonably likely to affect the outcome of the case. See e.g. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, we review the excluded exhibits solely for purposes of determining whether remand is appropriate. After considering the evidence for that purpose, we do not find that the evidence would likely affect the outcome of the case. Specifically, the evidence submitted by claimant shows that, to the extent Dr. Hill believed that claimant is not medically stationary, his opinion relied on nonaccepted conditions, e.g. fibromyalgia and sleep disturbance. With respect to the accepted condition, i.e., lumbar strain and upper back contusion, we do not find that Dr. Hill's chartnotes suggest that the condition is not medically stationary. Furthermore, we would nevertheless agree with the ALJ that, for the reasons expressed in the Opinion and Order, Drs. Dupuis, Brooks and Strum have provided the most persuasive opinion regarding the issue of premature closure.

Consequently, we conclude that, if we had the authority to remand this matter, we would decline to do so based on our conclusion that the evidence excluded by the ALJ is not reasonably likely to affect the outcome of this case.

ORDER

The ALJ's order dated December 6, 1996, as reconsidered January 14, 1997 and February 11, 1997, is affirmed.

In the Matter of the Compensation of
PAUL A. WELBURN, Claimant
WCB Case Nos. 96-10473 & 96-09562
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) affirmed an Order on Reconsideration award of 24 percent (76.8 degrees) unscheduled permanent disability; and (2) awarded claimant 26 percent (49.92 degrees) scheduled permanent disability for each arm, whereas the Order on Reconsideration awarded no scheduled permanent disability. On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled permanent disability

The ALJ affirmed the Department's unscheduled permanent disability award of 25 percent, which included an award of 15 percent impairment for the integumentary system pursuant to OAR 436-035-0440 and 3 percent impairment to the immune system under OAR 436-035-0450. We agree that the insurer did not meet its burden of proving that the Order on Reconsideration award was incorrect. We therefore affirm the ALJ on the issue of unscheduled permanent disability.

Scheduled permanent disability

The ALJ also found that claimant was entitled to an award of scheduled permanent disability for his contact dermatitis, pursuant to OAR 436-035-0110(5). However, on review, the insurer argues that the ALJ's order is internally inconsistent. Specifically, the insurer notes that OAR 436-035-0110(5) provides that "contact dermatitis of an upper extremity is rated in this section unless it is an allergic system reaction, which is rated pursuant to OAR 436-035-0450." (Emphasis supplied).

Here, the ALJ affirmed the Department's unscheduled award pursuant to OAR 436-035-0450. Consequently, we conclude that a scheduled award is not also available, in light of the restriction set forth in the Department's rule.[1] Accordingly, we reverse the ALJ's award of scheduled permanent disability.

Claimant's counsel is entitled to an attorney fee for services on review concerning the issue of 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 unscheduled permanent disability is $600, to be paid by the

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[1] Although claimant argues that he has both a contact dermatitis affecting his upper extremities as well as an impairment to his immune system, the Department's rule, nevertheless, provides for a scheduled rating only if the condition does not fall within the rule for an unscheduled award, which is OAR 436-035-0450. In this case, the Department has made such a finding and we have affirmed claimant's unscheduled permanent disability award which was based on that rule.

insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 31, 1997 is affirmed in part and reversed in part. The portion of the ALJ's order which affirmed the Order on Reconsideration award of 24 percent (76.8 degrees) unscheduled permanent disability is affirmed. For services on review concerning the issue of unscheduled permanent disability, claimant's counsel is awarded an assessed attorney fee of $600, to be paid by the insurer. The ALJ's award of scheduled permanent disability is reversed. Claimant's out-of-compensation attorney fee is also reversed. The October 23, 1996 Order on Reconsideration is affirmed in its entirety.

In the Matter of the Compensation of
JESSE M. WRIGHT, Claimant
WCB Case No. 96-07498
ORDER ON REVIEW
Max Rae, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the SAIF Corporation's denial of claimant's "new injury" claim. On review, the issue is responsibility.

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

Dr. Collada, treating surgeon, expressly stated that neither his firsthand examination of claimant's back during surgery nor his knowledge of claimant's pre-1996 period of working without back symptoms helped him compare the causal contributions from claimant's preexisting condition and his 1996 injury. (See Ex. 34-18-22). Instead, Dr. Collada reasoned that the 1996 injury was the major cause of claimant's current low back condition, solely because claimant's recent low back problems began with that incident.[1]

Under these circumstances, we agree with the ALJ that Dr. Collada's opinion is unpersuasive. In addition, because no other medical evidence suggests that claimant suffered a "new injury" within the meaning of ORS 656.308(1) in 1996, we further agree that responsibility does not shift in this case.

ORDER

The ALJ's order dated February 25, 1997 is affirmed.

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[1] Claimant argues that Dr. Collada's "precipitating cause" reasoning establishes that the claim is compensable under SAIF v. Nehl, 148 Or App 101 (1997). However, consistent with our recent conclusion that Nehl did not alter the standard for proving major contributing cause, as articulated by Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995), Nehl does not affect our reasoning or conclusion in the present case. See Gregory C. Noble, 49 Van Natta 764 (1997).

In the Matter of the Compensation of
GILBERT R. BALEY, Claimant
WCB Case Nos. 96-03214, 96-03213 & 95-10847
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Alice Bartelt (Saif), Defense Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denial of his current left rotator cuff condition. On review, the issue is compensability, and, if compensable, responsibility.

We adopt and affirm the ALJ's order, as corrected, with the following change and supplementation. We do not adopt the third paragraph on page 5.

On review, claimant is pursuing only his claim against SAIF, alleging that the October 27, 1992 injury is the major contributing cause of his current left rotator cuff condition. He relies on the opinions of Drs. Cohen and Sedgewick to prove compensability.

The ALJ was not persuaded by the opinions of Drs. Cohen and Sedgewick, in part, because they assumed that claimant had a torn left rotator cuff in 1992. The ALJ notes that Dr. Cohen diagnosed a muscle strain injury in October 1992.

On March 21, 1996, Dr. Cohen opined that claimant's October 27, 1992 injury "probably caused a tear of the rotator cuff." (Ex. 40B). Dr. Cohen concluded that the October 1992 injury was the major contributing cause of the left rotator cuff tear which was later aggravated by the 1995 injury. (Id.) Claimant argues that it is "extremely significant" to note that Dr. Cohen had suspected a slight tear of the left rotator cuff in October 1992. Although Dr. Cohen suspected a slight tear at that time, the subsequent medical reports do not support that conclusion. Moreover, Dr. Fuller's report persuasively contradicts that conclusion.

Claimant injured his left shoulder on October 27, 1992, while lifting a truck battery. On October 29, 1992, Dr. Cohen reported:

> "He is able to abduct the left shoulder very well, but when I put pressure on it, he has pain at the area of the acromion tip. This could mean he tore a little of the subacromial bursa. He may have even torn a little bit of the rotator cuff, but I don't think it is much of the rotator cuff torn." (Ex. 18).

Dr. Cohen felt that "this is a strain of the left shoulder, though I can't rule out a little tear." (Id.) He noted that, if the pain continued, claimant would need an arthrogram. Dr. Cohen released claimant for regular work as of October 1992. (Ex. 23). SAIF accepted a nondisabling left shoulder strain. (Ex. 22).

The next mention of treatment for the left shoulder was on July 21, 1993, after claimant had been using crutches following hip surgery. Dr. Sedgewick reported that claimant complained of left shoulder pain and was having trouble using crutches. (Ex. 26-1). Dr. Sedgewick recommended using a walker instead of crutches. He noted that claimant wanted an arthrogram to rule out a tear in the rotator cuff. (Id.)

On August 12, 1993, Dr. Sedgewick reported that claimant still had pain in his left shoulder. (Ex. 26-2). X-rays of the left shoulder showed "significant" degenerative joint disease in the AC joint, a marked amount of spurring on the entire lateral border of the acromion and distal aspect of the clavicle, and the glenohumeral joint had a mild spur. (Id.) Dr. Sedgewick noted that the left shoulder was "still a problem with impingement, rotator cuff tendinitis and subacromial bursitis." (Id.) He recommended an MRI to rule out a rotator cuff tear and possibly undergo a subacromial decompression.

On September 22, 1993, Dr. Sedgewick reported that some of the left shoulder symptoms had subsided and claimant did not want anything further done with it. (Ex. 26-3). Claimant's symptoms had abated since a cortisone injection.

In December 1993 and January 1994, claimant was treated for right shoulder pain, but there is no mention of left shoulder problems. (Exs. 26-3, -4). The next report of treatment for the left shoulder was in June 1995, following the April 1995 injury. (Ex. 28).

Dr. Fuller examined claimant on August 24, 1995. In reviewing the medical records, he noted that Dr. Cohen had commented on October 29, 1992 that he was uncertain whether claimant had a tear in his left shoulder. Dr. Fuller reported:

> "It doesn't appear that there was an acute tear given that he was 'able to abduct the left shoulder very well' according to Dr. Cohen. If he had an acute tear of any significance his range of motion would have been acutely painful. It is evident therefore that whatever was going on in 1992 was more of a strain rather than an acute tear of the rotator cuff." (Ex. 33-6, -7).

We agree with the ALJ that the conclusory opinions of Drs. Cohen and Sedgewick that claimant had a torn left rotator cuff in 1992 are not persuasive. Dr. Cohen did not explain why, if claimant had a left rotator tear as a result of the October 1992 injury, he was able to abduct the left shoulder "very well." Moreover, Dr. Cohen apparently only treated claimant on one occasion after the October 1992 injury and he released claimant for regular work the same month. The subsequent medical reports do not support the conclusion that claimant had a torn left rotator cuff tear in October 1992.

Similarly, we are not persuaded by Dr. Sedgewick's conclusory opinion. Although Dr. Sedgewick agreed with Dr. Cohen that claimant had a rotator cuff tear as a result of the 1992 injury (Exs. 42, 43), Dr. Sedgewick's July 21, 1993 chart note indicated that claimant's left shoulder pain was related to his use of crutches. (Ex. 26-1). Claimant testified that he experienced acute pain in his neck and left shoulder after the October 1992 injury and was given an injection by Dr. Cohen. (Tr. 17). Claimant was asked if he had any change in symptoms following the 1992 injury and he replied "I don't think I had any pain up until the time I started being on crutches because of my hip surgery, and all the time that I was on crutches I had shoulder pain." (Id.) Although Dr. Sedgewick recommended further testing to rule out a rotator cuff tear, claimant's left shoulder symptoms subsided and no further tests were performed until after the April 1995 injury.

We agree with the ALJ that Dr. Fuller's opinion is the most persuasive. Based on Dr. Fuller's report, we conclude that claimant had a strain rather than a rotator cuff tear as a result of the October 1992 injury. We are persuaded by Dr. Fuller's well-reasoned opinion that the major contributing cause of the left rotator cuff tear was due to impingement from the spur coming from the left acromioclavicular joint and probable impingement from hooking of the anterior rim of the left acromion. (Exs. 33, 44). Although Drs. Cohen and Sedgewick opined that claimant's rotator cuff tear was not caused by degenerative changes, we are not persuaded by their conclusory opinions. We agree with the ALJ that claimant's 1992 injury was not the major contributing cause of his current left rotator cuff tear and, thus, claimant did not prove compensability.

ORDER

The ALJ's order dated November 21, 1996, as corrected November 26, 1996, is affirmed.

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

On May 9, 1997, we withdrew our April 11, 1997 Order on Review that dismissed his request for hearing for lack of jurisdiction. Citing SAIF v. Shipley, 147 Or App 26 (1997), we had previously concluded that this case involved a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6). We withdrew our previous order to consider claimant's argument that, unlike Shipley, he sought benefits for an aggravation of his 1991 injury which required reopening for surgery. Having received the SAIF Corporation's response to our abatement order, we now proceed with our reconsideration.

On December 20, 1991, claimant injured his low back at work. SAIF accepted a claim for L4-5 lumbar disc herniation to the right. (Ex. 33). In February 1996, claimant underwent surgery for L4-5 discectomy, interbody fusion and internal fixation at L4-5 and L5-S1. On December 22, 1995, SAIF issued a partial denial of claimant's request for medical treatment. (Ex. 70). Claimant requested a hearing on SAIF's partial denial.

In our prior order, we found this case analogous to Shipley. We noted that, as in Shipley, claimant was seeking medical treatment of his current condition. SAIF did not deny compensability of claimant's original 1991 injury. Rather, SAIF denied medical treatment for the low back pain, which claimant felt was related to the 1991 injury. We concluded that this case involved a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6).

On reconsideration, claimant argues that, unlike Shipley, he sought benefits for an aggravation of his 1991 injury which required reopening for surgery. He asserts that SAIF's denial included a denial of the condition resulting in the need for treatment and disability. Therefore, claimant contends that Shipley does not apply to this case and the Board has jurisdiction.

In Shipley, the claimant received medical treatment for an off-the-job injury to his knee after closure of his compensable knee injury claim. Although the carrier denied that the claimant's compensable condition had worsened and denied a request to reopen the claim, it did not deny compensability of the original injury. On appeal, the carrier argued that the Board erred in assuming jurisdiction over the matter, since it involved only a claim for medical benefits on a previously accepted claim. The claimant contended that, because the carrier denied compensability of his current condition and need for treatment, it denied compensability of the "underlying claim" as described in ORS 656.245(6).

The court rejected the claimant's contention, reasoning that the parties appeared to agree that the claimant had never sought benefits for an aggravation of the compensable injury, nor had he sought to establish the compensability of a new consequential condition. 147 Or App at 29. Rather, the claimant sought only treatment of his current condition, contending that the treatment was compensable because it was materially related to the compensable injury. Relying on ORS 656.245(6) and Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995), the court concluded that since the dispute concerned only the compensability of medical services (and not the "underlying claim"), exclusive jurisdiction to review the dispute rested with the Director. Id. The court also determined that the fact that the carrier's denial encompassed more than what the claimant was seeking did not enlarge the scope of the dispute beyond the scope of the claim.

We briefly summarize the procedural facts in this case. As we mentioned earlier, on December 22, 1995, SAIF issued a partial denial of claimant's request for treatment. (Ex. 70). In the denial, SAIF acknowledged that it had accepted a claim for L4-5 lumbar disc related to the December 20, 1991 injury. SAIF stated:

> "We have recently received information that you are seeking treatment for discogenic and mechanical low back pain that requires an anterior retroperitoneal approach discectomy with vertebral body distraction using interbody cage internal fixation and fusion at

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

Claimant requested a hearing on the December 22, 1995 denial, raising issues of compensability, aggravation, penalties and attorney fees. At hearing, the ALJ framed the issue as "the compensability of medical services performed on February 13, 1996, and more specifically, whether the medical services performed on February 13, 1996 are causally related to claimant's accepted injury of December 20, 1991." (Tr. 2). SAIF's attorney agreed with that description of the issue. (Id.) Claimant's attorney agreed with the ALJ's statement of issues and responded:

> "I had also raised the issue of aggravation, but Counsel indicated, in his preliminary comments, that the -- that SAIF's position was that the issue here is whether or not these medical services are related; if they're related, that there's clearly an aggravation. And so that's why the issue is more correctly framed as you have stated it." (Id.; emphasis added).

Claimant's attorney commented that "we still understand that basically what we're talking about is whether or not Dr. Grewe's surgery was connected with the on-the-job injury." (Tr. 3). SAIF's attorney agreed that the denial was expanded to specifically include the surgery on February 13, 1996. (Id.)

In closing argument, claimant's attorney asserted that "the issue in this case boils down to one of what is the major cause of the need for treatment in '96?" (Ex. 77-31). Claimant's attorney argued that there was a "clear direct cause" between the 1991 incident and claimant's three surgeries. Claimant's attorney contended that "[t]he bottom line here is that the issue here is whether or not we've got a worsening of his condition so that the surgery and medical services that he received in February '96 was a result of the injury of December 20, 1991, and that that injury was the major cause of those need for services for surgery." (Ex. 77-32).

In closing argument, SAIF's attorney acknowledged that it was not questioning whether claimant had a compensable injury in 1991. (Ex. 77-33). Rather, SAIF's attorney asserted that the question was whether claimant's condition related back to the 1991 injury. (Id.)

The ALJ concluded that claimant's February 1996 surgery was causally related, in major part, to the compensable 1991 injury.

Claimant's attorney's comments at hearing indicated that the dispute revolved around the denial of medical services. Although claimant raised the issue of aggravation in his request for hearing, claimant's attorney agreed with the ALJ's characterization of the issue as whether the medical services performed on February 13, 1996 were causally related to the accepted injury. (Tr. 2). Claimant's attorney commented that he "had also raised the issue of aggravation," but the issue was more correctly framed by the ALJ. (Id.) Claimant's attorney indicated that if the medical services were related to the accepted injury, then there was an aggravation. (Id.) Thus, claimant's attorney's comments indicated that medical services would be litigated first and then the parties would address the aggravation issue.

In closing argument, although claimant's attorney referred to the "worsening" of claimant's condition (Ex. 77-32), the focus was clearly on medical services. Claimant's attorney contended that "the issue in this case boils down to one of what is the major cause of the need for treatment in '96?" (Ex. 77-31; emphasis added).

Under these circumstances, we adhere to our previous conclusion that this case involves a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6). Here, as in Shipley, claimant seeks medical treatment of his current condition. In closing argument, SAIF acknowledged that it was not questioning whether claimant had a compensable injury in 1991. (Ex. 77-33). Thus, as in Shipley, SAIF did not deny compensability of the underlying claim. See ORS

656.245(6).[1] Since neither the Hearings Division nor the Board has jurisdiction over this matter, claimant's request for hearing must be dismissed.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our April 11, 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] 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." (Emphasis added).

In the Matter of the Compensation of
LINDA B. LANDRETH-WIESE, Claimant
WCB Case No. 96-07489
ORDER ON REVIEW
Crispin & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for a mental disorder. In her respondent's brief, claimant moves for dismissal, contending that the insurer continues to assert the same insufficient defense it argued at hearing. On review, the issues are claimant's procedural motion and compensability. We deny the motion for dismissal and affirm the ALJ's order.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Procedural motion

On review, claimant contends that the insurer's request for review should be dismissed on the ground that the insurer has not raised a defense sufficient to support its denial. Specifically, claimant contends that the insurer denied the claim on the ground that activities leading claimant to file the claim were "generally inherent in your job." Claimant argues that the language of the denial is not sufficient under ORS 656.802 (i.e., which requires stressors not generally inherent in every working situation), and the employer is bound by the terms of its denial. Consequently, claimant contends that the insurer cannot now assert that the mental disorder was the result of a stressor which is "generally inherent in every working situation."

We do not find that claimant has asserted that the insurer untimely or improperly appealed the ALJ's order. Moreover, we do not find the above argument to be an adequate basis for challenging the Board's authority to review the ALJ's order. Rather, we consider claimant's arguments for purposes of determining whether the ALJ properly considered the "generally inherent" defense.

At hearing, the ALJ described the insurer's denial, but referred to the denial as involving the "statutory provision" concerning conduct. (Tr. 6). The ALJ further concluded that the defense was limited to a denial on that basis. Claimant did not object and did not assert that she was surprised or prejudiced by the ALJ's ruling, nor was a continuance requested.

We have previously held that the parties may, by agreement, try an issue that is outside the express terms of the denial. Terry Hickman, 48 Van Natta 1073 (1996). Here, we conclude that the parties agreed to try the case based on a "generally inherent" defense pursuant to the statute. ORS 656.802(3)(b). In this regard, we find that the basis on which the insurer contested the claim was obvious, despite the inartful wording of the denial. Under the circumstances, we deny claimant's motion to dismiss.

Compensability

We adopt and affirm the ALJ's "Opinion and Conclusion" on the issue of compensability. See Kenneth G. Abel, 48 Van Natta 1603 (1996); Lynn A. Horton, 45 Van Natta 2203 (1993); Gregory L. Brodell, 45 Van Natta 924 (1993).

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,300, to be paid by the insurer. 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 January 6, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,300, to be paid by the insurer.

In the Matter of the Compensation of
ROSA ALCAZAR, Claimant
WCB Case No. 96-00499
ORDER ON RECONSIDERATION
Quintin Estell, Claimant Attorney
John M. Pitcher, Defense Attorney

The insurer requests abatement and reconsideration of our June 27, 1997 Order on Review that reversed the Administrative Law Judge's (ALJ's) order upholding its denial of claimant's low back injury claim. In moving for reconsideration, the insurer asserts that we erroneously found that the ALJ's credibility finding was not based on demeanor. The insurer further argues that claimant's testimony was sufficiently contradicted that her testimony at hearing should be considered unreliable.

Even assuming that the ALJ based her credibility finding on demeanor, we continue to conclude that claimant's testimony is reliable. Although we generally defer to the ALJ's determination of credibility, such approach is not statutorily required. Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). For the reasons stated in our order, we continue not to defer to the ALJ's finding that claimant was not credible.

Accordingly, we withdraw our June 27, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our June 27, 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
GALE A. DRAPER, Claimant
WCB Case No. 95-11229
ORDER ON REVIEW
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall, Bock, and Haynes.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) upheld the self-insured employer's denial of claimant's injury claim for a right leg cellulitis condition; and (2) found that claimant was not entitled to temporary disability for the period from July 13, 1995 until July 26, 1995. Claimant argues that the ALJ erred in: (1) refusing to allow his testimony regarding what Dr. Tilley told claimant; and (2) allowing the employer to question him regarding an alleged prior criminal conviction. On review, the issues are evidence, compensability, and temporary disability. We reverse.

FINDINGS OF FACT

Claimant worked as a "batchmaker" of product for the employer. While working on July 10, 1995, claimant felt a sharp pain in his right shin. He felt as though someone had kicked him. (Tr. 16). Claimant told the employer's quality control person about his sudden pain and jokingly asked if he had kicked claimant in the leg. (Tr. 10).

The next day, Tuesday, July 11, 1995, claimant's leg was swollen and bothering him. He called his doctor before he went to work, but was unable to get an appointment. At work that day, claimant told his foreman and Mr. Van Houten, the employer's manufacturing manager, "about it." (Tr. 17, 22). He worked ten hours on Tuesday.

On Wednesday, July 12, claimant's leg was worse, but he worked about seven hours. On Thursday, July 13, claimant telephoned the employer and told Mr. Van Houten that he needed to see the company doctor. Claimant was fired at that time. (See Tr. 9, 15).

On Friday, July 14, claimant sought emergency room treatment from Dr. Tilley. Dr. Tilley diagnosed cellulitis, gave claimant an injection, and took him off work. On July 17, 1995, Dr. Flaming examined claimant, prescribed antibiotics, and released him from work until July 24, 1995.

On August 8, 1995, the employer denied claimant's injury claim.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that the ALJ erred in refusing to consider his testimony regarding what Dr. Tilley told him about his right leg condition. Claimant also argues that the ALJ erred in allowing the employer to question claimant about an alleged prior criminal conviction. (See Tr. 10-13, 17-18).[1] We need not address these arguments because our conclusion on the merits would be the same, regardless of whether we considered or rejected this disputed evidence.

Compensability

The ALJ upheld the employer's denial of claimant's injury claim for an insect bite/cellulitis condition, finding that claimant failed to prove that he suffered an insect bite at work or that such a bite caused his cellulitis condition. We disagree.

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[1] The employer asked claimant, "About 1987 you were convicted of a felony, isn't that true?" Claimant objected on relevancy grounds. He stated that he had not been convicted. His testimony in this regard is uncontradicted. The ALJ stated that she would "look at that and [] decide whether it's relevant." (Tr. 17-18).

Claimant persuasively described the sudden onset of pain in his right shin, which happened while he was working his regular shift for the employer. There is no evidence that claimant ever experienced anything similar off work and no reason to believe that the claimed right leg problem was associated with an off work circumstance or risk. Moreover, claimant's reporting to Dr. Flaming that "someone else at the place where he works had also had a similar type problem" is uncontroverted. (See Ex. 5). Under these circumstances, we find it more likely than not that claimant's July 1995 right leg condition arose out of and in the course and scope of his employment. See ORS 656.005(7)(a); Estela Velazquez, 47 Van Natta 1117, 1118 (1995) (A claimant need not identify a particular (i.e., exact) cause, if the persuasive evidence indicates that the condition is work related).[2]

The employer argues that the claim is not compensable because the medical evidence is insufficient to establish that claimant suffered an insect bite at work or that claimant's right leg condition is work related. We disagree.

Medical evidence is not always required to establish causation. The relevant factors for determining whether expert evidence concerning causation is required are: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly consults with a physician; (4) whether the worker promptly reports the occurrence to a superior; (5) whether the worker was previously free from disability of the kind involved; and (6) whether there was expert evidence that the alleged precipitating cause could not have caused the injury. Barnett v. SAIF, 122 Or App 279 (1993) (citing Uris v. Compensation Dept., 247 Or 420 (1967)).

In the present case, we find that the situation is not complicated, largely because claimant's symptoms appeared immediately and no off-work causes are implicated or medically indicated.[3] Claimant reported the injury to the employer and attempted to secure medical attention promptly, the day after the work incident. (He eventually obtained emergency treatment four days after the work event.) There is no expert evidence that an insect bite (the alleged precipitating cause) could not have caused the injury.[4] Under these circumstances, we conclude that this is a "simple" case, under the Barnett standard, and medical evidence establishing causation is not required. Accordingly, we are persuaded that claimant's July 1995 right leg problems were probably due to an insect bite sustained at work. (See also Ex. 4).

Finally, even if this case is characterized as "medically complex," we would find medical causation proven, based on Dr. Tilley's opinion: "I think [claimant] sustained a small insect bite and now has a secondary cellulitis of the right lower extremity." (Ex. 4). See Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992) (A claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work.); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Robinson v. SAIF, 78 Or App 581 (1986) (It is not a necessary predicate to compensability that the medical experts know the exact mechanism of a disease.); Volk v. Birdseye Division, 16 Or App 349 (1974); Carol D. Courtwright, 49 Van Natta 188 (1997); Velazquez, 47 Van Natta at 1118; Aaron D. Harris, 46 Van Natta 2229, 2230 (1994); Rita C. Shambow, 46 Van Natta 1174 (1994)

Temporary Disability

Claimant seeks temporary disability benefits for the period from July 13, 1995 until July 26, 1995.

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[2] Affirmed on other grounds, Bronco Cleaners v. Velazquez, 141 Or App 295 (1996).

[3] Dr. Tilley examined claimant on July 14, 1995 and stated, "I think [claimant] sustained a small insect bite and now has a secondary cellulitis of the right lower extremity." (Ex. 4). On January 25, 1996, Dr. Flaming stated, "The etiology of the right leg cellulitis was not determined conclusively." (Ex. 10-2). In an unsigned February 1996 "concurrence letter," Dr. Tilley (apparently) checked a box indicating that the etiology of the right leg cellulitis condition is "unknown." (Ex. 11-2). (Claimant testified that he did not know he had a bug bite until July 14, 1995, when Dr. Tilley made that diagnosis. (Tr. 22; see Ex. 4)).

[4] In Robert C. Toth, 47 Van Natta 712 (1995), there was evidence that the claimant was not bitten by a Brown Recluse spider, because no such spider has ever been found in Oregon. The present case is distinguishable from Toth, because here the evidence indicates that claimant's right leg condition probably arose as he claims. (See Exs. 4, 5). See n.3, supra; see also Ronald E. Casselman, 48 Van Natta 365 (1996) (Where the case was not uncomplicated and the medical evidence indicated that the cause of the claimant's condition was unknown, the medical evidence was insufficient to establish compensability).

Dr. Tilley took claimant off work due to the compensable condition on July 14, 1995 effective until claimant saw Dr. Flaming. (Exs. 2, 4). Dr. Flaming examined claimant on July 17, 1995 and authorized time loss until July 24, 1995. (Exs. 5, 5A). Accordingly, on this record, we find that claimant has established entitlement to temporary disability benefits for the period from July 14, 1995 until July 24, 1995.[5] See ORS 656.262(4).

ORDER

The ALJ's order dated November 25, 1996 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law, including payment of temporary disability compensation for the period from July 14, 1995 until July 24, 1995.

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[5] In reaching this conclusion, we find that Dr. Tilley was claimant's attending physician until Dr. Flaming assumed primary responsibility for claimant's right leg treatment on July 17, 1995. See First Interstate v. Morris, 132 Or App 98 (1994) (Only the attending physician may authorize a worker's time loss).

Board Member Haynes dissenting.

I dissent from the majority's conclusion that this case is uncomplicated and, thus, medical evidence is not necessary to prove causation. As the majority states, the following factors are considered to determine if medical evidence is required: (1) whether it is an uncomplicated situation; (2) whether the worker had the immediate appearance of symptoms; (3) whether the worker promptly reported the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there is no expert testimony that the alleged precipitating event could not have been the cause of the injury. Barnett v. SAIF, 122 Or App 279, 283 (1993). In applying these factors, the majority primarily relies on its findings that "claimant's symptoms appeared immediately and no off-work causes are implicated or medically indicated." The majority also notes that claimant "reported the injury to the employer and attempted to secure medical attention promptly" and there "is no expert evidence that an insect bite (the alleged precipitating cause) could not have caused the injury."

The facts are not in dispute. Claimant testified that, on July 10, 1995, he felt pain in his right shin while working. Claimant further testified that he informed his foreman and manager the next day about the incident. Although claimant apparently attempted to schedule an appointment with his doctor on July 11, he did not actually receive medical treatment until July 14, when he went to the hospital emergency room.

Based only on these facts, this clearly is not a simple case. An "uncomplicated situation" is one where the mechanism of injury and the injury are so consistent that the incident obviously caused the injury. E.g., Barnett, 122 Or App at 283 (claimant felt immediate low back pain after retrieving case of beer from overhead shelf). Here, claimant was not even aware of the mechanism of injury and there was no evidence of the presence of biting insects at the work place. Moreover, claimant did not promptly report the incident because he waited until the next day to tell management; there was no evidence that management personnel were not available on July 10. Claimant also did not promptly secure medical treatment because he waited four days before going to the emergency room. Although I agree that there were no "off-work causes" shown for the injury, that is because there was no evidence, on-work or off-work, explaining the cellulitis.

The medical evidence further shows that this is not a simple case. The emergency room physician, Dr. Tilley, found that claimant "sustained a small insect bite and now has a secondary cellulitis of the right lower extremity." (Ex. 4). Claimant then saw Dr. Flaming on July 17, 1995. Claimant told Dr. Flaming that, on July 10, he had the onset of pain while working and then had inflammation. (Ex. 5). Claimant also said that he "was not sure what happened" and Dr. Flaming discussed how claimant "might have initiated a skin infection * * * or perhaps even a bug bite." (Id.) Dr. Flaming also diagnosed cellulitis. (Id.)

Dr. Flaming later indicated that etiology of the cellulitis was "unknown" and "not determined conclusively." (Ex. 10-2). Dr. Tilley also indicated that etiology was "unknown" and that claimant "did not specifically report onset of pain at work to me." (Ex. 11-2).

We have held that medical evidence showing that etiology cannot be determined renders the case medically complicated. Kevin R. Ritchey, 48 Van Natta 1847, 1848 (1996). We have done so on the basis that we lack the expertise of a medical physician and, thus, it is not proper for us to supplant that judgment and find a situation uncomplicated. Id. Here, the majority fails to follow that holding. The medical evidence shows only that etiology is "unknown." Consequently, the physicians did not find that claimant's cellulitis was obviously caused by work. I cannot understand why the majority thinks it has the expertise to nonetheless find to the contrary.

Simply put, this case does not qualify as uncomplicated under the Barnett factors. Furthermore, because the medical evidence shows that causation is unknown, claimant did not carry his burden of proving compensability. ORS 656.005(7)(a). Thus, I would affirm the ALJ.

In the Matter of the Compensation of
JOSE L. VILLEGAS, Claimant
WCB Case No. 96-09207
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order which determined that the Hearings Division had jurisdiction to determine the rate of claimant's temporary disability. On review, the issue is jurisdiction.

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

SAIF closed claimant's compensable left foot claim by Notice of Closure of April 30, 1996, awarding temporary disability from October 27, 1995 through January 16, 1996. (Ex. 10). Although the closure notice did not specify claimant's temporary disability rate, SAIF apparently paid temporary disability based on an average weekly wage of $163.66. (Ex. 5A). Claimant requested reconsideration, indicating disagreement with the duration of the temporary disability award, but not with the rate at which his temporary disability was paid. (Ex. 10A).

A September 10, 1996 Order on Reconsideration awarded temporary disability for two additional days (until January 18, 1996). (Ex. 12). Claimant requested a hearing, seeking three more days of temporary disability (through January 21, 1996), as well as an increase in his temporary disability rate. SAIF argued that the ALJ lacked jurisdiction to decide the rate issue because claimant had failed to raise the issue during the reconsideration process. See ORS 656.283(7).

The ALJ determined that the Hearings Division had jurisdiction over the rate issue, even though it had not been raised at reconsideration. The ALJ reasoned that, unlike William Masters, 48 Van Natta 1788 (1996), the rate issue in this case arose out of the reconsideration order. The ALJ then awarded temporary disability through January 21, 1996 as claimant requested, based on an average weekly wage of $427.

On review, SAIF asserts that Masters is controlling and that the ALJ should have dismissed that portion of the hearing request concerning the rate of temporary disability because claimant failed to raise that issue during the reconsideration of the April 30, 1996 Notice of Closure. For the following reasons, we disagree with SAIF's contentions.

In requesting reconsideration from a Notice of Closure (NOC), the claimant in Masters had submitted a Director's form which identified the issue as "temporary total disability (TTD) or temporary partial disability (TPD) dates" along with a cover letter expressly contesting the medically stationary date found in the NOC. At the hearing concerning the eventual Order on Reconsideration (which did not modify the offset authorization or address the rate of claimant's TTD), the claimant challenged the

carrier's calculation of his TTD. The ALJ held that the claimant was precluded from contesting the rate of his temporary disability benefits at a hearing regarding an Order on Reconsideration because he had not raised that issue during the reconsideration proceeding.

On review in Masters, the claimant did not contend that he was not required to raise the rate issue at the reconsideration proceeding. Instead, the claimant argued that he had raised the issue during the reconsideration proceeding by checking "yes" on the box identifying temporary disability benefits as an issue on the request for reconsideration form. We rejected that argument. Moreover, in response to the dissent's contention that the claimant was not required to request reconsideration on the rate issue, we noted that the claimant had not asserted such a position on review. However, even if he had, we disagreed with the dissent's contention that the rate issue did not arise out of closure of the claim. We noted that the NOC awarded temporary disability benefits for the period of "7-26-94 through 10-14-94," and approved an offset against any overpaid benefits. Subsequent to the Notice of Closure and before the Order on Reconsideration, the carrier notified the claimant that, for the period "July 26, 1994 through July 31, 1994," the time-loss rate had been based on incorrect wage information. The carrier further informed the claimant of the total overpayment amount which would be deducted from future benefits. Under those circumstances, we concluded that the rate issue clearly arose from claim closure.

Unlike Masters, where the carrier made claimant aware of an alleged discrepancy in his temporary disability rate prior to the reconsideration proceedings, no dispute regarding the temporary disability rate arose prior to the reconsideration proceedings in this case. In addition, the closure notice in this case did not recite the temporary disability rate. Therefore, we conclude that the rate issue did not arise from the claim closure. Instead, we find that the rate issue arose after the reconsideration order awarded claimant two additional days of temporary disability and SAIF paid those benefits based on the weekly wage of $163.66, prompting claimant to request a hearing challenging SAIF's claim processing. Accordingly, under the circumstances of this case, we find that claimant was not required to raise the rate issue during reconsideration.[1]

Inasmuch as we have not disallowed or reduced claimant's compensation on review, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by 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 31, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by SAIF.

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[1] In Ferral C. Crowder, 48 Van Natta 2322 (1996), we held that, since the claimant had not challenged the rate of his unscheduled permanent disability (PPD) award granted by a Determination Order (DO) during the reconsideration proceeding, he was precluded from raising the issue at hearing. In awarding the claimant unscheduled PPD, the DO specified a dollar amount which was equivalent with a rate of $100 per degree. Following the claimant's reconsideration request, an Order on Reconsideration affirmed the DO's unscheduled PPD award and granted scheduled PPD. At hearing, the claimant contended that his PPD awards were payable at the higher rates set forth in amended ORS 656.214. We rejected claimant's contention, insofar as it pertained to the unscheduled PPD award. Inasmuch as it was apparent from the DO that the claimant's unscheduled PPD award had been calculated at a certain rate, we reasoned that it was incumbent on the claimant to have raised his objection during the reconsideration proceeding. We find Crowder distinguishable because, unlike that case where the PPD rate could be readily determined from the DO, the closure notice in this case did not specify claimant's temporary disability, nor could the rate be determined from the information contained in the document. (Ex. 10).

In the Matter of the Compensation of
CHARLES BERTUCCI, Claimant
WCB Case No. 96-03524
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) upheld the self-insured employer's partial denial of claimant's hearing loss incurred after September 24, 1984, the date claimant retired; and (2) found that claimant's current need for hearing aids was caused in major part by presbycusis. On review, the issues are compensability and medical services. We affirm in part and vacate in part.

FINDINGS OF FACT

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

Claimant's date of birth is October 15, 1929. In 1949, claimant began working at Hult Lumber Company and continued to work at the plant after it was purchased in 1972 by Roseburg Lumber Company, the employer in the present case. In 1984, claimant sustained a disabling back injury and never fully returned to work. On September 24, 1984, claimant retired. After his retirement, claimant was not exposed to work-related noise.

In 1995, claimant noticed hearing problems and was tested at a commercial hearing aid office. The results showed that claimant had a significant hearing loss, and hearing aids were recommended. On November 9, 1995, claimant filed a claim for bilateral hearing loss.

On February 29, 1996, the employer formally accepted claimant's "claim for industrial hearing loss incurred prior to 9/24/84." (Ex. 11). The employer expressly denied the compensability of "any hearing loss incurred subsequent to that date as well as any disability or need for treatment related to any subsequently incurred hearing loss." Id. Claimant filed a request for hearing on this partial denial.

On March 5, 1996, the employer issued a Notice of Closure awarding claimant 3.81 percent binaural hearing loss. (Ex. 12). This award was based on hearing tests conducted on October 28, 1983, the last test conducted before claimant's retirement. In calculating this award, the employer deducted the presbycusis factor relevant for claimant's age at the date of testing. (Exs. 8-8, 8-11, 12-5). Claimant did not file a request for reconsideration regarding this Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant has an accepted claim for noise-related binaural hearing loss incurred through the date of his retirement. The ALJ found that claimant failed to establish that his hearing loss incurred after his retirement was a compensable occupational disease. On review, claimant argues that the hearing loss incurred after his retirement is part of his compensable occupational disease claim. We disagree.

Due to the passage of time since claimant's retirement, we find that the causation issue in this case is a complex medical question which requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Dr. Owens, treating otolaryngologist, and Dr. Ediger, examining audiologist, provided the only medical opinions regarding the cause of claimant's post-retirement hearing loss.

Dr. Ediger opined that claimant's hearing loss since his retirement is due to presbycusis because claimant was not exposed to work-related noise after he retired. (Exs. 13-1, -2). Ediger explained that noise induced hearing loss is not progressive, i.e., once the noise exposure is eliminated, the noise-induced hearing loss ceases. (Ex. 13-2). Therefore, Dr. Ediger opined, all hearing loss incurred by claimant after retirement was not caused by his work exposure at the employer. Id.

Dr. Owens agreed, stating that "[s]ince [claimant] was not exposed to significant noise during the past 12 years [since his retirement,] it is reasonable to assume that the further deterioration was due to presbycusis." (Ex. 14-1). Dr. Owens also stated that claimant's hearing loss due to work-related noise exposure constituted a "material and significant part of [claimant's] current hearing loss." (Ex. 14-1-2). However, that statement does not support a finding that claimant's post-retirement hearing loss is related to industrial noise exposure.

Based on this record, we find that claimant has established no connection, material or otherwise, between his work-related noise exposure and the additional hearing loss he sustained after retiring. Therefore, the post-retirement hearing loss is not compensable as an occupational disease or under any other theory.

On review, claimant relies on Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996), to argue that the employer is precluded from denying his current hearing loss. In this regard, claimant notes that Dr. Ediger opined that claimant's hearing loss was caused in major part by noise exposure up until 1973 and that presbycusis was the major contributing cause of claimant's hearing loss from 1973 to 1984 (and to 1995). However, claimant notes, the employer accepted the claim through September 24, 1984 and awarded claimant 3.81 percent permanent disability based on audiology readings from October 28, 1983. Based on these facts, claimant argues "that the employer has accepted the alleged preexisting presbycusis as a compensable part of the claim and that the employer is now precluded from denying claimant's hearing loss" under Messmer. (Appellant's Brief, page 4). We disagree.

In Messmer, 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), 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.

Whether an acceptance occurs is an issue of fact. SAIF v. Tull, 113 Or App 449, 454 (1992). Whatever Dr. Ediger's opinion regarding the cause of claimant's hearing loss prior to claimant's retirement, the fact is that the employer accepted claimant's "claim for industrial hearing loss incurred prior to 9/24/84," the date of claimant's retirement. (Ex. 11). Thus, the employer did not explicitly accept hearing loss due to presbycusis. Moreover, in rating impairment due to this accepted condition, the employer used the most recent hearing test results prior to claimant's retirement (the October 28, 1983 tests) and deducted the presbycusis factor from those results. (Exs. 8-8, 8-11, 12-5). Therefore, the employer did not award any disability for claimant's presbycusis. Accordingly, Messmer does not apply to preclude the employer from denying presbycusis-related hearing loss incurred after retirement.

Medical Services

The ALJ held that the major contributing cause of claimant's need for hearing aids is presbycusis, not the accepted work-related hearing loss. Claimant argues that he need only establish a material contributing cause for ongoing medical services for a compensable condition. Based on the following reasoning, we find that jurisdiction over this medical services issue lies with the Director.

Subsequent to the ALJ's order, the court issued SAIF v. Shipley, 147 Or App 26 (1997), in which it held that, in a dispute concerning only the compensability of medical services (and not the compensability of the "underlying claim"), exclusive jurisdiction to review the dispute rested with the Director under ORS 656.245(6).[1] See Johnny R. Johnson, 49 Van Natta 628 (1997) (applying Shipley, Board found medical bill dispute which pertained to medical services for an accepted condition subject to jurisdiction of the Director under ORS 656.245(6), even though the claimant had filed an aggravation claim (the denial of which was upheld in litigation); medical bill was not encompassed within the aggravation claim or aggravation denial).

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[1] ORS 656.245(6) provides:

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

Here, the employer accepted claimant's noise-related hearing loss through the date of his retirement and denied any hearing loss incurred after that date. We have upheld the partial denial of the post-retirement hearing loss. Although the post-retirement hearing loss has been denied, the pre-retirement, noise-related hearing loss remains accepted. Therefore, pursuant to ORS 656.245(6), exclusive jurisdiction of the medical services issue rests with the Director. Shipley, 147 Or App at 29; Johnson, 49 Van Natta at 629.

ORDER

The ALJ's order dated March 12, 1997 is affirmed in part and vacated in part. That portion of the ALJ's order which addressed the medical services issue is vacated. The remainder of the order is affirmed.

In the Matter of the Compensation of
ANASTASIA C. COURIS, Claimant
WCB Case No. 96-05171
ORDER ON REVIEW
Heiling, Dodge, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order which: (1) did not admit "post-reconsideration" evidence on the issue of premature claim closure; and (2) determined that claimant's low back injury claim had not been prematurely closed. On review, the issues are evidence and premature closure.

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

Claimant contends that evidence not submitted in the reconsideration proceeding under ORS 656.268 should be admissible on the issue of whether her claim was prematurely closed. The self-insured employer responds that the issue was not properly raised before the ALJ and that we should, therefore, not address the issue.

We need not determine whether the employer's contention is correct. That is, even if claimant properly raised the evidentiary issue, we would conclude that "post-reconsideration" evidence is not admissible on the premature claim closure issue. In Arlie B. Tompkins, 48 Van Natta 1664 (1996), we concluded that, under amended ORS 656.283(7), evidence not submitted at reconsideration concerning the claimant's medically stationary status at the time of claim closure was statutorily inadmissible at a subsequent hearing. See also Jeffrey L. Scott, 49 Van Natta 503 (1997) (following Tompkins). Therefore, we reject claimant's argument that evidence at the hearing should not have been limited to evidence considered in the reconsideration proceeding.[1]

ORDER

The ALJ's order dated April 14, 1997 is affirmed.

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[1] Claimant asserts that she should be allowed to at least request "clarification" of evidence submitted at the reconsideration proceeding. We decline to allow her to do so because such "clarification" would still constitute evidence not submitted at the reconsideration proceeding. As previously noted, such evidence is inadmissible at a hearing on premature claim closure. Arlie B. Tompkins, 48 Van Natta 1665.

In the Matter of the Compensation of
JERRY L. BLISS, Claimant
WCB Case No. 96-09525
ORDER ON REVIEW
Neil Jackson, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests, and the insurer cross-requests, review of Administrative Law Judge (ALJ) Neal's order that affirmed an Order on Reconsideration that awarded 13 percent (41.6 degrees) unscheduled permanent disability for a dermatitis condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDING OF FACT

We adopt the ALJ's findings of fact with the following supplementation. After claimant had been taken off work from his job as a machinist for about four months by his treating physician, Dr. Weiss, the signs and symptoms of his dermatitis resolved. (Exs. 9, 14, 15). However, Dr. Weiss recommended that claimant be retrained to work in an occupation other than machinist because if claimant returned to work as a machinist with exposure to even small amounts of cutting oils, tramp oils, and coolants, the dermatitis would recur within a matter of days. (Exs. 11, 25).

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed an Order on Reconsideration that awarded 13 percent unscheduled permanent disability for claimant's dermatitis condition. On review, claimant argues that he is entitled to 81 percent unscheduled permanent disability for this condition and the insurer argues that claimant is entitled to no permanent disability.

Claimant worked for the employer as a machinist for three months. He had no history of skin disease or dermatitis prior to working for the employer. Several weeks before October 1995, claimant developed skin irritation on his arms, neck and face after a job change required him to work with liquid coolants. Gloves and topical creams did not help. On October 4, 1995, claimant sought treatment with Dr. Key, who treated him for allergic contact dermatitis. (Ex. 3). After Dr. Key recommended that claimant avoid work involving exposure to coolants, his condition improved. However, after returning to his regular job, claimant had a flare-up of dermatitis.

On December 26, 1995, the insurer accepted nondisabling "dermatitis - bilateral forearms and lateral neck rash." (Ex. 7). The insurer subsequently amended its acceptance, reclassifying the accepted condition as "disabling." (Ex. 12). In January 1996 and thereafter, claimant treated with Dr. Weiss, dermatologist. Testing revealed claimant reacted to Phenylenediamine, Blasco Cut, tramp oils, and Blaser 4000, products claimant used in his work as a machinist. Dr. Weiss advised claimant to avoid working around coolants.

Claimant was moved to a different milling machine with less exposure to coolants, but he continued to have severe dermatitis involving the forearms. (Ex. 9-2). Claimant was taken off work for periods of two weeks and ten days, which improved his condition. However, after returning to machinist work, claimant developed a severe flare-up of dermatitis. (Ex. 9-3). Dr. Weiss then took claimant off work for three months. Id. After being off work for several months, the signs and symptoms of claimant's dermatitis had resolved and Dr. Weiss found claimant medically stationary. Dr. Weiss recommended that claimant seek retraining in an occupation other than machinist to avoid recurrence of the dermatitis.

On August 6, 1996, the claim was closed by Determination Order that awarded temporary disability but no permanent disability. Claimant requested reconsideration, but did not object to the impairment findings, so no medical arbiter was appointed. On September 26, 1996, an Order on Reconsideration issued awarding 13 percent unscheduled permanent disability and affirming the Determination Order in all other respects. The ALJ agreed with the Appellate Reviewer that claimant's dermatitis prevented some regular work related activities. Thus, the ALJ determined claimant was entitled to 8 percent impairment pursuant to former OAR 436-035-0450(1)(b), and affirmed the 13 percent unscheduled permanent disability award made by the Order on Reconsideration.

On review, the insurer argues that claimant failed to meet his burden of proving any impairment due to the compensable condition. In support of this argument, the insurer contends that it accepted only a "transient skin disorder" and claimant failed to establish any permanent impairment due to this transient condition. We disagree.

The insurer accepted disabling "dermatitis - bilateral forearms and lateral neck rash." (Exs. 7, 12). Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). While a carrier may properly accept a "transient condition," see Russell J. Penturf, 48 Van Natta 2219 (1996), we do not find that, here, the insurer issued such an acceptance. Instead, the clear language of the insurer's acceptance establishes that it accepted "dermatitis." Contrary to the insurer's argument, the fact that the acceptance includes the description "bilateral forearms and lateral neck rash" does not indicate that the insurer merely accepted a transient skin condition. Furthermore, the acceptance does not exclude any particular type of dermatitis. Instead, it simply accepts "dermatitis" and adds the description "bilateral forearms and lateral neck rash." Accordingly, we find the accepted, compensable condition includes "dermatitis."

To be entitled to permanent disability compensation for his dermatitis, claimant must establish that the impairment is due to his compensable condition. ORS 656.214(5); 656.266. Under former 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)." Former OAR 436-035-0007(1) provides, in 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 compensable injury or disease including the compensable condition, a consequential condition and direct medical sequelae."

Following patch testing, which included the liquids to which claimant was exposed at work, Dr. Weiss opined that claimant had both allergic and irritant contact dermatitis. (Exs. 9, 11). The insurer argues that no medical evidence establishes that "allergic" means an "immunological response" or "impairment of the immune system." Therefore, the insurer argues, there is insufficient evidence to conclude that former OAR 436-035-0450[1] applies to rate claimant's impairment. We disagree.

Based on the following reasoning, we find that the rules themselves determine that former OAR 436-035-0450 applies to this claim. Former OAR 436-035-0110(5) provides that "[c]ontact dermatitis of an upper extremity is rated in this section unless it is an allergic systemic reaction, which is rated pursuant to former OAR 436-035-0450." Here, claimant has both allergic and irritant contact dermatitis. Therefore, we find that his condition is rated under former OAR 436-035-0450.

Finding that claimant's reaction prevented some of his regular work, the ALJ found claimant entitled to 8 percent impairment pursuant to former OAR 436-035-0450(1)(b). Claimant argues that he is entitled to 13 percent impairment pursuant to former OAR 436-035-0450(1)(c) because his reaction prevents him from performing most of his regular work activities. We agree. Dr. Weiss recommended that claimant be retrained to perform an occupation other than machinist because, if claimant returned to work as a machinist, the dermatitis would return within a matter of days and would significantly interfere with work related activities as long as claimant maintained employment as a machinist. We find Dr. Weiss' unrebutted opinion establishes that claimant's reaction prevents him from performing most regular work activities. Former OAR 436-035-0450(1)(c).

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[1] Former OAR 436-035-0450 provides:

"(1) When exposure to physical, chemical, or biological agents has resulted in the development of an immunological response, impairment of the immune system shall be valued as follows:

"(a) 3% when the reaction is a nuisance but does not prevent most regular work related activities; OR,

"(b) 8% when the reaction prevents some regular work related activities; OR,

"(c) 13% when the reaction prevents most regular work related activities."

Furthermore, we find that Dr. Weiss relates the permanent impairment to the compensable dermatitis condition and his employment as a machinist. (Ex. 25). Although Dr. Weiss initially stated that claimant did not have any disability, he consistently opined that claimant could not return to his regular work with exposure to the chemicals causing his dermatitis and recommended retraining for another profession. (Exs. 11, 13, 15, 16). However, when Dr. Weiss later considered this limitation in considering whether claimant had permanent disability, he concluded that claimant has a "Class III impairment" related to chronic dermatitis and "associated with his employment as a machinist." (Ex. 25). We disagree that claimant has established a "Class III impairment" pursuant to former OAR 436-035-0440(2), as later explained in the body of our opinion. However, we find that Dr. Weiss' opinion as a whole establishes that claimant has permanent disability due to the compensable condition. Here, Dr. Weiss' impairment findings are consistent with claimant's compensable dermatitis condition and he does not attribute the impairment to causes other than the compensable condition. Therefore, we find the impairment is due to the compensable condition.

Claimant argues that he is also entitled to impairment pursuant to former OAR 436-035-0440. We adopt the ALJ's reasoning and conclusions regarding this argument with the following supplementation. The ALJ addressed this argument in the next to the last paragraph of her opinion. We change the second and third rule citations to read "former OAR 436-035-0440." In addition, by its terms, former OAR 436-035-0440(2) requires that "signs or symptoms of skin disorder are present." Here, Dr. Weiss stated that the "signs and symptoms" of claimant's dermatitis had resolved following his removal from exposure to cutting oils, lubricants and other chemicals on his job as a machinist. (Ex. 25). Therefore, for these reasons, in addition to those addressed by the ALJ, we find that former OAR 436-035-0440 does not apply to claimant's claim.

Accordingly, claimant has 13 percent impairment due to his compensable dermatitis condition. This results in an adaptability factor of 2. OAR 436-035-0003(3); 436-035-0310(8) (WCD Admin. Order 96-072). Claimant is over 40, which results in an age factor of 1. Former OAR 436-035-0290. His formal education factor (0) is added to his skills factor (4), resulting in a total education factor of 4. Former OAR 436-035-0300(2), (5), and (6). Adding the age factor (1) and the education factor (4), results in the sum of (5), which is multiplied by the adaptability factor (2), for a total nonimpairment value of 10. This value is added to the impairment value (13), for a total award of 23 percent unscheduled permanent impairment. Former OAR 436-035-0280.

Accordingly, we modify the ALJ's order. In lieu of the ALJ's and the reconsideration order's award of permanent disability, claimant is awarded 23 percent unscheduled permanent disability.

Because we have modified the ALJ's order which affirmed the unscheduled award made by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is entitled to an attorney fee in the amount of 25 percent of the increased compensation created by this order, not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1).

Inasmuch as the insurer appealed the ALJ's order and we have not reduced or disallowed claimant's compensation as granted by the ALJ's order, 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 $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 reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 23, 1997 is modified. In addition to the ALJ's and Order on Reconsideration's award of 13 percent (41.6 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, giving him a total award of 23 percent (73.6 degrees) unscheduled permanent disability for the dermatitis condition. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
LYNN M. BROWN, Claimant
WCB Case No. 96-05732
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock and Haynes.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On December 14, 1995, three men entered the convenience store in which claimant was employed as a cashier/clerk. When one of the men attempted to leave the store without paying for some beer, claimant confronted the individual. One of the other men struck claimant in the face, breaking her glasses. Claimant also sustained a laceration under the left eye, which required emergency room treatment. (Ex. 2).

Before claimant received medical treatment, she made a statement to responding police officers. Claimant positively identified the perpetrators of the assault before being taken to the emergency room. The officers noted her deep laceration and bruise on her left cheek. (Ex. 4A-12). After police apprehended the men involved in the robbery and assault, claimant testified at the criminal trial of one of the men, which resulted in a conviction and 70-month jail sentence. The other suspect skipped bail and had not yet been apprehended.

Claimant returned to regular work a week after the assault. SAIF accepted a nondisabling claim for a laceration and left cheek contusion.

In March 1996, claimant treated with her family physician, Dr. Schwerzler, for her facial injuries. Diagnosing "post traumatic stress syndrome," Dr. Schwerzler referred claimant to a psychologist, Dr. Malone, after claimant expressed anxiety, fear, and depression when she had to work alone. (Ex. 16). Dr. Malone diagnosed post traumatic stress disorder (PTSD). (Ex. 18).

SAIF denied the PTSD condition on May 23, 1996. Claimant appealed the denial.

The ALJ upheld SAIF's denial of claimant's mental disorder claim, reasoning that claimant failed to prove that she had a diagnosable mental disorder. See ORS 656.802(3)(c). In making this compensability determination, the ALJ relied on the medical opinion of examining psychiatrist Dr. Klecan, who opined that claimant did not meet the diagnostic criteria for PTSD (Ex. 22),[1] over the opinions of Dr. Schwerzler and Dr. Malone.

Asserting that we should give the greatest weight to the opinions of the treating doctors, claimant contends on review that a preponderance of the medical evidence establishes the diagnosis of PTSD resulting from the assault. We agree.

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[1] Dr. Klecan opined that claimant presented an "embellished" claim, noting that her ability to work for three months after the assault was very consistent with a relatively mild degree of trauma. Moreover, Dr. Klecan stated that claimant had developed an array of "implausible, actually impossible, symptoms for which there is no medical explanation." Noting that it was currently popular to invoke PTSD as a diagnosis, Dr. Klecan asserted that PTSD is a condition which only follows "extraordinary psychological trauma which includes an experience of being held in helpless terror." Dr. Klecan emphasized that claimant's assault was not of sufficient severity to merit the diagnosis. Dr. Klecan also attended the hearing and listened to claimant's testimony. His testimony again emphasized that the trauma claimant experienced could not have caused PTSD. (Tr. 89, 90, 94).

To establish the compensability of a mental disorder, claimant must prove that employment conditions were the major contributing cause of the disorder. ORS 656.802(2)(a). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment, or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

The primary issue in this case is whether, as a result of the work-related assault, claimant developed a generally recognized mental or emotional disorder. Stated differently, did claimant develop PTSD as a result of the December 14, 1995 assault?

Here, the medical opinions are divided into two camps: both Dr. Malone and Dr. Schwerzler believe that claimant meets the diagnostic criteria for PTSD; Dr. Klecan does not. However, when the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).[2] In this case, we conclude there are no persuasive reasons not to defer to the opinion of the attending physicians that claimant developed PTSD after being assaulted at work.

Dr. Schwerzler, who treated claimant's physical injuries, noted that claimant was experiencing anxiety, fear and depression when she was required to work alone after the assault. (Ex. 16). Dr. Schwerzler referred claimant to Dr. Malone for treatment for "post-traumatic stress syndrome." Id. Dr. Schwerzler later reiterated his diagnosis, emphasizing his opinion that claimant met the diagnostic criteria for the psychological condition. (Ex. 30).

The ALJ discounted Dr. Schwerzler's opinion as to the diagnosis of claimant's psychological complaints due to his lack of psychiatric/psychological expertise. However, that a physician is not a specialist does not mean that his opinion is not entitled to any weight. See Barrett v. Coast Range Plywood, 294 Or 641, 649 (1983); Lucille G. Major, 47 Van Natta 617, 618 (1995); Keith J. Prondzinski, 46 Van Natta 290, 291 (1994). Accordingly, we conclude that Dr. Schwerzler's provides some probative evidence to support claimant's argument that she does have a diagnosable mental disorder, namely, PTSD.

Dr. Malone, in a August 25, 1996 report, confirmed his opinion that claimant had PTSD. In that report, Dr. Malone took issue with the report of Dr. Klecan, who opined that claimant did not meet the diagnostic criteria for PTSD. (Ex. 32). Dr. Malone specifically noted that the first sentence of the DSM-IV stated that the essential feature of PTSD was the development of characteristic symptoms following exposure to extreme traumatic stressors involving a direct personal experience of an event involving threatened death or serious injury. Id. Noting that physical attacks and muggings were listed as examples of traumatic events, Dr. Malone concluded that claimant had experienced a threatened serious injury. Id.

Finally, in contrast to Dr. Klecan, Dr. Malone stated that claimant's ability to function in the environment in which the trauma occurred and her lack of emotion in recounting her trauma were consistent with the PTSD diagnosis. (Ex. 32). Dr. Malone concluded: "Overall, I can respect that there are divergent ways of looking at many situations. I know people do fabricate symptoms. However, every line of reasoning Dr. Klecan uses to support fabrication is faulty. Moreover, my experience with [claimant] is that she was genuinely struggling with difficult feeling." Id.

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[2] Even if this case depended more on expert analysis, rather than expert external observation such as that which an attending doctor provides, see Allie v. SAIF, 79 Or App 284, 287 (1986), we would still conclude that claimant satisfied her burden of proof based on the medical opinions of the attending physicians.

Because Dr. Malone's opinion is thorough and well-reasoned, and because it is based on extensive familiarity with claimant's psychological symptoms, we find it persuasive.[3] See Somers v. SAIF, 77 Or App 259, 263 (1986). Moreover, we find it considerably more persuasive than Dr. Klecan's opinion.

First, Dr. Klecan only examined claimant on one occasion and hence has less familiarity with claimant's psychological complaints than either Dr. Malone or Dr. Schwerzler. Second, Dr. Klecan discounts claimant's assault as not of sufficient severity to merit the PTSD diagnosis. However, that opinion appears to be contradicted by the DSM-IV, which, according to Dr. Malone, lists muggings and physical assault as events that can cause PTSD. Moreover, we are not persuaded by Dr. Klecan's opinion given the nature of the assault and the surrounding circumstances. Claimant required emergency room treatment (which was delayed while she gave a statement to the police) and considerable follow-up medical treatment for her injuries. She also had to identify her assailants and participate in a criminal trial. In addition, claimant had to work alone at night in an unlocked store while one of the robbers was still at large. Considering the severity of claimant's injuries and the aftermath of the assault, we find that Dr. Klecan seriously underestimated the impact of the assault on claimant.

In conclusion, we find that claimant satisfied her burden of proving that she suffered a compensable mental disorder (PTSD) as a result of a work-related assault on December 14, 1995. Since, there is no dispute that claimant's psychological claim satisfies the other statutory criteria in ORS 656.802(3), we reverse the ALJ's decision upholding SAIF's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $7,827.50, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's attorney's statement of services, and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 7, 1996 is reversed. SAIF's denial of claimant's mental disorder claim is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $7,827.50, to be paid by SAIF.

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[3] The dissent argues that Dr. Malone's opinion is not persuasive because he did not consider the impact of potential off-the-job stressors such as claimant's gambling debts, bankruptcy and marital difficulties. However, we do not find this to be a fatal flaw in Dr. Malone's opinion because claimant's marital problems had either resolved or improved significantly at the time of the assault and thereafter (claimant's husband was in the store when she was attacked and spent time with claimant in the store after the assault) and claimant's financial difficulties had improved. (Tr. 60, 61).

Board Member Haynes dissenting.

The majority concludes that claimant developed post traumatic stress disorder (PTSD) as a result of being struck in the face after she tried to prevent two men from shoplifting. Because this record does not support the majority's conclusion, I must dissent.

At the outset, I wish to emphasize that I do not condone the conduct of the person who struck claimant. Moreover, I do not doubt that this incident was disturbing to claimant, as I am sure it would be to anyone. Having said this, I nevertheless do not understand how the majority could conclude that this assault led to PTSD, a diagnosis that pertains to the most extraordinary psychological trauma.

The facts surrounding claimant's injury are simply stated. Claimant was attempting to prevent some relatively minor shoplifting when she confronted one of two men who were about to leave the convenience store without paying for some beer. Neither of the men were armed. One of the men suddenly struck claimant in the face, breaking her glasses and causing a deep laceration under the left eye. Both men quickly fled the scene. The assault itself lasted a matter of seconds.

In determining that this incident caused PTSD, the majority finds the medical opinions of Dr. Schwerzler, claimant's family physician, and Dr. Malone, a psychologist, more persuasive that Dr. Klecan, the examining psychiatrist. However, the medical evidence on which the majority relies is seriously flawed.

As the ALJ correctly noted, Dr. Schwerzler has no expertise in dealing with psychological disorders. Moreover, his records demonstrate a fundamental misunderstanding of the nature of the assault. In his March 9, 1996 chart note, Dr. Schwerzler reports that claimant was "held up at gunpoint." (Ex. 24). If Dr. Schwerzler was accurately reporting what claimant told him, then this supports Dr. Klecan's view that claimant was embellishing or fabricating her psychological symptoms because there is no evidence that claimant was held up at gun point or that any weapon was involved. At the very least, the chart note demonstrates that Dr. Schwerzler had an inaccurate history which requires that his opinion be discounted. Miller v. Granite Construction Co., 28 Or App 470 (1977); Steven R. Lewis, 49 Van Natta 327, 329 (1997).

Dr. Malone's opinion is also seriously deficient. As the ALJ noted, Dr. Malone demonstrated no awareness of significant off-the-job stressors involving claimant's marital problems, gambling debts and financial difficulties. (Ex. 32). Claimant admitted on cross-examination that her financial problems continued after her assault. (Tr. 47). Although claimant testified that her financial situation improved, it is clear that she still owed thousands of dollars in gambling debts. (Tr. 52). It is therefore clear that Dr. Malone was unaware of potentially significant of-the-job stressors. Despite this, the majority overlooks the legion of cases which clearly hold that, to be persuasive, a medical opinion must be based on a complete and accurate history. E.g., Patricia A. Dropinski, 49 Van Natta 206, 209 (1997). I respectfully suggest that the majority errs in finding the attending physicians' opinions persuasive, when those doctors lacked the most fundamental information about claimant's personal life.

Finally, I find Dr. Klecan's opinion that PTSD is an overused diagnosis and does not apply in this case to be very persuasive. It appears that the majority has all too willingly embraced a diagnosis that is clearly not justified by the severity of the assault. Dr. Klecan explained in his April 25, 1996 report that, while it is currently popular to invoke PTSD as a diagnosis, this is in actuality a condition that follows "extraordinary psychological trauma which includes an experience of being held in helpless terror." (Ex. 22-11). Dr. Klecan convincingly reasoned that being struck in the face, an incident that took a matter of seconds, can hardly be compared to being held a prisoner of war, being tortured or witnessing a violent death, which were examples of the kind of extreme psychological trauma that can lead to PTSD. Id.

Dr. Klecan also noted other evidence in this case that militated against a diagnosis of PTSD. Dr. Klecan reported that claimant mentioned symptoms of PTSD only when asked leading questions. Id. According to Dr. Klecan, the symptoms claimant did mention were unconvincing and were unaccompanied by the corresponding affect of PTSD. (Ex. 22-12). Dr. Klecan could find no diagnosable psychiatric condition, noting that a diagnosis of PTSD was contradicted by both claimant's history and her objective findings. Id.

Even though Dr. Klecan only examined claimant one time, he attended the hearing and listened to claimant's testimony given under oath. Included in that testimony was information (apparently withheld from Drs. Schwerzler and Malone) regarding claimant's off-the-job stressors. Based on what he had seen and heard at hearing, Dr. Klecan testified that he would reach the same conclusions that he did in his written report. (Tr. 105). Therefore, even though Drs. Schwerzler and Malone may have had more office visits, it seems clear that Dr. Klecan had more complete and accurate information than either of those doctors.

On this record, I would find Dr. Klecan's opinion to be the most accurate and well-reasoned. It also makes the most sense from a lay perspective. The majority makes a grave mistake in discounting Dr. Klecan's opinion and accepting the diagnosis of PTSD. For this reason, I must respectfully dissent.

In the Matter of the Compensation of
DIANNE C. CARLSON, Claimant
WCB Case No. 96-04688
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Stoel Rives, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's right shoulder strain. Claimant cross-requests review of that portion of the ALJ's order that did not address the employer's denial of her right biceps tendinitis condition. On review, the issue is compensability. We reverse that portion of the ALJ's order concerning the right shoulder strain.

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 read: "Claimant compensably injured her low back on March 29, 1993, while moving luggage during her attendance at a professional conference in connection with her employment as a speech pathologist." In the eighth paragraph on page 2, we change the date in the first sentence to "July 31, 1996." We delete the last paragraph of the findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is a speech pathologist. On January 23, 1996, she reached into a cupboard at her workplace while preparing breakfast for a patient. She immediately developed pain in her right arm, shoulder, neck, leg and foot. She was treated by Drs. Conrad and Takacs.

The ALJ concluded that claimant's January 23, 1996 work incident was a material contributing cause of her right shoulder strain. The ALJ did not specifically address the employer's denial of the right biceps tendinitis condition.

The employer contends that the claim is not compensable because, in part, claimant failed to establish objective findings of an injury. Claimant argues that we should not consider the issue of objective findings because the employer raised the issue for the first time on review.

We need not address this issue because, even if we assume that claimant had "objective findings" of an injury, we conclude that she did not meet her burden of proving medical causation.

Right Shoulder Strain

The employer argues that the ALJ erred by not applying the major contributing cause standard under ORS 656.005(7)(a)(B) to this claim. The employer asserts that claimant's preexisting cervical condition is the major contributing cause of her need for medical care and treatment.

The record establishes that claimant had cervical disc disease that preexisted her January 23, 1996 injury. Claimant sought treatment for neck and shoulder symptoms on December 11, 1995. (Ex. 102). Dr. Takacs was concerned that claimant had osteoarthritis spurs in the neck with radicular symptoms and she ordered x-rays. (Id.) The cervical x-rays showed some foraminal narrowing in the C5, 6 area bilaterally. (Ex. 104). In a June 6, 1996 report, Dr. Takacs reported that claimant had cervical disc disease that preexisted the January 23, 1996 work incident. (Ex. 131).

In determining whether ORS 656.005(7)(a)(B) applies, we must determine whether claimant's preexisting cervical disc disease "combined" with her January 1996 injury to cause disability or a need for medical treatment. On June 6, 1996, Dr. Takacs reported that claimant's January 23, 1996 "strain from the shoulder girdle does cause a worsening of the pre-existing condition because of the muscle pull." (Ex. 131-2). We construe Dr. Takacs' report to mean that claimant's January 23, 1996 shoulder injury combined with her preexisting cervical disc disease to cause her disability or need for medical treatment. Dr. Kirschner also indicated that claimant's work activities may have exacerbated a preexisting condition. (Ex. 137-5).

Consequently, we conclude that this case is properly analyzed under ORS 656.005(7)(a)(B). Thus, claimant has the burden of proving that her January 23, 1996 work incident was the major contributing cause of the disability or need for treatment of the combined condition.

Claimant relies on Dr. Takacs' opinion to prove compensability. 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). While we generally defer to the opinion of the attending physician, see Weiland v. SAIF, 64 Or App 810 (1983), we find persuasive reasons not to do so in this case.

As we discussed earlier, claimant sought treatment for neck and shoulder symptoms before the January 23, 1996 work injury. On December 11, 1995, claimant sought treatment Dr. Takacs for neck and shoulder problems. Dr. Takacs reported:

> "Unrelated to [low back] work comp claim: She reports she feels as if there is weakness in her shoulders. 6 weeks ago she had a flu shot, there was discomfort in her left arm. She feels as if she has lost some strength in both arms. She has always been sensitive over the right ulnar nerve at the elbow since a child. If she moves quickly, she gets white lightening severe pain in the middle of her neck. Her sister has recently diagnosed as having Rheumatoid Arthritis and another sister as having Osteoarthritis." (Ex. 102).

Dr. Takacs found slight weakness in the left deltoid and with external rotation of the shoulder. (Id.) Claimant avoided neck extension because of pain. Dr. Takacs' concern was "osteoarthritis spurs in the neck with radicular symptoms." (Id.)

On January 23, 1996, claimant developed pain in the right arm, shoulder, neck, leg and foot at work. Dr. Conrad examined claimant on January 26, 1996, reporting that she had injured her shoulders about two weeks ago when reaching for a towel at work. (Ex. 104). Recent cervical x-rays showed some foraminal narrowing in the C5-6 area bilaterally. (Id.) Dr. Conrad diagnosed "cervical strain vs. cervical disc" and recommended an MRI. (Exs. 104, 105).

An MRI on February 3, 1996 revealed multi-level cervical disc bulges. (Ex. 106).

Claimant was examined by Dr. Takacs on February 20, 1996. Dr. Takacs referred to the January 23, 1996 work incident and diagnosed "[r]ight biceps tendinitis, new" and possible cervical radiculopathy. (Ex. 112).

Dr. Takacs subsequently changed her mind several times regarding claimant's diagnosis. On March 18, 1996, she diagnosed right biceps tendinitis and cervical thoracic strain. (Ex. 116). On April 11, 1996, Dr. Takacs diagnosed biceps and rotator cuff tendinitis, which had progressed to impingement due to her increased activity during the recent examination by Drs. Tesar and Mangum, and "[s]econdary cervical, thoracic, and rib somatic dysfunction as a result of scapular thoracic strains to pre-existing lumbosacral somatic dysfunction improved." (Ex. 120). On April 22, 1996, Dr. Takacs diagnosed biceps tendinitis, secondary cervical, thoracic and rib somatic dysfunction and scapula thoracic strain and "[p]reexisting degenerative disc disease, cervical bulge on MRI." (Ex. 124). On May 16, 1996, Dr. Takacs reported that claimant had biceps tendinitis with secondary adhesive capsulitis and "[c]ervical strain component resolving." (Ex. 129). On June 6, 1996, Dr. Takacs referred to claimant's diagnosis as "biceps, rotator cuff tendinitis with intermittent impingement and with secondary strain to the scapula/thoracic joint resulting in somatic dysfunction, cervical/thoracic spine, ribs and myofascial pain." (Ex. 131-1). On June 14, 1996, Dr. Takacs reported biceps, supraspinatus tendinitis "improved," "[s]econdary cervical/thoracic strain resolved?" and "[m]ild sacral somatic dysfunction (pre-existing)." (Ex. 132A). Approximately one month later, Dr. Takacs reported that claimant had "[i]mpingement syndrome developing adhesive capsulitis." (Ex. 133A).

Opinions regarding the cause of claimant's conditions were provided by Drs. Takacs, Kirschner, Tesar and Mangum.

Dr. Takacs explained that, because of claimant's preexisting cervical disc disease, she ordered an MRI and performed an EMG and determined that there was no nerve compromise at the neck. (Ex. 131). Dr. Takacs felt that all claimant's symptoms were due to the shoulder injury itself because claimant had not had this degree of tightness and spasm in the cervical/thoracic area before the shoulder

injury. (Ex. 131-2). Dr. Takacs concluded that claimant's current shoulder injury was directly related to the January 23, 1996 incident and that injury was the major contributing cause of claimant's current condition and need for treatment. (Id.) Dr. Takacs acknowledged that there was preexisting cervical disc disease and she commented that the "strain from the shoulder girdle does cause a worsening of the preexisting condition because of the muscle pull." (Ex. 131-2).

Dr. Kirschner, neurologist, examined claimant on July 31, 1996, and found claimant's office visit with Dr. Takacs on December 11, 1995 to be significant. (Ex. 137-1). Dr. Kirschner also noted that Dr. Conrad had referred to the onset of symptoms approximately two weeks earlier. Dr. Kirschner concluded:

> "The onset of [claimant's] symptoms cannot be readily attributed to the work-related activity because of the records suggesting symptoms preceding that activity. Furthermore, many of her symptoms may be related to degenerative disc disease. In addition to the well-documented disk disease in her cervical spine there are at least two chart notes that suggest she was having symptoms of discomfort in her neck and shoulders, on the one hand two weeks, and on the other over a month prior to the stated date of injury. This suggests that the actions at her work did not directly cause her neck and arm pain, though they may have exacerbated a preexisting condition." (Ex. 137-5).

Dr. Kirschner commented on claimant's psychological makeup as another important factor that may produce hypochondriacal behavior in claimant. (Id.) Moreover, he found that claimant's description of her symptoms immediately following the work incident seemed "peculiar" and "do not affect sensory pathways that are usually connected." (Ex. 137-6). Dr. Kirschner concluded that claimant's preexisting cervical degenerative disk disease was the major contributing cause for treatment. (Id.) In a subsequent report, he commented that there were "psychological factors of great significance that far outweigh her work activity in the cause of her symptoms." (Ex. 139).

On April 4, 1996, Drs. Tesar and Mangum examined claimant on behalf of the employer. They found no objective orthopedic or neurologic abnormality on physical examination and they diagnosed cervical degenerative disc disease, multiple levels, preexisting and unrelated to an industrial injury. (Ex. 119-7, -8). In a later report, Dr. Tesar reported that the major contributing cause for the development of symptoms "was the pre-existing condition, that is the patient's propensity to develop these pains when moving quickly and reaching due to the way she handles the everyday stresses of life." (Ex. 135-2).

After reviewing the aforementioned opinions, we are not persuaded by Dr. Takacs' opinion. Claimant had preexisting neck and arm symptoms for which she sought treatment prior to the January 23, 1996 work incident. She also had preexisting cervical degenerative disc disease. Dr. Takacs did not adequately explain why, in light of claimant's preexisting cervical disc disease, her work injury was the major contributing cause of claimant's current condition and need for treatment.

Moreover, Dr. Takacs' opinion is not persuasive because it is inconsistent. On the one hand, she reported that "all the symptoms were due to the shoulder injury itself." (Ex. 131-2). In the same report, however, she noted that claimant's shoulder strain caused a worsening of the preexisting cervical disc disease because of the muscle pull. (Id.) Dr. Takacs' comment that the injury caused a "worsening" of the cervical disc disease indicates that at least some of claimant's symptoms were due to the preexisting condition. However, Dr. Takacs opined that "all" of the symptoms were due to the injury, rather than the preexisting condition. In light of the apparent inconsistencies, we are not persuaded by Dr. Takacs' opinion.

In contrast, we are persuaded by Dr. Kirschner's well-reasoned opinion that claimant's preexisting cervical degenerative disk disease was the major contributing cause for treatment. We conclude that claimant's right shoulder strain condition is not compensable.

Right Biceps Tendinitis

Claimant contends that the employer's denial of her right biceps tendinitis condition should be set aside. On June 6, 1996, Dr. Takacs explained that the diagnosis related to claimant's January 23, 1996 injury was "biceps, rotator cuff tendinitis with intermittent impingement and with secondary strain to the scapula/thoracic joint resulting in somatic dysfunction, cervical/thoracic spine, ribs and myofascial

pain." (Ex. 131-1). Dr. Takacs opined that claimant's January 1996 work injury was the major contributing cause of her current condition and need for treatment. (Ex. 131-2). Dr. Takacs did not explain how claimant's work-related reaching incident on January 23, 1996 resulted in a tendinitis condition.

On the other hand, Drs. Tesar and Mangum found no evidence of a tendinitis condition. (Ex. 119-8). Similarly, Dr. Kirschner did not diagnose a right biceps tendinitis condition. (Ex. 137).

As we noted earlier, Dr. Takacs changed her mind several times regarding claimant's diagnosis. Nevertheless, even if we assume that Dr. Takacs correctly diagnosed tendinitis, we are not persuaded by her opinion for the reasons we discussed above. We conclude that claimant's right biceps tendinitis condition is not compensable.

ORDER

The ALJ's order dated September 9, 1996 is reversed. That portion of the ALJ's order that set aside the self-insured employer's denial of claimant's right shoulder strain condition is reversed. The employer's denial of claimant's right shoulder strain condition is reinstated and upheld. The employer's denial of claimant's right biceps tendinitis condition is upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
JANICE ROSSITER, Claimant
WCB Case No. 95-13187
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller, Bock and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and supplementation. We do not adopt the ALJ's ultimate findings of fact.

In July 15, 1992, claimant injured her low back while working for a previous employer. (Ex. AA-1). As a result of this injury, medication, rest and light duty work were prescribed. Claimant was scheduled for physical therapy. Before claimant could commence physical therapy, she reinjured her low back in a motor vehicle accident involving a collision with an elk. Id. As a result, claimant continued to be prescribed medication, was released from work and was prescribed bed rest for the next couple of days. On July 27, 1992, claimant was still on light duty and was prescribed physical therapy. (Ex. AA-2). On August 26, 1992, following a period of improvement, claimant returned for medical treatment, reporting a five to six day history of an acute exacerbation of low back symptoms. (Ex. AA-4). Claimant was subsequently limited to light duty work for two more weeks.

Claimant did not report these past low back injuries and treatment to her treating physicians for her current low back condition, Dr. Saks, M.D., Dr. Goldberg, M.D., and Dr. Miller, chiropractor.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinions of claimant's current treating physicians, Drs. Saks, Goldberg, and Miller, the ALJ concluded that claimant established a compensable lumbosacral injury claim. We disagree.

Claimant has the burden of proving a compensable claim. ORS 656.266. Here, claimant has preexisting L4-5 disc narrowing, prior low back injuries, and two incidents at work that allegedly contributed to her current low back condition. Therefore, the causation issue presents a complex medical question which must be resolved on the basis of expert medical evidence. Barnett v. SAIF, 122 Or App 281 (1993); Uris v. Compensation Dept., 247 Or 420, 426 (1967). However, medical evidence that is not based on a complete and accurate history is not persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

The opinions of Drs. Saks, Goldberg, and Miller support compensability of claimant's claim. However, for the following reasons, we find their opinions unpersuasive.

On October 9, 1995, claimant completed an 801 claim form indicating that she had fallen and injured her back on the right. (Ex. 1). Claimant checked a box indicating that she had not injured the same body part before. (Id.). Claimant subsequently completed a health history form indicating that she had previously suffered from myriad ailments including eye pain, skin trouble, irregular cycles, and tingling or numbness in her arms, legs and shoulders. However, she left unmarked the inquiry concerning prior low back pain. (Ex. 3A-1). Similarly, claimant signed the worker portion of an 827 claim form on July 10, 1995 that included a check mark indicating that she had not injured the same body part before. (Ex. 4). This form was signed by Dr. Miller. Further, a Macadam Clinic patient survey indicated that claimant had no prior history. (Ex. 7-3). Both Drs. Saks and Goldberg work at the Macadam Clinic. (Ex. 12). Moreover, claimant was referred to Portland Rehabilitation by Dr. Saks. Under the topic "Past Medical History" in the ensuing report, no mention was made of her prior slip and fall, although there was discussion of three other prior injuries. (Ex. 21-39).

Claimant informed Dr. Arbeene, during a November 2, 1995 insurer-arranged medical examination, that she fell at work four years earlier, but that "[s]he did not lose time from work, and she did not seek any medical evaluation * * *." (Ex. 5-3). It is not apparent from Dr. Arbeene's report that claimant informed the physician what body part was injured in her prior fall. Claimant similarly reported to Drs. Scheinberg and Rich, during a February 1996 insurer-arranged medical examination, that she previously fell at work in 1992 "but did not see a doctor and did not miss any work." (Ex. 17A-3). Again, there is no mention of what body parts may have been involved in the fall.

Dr. Saks' medical reports contain no mention of any prior low back injuries or symptoms. To the contrary, on review of Dr. Arbeene's report, Dr. Saks took exception to Dr. Arbeene's discussion (limited though it was) of claimant's prior injuries. Specifically, Dr. Saks stated that "[a]nother inconsistency [between his evaluation of claimant and Dr. Saks' evaluation] is the fact that [Dr. Arbeene reported that claimant] has had falls in the past, with claims filed but not seeking any medical evaluation, as well as another fall where she missed only one or two days of work." (Ex. 12-2).

Earlier medical records stand in stark contrast to claimant's later reports of either no prior low back injuries or injuries to unstated body parts resulting in no medical evaluation and no missed time from work. Such medical records establish that claimant in fact injured her low back in July 1992 while working for a previous employer. (Ex. AA). That injury, like claimant's current claim, resulted from a reported slip and fall onto a concrete floor. As a result of that earlier injury, claimant was seen at the St. Vincent Urgency Care Clinic. (Ex. AA-1). Medication, rest and light duty work were prescribed. Claimant was scheduled for physical therapy.

Before claimant could commence physical therapy, claimant reinjured her back in a motor vehicle accident involving a collision with an elk. Id. Claimant experienced increased upper and lower back pain following the accident. She was taken to the emergency room at Tillamook Hospital by ambulance. Claimant was released from her regular work. She was prescribed bed rest for the next couple of days. One week later, on July 27, 1992, she was still on light duty and was prescribed three sessions of physical therapy. (Ex. AA-2). On August 26, 1992, following a period of improvement, claimant reported experienced a five to six day history of an acute exacerbation of low back symptoms. (AA-4). Claimant reported that she had been back at full duty for only two days when the acute exacerbation occurred. She was subsequently limited to light duty work for two more weeks.

It is apparent that Drs. Saks, Miller and Goldberg had no knowledge regarding claimant's prior low back injuries. Therefore, their opinions are based on an inaccurate history and are not persuasive. Miller v. Granite Construction Co., 28 Or App at 476. In addition, they offer no explanation for their

conclusion that the work incident is the major contributing cause of claimant's low back injury. (Exs. 15-3, 17-2). See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). This lack of explanation is particularly fatal to claimant's claim for benefits in light of the fact that claimant testified she did well following her September 24, 1995 slip and fall, and that it was only after a subsequent reaching incident that her symptoms became serious.

Therefore, because the only medical opinions that support claimant's claim are based on a markedly inaccurate history provided by claimant and are inadequately explained, claimant has failed to sustain her burden of establishing compensability of her claim. Accordingly, the insurer's denial is upheld.

ORDER

The ALJ's order dated August 28, 1996 is reversed. The insurer's denial of claimant's lumbosacral strain injury claim is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

The majority greatly increases the magnitude of two minor back injuries that occurred more than three years before the witnessed low back injury that is before us. In fact, the entire treatment for these prior back injuries consisted of some physical therapy and four visits to a doctor over a period of about a month, with two of those visits primarily involving treatment of health problems totally unrelated to claimant's low back. (Ex. AA). Furthermore, claimant had no need for treatment for her low back for a period of three years, until she injured her back at her current employment.

Because I find that the majority inappropriately overfocuses on these minor injuries, which had resolved years earlier, to avoid deferring to the treating physicians' opinions, I respectfully dissent. Furthermore, I agree with the ALJ's analysis of the compensability issue. Therefore, I would affirm the ALJ's order.

July 23, 1997 Cite as 49 Van Natta 1145 (1997)

In the Matter of the Compensation of
DAVID A. DONNELLY, Claimant
WCB Case Nos. 94-13449, 94-13398, 94-13448 & 94-13399
ORDER OF ABATEMENT
Quintin Estell, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

The SAIF Corporation requests abatement and reconsideration of our June 27, 1997 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order finding claimant's low back condition compensable and assigning responsibility for the condition to SAIF. In moving for abatement, SAIF asserts that the medical evidence did not meet the proper standard for shifting responsibility from Liberty Northwest Insurance Corporation to SAIF.

In order to consider this matter, we withdraw our June 27, 1997 order. Liberty and claimant are granted an opportunity to respond. To be considered, the responses must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WAYNE M. GRAY, Claimant
WCB Case Nos. 96-07034 & 96-04819
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Liberty Northwest Insurance Corporation, on behalf of Ramsay Construction (Ramsay), requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) found that claimant had timely notified Ramsay of his injury claim; and (2) set aside its denial of claimant's low back injury. On review, the issues are timeliness and compensability.

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

The ALJ found that, because Liberty received the Ramsay injury claim on October 23, 1995, claimant had timely provided notice to the employer pursuant to ORS 656.265(1) within 90 days of the injury. We agree. However, we also find that claimant timely notified the employer under ORS 656.265(4), which provides that failure to give notice within 90 days bars a claim unless the notice is given within one year after the date of the accident and the employer had knowledge of the injury or death. ORS 656.265(4)(a).

Here, the ALJ found claimant to be credible, based on the substance of his testimony and on demeanor. The insurer has provided no basis for us to disturb that credibility finding. Claimant testified that, on August 25, 1995, the day the injury occurred, he reported the injury to Ramsay's acting supervisor. See Timothy Bloemendaal, 48 Van Natta 591 (1996) (When an individual in a supervisory position has knowledge of a worker's injury, that knowledge may be imputed to the employer). Claimant's testimony is unrebutted. Claimant subsequently filled out an 801 form against Ramsay and filed it in February 1996. (Ex. 43; Tr. 52-54). Accordingly, claimant gave Ramsay notice within one year after the date of the accident and the employer had knowledge of the injury. Therefore, claimant also timely provided notice under ORS 656.265(4)(a).

Finally, on review, Liberty, on behalf of Northwest Builders Group, notes that the ALJ's Opinion and Order incorrectly refers to the dates of its denials as November 8, 1996 and November 12, 1996. The actual dates of Liberty/Builders' denials are October 15, 1996, and (as amended) November 8, 1996. Accordingly, we modify the ALJ's order to reflect the corrected dates.

Claimant's counsel is entitled to an 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 $1,600, to be paid by Liberty/Ramsay. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 12, 1997, as corrected and modified herein, is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,600 for services on review, to be paid by Liberty Northwest Insurance Corporation, on behalf of Ramsay Construction.

In the Matter of the Compensation of
R. D. JACKA, Claimant
WCB Case No. 96-08246
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the self-insured employer's denial of his current low back condition and current lumbar radiculopathy condition. On review, the issue is compensability and claim preclusion.

We adopt and affirm the ALJ's order with the following change and supplementation. In the second sentence of the first paragraph of the findings of fact, we change the date to "January 3, 1996."

Claim Preclusion

Citing Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), rev den 309 Or 645 (1990), claimant contends that since there is no allegation and no evidence that his condition changed between the date the claim was accepted and the date the claim was denied, the employer's denial of his current condition, including the radiculopathy condition, is barred by the principles of claim preclusion. He also argues that the employer's denials are contrary to the "law of the case." We decline to address these arguments because they are being raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Current Low Back Condition

The ALJ was not persuaded by the opinions of Drs. Lorish or O'Neill that claimant's January 3, 1996 strain injury remained the major contributing cause of his current low back condition. Since there were no other medical opinions supporting the claim, the ALJ concluded that claimant had not established that his current low back condition was compensable.

Claimant contends that Dr. O'Neill's opinion establishes compensability of his current low back condition. In a "check-the-box" report from claimant's attorney, Dr. O'Neill agreed that the work-related lumbar strain claimant incurred on January 3, 1996 remained the major contributing cause of his disability and need for treatment as compared to his preexisting spinal degenerative changes. (Ex. 38-1). In a later report, Dr. O'Neill explained:

> "The degenerative disc disease is unquestionably a preexisting condition. [Claimant] did not have symptoms prior to this event at work and had symptoms following. I believe his clinical presentation and the clinical symptoms he is currently experiencing are due directly to a work related event." (Ex. 43-2).

On the other hand, Dr. Stanford, who first examined claimant on April 1, 1996, reevaluated claimant on June 24, 1996 and opined that claimant's preexisting degenerative arthritis had become the major contributing cause of his low back pain. (Ex. 29). Dr. Stanford explained that a low back strain superimposed on preexisting degenerative arthritic change will be slow to resolve. (Ex. 29-5). However, he believed that, at six months after the injury, claimant's degenerative changes were now the major contributing cause of his low back pain. (Ex. 29-6).

Because claimant's current low back condition is subject to the major contributing cause standard, the persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined. See Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). The fact that a work injury precipitated a claimant's condition does not necessarily mean that the injury was the major contributing cause of the condition. Id.; see also Robinson v. SAIF, 147 Or App 157, 162 (1997).

In determining medical causation, we rely on medical opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Furthermore, we tend to give greater weight to the conclusions of claimant's treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. O'Neill.

The main problem with Dr. O'Neill's opinion is that it is too conclusory. See Marta I. Gomez, 46 Van Natta 1654 (1994) (the Board gives little, if any, weight to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports). Dr. O'Neill did not respond to Dr. Stanford's opinion that a back strain will generally resolve in a matter of a few weeks. Dr. O'Neill did not explain why claimant continued to have a lumbar strain six months after the injury. Although Dr. O'Neill had apparently considered claimant's preexisting condition, he did not explain why the lumbar strain continued to be the major contributing cause of the low back condition. In sum, we are not persuaded by Dr. O'Neill's opinion that claimant's accepted lumbar strain is the major contributing cause of his current disability or need for treatment of his current low back condition. We agree with the ALJ that Dr. Lorish's opinion is not persuasive. Since there are no other medical opinions supporting the claim, we conclude that claimant has not established that his current low back condition is compensable.

Current Lumbar Radiculopathy

Applying the major contributing cause standard, the ALJ concluded that claimant did not establish a compensable claim for his current left leg condition. Claimant contends that the ALJ improperly analyzed his lumbar radiculopathy as a "combined condition." He asserts that there is no evidence that would support a finding that his radiculopathy condition is a combined condition, and, therefore, a material contributing cause standard applies. The employer contends that claimant did not raise the material contributing cause standard of proof at hearing.

Even if we assume that claimant properly raised the issue of a material contributing cause standard of proof, we do not find his argument persuasive. As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995), and Michele K. Dibrito, 47 Van Natta 970 (1995)).

Here, we agree with the ALJ that the major contributing cause standard applies to claimant's current left leg condition. Claimant has degenerative arthritis in the lumbar spine that preexisted his January 3, 1996 injury. (Exs. 12, 16, 19, 43). The medical evidence establishes that claimant's preexisting degenerative arthritis in the lumbar spine combined at the outset with his January 2, 1996 injury to cause disability and need for treatment of both the low back and left leg symptoms.

Claimant's radicular symptoms were identified soon after the January 3, 1996 injury. Claimant testified that he felt pain down his left leg 3 or 4 days after the injury. (Tr. 17). The January 9, 1996 Health Services report indicated that claimant had low back pain and pain in his left hip which radiated to the anterior thigh and he had reported that his left leg felt "heavy." (Ex. 3). Claimant's treating physicians attributed his low back and left lower extremity symptoms to lumbosacral strain with possible nerve root irritation. (Exs. 6, 10, 11, 13, 14, 17). An MRI on January 31, 1996 showed degenerative changes from L3 to S1, most prominently involving L4-5, where there was a mild spinal canal stenosis. (Ex. 12).

On May 30, 1996, Dr. O'Neill referred to the MRI findings, including degenerative changes at L3-4, L4-5 and L5-S1, and he diagnosed a low back strain and possible left leg radicular symptoms. (Ex. 28-2). A lumbar myelogram on September 3, 1996 showed "[a]symmetric incomplete filling left nerve root sheath at L4-5 with slight angulation raising question of possible focal disc herniation." (Ex. 35). Dr. O'Neill recommended conservative treatment to improve claimant's symptomatology and resolve his radiculopathy. (Ex. 37).

In a "check-the-box" report from claimant's attorney, Dr. O'Neill agreed that the January 1996 work-related lumbar strain remained the major contributing cause of claimant's disability and need for treatment, as compared to his preexisting spinal degenerative changes. (Ex. 38-1). Dr. O'Neill also agreed that the work injury was the "major contributing cause of the low back radiculopathy * * * when

compared to the pre-existing degenerative changes." (Ex. 38-2). Dr. O'Neill agreed that claimant was disabled from performing his regular work as a result of the lumbar strain and the lumbar radiculopathy condition he sustained in the January 3, 1996 injury. (Exs. 38-2, 41). On November 27, 1996, Dr. O'Neill reported that the lumbar myelogram report was consistent with nerve compression and he concluded it was causing claimant's radiculopathy. (Ex. 43-1). He acknowledged that claimant had preexisting degenerative disc disease and he reported that claimant's radiculopathy was directly related to an event at work and "his clinical presentation and the clinical symptoms he is currently experiencing are due directly to a work related event." (Ex. 43-2).

We construe Dr. O'Neill's reports to mean that claimant's preexisting degenerative condition combined at the outset with his January 3, 1996 injury to cause disability and need for treatment of both the low back and left leg symptoms. As we mentioned above, Dr. O'Neill recommended conservative treatment to improve claimant's symptomatology and resolve his radiculopathy. (Ex. 37). In reporting that the work injury was the major cause of the radiculopathy, Dr. O'Neill said that he had compared the contribution from the preexisting degenerative changes. (Ex. 38). Although Dr. O'Neill did not expressly state that claimant's January 1996 injury "combined" with the preexisting degenerative condition, it is well-settled that medical opinions need not mimic statutory language or use "magic words." See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992).

Based on Dr. O'Neill's reports, we conclude that claimant's January 1996 injury "combined" with the preexisting degenerative condition to cause the disability or need for treatment of the lumbar radiculopathy, as well as the low back condition. In addition, Dr. Stanford testified that degenerative arthritis "very often" results in radiculopathy. (Ex. 39-31). We agree with the ALJ that claimant's radiculopathy condition is subject to the major contributing cause standard of proof under ORS 656.005(7)(a)(B). See Robert K. Warnock, 49 Van Natta 171 (1997). For the reasons we discussed earlier, we agree with the ALJ that the opinions of Drs. O'Neill and Lorish are not persuasive and we conclude that claimant has failed to establish that the January 1996 work injury was the major contributing cause of the radiculopathy condition.

ORDER

The ALJ's order dated January 10, 1997 is affirmed.

July 23, 1997 Cite as 49 Van Natta 1149 (1997)

In the Matter of the Compensation of
TERESA McPHERSON, Claimant
WCB Case No. 95-10760
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) Michael V. Johnson's order that: (1) upheld the insurer's denial of claimant's current neck condition; and (2) upheld the insurer's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we briefly summarize as follows:

Claimant sustained an injury to her neck on August 7, 1992. She sought treatment from Dr. Richards, chiropractor, complaining of pain in her neck, the rear portion of her right shoulder, and into the right arm. X-rays showed severe cervical kyphosis at C4-6 and spurring at C5. The insurer accepted a disabling cervical strain. Claimant returned to regular work on August 23, 1992, and the insurer closed her claim on December 1, 1992 by Notice of Closure that awarded no permanent disability. Claimant continued to work until February 9, 1994, when she quit for personal reasons.

On July 26, 1995, claimant sought treatment from Dr. Jones, chiropractor, and on August 2, 1995, from Dr. Drye, M.D., for right shoulder, back and arm complaints and episodic headaches. Dr. Drye diagnosed cervical strain with acute flare-up, and filed an aggravation claim. The insurer denied compensability of claimant's current neck condition and her aggravation claim.

Claimant was subsequently examined by Dr. Willard, M.D.; Dr. Jessen, neurologist, and Dr. Coletti, orthopedist; and Dr. Meyer, neurosurgeon.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to establish that her 1992 neck injury was the major contributing cause of her current neck and headache condition. In so finding, the ALJ rejected claimant's argument that she had no "preexisting condition" prior to her 1992 injury. In addition, the ALJ held that the Hearings Division does not have the authority to address claimant's federal preemption argument and lacked jurisdiction to consider her challenge to the definition of "preexisting condition" in ORS 656.005(24) under the Americans With Disabilities Act (ADA).

After reviewing the medical evidence, we agree with the ALJ that claimant had both kyphosis and degenerative spurring in the cervical spine, which preexisted her 1992 injury and combined with her injury to prolong her need for treatment.[1] We also agree with the ALJ that claimant failed to sustain her burden to prove compensability of her current condition under ORS 656.005(7)(a)(B).

Due to the passage of time, the causation of claimant's current neck and headache condition is a complex medical question; therefore, expert medical opinion is necessary for claimant to prove compensability. See Uris v. Compensation Dept., 247 Or 420 (1967). Although Dr. Jones, claimant's treating chiropractor, opined that the major contributing cause of claimant's current need for treatment was the 1992 injury, he based his opinion on the premise that claimant had needed markedly increased conservative care since the 1992 injury. This premise is contrary to the evidentiary record showing that claimant sought no treatment for her neck condition from November 1992 until July 1995. See Somers v SAIF, 77 Or App 259 (1986) (medical evidence on causation is only as competent as the history upon which it is based). Moreover, although Dr. Jones acknowledged that claimant had kyphosis and degenerative changes in her neck, as well as non-work related stress, he failed to analyze the relative contribution of these other, non-work related factors, as is required under the major contributing cause analysis. 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). Accordingly, we find Dr. Jones' conclusory opinion insufficient to establish medical causation. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (unexplained medical report discounted).

Moreover, even if we did not consider claimant's kyphosis and degenerative neck condition as "preexisting conditions," because Dr. Jones had an inaccurate history (as discussed above), we are not persuaded that the medical evidence establishing the compensability of claimant's current neck condition claim.

Claimant also contends that, to avoid running afoul of the ADA, we should apply the "material contributing cause" standard to determine whether her current condition is compensable. However, claimant's claim also fails under the material contributing cause standard, because Dr. Jones had an inaccurate history and his opinion must be discounted accordingly. Thus, even if we agreed with claimant's ADA argument, we would continue to find that the record does not establish the compensability of her claim.

ORDER

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

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[1] ORS 656.005(24), defines a "preexisting condition" as including any condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial injury claim, or that precedes a claim for worsening pursuant to ORS 656.273.

In the Matter of the Compensation of
BENITO J. NAVARRETE, Claimant
WCB Case No. 96-09742
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) increased claimant's unscheduled permanent disability award for a low back condition from 26 percent (83.2 degrees), as awarded by a Reconsideration Order, to 36 per cent (115.2 degrees); and (2) affirmed that portion of the Order on Reconsideration which awarded no scheduled permanent disability for loss of use or function of claimant's right foot. On review, the issue is extent of permanent disability, scheduled and unscheduled.

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

On review, claimant argues that the medical arbiter process is constitutionally flawed because it deprives him of his right to cross-examine the arbiter for the purpose of testing the validity of the arbiter's findings.

There is no indication in the record that this argument was raised at hearing and the ALJ did not address it. We have consistently held that we will not consider an issue raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Kenneth L. Devi, on recon, 49 Van Natta 108 (1997). Accordingly, we decline to consider the late-raised constitutional issue in this case.[1]

ORDER

The ALJ's order dated February 24, 1997 is affirmed.

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[1] Accordingly, we direct the parties to our recent decision in Richard D. Nelson, 49 Van Natta 458, 459 (1997), wherein we found that claimant had no statutory right to cross-examine the medical arbiter about his findings.

In the Matter of the Compensation of
JIM L. STONE, Claimant
WCB Case Nos. 96-05875, 96-03028 & 96-03027
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's which: (1) upheld the SAIF Corporation's denial of her injury claim for a "failed back surgery syndrome" condition in relation to a compensable November 29, 1995 low back injury; (2) declined to award an attorney fee under ORS 656.386(1); (3) declined to direct SAIF to process several low back conditions to closure; and (4) declined to award a penalty for an allegedly unreasonable "de facto" denial. On review, the issues are claim processing, penalties, attorney fees, and compensability. We modify in part and affirm in part.

FINDINGS OF FACT

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

Claimant sustained a compensable low back injury on May 1, 1982, while employed by the City of Coquille, insured by SAIF. The claim was closed by Determination Order in October 1982. (Ex. 69F). Several surgeries were subsequently performed. In May 1992, claimant requested that his claim be reopened. SAIF agreed in November 1992 to recommend to the Board that the claim be reopened under the Board's Own Motion authority under ORS 656.278. Id. SAIF later issued a Notice of Closure of the Own Motion claim on September 29, 1993.

In May or June 1994, claimant began work as a plumbing inspector for the City of Coos Bay, also insured by SAIF. (Ex. 103). On November 29, 1995, claimant sustained a back injury while performing a plumbing inspection. (Ex. 116). A consulting neurosurgeon, Dr. Burchiel, diagnosed a "failed back surgery syndrome." (Ex. 128).[1] SAIF specifically accepted an acute lumbosacral spine strain on February 22, 1996. (Ex. 131).

On March 19, 1996, SAIF denied the compensability of claimant's failed back surgery syndrome and scar formation around the left S1 nerve root on the ground that the November 29, 1995 injury was not the major contributing cause of those conditions. (Ex. 135). On April 10, 1996, claimant's attorney requested that the denied conditions, as well as spinal stenosis, degenerative disease, scarring at L3-4 and a "slight" disc bulge at L3-4 be processed as an occupational disease claim. (Ex. 144). SAIF, under the 1982 claim, then specifically clarified on April 25, 1996 that left L4 through S1 disc herniation, bulging disc at L3-4 and failed fusion at L5-S1 were accepted conditions. (Ex. 145).

On April 30, 1996, claimant's attorney wrote SAIF that it should process the accepted conditions to closure and that it should indicate whether degenerative disease and scar formation around the left S-1 nerve root were also accepted under the 1982 claim. (Ex. 145B). On June 14, 1996, SAIF denied claimant's occupational disease claim. (Ex. 151). In its denial letter, SAIF stated that the conditions listed in its April 25, 1996 letter were accepted under the 1982 claim and that treatment for claimant's current back condition was being paid for under that claim. Id.

On June 19, 1996, claimant's counsel requested that SAIF process a claim for a pathological worsening of a preexisting back condition under the November 1995 claim. (Ex. 152). SAIF subsequently recommended on September 26, 1996 that the Board reopen the 1982 claim for temporary disability. (Ex. 165). SAIF agreed that claimant's current condition was causally related to the accepted low back condition and that it was responsible for the current low back condition. Id.

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[1] The ALJ found, and the parties do not dispute, that "failed back surgery syndrome" consists of left L4 through S1 herniation, bulging disc at L3-4, failed fusion at L5-S1, scar formation around left S1 nerve root, degenerative disease, spinal stenosis, and scarring at L3-4.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of claimant's occupational disease claim, concluding that the medical evidence did not establish that claimant suffered from an occupational disease separate from his compensable injuries. Finding that SAIF had properly processed every aspect of claimant's failed back surgery syndrome under the 1982 injury claim, the ALJ determined that claimant failed to prove that his current low back condition was a compensable consequence of the 1995 compensable injury. Therefore, the ALJ upheld SAIF's March 1996 denial that the failed back surgery syndrome was part of the 1995 injury claim. Rejecting claimant's argument that all elements of claimant's failed low back surgery syndrome should be processed to closure under the 1982 claim, the ALJ further held that claim processing should be accomplished under the Board's Own Motion jurisdiction. See Dan Cone, 47 Van Natta 2343 (1995); Mark D. Fuller, 46 Van Natta 63 (1994). Finally, the ALJ determined that, while claimant's attorney rendered considerable services in requesting that SAIF process all aspects of the claim, there was no statutory provision that authorized the assessment of an attorney fee.

On review, noting that the ALJ did not specifically order acceptance of his failed back surgery syndrome under the 1982 claim, claimant requests that we do so now. Claimant also asserts entitlement to an assessed attorney fee under ORS 656.386(1), arguing that there was a "denied claim" within the meaning of that statute. Claimant further contends that all "late-accepted" conditions should be processed to closure pursuant to ORS 656.268 under the 1982 claim. Alternatively, claimant argues that a claim for a pathologically worsened back condition should be accepted under the 1995 claim.

For the reasons cited by the ALJ, we find that SAIF properly processed claimant's failed back surgery syndrome under the 1982 claim. Moreover, we agree with the ALJ's reasoning that processing of this condition is properly accomplished under the Board's Own Motion jurisdiction. However, we agree with claimant that SAIF should formally accept the failed back surgery syndrome under the 1982 claim. Despite this conclusion, we do not find that claimant's attorney is entitled to an assessed fee under ORS 656.386(1).

ORS 656.262(7)(a) provides:

> "After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

Under ORS 656.262(7)(a), a carrier is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. In this case, SAIF has formally accepted certain elements of claimant's failed back surgery syndrome: Left L4 through S1 disc herniation, bulging disc at L3-4 and failed fusion at L5-S1. However, the parties do not dispute that the failed back surgery condition consists of several more components that SAIF has not accepted. Although the statute clearly does not require that a carrier must accept every diagnosis with particularity, we conclude that, given the complex nature of claimant's failed back surgery syndrome condition (which consists of numerous individual components), SAIF's current acceptance does not reasonably apprise claimant of the nature of

his compensable condition. Therefore, we find that SAIF must formally accept claimant's failed back surgery syndrome under the 1982 claim.[2]

Having made the determination that SAIF must formally accept claimant's failed back surgery syndrome, we now decide whether claimant's counsel's efforts in securing acceptance of additional conditions under the 1982 claim merit an assessed fee. For the following reasons, we conclude that they do not.

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.

Here, SAIF denied claimant's failed back surgery syndrome, but that denial was issued in regard to the 1995 injury claim. We have upheld that denial. With respect to the 1982 claim, SAIF paid all benefits under that claim. There was no refusal by SAIF to pay compensation under the 1982 claim on the express ground that condition for which compensation was claimed (failed back surgery syndrome) was not compensable or otherwise did not give rise to an entitlement to compensation.[3]

To the contrary, all medical bills have been paid and SAIF has recommended reopening of claimant's 1982 claim pursuant to the Board's Own Motion authority under ORS 656.278. We recognize that claimant's counsel expended considerable effort on claimant's behalf in insuring that SAIF processed his failed back surgery syndrome. However, entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). Under the current version of ORS 656.386(1), there is no basis for an attorney fee award in this case.

ORDER

The ALJ's order dated January 8, 1997 is modified in part and affirmed in part. SAIF is ordered to formally accept claimant's "failed back surgery syndrome" under the compensable 1982 injury claim. The remainder of the ALJ's order is affirmed.

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[2] Although claimant asserts that SAIF should be penalized because it did not formally accept his failed back surgery syndrome, we decline to do so. 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 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). While we have determined that SAIF should formally accept the failed back surgery condition, we are not persuaded that SAIF's failure to do so was unreasonable in light of the statutory language contained in ORS 656.262(7)(a). In this regard, we note that there was no case law precedent interpreting the portion of ORS 656.262(7)(a) at issue in this case. Moreover, several components of claimant's "failed back surgery syndrome" had been accepted by SAIF.

[3] We distinguish this case from Shamyia M. Ford, 49 Van Natta 2 (1997), where we held the claimant was entitled to an attorney fee under ORS 656.386(1) even though there was no contention that the carrier withheld any benefits from the claimant. In contrast to Ford, where the carrier questioned the existence of the claimed condition, SAIF has not questioned the existence of the failed back surgery syndrome or the causal relationship between that condition and the accepted 1982 injury. In fact, SAIF has expressly conceded that claimant's current back condition is compensable in relation to the 1982 claim. (Ex. 165-3).

In the Matter of the Compensation of
MYCHAL B. AMOS, Claimant
WCB Case No. 96-06105
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) affirmed the Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability for neck and low back conditions; (2) assessed a penalty of $500 pursuant to ORS 656.382(3); and (3) awarded an assessed attorney fee of $1,800. In his brief, claimant requests assessment of an additional penalty for the employer's allegedly frivolous appeal. On review, the issues are extent of unscheduled permanent disability, 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

Unscheduled Permanent Disability

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

Penalties

The ALJ assessed a $500 penalty against the employer pursuant to ORS 656.382(3), which provides:

> "If upon reaching a decision on a request for hearing initiated by an employer it is found by the [ALJ] that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the [ALJ] may order the employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances."

The ALJ found that the employer's arguments in support of reversing the Order on Reconsideration award were so specious that he could not conclude that the hearing request was interposed for any reason other than delay. On review, the employer contends that it had a legitimate, colorable argument for reversing the reconsideration order and that a penalty therefore is not warranted. We agree and reverse the penalty.

We have previously applied ORS 656.382(3) in Larry G. Tabor, 47 Van Natta 754 (1995). In Tabor, we reversed an ALJ's penalty assessment under ORS 656.382(3) based on the finding that the employer had a legitimate basis for initiating the hearing in that case. Id. at 757.

Here, we conclude that the employer also had a legitimate basis for initiating the hearing to challenge the reconsideration order award. The award was based on the medical arbiter's findings of lost ranges of motion in the cervical and lumbar spine. (Ex. 34-5). At hearing, the employer argued that the greater weight of the medical evidence established no permanent impairment; it relied on the January 3, 1996 examination report of Dr. Neumann, with which the attending physician, Dr. Glidden, concurred. (Exs. 28, 29). Dr. Neumann opined that there was no objective evidence of impairment due to the compensable injury and that claimant was in need of a muscle strengthening/conditioning program due to deconditioning. He added that the conditioning program would decrease claimant's limitations. (Ex. 28-5).

Given the attending physician's concurrence that claimant was deconditioned and that muscle conditioning would decrease his limitations, we are persuaded that the employer had reasonable grounds to argue that claimant's limitations were due to temporary deconditioning, not to permanent impairment resulting from the compensable injury. Although we ultimately were more persuaded by the medical arbiter's opinion that his impairment findings were valid and related to the compensable injury, we do not believe that a penalty is warranted based on this record.[1] For this same reason, we deny claimant's request for further sanctions on review.

Attorney Fee

The employer also contends that the ALJ's award of an assessed fee of $1,800 for claimant's attorney services at hearing is excessive. We disagree. After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that $1,800 is a reasonable attorney fee award for claimant's attorney's services at hearing regarding the extent of disability issue, to be paid by the employer. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the hearing record), the average complexity of the issue, and the value of the interest involved (claimant's 6 percent unscheduled permanent disability award), and the risk that claimant's counsel might go uncompensated. Accordingly, we affirm the ALJ's assessed fee award.

Claimant is also entitled to an assessed attorney fee for prevailing against the employer's appeal of the permanent disability award. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable attorney fee for claimant's attorney's services on review regarding the extent of disability issue is $600, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have not considered claimant's attorney's services regarding the ALJ's penalty and attorney fee awards.

ORDER

The ALJ's order dated October 4, 1996 is reversed in part and affirmed in part. The ALJ's penalty assessment is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $600, to be paid by the employer.

[1] We note that the employer's closing argument at hearing, which the ALJ described as "specious," was not transcribed for our review. Therefore, we do not render any judgment regarding the merits of the argument presented to the ALJ at hearing. Based on the arguments presented on Board review, however, we find a legitimate basis for the employer's hearing request.

In the Matter of the Compensation of
DEBORAH S. AMUNDSEN, Claimant
WCB Case No. 96-03989
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found inadmissible two "post-reconsideration" reports submitted by the employer; and (2) affirmed an Order on Reconsideration awarding 30 percent (96 degrees) unscheduled permanent disability for a head condition. The insurer also asserts that the ALJ's evidentiary ruling violates its right to due process. On review, the issues are evidence, constitutional challenges, and extent of unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for mild closed head trauma. A December 1995 Notice of Closure awarded only temporary disability. The Order on Reconsideration found that claimant proved permanent impairment and awarded 30 percent unscheduled permanent disability. The employer requested a hearing.

The ALJ first found that, because the employer appealed the Order on Reconsideration, it had the burden of proof. Pursuant to ORS 656.283(7), the ALJ also refused to admit two documents generated after the Order on Reconsideration and, relying on Joe R. Ray, 48 Van Natta 325 (1995), rejected the employer's assertion that the ruling violated its constitutional right to procedural due process. Finally, relying on the opinion of the medical arbiter, Dr. Burt, the ALJ agreed that claimant was entitled to 30 percent unscheduled permanent disability.

The employer first asserts that it did not have the burden of proof at hearing. We have held to the contrary. See Roberto Rodriguez, 46 Van Natta 1722, 1723 (1994); Maria Jolley, 48 Van Natta 2316 (1996). In particular, the employer had the burden to show by a preponderance of evidence that the standards were incorrectly applied in the reconsideration proceeding. See ORS 656.283(7). Moreover, we agree with and adopt the ALJ's reasoning concerning the exclusion of the post-reconsideration evidence.

Impairment for injuries that result in brain damage is based on six classes. Former OAR 436-35-390(10) (WCD Admin. Order 6-1988). The first two classes are relevant in this case. Class I has 10 percent impairment and provides:

> "The worker functions at a Rancho Los Amigos Scale of 8 (e.g. the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events) and is ADL Independent. If there is a language deficit, it is no more than minimal (e.g. language comprehension or production might be less than normal, but it is adequate for daily living). If there are emotional disturbances or personality changes, they are minimal and occur only during stressful situations and events. If there are episodic sleep disturbances and/or lethargy, they are minimal (e.g. any sleeping irregularity or lethargy does not interfere with daily living). If there is an episodic neurologic disturbance, it is controlled and does not interfere with daily living."

Class II has 30 percent impairment and provides:

> "The worker functions at a Rancho Los Amigos Scale of 8 (e.g. the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events) and is ADL Independent. Language deficit is mild (e.g. language comprehension or production might occasionally interfere with daily living). Emotional disturbances or personality changes are mild (while they may be disproportionate to the stress or situation, they do not significantly impair the worker's ability to relate to others or to live with others). Episodic sleep disturbances and/or lethargy are mild (e.g. any sleeping irregularity or lethargy only occasionally interferes with daily living). Any episodic neurologic disorder is not completely controlled. For example, it may interfere with daily living and cause the worker to have driving restrictions, limit the worker's ability to operate industrial machinery and/or cause the worker to avoid heights."

Claimant was primarily treated by Dr. Gaskell, who eventually referred claimant to a neurologist because she continued to experience chronic headaches and vertigo following the January 1995 head injury. (Ex. 6). By October 1995, after being prescribed Relafen, claimant reported to Dr. Gaskell that her headaches and vertigo had improved. (Ex. 8-1).

Claimant then saw Dr. Epley, who had previously treated claimant in 1987 for an inner ear concussion. After Dr. Epley prescribed an anti-inflammatory medication in October 1995, Dr. Gaskell found that claimant exhibited no evidence of vertigo. (Ex. 8-2). On November 16, 1995, Dr. Gaskell performed a closing examination and noted that claimant had "no problems with persistent vertigo" and "some intermittent headaches not totally controlled by the anti-inflammatory medication[.]" (Ex. 8-3).

He diagnosed injury-related vertigo "resolved on anti-inflammatories." Dr. Gaskell also stated that claimant had returned to regular work although he advised that claimant "try and avoid any vertiginous type activity." (Id. at 4).

Claimant saw two medical arbiters, Dr. Stoner, otolaryngologist, and Dr. Burt, psychiatrist. Dr. Stoner found no ratable otologic impairment. (Ex. 10-3). Claimant told Dr. Burt that, although her headaches had decreased to "one to two per week," the pain was so severe that at times she became nauseous and would "even vomit." (Ex. 11-2). Claimant also told Dr. Burt that her vertigo had decreased with medication but she continued to have intermittent episodes of dizziness and she also had difficulty with short term memory. (Id. at 2-3).

Dr. Burt placed claimant in Class I to Class II for cognitive functioning; Class I for language, emotional, and sleep disorder; and Class II for episodic neurologic disorder. (Id. at 7). With regard to the last category, Dr. Burt explained that the classification was based on claimant's feeling that her post concussion syndrome and episodic vertigo "impairs her daily functioning to some degree, and is not completely controlled by medications." (Id.)

Impairment is determined by a medical arbiter where one is used "except where a preponderance of medical evidence establishes a different level of impairment." Former 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." Former 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).

Here, we find Dr. Burt's reasoning insufficient to support Class II impairment. For instance, Dr. Burt found that, overall, claimant's "attention and concentration were very good, and her judgment and insight appeared to be good as well." (Ex. 11-5). Dr. Burt also reported that, although claimant reported short term memory loss, during his examination, claimant "did relatively well, with immediate and short term recall, although she had some difficulties with digit span, I believe some of this may have been related to comprehension of the task initially, and anxiety." (Id. at 6). Dr. Burt also noted that claimant's "ability to manage and balance the family books, and also her ability to continue to work extensively, and now to pursue re-training as a road supervisor, suggests that her memory deficits are subtle, and most apparent to her[.]" (Id.) In sum, it appears that Dr. Burt found that claimant's conditions impaired her daily functioning to some degree because claimant reported such to him rather than based on examination findings.

Dr. Burt's report also failed to show that he personally reviewed claimant's medical record. The history portion is mostly based on claimant's "reports." Dr. Burt at no time referred to Dr. Gaskell and his chartnotes showing that, as of November 1995, while taking medication, claimant exhibited no symptoms of vertigo and the frequency and intensity of the headaches had greatly decreased. Dr. Burt's recitation that claimant reports her vertigo has been a factor in her driving is also inconsistent with Dr. Stoner's report that claimant can drive without impairment. (Ex. 10-2).

Dr. Burt shows, however, that claimant's post concussive syndrome and episodic vertigo qualify as an "episodic neurologic disorder" under former OAR 436-35-390(10). As Dr. Gaskell explains, claimant controls this condition with medication so that it does not interfere with her daily life. Thus, based on Dr. Burt's and Dr. Gaskell's opinions, we conclude that the employer carried its burden of showing that the standards were not correctly applied at the reconsideration proceeding to the extent that claimant is not entitled to 30 percent impairment. We further conclude, however, that claimant is entitled to 10 percent impairment under former OAR 436-35-390(10) because the record shows that her "episodic neurologic disturbance" is "controlled and does not interfere with daily living."

ORDER

The ALJ's order dated February 11, 1997 is modified in part and affirmed in part. In lieu of the ALJ's and Order on Reconsideration's award of 30 percent (96 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability. The out-of-compensation attorney fee is modified accordingly. The remainder of the order is affirmed.

In the Matter of the Compensation of
PATTI E. BOLLES, Claimant
WCB Case No. 96-05499
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, age 44 at the time of hearing, began working for the employer in 1986. At all pertinent times, she worked in the employer's in-store bakery department, primarily as a cake decorator. Claimant is also a member of a union, Local 114, bakery, confectionery and tobacco workers, and serves as a shop steward.

Over the years, claimant has been supervised by a number of managers in the bakery department, some of whom she worked well with and others with whom she did not. In 1993 and 1994, claimant sought counseling because she was having difficulty getting along with the bakery department's then-manager, Debbie Kibbee. In December 1994, claimant sought treatment for depression and was prescribed Zoloft.

Meanwhile, in November of 1994, Tim Pohs became claimant's manager. At that time, claimant was the assistant manager of the bakery. Claimant found Mr. Pohs to be very demanding, and also unpredictable, aggressive and disrespectful to his staff. At some point in March 1995, Mr. Pohs switched claimant's days off, so that she no longer had two days off in a row.

In late September 1995, claimant was granted a vacation and took eleven days off to travel with her family. Within hours of her return to work on Tuesday, October 3, 1995, Mr. Pohs confronted claimant, gave her a verbal reprimand for performance deficiencies and threatened to suspend her. Mr. Pohs advised claimant that her cake decorating production was low, and accused her of being unorganized, coming in late, taking long breaks and lacking leadership qualities. Mr. Pohs further told claimant that it was her fault he had not gotten a bonus check, because the bakery did not have enough product available for sale.

Claimant advised Mr. Pohs that if he wanted to take formal disciplinary action against her, she wanted a union representative present. Mr. Pohs yelled at claimant that he was not intimidated by her union affiliation, as some of her previous managers had been. He also told claimant that as long as he was working there, she would never be promoted to a manager. In response, claimant resigned as the assistant manager of the bakery.

Mr. Pohs was off the next day, and claimant worked with a salesperson who had been called in to help in the bakery. On Thursday, October 5, 1995, claimant came to work at her scheduled time, 6:00 a.m. Mr. Pohs arrived at 7:00 a.m., and appeared to claimant to be in a poor mood. He demanded to know who had called in the salesperson in his absence. Later, when Mr. Pohs was advised that claimant had taken a large order the day before that required additional production that morning, he threw a fit, yelling at claimant and throwing and smashing baked bread down on the counter. Mr. Pohs exclaimed that he "did not need this," and threatened to quit. He cursed at claimant and walked out of the bakery. He then returned a few moments later, called another bakery worker into his office, appointed her the new assistant manager and left for the day. Claimant worked the remainder of her shift.

The next day, claimant asked one of the store managers, Heidi Olson, about Mr. Pohs' status and was advised that he was still the bakery manager. Claimant also asked about her job, and was told that her job was not in jeopardy and that she should try to get along with her supervisor. Claimant told Ms. Olson that she was unable to work with Mr. Pohs because of his unpredictable behavior and requested a leave of absence until the problem could be resolved. Ms. Olson advised against a leave of

absence, noting that the bakery would be busy in the next few weeks and that the employer needed claimant to be there to decorate cakes. When claimant saw Mr. Pohs on Friday, he treated her coolly and essentially avoided her, whereas he was friendly with others. Claimant felt ill and was allowed to leave work early.

On completing her shift on Saturday, October 7, 1995, claimant ran into Mr. Pohs near the time clock even though it was his scheduled day off. Claimant then went to speak to the store's food manager, Jim McNamee. Mr. McNamee advised claimant that the employer had changed the work schedule for all cake decorators, and that she would now be required to work from 10:00 a.m. to 7:00 p.m. rather than the early morning shift she preferred. Claimant told Mr. McNamee that she could not work the later shift because she wanted to be home in the afternoon when her boys got home from school. Claimant also advised that she could not work with Mr. Pohs any longer and told Mr. McNamee that she wanted to quit. Mr. McNamee advised claimant that Mr. Pohs would likely be transferred to a new store within a few months, but that in the meantime, claimant would have to learn to deal with his management style. Claimant became upset and left.

Later that day, claimant called Mr. McNamee and asked for a few days leave. He arranged to have her shifts covered. On October 11, 1995, claimant sought treatment from her regular physician, Dr. Erickson, complaining of uncontrollable crying, anxiety and depression. Dr. Erickson released claimant from work and referred her to Dr. Paulsen, a psychiatrist. Claimant began treating with Dr. Paulsen on October 20, 1995. Dr. Paulsen diagnosed adjustment disorder with mixed anxiety and depression related to her work situation and switched claimant from Zoloft to Paxil.

On March 18, 1996, claimant was examined by Dr. Glass, a psychiatrist, at the employer's request. Dr. Glass concluded that claimant had an occupational problem but no diagnosable mental disorder. He attributed claimant's adjustment problems to preexisting personality factors.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established the compensability of her mental disorder claim under ORS 656.802(3). On review, the employer challenges the ALJ's determination and asserts that (1) the employment conditions allegedly producing claimant's stress did not exist in a real and objective sense; (2) the employment conditions allegedly producing claimant's stress were conditions generally inherent in every working situation or were reasonable supervisory, disciplinary or corrective measures; (3) claimant's stress did not constitute a diagnosable mental disorder generally recognized in the medical or psychological community; and (4) claimant did not establish by clear and convincing evidence that her employment conditions were the major contributing cause of her stress reaction.[1] We address each issue in turn.

The ALJ found that claimant was credible by demeanor and substance of testimony. Although the employer does not specifically challenge claimant's credibility on review, the employer does assert that claimant's personality traits have skewed her perceptions of her work conditions. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

After our de novo review of the record, we conclude that claimant is a credible witness and that the employment conditions she described as giving rise to her anxiety and stress existed in a real and objective sense. See ORS 656.802(3)(a). In other words, we are persuaded that Mr. Pohs, her supervisor, had unpredictable moods, and that, when claimant returned from her vacation in the first week of October 1995, Mr. Pohs confronted claimant, reprimanded her, yelled at her and criticized her work performance in the presence of others. We also accept claimant's testimony that he later lost his temper with her and physically displayed his anger by crushing and throwing bread around the bakery.[2]

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[1] Pursuant to ORS 656.802(3), claimant has the burden of establishing all of the factors contested above.

[2] Other witnesses corroborated claimant's testimony in this regard, testifying that Mr. Pohs was, at times, overbearing, hot-tempered and critical of claimant and other bakery staff, and that he would get physical and slam goods around the bakery when he was angry. (See, e.g. Tr. 51-53, 62-64).

The next question is whether these are conditions other than conditions generally inherent in every working situation or constitute reasonable disciplinary, corrective or job performance evaluation actions by the employer. The phrase "generally inherent in every working situation" means those conditions that are usually present in all jobs and not merely in the specific occupation involved. See Merry J. Morgans, 47 Van Natta 147 (1995). We have held that changes in management and changes in procedure constitute conditions generally encountered in every working situation. See Gary W. Helzer, 47 Van Natta 143 (1995) (new manager's "stricter" management style is not a cognizable basis for a compensable stress claim); Karen M. Colerick, 46 Van Natta 930 (1994). We have also held that interpersonal conflict and personality clashes between co-workers are conditions generally inherent in every work place. See, e.g., Lynn A. Horton, 45 Van Natta 2203 (1993); Gregory L. Brodell, 45 Van Natta 924 (1993). In addition, we have found that stress caused by the employer's *reasonable* corrective actions may not be considered in determining the major contributing cause of claimant's mental disorder. See Iraj Ostovar, 47 Van Natta 2196 (1995); Robert T. Ortez, 46 Van Natta 2472 (1994)

On the other hand, we have recognized that it is not reasonable, nor is it a condition generally inherent in all work situations, for a worker to be shouted at, berated by and threatened by his or her supervisor. See Kenneth G. Abel, 48 Van Natta 1603 (1996) (where the claimant established that his general manager regularly shouted at him, sometimes in front of customers, using demeaning language and throwing objects, such treatment was not generally inherent in all work situations); see also Merry J. Morgans, 47 Van Natta at 150 (a hostile work environment, where managers described certain employees in critical and disparaging terms, is not a condition generally inherent). We have also held that a supervisor's inconsistent and unpredictable behavior is not a condition that is generally inherent in every working situation. See Mike A. Martell, 42 Van Natta 1588 (1990).

In this case, claimant cites to Mr. Pohs' unpredictable behavior, his verbal abuse and his physically threatening temper tantrums as the source of her stress. We conclude that claimant was subjected to treatment by her direct supervisor that is not generally inherent in a working situations. We also conclude that even if Mr. Pohs had legitimate reasons for disciplining or correcting claimant on her return from vacation (due to low production and/or tardiness), he did not act in a reasonable manner in doing so.

The employer also disputes whether claimant suffered from a mental disorder generally recognized in the medical community. See ORS 656.802(3)(c). Claimant's attending physician, Dr. Paulsen, diagnosed claimant's condition as adjustment disorder with mixed anxiety and depression, a DSM IV diagnosis that is generally recognized in the medical community. Dr. Glass, who examined claimant on one occasion in March 1996, five months after the key events took place, opined that claimant had an "occupational problem" but no diagnosable mental disorder. In response to Dr. Glass' report, Dr. Paulsen explained that at the time she began treating claimant in October 1995, claimant was exhibiting symptoms to support the mental disorder diagnosis, but that she improved after she was removed from the causative problem and treated with medication designed to decrease her anxiety, worry and nervousness.

After considering the above medical evidence, we find no persuasive reason not to rely on Dr. Paulsen's diagnosis, particularly because she had the opportunity to evaluate claimant's condition on several occasions and closer in time to the events which lead to claimant's need for treatment. See 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). Consequently, we conclude that claimant has established that she experienced a mental disorder generally recognized in the medical community.

In its final challenge to the ALJ's order, the employer asserts that claimant has failed to establish that her employment conditions were the major contributing cause of her mental stress. The employer argues, based on Dr. Glass' report, that claimant's condition results from her preexisting personality traits and familial conflicts. We find to the contrary.

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, as noted above, 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). Dr. Paulsen, claimant's treating psychiatrist, saw claimant several times during the Fall of 1995 and concluded that claimant's adjustment disorder was caused by her manager's unpredictable and physically threatening manner. Dr. Paulsen specifically rejected Dr. Glass' determination that claimant's problem resulted

from preexisting personality traits, noting that despite her difficult childhood and prior problems with authority (including her conflict with a previous manager), claimant was "an emotionally capable person" who was subject to an "irrational situation beyond her control." Because Dr. Paulsen specifically cited to Mr. Pohs' abusive behavior (a condition we have found that falls outside the exceptions set forth in ORS 656.802(3)(b)) as the source of claimant's stress, and we find Dr. Paulsen's opinion to be persuasive, we conclude that claimant has established by clear and convincing evidence that her mental disorder arose out of and in the course of her employment.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, 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 February 21, 1997 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
JOSEPH F. KREFT, Claimant
WCB Case No. 96-09183
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of claimant's right shoulder/arm condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant works in the distribution center of a department store. On May 31, 1996, after unboxing suits and hanging them on trolleys, claimant experienced right shoulder and arm pain. On June 11, 1996, claimant sought treatment.

Claimant first saw Dr. Maness, who noted that claimant's work "is the major contributing cause of his pain." (Ex. 1). Claimant then consulted Dr. Baertlein, who found "[i]ntermittent right shoulder discomfort, etiology uncertain." (Ex. 3-1).

Claimant next saw Dr. Harris, orthopedic surgeon. Based on x-rays and an MRI, Dr. Harris thought that claimant had cervical degenerative disc disease and, although the condition was not caused by work, claimant's employment "probably brought on the right arm symptoms by irritating the nerve root as it passes through the narrowed foramen." (Ex. 9-1).

Finally, claimant was examined by Dr. Schmidt, neurosurgeon, who understood that claimant's job entailed lifting "up to 800 to 900 times per day unpacking clothes from a table and hanging these on a rack." (Exs. 10-2, 16). Dr. Schmidt thought that claimant's "pain pattern is related to his cervical radicular irritation which appears to be associated with spondylotic changes and foraminal stenosis on his MRI scan." (Ex. 11-1). Dr. Schmidt also reported that, if he correctly understood claimant's work activities, claimant's job was "definitely capable of producing the type of cervical root irritation that he developed," which he interpreted as "the major contributing cause for [claimant's] need to seek medical care." (Ex. 16).

There is no medical evidence that claimant sustained a compensable injury that combined with a preexisting condition. Thus, we agree with the parties that compensability should be analyzed under ORS 656.802 rather than ORS 656.005(7)(a)(B), which the ALJ applied. As an occupational disease, claimant must show that employment conditions were the major contributing cause of his condition and not merely his symptoms. E.g., Aetna Casualty v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991).

Like the ALJ, we find the medical evidence does not carry claimant's burden of proof. Although Dr. Maness stated that claimant's work was the major contributing cause of claimant's "pain," his opinion was conclusory and without benefit of the subsequent x-rays and MRI showing degenerative disc disease. Consequently, his opinion is not persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Baertlein could not determine causation. Dr. Harris indicated only that claimant's work made his condition symptomatic without causing it, which, as discussed above, is inadequate to meet claimant's burden of proof under ORS 656.802.

Finally, we agree with the ALJ that Dr. Schmidt's understanding of claimant's work activities was not consistent with claimant's testimony at hearing since claimant stated that on only one occasion did he hang 1,000 suits and, otherwise, he handled between 150 to 400 suits. Furthermore, we consider Dr. Schmidt's opinion inconsistent since, in a report to Dr. Harris, he stated that claimant's cervical radicular irritation was "associated with spondylotic changes and foraminal stenosis" but, in reporting to claimant's attorney, he indicated that the major contributing cause for the need for treatment was claimant's work. Thus, we find Dr. Schmidt's opinion also to be unpersuasive. Somers, 77 Or App at 263.

Finding an absence of persuasive medical opinion showing that claimant's employment conditions were the major contributing cause of his right shoulder and arm condition, we conclude that claimant failed to prove compensability. ORS 656.802(2).

ORDER

The ALJ's order dated January 30, 1997 is affirmed.

July 24, 1997 Cite as 49 Van Natta 1163 (1997)

In the Matter of the Compensation of
CRAIG J. LAMONT, Claimant
WCB Case No. 96-08186
ORDER ON REVIEW
Malagon, Moore, 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) Neal's order that: (1) upheld the SAIF Corporation's denial of his claims for costochondritis of the left anterior chest and partial rotator cuff tear of the left shoulder; and (2) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

We change the first sentence of the findings of fact to read: "Claimant worked after June 30, 1996 for the employer as a truck driver, driving loads of food and flower products to locations in California." In the fourth paragraph on page 3, we delete the first sentence. We change the ninth sentence of the last paragraph that begins on page 3 to read: "His left shoulder symptoms were minimal at first, but severe later when he saw Dr. Wells and Dr. Carvalho, even though he had not been working for months." On page 4, we delete the second full paragraph. We delete the last sentence of the last paragraph that begins on page 4.

We change the section on Penalties and Attorney fees to read:

"Claimant requests penalties and attorney fees for an alleged unreasonable denial. Inasmuch as we have concluded that claimant's shoulder and costochondritis conditions are not compensable, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty or a penalty-related fee."

ORDER

The ALJ's order dated January 27, 1997 is affirmed.

In the Matter of the Compensation of
DAVE R. MORITZ, Claimant
WCB Case No. 96-07960
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Jerome P. Larkin, Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of claimant's right inguinal hernia condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant proved neither a compensable injury nor occupational disease. Claimant asserts that his hernia claim should be analyzed as one for accidental injury under ORS 656.005(7)(a) and that he proved the compensability of such a claim.

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)).

Here, claimant testified that, on Thursday, May 23, 1996, while stepping down from a Hyster at work, he first noticed a "heavy feeling" in his right groin area. (Tr. 15-16). The following Monday, May 27, claimant noticed a bulge. (Id. at 17). The next day, claimant sought treatment from Dr. Van Camp and was diagnosed with right inguinal hernia. (Ex. 9-1).

Dr. Van Camp provided an opinion that claimant's initial symptom of "fullness," followed by the bulge, was consistent with the development of a hernia. (Ex. 16-2). Dr. Van Camp explained that "hernias can protrude and reduce over a period of time" and often are not visible to the patient. (Id.) Dr. Van Camp also stated that claimant's lifting activity at work was a material contributing cause of his hernia. (Id.)

We understand Dr. Van Camp as showing that claimant sustained a hernia with the heavy lifting he performed at work and he became aware of the condition once it had sufficiently protruded. Because Dr. Van Camp relates the development of the hernia with specific activity during a specific time, we find that his opinion shows that claimant's condition qualifies as an "event" or accidental injury. Mathel, 319 Or at 241-42.

The remaining opinion is from Dr. Edwards, who performed a record review at SAIF's request. Dr. Edwards found "no reason to implicate work as the major contributing cause" for the hernia based on the history that claimant did not experience pain until at home. (Ex. 14-2). Instead, Dr. Edwards thought that chronic bronchitis, due to smoking, caused the hernia either during a single episode of overexertion or stress or chronic low grade injuries such as those sustained by a chronic cough. (Id. at 3).

In evaluating medical opinions, we generally rely on the treating physician, unless there are reasons to do the contrary. Weiland v. SAIF, 59 Or App 810 (1983). Here, we find no reason to reject Dr. Van Camp's opinion. It is based on an accurate history and provides reasoning for the conclusion. Dr. Edwards, on the other hand, did not examine claimant. Furthermore, there is nothing in his report showing that he was aware of claimant's "full" sensation that he felt at work, indicating that he did not have an accurate history. Finally, as explained by Dr. Van Camp, (Ex. 16-2), there is no medical evidence to support Dr. Edwards' opinion that claimant suffered from chronic bronchitis.

Consequently, we find Dr. Van Camp's opinion most persuasive. As explained above, under his opinion, the hernia condition is most appropriately analyzed as an accidental injury. Because Dr. Van Camp also demonstrated that work activities were a material contributing cause of claimant's hernia, claimant carried his burden of proving compensability. ORS 656.005(7)(a).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, 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 appellant's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 20, 1996 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by the SAIF Corporation.

July 24, 1997 Cite as 49 Van Natta 1165 (1997)

In the Matter of the Compensation of
CATHERINE G. RENFRO, Claimant
WCB Case Nos. 96-02773 & 95-11919
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Ronald Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) denied the insurer's motion to dismiss claimant's request for hearing on the ground that claimant did not file her aggravation claim on the correct form; (2) set aside the insurer's denials of claimant's aggravation claim; and (3) awarded an assessed attorney fee. On review, the issues are dismissal, aggravation and attorney fees.

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

On review, the insurer argues that the ALJ incorrectly found that claimant was not required to file her aggravation claim on the new Director's aggravation form pursuant to amended ORS 656.273(3). Specifically, the insurer argues that the Department's agent testified that the form was available at the time claimant filed her aggravation claim, and claimant could have obtained the form by contacting the Department.

We have previously held that we will not impose the "Department form" requirement retroactively in a case where the claimant would be required to comply with notice procedures that were not even in existence at the time the claimant filed the aggravation claim. See Rick A. Webb, 47 Van

Natta 1550 (1995); Ilene M. Herget, 47 Van Natta 2285 (1995). The insurer contends that those cases are distinguishable, as the Department's form was in existence at the time claimant filed her claim, and by making an inquiry, claimant could have obtained the form.

The Department's agent, Mr. Bruyns, testified that the new form was accompanied by DCBS Bulletin No. 284, dated July 6, 1995. (Ex. 91). The Bulletin advised parties of the requirement of a new form pursuant to the passage of SB 369. The Bulletin also provided that a "claim for aggravation may be made in any written form and accompanied by the attending physician's report until this form is fully distributed and available to injured workers." (Ex. A).

Here, the insurer argues that the form was available to claimant at the time she filed her aggravation claim on July 10, 1995. However, the Department's Bulletin permits filing under the "old" law until the form was both available and had been fully distributed. As the ALJ found, based on Mr. Bruyns' testimony, the mailing of the forms had not been completed until July 11, 1995. Under such circumstances, we agree that, at the time claimant filed her claim, the form was not "fully distributed and available." Accordingly, the ALJ correctly found that the claim was properly filed.

With respect to the merits of the claim, the insurer argues that claimant has not proven an actual worsening of the compensable condition. ORS 656.273(1); SAIF v. Walker, 145 Or App 294, 305 (1996). The insurer contends that, although the ALJ relied on the opinion of Dr. Black, that medical opinion can only be construed to show a possible worsening of her scheduled condition (hearing loss), and does not show an increased loss of earning capacity beyond that taken into account by the prior award of 80 percent unscheduled permanent disability.

We conclude that Dr. Black's opinion supports an actual worsening of both claimant's scheduled and unscheduled conditions. Dr. Black opined that claimant "suffered (sic) worsening of her condition." Dr. Black described that worsening as including a reopened right perilymph fistula, a progression of right hearing loss and an aggravation of her vestibular systems abnormalities, which "clearly and unequivocally establish loss of auditory and vestibular function." (Ex. 82).

Dr. Black's opinion discussing claimant's vestibular condition and hearing loss condition supports a worsening of both claimant's unscheduled and scheduled conditions. See OAR 436-035-0390; OAR 436-035-0250. Additionally, although the insurer argues that there is no evidence of a diminished earning capacity in this case, we have previously held that the amended version of ORS 656.273(1)[1] now defines a "worsened condition" as an "actual worsening of the compensable condition supported by objective findings." Jason S. Palmer, 48 Van Natta 2394 (1996). In Palmer, we found that the legislature intended to focus on a worker's physical condition, rather than on a loss of earning capacity or loss of use or function in a legal sense. Therefore, it is no longer necessary for a claimant to prove diminished earning capacity in order to establish a worsened condition involving an unscheduled body part.

Consequently, based on Dr. Black's opinion, we conclude that claimant has proven by direct medical evidence that her compensable condition actually worsened. Walker, 145 Or App at 305. We therefore agree with the ALJ's conclusion that claimant has established an aggravation pursuant to ORS 656.273(1).

Claimant's attorney is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved.

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[1] Both parties have argued, and we agree, that the current version of ORS 656.273 applies to the merits of this case. We conclude that such an application is not inconsistent with our decision that the "form requirement" aspect of the statute does not apply in a case where the form itself was not distributed and available to the worker at the time of claim filing. See, e.g., Ilene M. Herget, 47 Van Natta 2285 (1995) ("Department form requirement" not imposed retroactively, but the claimant was required to comply with the remainder of amended ORS 656.273(3)).

ORDER

The ALJ's order dated December 9, 1996 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,400 for services on review, to be paid by the insurer.

In the Matter of the Compensation of
WINFRIED H. SEIDEL, Claimant
WCB Case No. 96-09311
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that awarded claimant 9 percent (17.28 degrees) scheduled permanent disability for loss of use or function of the left arm and 5 percent (9.6 degrees) for loss of use or function of the right arm. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Loss of Strength

The ALJ awarded claimant 4 percent (17.28 degrees) scheduled permanent disability for loss of use or function of the left arm. The ALJ relied on Dr. Potter's finding of muscle strength loss of 4.5/5 in the median intrinsic on the left side.

SAIF argues that the loss of strength of the median intrinsic muscle is not related to the compensable shoulder injury. SAIF contends that Dr. Potter's report is ambiguous and incomplete and, because he did not explain how loss of strength of the median intrinsic muscle could be related to the accepted shoulder injury, the Board should not rely on his report. SAIF asserts that this case is analogous to Silverio Frias-Molinero, 48 Van Natta 1285 (1996). We disagree.

In Frias-Molinero, the arbiters found low back and left foot impairment due to a low back strain. However, there was no evidence that the arbiters were aware of the claimant's intervening low back injury and the medical history for the August 1994 injury was absent from their analysis. Under those circumstances, we were not persuaded that the low back and left foot impairment found by the arbiters constituted findings of impairment due to the February 1994 compensable injury.

Here, unlike Frias-Molinero, the medical arbiter in this case was aware of claimant's intervening bilateral carpal tunnel surgery. Dr. Potter reported that claimant had surgery for bilateral carpal tunnel syndrome in May 1996. (Ex. 33-2). Dr. Potter noted that claimant was off work due to his hands, and not his shoulders. In reporting claimant's muscle strength findings, Dr. Potter reported that the muscle strength of "all muscle groups around the shoulders, elbows, wrists and intrinsics were 5/5, with the exception of the median intrinsic on the left side which was 4.5/5." (Ex. 33-3).

Dr. Potter was asked to

> *"Describe any **MUSCLE STRENGTH** loss, **DUE TO THIS INJURY**, in the 0-5/5 method. Identify the specific body part and applicable peripheral nerve, nerve root, or muscle. Include a comment on whether the loss of strength is **due to** loss of muscle, nerve damage, disruption of the musculotendinous unit, range of motion loss, or other. If other, explain the etiology in detail."* (Ex. 33-4; emphasis in original).

Dr. Potter responded that "[m]uscle strength testing has been carried out and the results are noted in the physical examination above." (Id.)

If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550 (1997). However, where the treating physician or medical arbiter attributes the claimant's impairment to causes other than the compensable injury, the opinion is not considered persuasive evidence of injury-related impairment. See, e.g., Marcia G. Williams, 49 Van Natta 313 (1997).

Here, Dr. Potter was asked about impairment concerning claimant's accepted conditions of right shoulder strain and left shoulder impingement syndrome. (Ex. 33-1). Dr. Potter was aware of claimant's intervening bilateral carpal tunnel surgery. Nevertheless, in responding to the inquiry about muscle strength loss due to the compensable injury, Dr. Potter did not indicate that any impairment was due to causes other than the compensable injury. (Ex. 33-4). There is no medical evidence from the record that muscle strength loss of the median intrinsic on the left side was inconsistent with claimant's accepted shoulder conditions. Given the fact that Dr. Potter did not attribute the findings to causes other than the compensable conditions and given that he rated impairment in response to a specific inquiry regarding claimant's impairment due to this injury, we construe those findings as being due to the compensable conditions. Danboise, 147 Or App at 550.

SAIF relies on Dr. Chamberlain's May 7, 1996 closing examination, in which he opined that claimant "may return to his regular work without limitation, as far as the shoulders are concerned." (Ex. 26). He reported that claimant had 5/5 strength for resisted abduction, and internal and external rotation. Dr. Chamberlain found no evidence of neurologic damage and "no residual impairment." (Id.)

Dr. Chamberlain's May 7, 1996 report appears to be inconsistent with an earlier report. On April 2, 1996, Dr. Chamberlain had concurred with a report from Drs. Neumann and Rich, which stated that claimant had 5/5 muscle strength about the shoulder girdle in the biceps and triceps except for "on the left side, which demonstrates 4/5 strength from give-way weakness." (Exs. 19-4, 23). Drs. Neumann and Rich found no evidence of functional overlay or secondary gain. (Ex. 19-8).

OAR 437-035-0007(13) (WCD Admin. Order No. 96-051) provides, in part:

> "On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence."

In this case, we rely on the medical arbiter's findings, because Dr. Potter's report is a complete, well-reasoned evaluation of claimant's impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment). We are not persuaded by Dr. Chamberlain's May 7, 1996 report because he did not explain his apparent change of opinion. We agree with the ALJ that claimant is entitled to a 4 percent award for loss of use or function of the left arm. See OAR 436-035-0110(8); OAR 436-035-0007(18) & (19).

Chronic Condition

The ALJ awarded 5 percent "chronic condition" awards for both the left and right arm. The ALJ found that Dr. Potter specifically enumerated the arms as the restricted body parts.

OAR 436-35-0010(5) provides, in part:

> "A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following four body parts:

"* * * * *

"(d) Arm (elbow and above)."

Citing Kim S. Anderson, 48 Van Natta 1876 (1996), SAIF argues that claimant is not entitled to chronic condition awards for his right and left arms. According to SAIF, Dr. Potter specified only that claimant had limited ability to repetitively use both shoulders and he made no similar findings regarding the arms.

In Anderson, the ALJ found that, although the claimant's accepted condition was a left shoulder condition, which had resulted in an award of 24 percent unscheduled permanent disability, the claimant was nevertheless entitled to an additional scheduled permanent disability award for a chronic condition limiting the repetitive use of her left arm. Although the claimant specifically requested that an arbiter exam was being sought in order to determine whether the claimant had a "right arm chronic use award," the arbiter did not find that the claimant had such a condition. Rather, the arbiter found that the claimant had a "limited or partial loss of ability to repetitively use the shoulder * * *." (Ex. 92-4). We concluded that the arbiter's opinion specified only that the claimant was unable to repetitively use her shoulder. Because the statute and the rules required a medical opinion which establishes evidence regarding the body part, we were unable to substitute our own opinion to find that the chronic condition was actually for the claimant's arm, when the arbiter specified that the chronic condition impairment was found in the shoulder.

We distinguished the Anderson case from Alvena M. Peterson, 47 Van Natta 1331 (1995). In Peterson, we found that the claimant was entitled to a scheduled chronic condition award for her arm, in addition to an unscheduled award for a shoulder condition. Relying on Foster v. SAIF, 259 Or 86 (1971), we found that, if an injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions, a claimant is entitled to separate disability awards. Accordingly, in Peterson, we found that, because the medical arbiter had found a chronic condition ("limitations related to chronic and repetitive use of [the] right arm"), the claimant was entitled to a separate scheduled permanent disability award for her chronic arm condition.

Here, we agree with the ALJ that this case is similar to Peterson. In response to a question as to whether claimant had limited or partial loss of ability to repetitively use the shoulder, Dr. Potter responded that claimant had limited ability to repetitively use both shoulders in overhead work. (Ex. 33-4). In section 6 of his report, Dr. Potter was asked to describe claimant's residual functional capacity "with reference to the accepted condition(s) and/or sequelae[.]" (Ex. 33-5). Part c of section 6 asked Dr. Potter to state whether claimant was permanently precluded from frequently performing any or all of the following activities. (Id.) Dr. Potter responded:

> "There are no permanent restrictions in stooping, twisting, climbing, reaching, crouching, kneeling, balancing, or pushing. However, he is restricted from climbing with his arms. He has restriction in repetitive pulling. He also has restriction in crawling due to his upper extremities." (Id.)

We agree with the ALJ that Dr. Potter specifically enumerated the arms as restricted body parts. We rely on the medical arbiter's findings, because the arbiter's reports are a complete, well-reasoned evaluation of claimant's impairment. We conclude that claimant is entitled to a scheduled chronic condition award for his arms, in addition to an unscheduled award for a shoulder 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 $1,200, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 3, 1997, as amended March 7, 1997, is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
MARK C. BRUNSON, Claimant
Own Motion No. 97-0320M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable partial amputation of his right thumb and long finger injury. Claimant's aggravation rights expired on June 1, 1994. SAIF opposes reopening of the claim, contending that claimant was not in the work force at the time of disability.

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

In a June 9, 1997 report, Dr. Dreyer, claimant's attending physician, opined that claimant required surgery for removal of a right thumb mass, retained nail and possible neuroma. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

SAIF contends that claimant was not "in the labor market or actively seeking work." SAIF further contends that claimant was unable to provide proof of earnings for the past two years. Claimant contends that he qualifies for temporary disability compensation because, subsequent to being released from incarceration in February 1996, he performed "odd jobs," and, since September 1996, provided handyman work for Mr. Moe in exchange for room and board. 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 a July 14, 1997 affidavit, claimant stated that, since February 1996, he "looked for work with various and numerous employers, mostly without success." Claimant attested that he performed odd jobs around a junk yard in Coburg, Oregon, for Mr. Winthrow. Claimant further stated that, since September 1996, Mr. Moe "provides me lodging, consisting of a studio with bed, bathroom, appliances, over a shop; he also pays me occasionally for my work." In a July 14, 1997 letter, Mr. Moe verified that claimant has resided in his home since September 1996, and "he often helps [with chores] if the need arises."

We have previously found that room and board, with or without pay, can equal wages, and, thus, qualifies as "wages" under ORS 656.005(29). See George L. Peachy, 48 Van Natta 2115 (1996); Orvel L. Chaney, 48 Van Natta 612 (1996); James L. Emerich, 45 Van Natta 1701 (1993). Here, claimant worked as a handyman for Mr. Moe, however, that work was interrupted by claimant's recent surgery. Therefore, claimant is entitled to receive pay for the work he would normally have performed for Mr. Moe had he not undergone surgery for his compensable injury.

In the alternative, SAIF contends that claimant has not provided "proof of earnings for the past two years." We have previously found that a claimant must provide persuasive evidence that the claimant was in the work force during the "relevant period." That period does not necessarily include the time period for two years prior to the current disability, as SAIF suggests. See Michael C. Batori, 49 Van Natta 535 (1997). Here, claimant has provided evidence that he has been seeking work since his parole in February 1996, and has been exchanging work for room and board (and occasional pay) since September 1996. Although claimant would not be entitled to temporary disability compensation while incarcerated, we conclude that, although he was temporarily removed from the work force while incarcerated, he reentered the work force when he was released and began seeking employment. See SAIF v. Stephen, 308 Or 41 (1990); Howard L. Browne, 49 Van Natta 864 (1997). Therefore, we conclude that claimant is entitled to temporary disability compensation to compensate for the loss of income he incurred beginning with his recent surgery.

On this record, we conclude that claimant has established that he was in the work force at the time of disability.

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

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
LEAH M. COLUMBUS, Claimant
WCB Case Nos. 97-00898 & 95-09411
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's December 26, 1994 low back (internal disc disruption) injury claim. On review, the issue is compensability.[1] We reverse.

FINDINGS OF FACT

Claimant, age 41 at hearing, has worked as a home health aide for the employer since February 1993. In the mid-1980's, claimant experienced sudden numbness in her right leg and tingling in her toes, for which she was referred to Dr. Randle, neurologist. A month later, claimant experienced pain radiating from her right abdominal region into her right groin. Dr. Randle diagnosed a femoral nerve entrapment syndrome, which he treated conservatively. Subsequently, claimant experienced generalized fatigue and weakness in the right leg and arm, worse with exposure to cold or heat. After testing in 1989 eliminated possible demyelating disease, claimant was diagnosed with fibromyalgia. Claimant continued to experience recurring episodes of fatigue with weakness in the right upper and lower extremities, as well as abdominal pain radiating into her groin. Claimant also reported a history of a broken coccyx many years ago. (Ex. 2, Tr. 23). Claimant also experienced a low back strain injury in about 1990 or 1991 while working as a CNA at a prior employer. (Ex. 6c-11).

On February 23, 1994, claimant reported to her employer that she strained her back in a slip and fall incident that occurred that day. (Ex. 1). She sought no medical attention and missed no time from work.

In November 1994, claimant sought treatment for her worsened pain condition. On January 6, 1995, Dr. Jensen evaluated claimant's pain, which included pain in her low back, right leg, calf, and bottom of the foot. Dr. Jensen thought the low back and right leg pain was suggestive of right S-1 radiculopathy and referred claimant to Dr. Karasek, neurologist, for further evaluation. (Ex. 2).

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[1] The insurer also raises the issue of the timeliness of claimant's February 23, 1994 low back strain claim. The ALJ determined that claimant filled out an accident report for the employer on February 23, 1994. However, the ALJ concluded that the February 23, 1994 claim was not compensable. Claimant did not cross-appeal the ALJ's compensability finding. Thus, the timeliness issue is moot.

Dr. Karasek reported that claimant had experienced low back pain for three or four years, and about a year previously (about February 1994), she experienced increased right low back pain with pain radiating down the right thigh into her foot. (Ex. 3). Dr. Karasek diagnosed a possible L5-S1 disc abnormality consistent with intrinsic disc dysfunction and intermittent S1 nerve root irritation. He treated claimant with facet blocks at L4 and L5 and a nerve block at S1. (Exs. 3a, 3b, 3c).

On April 20, 1994, claimant returned to Dr. Ewing, who prescribed physical therapy. (Exs. 3d, 4, 6A).

On April 21, 1995, claimant told her physical therapist that her original injury took place about a year ago on the job, with a dramatic increase in symptoms late in the winter after an increased work load, overtime, and dealing with heavy patients. (Ex. 4).

On April 24, 1995, claimant filed an injury claim for the February 1994 back strain incident. (Ex. 5). On April 25, 1995, claimant filed a claim for a low back strain, which she attributed to a heavy patient load in December 1994, January and February 1995. (Ex. 6).

In May 1995, claimant fell twice at home, contusing her right hip. Later in the same month, claimant felt a popping sensation and acute pain in her low back after falling while pulling laundry out of a dryer at home. (Exs. 4-2, 6A-2, 6C-10).

On July 14, 1995, the insurer denied each of claimant's low back injury claims. (Exs. 7, 9).

On November 14, 1995, Dr. Hacker, neurosurgeon, evaluated claimant's low back and right leg pain on referral from Dr. Karasek. Claimant reported an injury to her back on or about December 26, 1994, when she reached across a bed to do vigorous physical rehabilitation maneuvers with a patient. Dr. Hacker noted that claimant had no similar history of low back or leg pains, though she did suffer a "muscle strain" to her low back years ago which resolved within a matter of days. Dr. Hacker diagnosed claimant with internal disc disruption at L5-S1, with mechanical low back pain and irritative radiculitis. (Exs. 11A, 12A, 12B).

On February 14, 1996, claimant was evaluated for the insurer by Drs. Tsai and James, who diagnosed preexisting degenerative disc disease. (Ex. 12).

On May 2, 1996, Dr. Hacker performed fusion surgery at L5-S1. (Ex. 13).

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Hacker, the ALJ concluded that claimant established that her December 26, 1994 injury was the major contributing cause of her disability and need for treatment related to her internal disc disruption (IDD). On review, the insurer contends that claimant failed to carry her burden of proof, as Dr. Hacker had an incorrect history of the onset of claimant's IDD. We agree.

In order to prove compensability of her IDD injury claim, claimant must establish that her work activities were a material cause of her disability or need for treatment; or, if claimant has a preexisting condition that combined with her work injury, she must establish that the injury was the major contributing cause of the disability or need for treatment resulting from the combined condition. ORS 656.005(7)(a); 656.005(7)(a)(B).

We begin with a brief summary of the relevant facts. In January 1995, claimant sought evaluation of her chronic pain, which had worsened in about November 1994, from Dr. Jensen. Claimant complained of pain in her right arm, right shoulder, neck and low back. The pain from her low back radiated into the back of her right leg and down into her foot. Claimant reported that her problems began in the mid-1980's, when she first noticed sudden numbness in her right leg. Claimant did not report any injury to her low back in February or December 1994, or earlier. Dr. Jensen referred claimant to Dr. Karasek for evaluation of her low back condition.

Claimant reported to Dr. Karasek that she had experienced low back pain for at least three or four years, and that approximately a year before (February 1994) she experienced increasing pain in her right lower back, which radiated down the back of her right leg and into the bottom of her foot. (Exs. 3-1, 16-6). Claimant did not report any injury to her low back at work in February or December 1994, or earlier. (Exs. 3, 3a, 3c, 16-7).

In April 1995, claimant reported to her physical therapist that she originally injured her back about a year earlier, when she slipped and fell on the job, with a dramatic increase in symptoms late in the winter of 1994 due to increased work load and overtime, and dealing with heavy patients. (Ex. 4-1).

In May 1995, when treating with Dr. Ewing, claimant stated on the Form 827 that her back pain was due to a heavy work load and long hours. (Ex. 3d). Although claimant identified the February 1994 injury as a prior injury, she did not identify a December 1994 incident as the cause of her low back and right leg pain. (Ex. 11). In mid-May 1995, claimant experienced popping and sharp pain when she fell while pulling sheets from her washer to her dryer at home. (Ex. 4-2).

In November 1995, Dr. Hacker, neurosurgeon, evaluated claimant's low back and right leg pain. Claimant told Dr. Hacker that she experienced an acute low back injury in December 1994, while reaching across a bed to do vigorous physical rehabilitation maneuvers with a patient. Claimant also indicated to Dr. Hacker that she had no similar history of low back or leg pain, although she did report that she suffered a muscle strain to her low back "years ago," which resolved within days. (Exs. 11A-2, 13-23, 15-5).

We agree with the ALJ that this case involves complex medical questions regarding the cause of claimant's IDD. 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 is 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. Hacker is the only medical expert to diagnose IDD at L5-S1 and to relate that condition to claimant's December 26, 1994 injury.[2] (Exs. 15-12, 15-15). Unlike the ALJ, we are unpersuaded by Dr. Hacker's opinion on causation 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).

In forming his opinion that claimant's work injury was the major contributing cause of claimant's IDD, Dr. Hacker relied on claimant's report of the onset of her low back pain to a lifting and twisting injury on December 26, 1994, and her denial of a history of low back or leg pains. (Exs. 11A-2, 15-16 through -27). Claimant also reported to Dr. Hacker that she suffered a "muscle strain" to her low back "years ago" which resolved within a matter of days. However, the history claimant reported to Dr. Hacker is not consistent with the contemporary medical records, none of which documents the onset of claimant's low back symptoms as the result of a specific incident on or about December 26, 1994.

First, claimant did not report the December 26, 1994 incident to Ms. Keller, her supervisor. In March 1995, when Ms. Keller became aware that claimant was having low back problems, she talked to claimant about filling out an injury report. Claimant did not want to fill out an injury report, as she was not sure that her injury was work related. (Tr. 51).

Second, claimant told Dr. Jensen that her pain problems, including right leg and foot symptoms, began in the mid 1980's. In November 1994, she scheduled her appointment with Dr. Jensen because her pain condition had worsened. (Tr. 28). Moreover, under cross-examination, claimant was unable to say when her symptoms worsened or whether her pain started in November or December 1994, because she had been "seeing home health patients over the last year." (Tr. 28, 38). Claimant also testified that her right leg and low back remained symptomatic after the February 1994 incident. (Tr. 12, 38).

Third, claimant told Dr. Karasek, as well as her physical therapist, that her pain had existed for three to four years, and had increased approximately a year earlier (February 1994). Finally, claimant did not report a specific incident at work in December 1994 to Dr. Ewing, and, while he had a general sense that claimant's work was heavy, he had no indication that her condition was occupationally related. (Ex. 11).

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[2] Dr. Karasek diagnosed L5-S1 disc disruption and intermittent nerve root irritation, which he treated with facet blocks at right L4 and L5 and a nerve block at S1. (Exs. 3, 3a, 3b, 3c, 16-7). However, he did not attribute the onset of her condition to a specific injury. (Ex. 16-9).

In contrast to these contemporary reports, when claimant sought treatment from Dr. Hacker in November 1995, she reported that her low back pain began in December 1994, while reaching across a bed to do vigorous physical rehabilitation maneuvers. Claimant also indicated to Dr. Hacker that she had no similar history of low back or leg pain, although she told him she had suffered a muscle strain to her low back "years ago," which resolved within days.

Because the record does not support Dr. Hacker's premise that claimant experienced the abrupt onset of severe low back and leg pain on or about December 26, 1994, his opinion as to the cause of her IDD is unpersuasive. Moreover, because Dr. Hacker's history was incomplete, he was unable to assess the relative contributions that claimant's preexisting degenerative condition, 1990 back strain, and the February 1994 injury may have had in the development of her IDD. Consequently, on this record, we conclude that claimant has not established the compensability of her IDD 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).

ORDER

The ALJ's order dated January 21, 1997 is affirmed in part and reversed in part. That part of the order setting aside the denial of claimant's IDD condition is reversed, and the insurer's denial is reinstated and upheld. The ALJ's attorney fee is reversed. The remainder of the order is affirmed.

July 24, 1997 Cite as 49 Van Natta 1174 (1997)

In the Matter of the Compensation of
VERONICA M. STRACKBEIN, Claimant
WCB Case No. 96-03694
ORDER OF ABATEMENT
Darris K. Rowell, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our June 27, 1997 Order on Review, in which we reversed the ALJ's award of permanent total disability. Claimant contends that our order is at odds with a May 20, 1997 Opinion and Order in WCB Case No. 96-08239 finding claimant's current condition to be compensable, and that we improperly determined the compensability of claimant's current condition in the context of a hearing on extent of permanent disability. See Robin W. Spivey, 48 Van Natta 2363 (1996).

In order to consider this matter, we withdraw our June 27, 1997 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH C. HUMPHREY, Claimant
WCB Case No. 96-03794
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the insurer's denial of his low back aggravation claim; and (2) declined to award penalties and attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are aggravation, 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

Aggravation

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

Penalties and Attorney Fees

Claimant alleged that he was entitled to an award of penalties and attorney fees, asserting that the insurer's aggravation denial was untimely and unreasonably issued. Claimant also contended that the insurer had unreasonably failed to pay temporary disability within 14 days of notice or knowledge of the aggravation claim. See ORS 656.273(6). Although acknowledging there was merit to claimant's arguments, the ALJ declined to award penalties, reasoning that penalties for unreasonable resistance to the payment of compensation can only be assessed within the context of a compensable claim. See Randall v. Liberty Northwest, 107 Or App 599 (1991) (where aggravation claim was not compensable, no unreasonable resistance to payment of compensation, even though claim was untimely denied).

We agree with the ALJ's reasoning with respect to the issues of untimely and unreasonable denial. Steve D. Edwards, 48 Van Natta 2162 (1996) (no penalty for allegedly unreasonable denial where underlying claim was not compensable); Donald M. Hughes, 46 Van Natta 2281 (1994) (no penalty for allegedly untimely denial where underlying claim was not compensable). However, claimant's entitlement to interim compensation (in the form of temporary disability benefits) depends on whether the 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) and thus constitutes prima facie evidence in the form of objective findings that claimant's compensable condition has worsened. See ORS 656.273(6); Ilene M. Herget, 47 Van Natta 2285, 2286 (1995). The statutory obligation to pay interim compensation does not depend on whether the claim is ultimately determined to be compensable. Anthony J. McKenna 49 Van Natta 97, 102 (1997); Patricia J. Sampson, 45 Van Natta 771 (1993).

Here, notice of an aggravation claim was filed on March 12, 1996. (Ex. 31). The insurer conceded that the first payment of interim compensation was untimely paid on April 19, 1996. (Ex. 40). The insurer provided no explanation for its untimely payment of interim compensation. Therefore, we find that the insurer's claim processing was unreasonable. Inasmuch as claimant's entitlement to interim compensation does not depend on the compensability of the aggravation claim, we further conclude that a 25 percent penalty should be assessed pursuant to ORS 656.262(11). This penalty should be based on the amounts "then due" claimant at the time of the insurer's untimely payment of interim compensation, payable in equal shares to claimant and his attorney. See Pamella K. Pruett, 41 Van Natta 2347, 2349 (1989).

ORDER

The ALJ's order dated March 18, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that declined to award a penalty for untimely payment of interim compensation is reversed. SAIF is ordered to pay a 25 percent penalty on amounts due at the time of the insurer's untimely payment of interim compensation, payable in equal shares to claimant and his attorney. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
STEVEN J. LANDER, Claimant
WCB Case No. 95-12476
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Bock, Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's left shoulder claim. On review, the issue is compensability.

We adopt and affirm the order of the ALJ.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 16, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,250, to be paid by the SAIF Corporation.

Board Member Haynes dissenting.

I disagree with the majority that claimant proved compensability. Consequently, I must respectfully dissent.

The medical opinions are not very different. Dr. Snider essentially stated that, although claimant's work did not cause the arthrosis, such activities were the major contributing cause of a worsening of claimant's preexisting left shoulder arthrosis. (Exs. 11, 14). Dr. Duff also found that claimant's work did not cause the condition, but contributed to the arthrosis becoming symptomatic. (Exs. 12, 13-17, 13-18).

In my opinion, a worsening of a preexisting condition does not translate into proof that a compensable injury is the major contributing cause of claimant's need for treatment of a combined condition. On the contrary, it shows that the preexisting condition, and not a "combined condition," is the condition requiring medical treatment. Furthermore, based on Dr. Snider's other statements that claimant's work "caused his pain" and was the factor causing the preexisting condition to "become symptomatic," I interpret Dr. Snider's use of "worsening" as meaning that claimant's work only precipitated symptoms and was not necessarily the primary cause of the need for treatment of the combined condition.

Based on my analysis of this medical evidence, I disagree with my fellow members' decision to affirm the ALJ's conclusion that claimant had established the compensability of his claim.

In the Matter of the Compensation of
MARTHA E. LEYVA, Claimant
WCB Case No. 96-02933
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) Kekauoha's order that: (1) found that claimant's claim for a closed head injury, post-traumatic headaches, and a lumbar strain was not prematurely closed; (2) awarded no additional temporary disability; and (3) affirmed an Order on Reconsideration that awarded no scheduled or unscheduled permanent disability. On review, the issues are premature closure, and, if claimant's claim was not prematurely closed, temporary disability, and extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and summarize as follows.

On October 20, 1995, claimant sustained a fall at work that resulted in a closed head injury with amnesia and a back strain. The insurer accepted closed head injury, post-traumatic headaches and lumbar strain. Dr. Buza, neurosurgeon, treated claimant with physical therapy for her back and Tylenol for her headaches. On November 9, 1994, Dr. Buza discontinued physical therapy, and, on November 13, 1995, recommended that the insurer obtain a closing examination, which took place on December 29, 1995.

The examining physicians, Drs. Gancher, neurologist, and Staver, orthopedist, opined that claimant was not medically stationary and recommended additional treatment for her back and headache conditions. They stated that "[i]t is recognized that post traumatic headaches are somewhat long lasting after closed head injuries and it is not atypical for individuals to have post traumatic headaches for 12-18 months after an injury."

On January 29, 1996, Dr. Buza, noting that he was not a neurologist, deferred comment regarding concurrence with the examiners' opinion. Dr. Buza recommended referring claimant for further evaluation, indicating that, if the evaluators concurred with Dr. Gancher's treatment plan, he would concur with Drs. Gancher and Staver's findings. Dr. Buza also noted in a separate letter to the insurer that claimant had last been seen by him on November 13, 1995.

On March 1, 1996, the insurer wrote to claimant, with a copy to claimant's attorney, as follows:

> "Current information indicates you have not received medical treatment relative to your injury/condition for a period of at least 30 days.
>
> "Going without medical treatment for 30 days or not attending a closing examination must have approval of your attending physician. If you do not have approval of your attending physician and there are reasons beyond your control for not seeking treatment, please contact this office.
>
> "Your claim cannot be held in open status indefinitely. If you feel your accepted condition still requires medical treatment, you or your physician must respond to this letter within two weeks from the date of this letter or it will be assumed that you have completely recovered without disability and actions will be taken to close your claim, based on failure to seek medical treatment.
>
> "If you have any questions or concerns, please contact this office immediately." (Ex. 21a).

On March 13, 1996, claimant was evaluated by Dr. Keller, neurologist, on referral from Dr. Buza. Dr. Keller diagnosed post-traumatic headache disorder and signs of S1 radiculopathy and concluded that claimant needed further treatment. (Ex. 21A).

On March 20, 1996, the insurer requested that the Department close claimant's claim by Determination Order, indicating that the claim statutorily qualified for closure on March 15, 1996. (Ex. 23). On April 3, 1996, a Determination Order issued which administratively closed claimant's claim, finding that claimant statutorily qualified for closure on December 29, 1995, and awarding temporary disability from October 20 through October 24, 1995, and no permanent disability. (Ex. 25). Claimant requested reconsideration, raising issues of premature closure; temporary disability; and extent of permanent disability, requesting appointment of a medical arbiter. (Ex. 25).

On June 19, 1996, Drs. Neumann, orthopedic surgeon; Olson, neurosurgeon; and Burt, psychiatrist; performed an arbiter examination. On July 25, 1996, an Order on Reconsideration issued which found that claimant qualified for statutory claim closure as of December 13, 1995, and affirmed the April 3, 1996 Determination Order in all other respects.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The ALJ found that the insurer fully complied with the statutory and regulatory prerequisites for closure of a non-medically stationary claim, and concluded that claim closure was not premature. Claimant contends that her claim was prematurely closed and that the insurer's March 1, 1996 notice did not strictly comply with OAR 436-030-0034(1) and (4). Therefore, she argues, the insurer's administrative closure based on her alleged failure to seek treatment should be set aside. The insurer contends that claimant did not raise the issue of "strict compliance" with OAR 436-030-0034(4) at hearing and that, therefore, we should not consider it on review. We disagree.

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 her request for hearing on the July 25, 1996 Order on Reconsideration, claimant raised the issues of premature closure, temporary and permanent disability. With the exception of the change in the date on which claimant statutorily qualified for administrative closure,[1] the Order on Reconsideration affirmed the April 3, 1996 Determination Order in all respects. The Determination Order closed the claim administratively under OAR 436-030-0034. Therefore, claimant raised the issue of premature administrative closure by filing her hearing request.

In lieu of a hearing, the parties agreed to submit the matter on the documentary record and closing arguments were not recorded. The ALJ decided the premature closure issue by applying the theory of "strict compliance" with the rule governing administrative closures.[2] The insurer offers no evidence that the theory of "strict compliance" was limited at hearing solely to the requirements of OAR 436-030-0034(1),[3] nor does the insurer argue that it was prejudiced by claimant's alleged failure to specifically raise "strict compliance" with the requirements of OAR 436-030-0034(4) at hearing. Given these circumstances, we conclude that the theory of "strict compliance," which includes strict compliance with all applicable administrative closure requirements under OAR 436-030-0034, was before the ALJ at hearing.

Moreover, even if claimant did not specifically raise "strict compliance" with OAR 436-030-0034(4), we would consider the application of that subsection analogous to a "new legal theory," which can be considered on review. See Anita A. Bade, 36 Van Natta 1093 (1984), aff mem, 73 Or App 344

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[1] The Order on Reconsideration found that claimant statutorily qualified for closure on December 13, 1995, rather than December 29, 1995, as specified in the Determination Order.

[2] The insurer also argues that, because claimant statutorily qualified for closure on December 29, 1995, prior to the February 17, 1996 effective date of the amended rule, the requirement under OAR 436-030-0034(4) that the attending physician be copied on all notification letters does not apply in this case. The ALJ addressed the applicability of the amended rule to this case, albeit focusing on the applicability of section (1). (O&O at 5, 6). The ALJ's analysis is applicable to all the provisions of OAR 436-030-0034 (WCD Admin. Order 96-052), including section (4). See OAR 436-030-0003(1). We adopt the ALJ's reasoning and conclude that OAR 436-030-0034(4) applies in this case.

[3] OAR 436-030-0034(4) provides: "The attending physician shall be copied on all notification and denial letters applicable to [OAR 436-030-0034]."

(1985) (distinguishing between a "new issue" and alternative legal theory advanced for the first time on review, and considering the new theory where there was no prejudice to the adverse party); see also Margaret F. Blakeley, 38 Van Natta 515 (1986) (same).[4]

We proceed to the merits of the case. ORS 656.268(1)(b)[5] permits a carrier to close a claim without the worker's condition being medically stationary where the worker fails to seek medical treatment for 30 days without the attending physician's approval, and the worker fails to affirmatively establish that such failure was beyond his or her control.

Here, claimant's claim was administratively closed pursuant to OAR 436-030-0034(1) and (4) (WCD Admin. Order 96-052), which provide:

> "(1) A claim may be closed by the insurer or Department when the worker is not medically stationary and the worker has not sought medical care for a period in excess of 30 days, without the instruction or approval of the attending physician, for reasons within the worker's control; and
>
> "(a) The insurer has notified the worker, by certified letter, that claim closure will result for failure to seek medical treatment for a period of 30 days. The notification letter shall inform the worker of the worker's responsibility to seek medical treatment in a timely manner, and shall inform the worker of the consequences for failing to do so, including claim closure.
>
> "(b) Workers shall be given 14 days to respond to the certified notification letter before any further action is taken by the insurer towards claim closure.
>
> "(c) The date the claim qualifies for closure (statutory closure date) shall be the later (most chronologically recent) of the following which occurs prior to the closure:
>
> "(A) 30 days from the last qualified physician examination date;
>
> "(B) the date the physician recommended a follow-up visit and the worker failed to attend for reasons within the worker's control;
>
> "(C) the date the worker returns to or is released to regular work if it is after the last examination date;
>
> "(D) the date the insurer receives, prior to the 14th day after the notification letter was mailed, a written response from the worker regarding the certified notification letter and failure to treat.
>
> "* * * * *
>
> "(4) The attending physician shall be copied on all notification * * * letters applicable to this rule."

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[4] As noted above, the insurer did not indicate it would be prejudiced by our consideration of strict compliance with OAR 436-030-0034(4). Moreover, we find no prejudice to the insurer by considering this argument on review, as the evidentiary record was statutorily limited to the reconsideration record. ORS 656.283(7); e.g., Gunther H. Jacobi, 41 Van Natta 1031 (1989) (fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue).

[5] ORS 656.268(1) provides, in relevant part:

> "(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:"* * * *
>
> "(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

It is well-established that notice given by a carrier must be in strict compliance with the applicable rule in order for the administrative closure to be proper. Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288 (1993); Bertha Paniagua, 46 Van Natta 55 (1994).[6] When a rule specifically and unambiguously requires the carrier to follow a certain procedure, substantial compliance is not sufficient. SAIF v. Robertson, 120 Or App 1 (1993); Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986). See also Victor Magdaleno-Gonzalez, 48 Van Natta 1683 (1996).

Here, the insurer's March 1, 1996 notice stated that claimant had not received medical treatment for at least 30 days and that going without medical treatment for 30 days must have approval of her attending physician. In addition, the notice stated that, if claimant felt that her condition still required medical treatment, either she or her physician were required to respond to the letter within two weeks of the date of the letter or it would be assumed that she had recovered completely and "actions [would] be taken" to close her claim, based on her failure to seek medical treatment. (Ex. 21a). The insurer failed to send a copy of the notification letter to the attending physician, as required by OAR 436-030-0034(4), thereby forestalling any response from him.

Because the insurer failed to strictly comply with OAR 436-030-0034(4), the administrative closure rule, we conclude that the insurer's administrative closure was improper. Accordingly, we set aside the July 25, 1996 Order on Reconsideration and the April 3, 1996 Determination Order as premature.

Given our conclusion that the Determination Order was premature, the temporary disability and extent of disability issues are moot.

ORDER

The ALJ's order dated December 23, 1996 is reversed. The Order on Reconsideration and Determination Order are set aside as premature, and the claim is remanded to the insurer for further processing according to law. Claimant's attorney is awarded an "out-of-compensation" attorney fee equal to 25 percent of any additional compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

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[6] In Bertha Paniagua, which issued prior to the amendment of ORS 656.268(1)(b), we reasoned that the purpose of the former rule which permitted claim closure for failure to seek medical treatment was not to penalize the worker for failing to see his or her doctor. Rather, we explained, the former rule appropriately allowed claim closure based on a presumption that, if the worker needed medical treatment, she would have sought medical treatment. In David M. Chandler, 48 Van Natta 1500 (1995), in which we applied the former rule pursuant to amended OAR 656.268(1)(b), we continued to adhere to that interpretation. In light of the provisions of OAR 436-030-0034(1) and (4), which permit administrative closure to be instituted only after written notice to claimant and her doctor, we find no reason to change our interpretation of the purpose of the rule.

In the Matter of the Compensation of
MARK V. MOSER, Claimant
WCB Case Nos. 96-03743 & 96-03516
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation, on behalf of On Track, Inc., requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denials of compensability and responsibility for claimant's March 1996 "new injury" claim for a low back condition; and (2) upheld Liberty Northwest Companies' (Liberty) compensability and responsibility denial, on behalf of the same employer, of the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

Claimant has worked for the employer since 1991. (Tr. 4). Before 1993, claimant had not received medical treatment for low back problems. (Tr. 5). In approximately March 1993, claimant lifted a piece of concrete at work and injured his back. (Tr. 5, 6). He reported the injury to the employer, but did not file a claim. (Tr. 6, 15, 16). Claimant was treated by Dr. Brown and the employer paid for the treatment. (Tr. 6). He performed modified work for two weeks and returned to regular work. (Id.) Between March 1993 and September 16, 1993, claimant's back "went out" approximately 20 times. (Tr. 20, 21). When claimant "lifted something wrong," he had pain and would need to take it easy for two or three days. (Tr. 21).

On September 16, 1993, claimant injured his low back lifting a sofa at work. (Ex. 1, Tr. 7). Claimant was examined by Dr. Robertson and was diagnosed with a musculoskeletal low back strain. (Ex. 3). Claimant testified that Dr. Robertson gave him chiropractic treatment and medication. (Tr. 8). Dr. Robertson released claimant to regular work on October 18, 1993. (Ex. 7). On November 1, 1993, Liberty accepted a nondisabling low back strain. (Ex. 8).

Claimant testified that, between September 1993 and September 1995, his back "went out" approximately 40 times. (Tr. 22). He sought treatment on those occasions when the pain was so severe that he could not deal with it at work. (Id.)

On August 30, 1995, claimant sought treatment from Dr. Robertson for low back pain and occasional shooting pain through the kneecap. (Ex. 10-1). Dr. Robertson noted: "Back does not seem right since injury 9/93." (Id.) On October 30, 1995, Dr. Robertson reported that claimant continued to have a dull ache in his low back. (Id.) Dr. Robertson reported on December 6, 1995 that an MRI showed "[d]essication of the L5-S1 intervertebral disk with a slight annulus bulge present, not causing spinal canal stenosis or thecal sac compression." (Id.) Dr. Robertson continued to prescribe pain medication. On January 12, 1996, Dr. Robertson reported that claimant continued to have a musculoskeletal strain with right sacroiliac tenderness. (Ex. 12). Claimant testified that the low back pain on his right side in January 1996 was a continuation of the pain he had been having previously. (Tr. 24, 25).

Claimant's pain became more intense and he decided to get a second opinion from Dr. Clark. (Tr. 10). On January 31, 1996, Dr. Clark found "severe" muscular spasm in the low back with limited range of motion. (Ex. 25-5).

On March 12, 1996, claimant injured his low back while moving a washing machine at work. (Ex. 15). He testified that, before the March 12, 1996 incident, he was not having much pain, although he was taking medications of Vicodin and Soma. (Tr. 12). Claimant said that, before the March 1996 incident, he had a constant dull aching pain. (Id.) After that incident, he had a sharp stabbing pain. (Id.) Claimant said that the area of the back that he injured in March 1996 was in the "[e]xact same place" as the previous back pain. (Tr. 25).

Dr. Clark examined claimant on March 18, 1996 and reported that claimant had a flare in back symptoms, worsened by lifting a refrigerator. (Ex. 16A). Dr. Clark reported that the "pain is still lumbosacral in origin, non radiating, no radicular signs." (Id.) He diagnosed "[r]ecurrent lumbosacral strain." (Id.) On April 1, 1996, claimant continued to have severe lumbosacral pain and Dr. Clark recommended an MRI. (Ex. 19A).

On May 29, 1996, Dr. White examined claimant on behalf of the SAIF Corporation. (Ex. 23). He did not believe claimant's March 1996 injury involved a pathological worsening. (Ex. 23-4). Rather, Dr. White opined that claimant's recent symptoms were a continuation of his previous symptoms. (Id.)

On July 31, 1996, Dr. Clark reported that claimant had persistent lumbosacral pain and he referred claimant to Dr. Grant. (Ex. 23A). Dr. Grant diagnosed chronic myofascial/mechanical low back and right greater than left lower extremity pain syndrome. (Ex. 24A).

On April 5, 1996, SAIF issued a disclaimer of responsibility and claim denial. (Ex. 20). Liberty issued a denial of compensability and responsibility on April 17, 1996. (Ex. 21). Claimant requested a hearing on both denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Clark's opinion to conclude that SAIF was responsible for claimant's March 1996 low back injury.

SAIF argues that the ALJ erred in concluding that the medical evidence established that claimant's March 12, 1996 work incident was the major contributing cause of the need for treatment of the combined chronic low back pain condition. SAIF contends that claimant's symptoms after March 12, 1996 were a continuation of his preexisting low back condition and the preexisting condition was the major contributing cause of the disability and need for treatment.

The medical evidence establishes that claimant has a chronic low back condition that preexisted the March 1996 work injury. There is no contrary medical evidence. Thus, claimant's chronic low back condition constitutes a "preexisting condition." See ORS 656.005(24).

Claimant's treating physician, Dr. Clark, testified that claimant's March 1996 injury "took place upon the substrate of pre-existing chronic low back pain." (Ex. 25-14). Dr. Clark related claimant's condition, in part, to his chronic condition. (Ex. 25-15). We construe Dr. Clark's opinion to mean that claimant's compensable injury combined with the preexisting chronic low back condition to cause or prolong his disability or need for treatment. There are no contrary medical opinions. Therefore, ORS 656.005(7)(a)(B) applies to this case.

Under ORS 656.308(1), the first employer remains 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." When a worker sustains a second injury to the same body part, 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. SAIF v. Britton, 145 Or App 288, 292 (1996). ORS 656.308, however, applies only if claimant's current condition is the "same condition" as that previously accepted by Liberty. See Sanford v. Balteau Standard/SAIF Corp., 140 Or App 177 (1996); Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993), on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

Claimant asserts that his current low back condition at issue is the same condition as the one previously accepted by Liberty. We agree.

Liberty accepted a nondisabling low back strain as a result of claimant's September 16, 1993 injury. (Ex. 8). Claimant testified that, between September 1993 and September 1995, his back "went out" approximately 40 times. (Tr. 22). He sought treatment on those occasions when the pain was so severe that he could not deal with it at work. (Id.) On March 12, 1996, claimant injured his low back while moving a washing machine at work. (Ex. 15). He testified the area of the back that he injured in March 1996 was in the "[e]xact same place" as the previous back pain. (Tr. 25).

The medical opinions establish that claimant's current low back condition is the same condition as the one previously accepted by Liberty. When Dr. Clark examined claimant on March 18, 1996, he reported that claimant had a "flare" in back symptoms and he diagnosed "[r]ecurrent lumbosacral strain." (Ex. 16A). Dr. Clark reported that the "pain is still lumbosacral in origin, non radiating, no radicular signs." (Id.) In a later report, Dr. Clark agreed that claimant's March 1996 involved the same condition as the September 1993 low back injury accepted by Liberty. (Ex. 24).

Dr. White opined that claimant's recent symptoms were a continuation of his previous symptoms. (Ex. 23-4). Dr. Robertson concurred with Dr. White's report. (Ex. 26).

Based on the medical reports and claimant's testimony, we conclude that claimant's 1996 injury involved the "same condition" as the low back strain accepted by Liberty. Therefore, under ORS 656.308(1), Liberty remains responsible for future compensable medical services and disability relating to the compensable condition unless it can prove that the March 1996 incident was the major contributing cause of claimant's disability and need for treatment. See SAIF v. Britton, 145 Or App at 292.

Claimant and Liberty rely on Dr. Clark's opinion to establish that the March 1996 incident was the major contributing cause of claimant's disability and need for treatment. Dr. Clark opined that the March 12, 1996 incident represented a new injury and was the major cause of claimant's need for medical care. (Exs. 24, 25).

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons to do otherwise.

We are not persuaded by Dr. Clark's opinion because he did not have an accurate history of claimant's previous low back injuries. On April 1, 1996, Dr. Clark reported that claimant's low back pain was initially the result of a work injury in late 1995. (Ex. 19). He understood that claimant was out of work for some time due to that injury. Dr. Clark reported that claimant "was recovering but had a reinjury of the area in early March[.]" (Id.) However, in a concurrence letter from claimant's attorney, Dr. Clark agreed that claimant had a chronic low back condition as a result of a work injury on September 16, 1993. (Ex. 24).

In a deposition, Dr. Clark testified that claimant had an injury at the end of 1995 that initially injured his back. (Ex. 25-6). When he first saw claimant in January 1996, he understood that claimant had been having symptoms continually since the injury at the end of 1995. (Id.)

It is apparent from Dr. Clark's deposition testimony that he had an incorrect history that claimant initially injured his back in late 1995. Dr. Clark said that claimant did not make it clear that he had a back injury in September 1993. (Ex. 25-10). Furthermore, Dr. Clark was not aware of the concrete lifting episode that preceded the September 1993 injury. (Ex. 25-19). Dr. Clark testified that it did not really matter to him when claimant had prior injuries. (Ex. 25-12). Medical opinions based on an inaccurate or incomplete history are entitled to little weight. Miller v. Granite Construction Co., 28 Or App 473 (1977). Because Dr. Clark did not have a complete and accurate history of claimant's prior back injuries, his opinion on causation is not persuasive.

In reaching his conclusion that claimant had sustained a "new injury," Dr. Clark relied on the fact that claimant had improved to the point where he was back at work. (Ex. 25-15). Dr. Clark opined that, between January 1996 and March 1996, claimant's symptoms had "remitted or improved to a substantial degree in the interim" and he had returned to work. (Ex. 25-6, -7). Although claimant testified that he "wasn't having much pain" before the March 12, 1996 incident, he said he was taking Vicodin twice a day and Soma in the evening. (Tr. 12). Claimant said that, before the March 1996 incident, he had a constant dull aching pain. (Id.) Dr. Clark's testimony that claimant's symptoms had "remitted or improved to a substantial degree" since January 1996 appears inconsistent with claimant's testimony that he had a constant dull aching pain and was taking pain medication before the March 12, 1996 incident.

Liberty argues that the March 12, 1996 incident caused pathological changes to the supporting tissues of claimant's spine. Liberty refers to Dr. Clark's finding of muscle spasms at the March 18, 1996 examination to argue that claimant sustained a new injury. However, when Dr. Clark first examined claimant on January 31, 1996, he found "severe" muscular spasm in the low back with limited range of motion. (Ex. 25-5). Since claimant had a "severe" muscular spasm before the March 1996 injury, we are not persuaded that Dr. Clark's finding of muscle spasms in March 1996 supports the conclusion of a "new injury."

Furthermore, we are not persuaded by Dr. Clark's opinion that the March 12, 1996 incident caused any pathological changes. Dr. Clark opined that the April 9, 1996 MRI was essentially unchanged from the December 1995 MRI. (Ex. 25-8). He felt that claimant mainly had a soft tissue injury. (Ex. 25-21). Dr. Clark testified that the March 1996 injury probably caused some trauma to the surrounding muscles and tendons. (Id.) However, when he was asked whether there was a way to document the tearing of the muscles, he responded that was outside his range of expertise. (Ex. 25-24).

The proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause of an injury, including the precipitating cause, to establish which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). The precipitating cause is not necessarily the major contributing cause of those symptoms. Id.

Dr. Clark testified that his conclusion that claimant had a new injury was based on a "well defined event that occurred that resulted in physical disturbance to the patient after which he noted new pain." (Ex. 25-11). Dr. Clark explained: "You have a man who has back pain, was incapacitated in December and January, got better, went to work. Had a fall. Got worse. There's a new injury. It's pretty simple." (Ex. 25-13). Dr. Clark's opinion relies on a temporal relationship between claimant's symptoms and the March 1996 injury and does not properly evaluate the relative contribution of each cause, particularly since he did not have an accurate history of claimant's prior injuries and symptoms before the March 12, 1996 injury. We are not persuaded by Dr. Clark's opinion that claimant's March 1996 injury was the major contributing cause of his disability and need for treatment.

The remaining medical opinions do not support Liberty's argument that claimant sustained a "new injury." Dr. White concluded that claimant's March 1996 injury did not involve a pathological worsening. (Ex. 23-4). Rather, Dr. White opined that claimant's recent symptoms were a continuation of his previous symptoms. (Id.) Dr. Robertson concurred with Dr. White's report. (Ex. 26).

We conclude that Liberty has failed to prove that claimant sustained a "new compensable injury" on March 12, 1996. Therefore, under ORS 656.308(1), Liberty remains responsible for claimant's low back condition.[1]

Claimant's attorney is entitled to an assessed fee for services on review regarding compensability. 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 Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 9, 1997 is reversed. Liberty's denial of claimant's low back condition is set aside, and the claim is remanded to Liberty for processing according to law. The SAIF Corporation's responsibility denial of claimant's low back condition is reinstated and upheld. The ALJ's assessed fee of $3,500 shall be paid by Liberty, rather than SAIF. For services on review, claimant's attorney is awarded $1,000, payable by Liberty.

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[1] Liberty asserts that claimant's testimony indicated that his back problems actually began with an earlier noncompensable work incident in March 1993. Claimant testified that he lifted a piece of concrete at work and injured his back in approximately March 1993. Although claimant reported the injury to the employer and received medical treatment, he did not file a claim. To the extent that Liberty is attempting to argue that the March 1993 injury is the major contributing cause of claimant's current low back condition, we reject that contention. See Bonni J. Mead, 46 Van Natta 1185 (1994) (the carrier's acceptance was a concession that a new compensable injury had occurred).

In the Matter of the Compensation of
JACQUELINE J. ROSSI, Claimant
WCB Case Nos. 95-09628 & 95-08655
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

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 insurer's partial denial of her right knee condition, involving congenital/ developmental bilateral patella alta with lateral subluxation, poor patellar tracking and loss of articular cartilage. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant was compensably injured on June 29, 1994 when a spring broke on a dishwasher door causing the door to fall open and strike claimant on the right knee. She was initially diagnosed with a right knee strain, which the insurer accepted.

Claimant had experienced occasional right sided knee pain prior to her injury, which became constant post-injury. When her symptoms had not improved by late July 1995, Dr. Heyerman referred claimant to Dr. Galt, an orthopedic surgeon. Dr. Galt diagnosed extensor mechanism malalignment with significant patella alta and advanced patellofemoral chondrosis. He noted that claimant had been at risk for patellofemoral symptoms because of her preexisting malalignment, but that she had become symptomatic because of the traumatic injury to the right patella.

Claimant's strain injury claim was closed by a December 27, 1994 Determination Order, which awarded 12 percent scheduled permanent disability for loss of use or function of the right leg (knee). Claimant's right knee remained symptomatic. In April 1995, Dr. Galt recommended surgery, a distal realignment of the extensor mechanism and lateral retinacular release.

Claimant was examined by Dr. Donahoo on May 15, 1995. Dr. Donahoo opined that claimant's patellofemoral chondrosis and patellar malalignment preexisted her injury and her preexisting right knee condition was the major contributing cause of her right knee disability, even if the injury caused her to become symptomatic. Dr. Galt agreed with all of Dr. Donahoo's findings except his apportionment on causation. Dr. Galt reported that claimant's injury was 51 percent of the cause of her right knee condition.

On June 12, 1995, Dr. Galt performed surgery on claimant's right knee. In addition to realigning the extensor mechanism and releasing the lateral retinacular, Dr. Galt also repaired a partially torn medical meniscus that he encountered during the surgery.[1]

On July 24, 1995, the insurer denied claimant's claim for congenital/developmental, bilateral patella and other conditions, asserting that her accepted right knee strain injury was not the major contributing cause of her right knee condition. Claimant timely requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Notwithstanding the conditions set forth in the insurer's July 24, 1995 denial, the parties stipulated at hearing that the real dispute centered on the compensability of claimant's current right knee condition and need for surgery.[2] Claimant conceded that her compensable injury did not cause the malalignment of her knee cap, but argued her disability and need for surgery was caused by the June 29, 1994 injury to her right knee. (Tr. 2).

The ALJ found that claimant failed to sustain her burden of proof under ORS 656.225,[3] because a preponderance of the evidence failed to establish that her accepted injury caused a pathological change in her preexisting knee condition. Alternatively, applying ORS 656.005(7)(a)(B), the ALJ concluded that claimant's accepted injury was not the major contributing cause of her combined condition or need for treatment of the combined condition.

On review, claimant argues that the ALJ erred in relying on the opinion of Dr. Donahoo, who examined claimant at the insurer's request, over that of Dr. Galt, claimant's treating physician and surgeon. Claimant cites to Dr. Galt's testimony that the major contributing cause of claimant's right knee symptoms and, therefore, her need for treatment was the blunt trauma to her knee cap. (Ex. 25-12). In addition, claimant asserts that the ALJ erred in applying ORS 656.225 because: (1) claimant's kneecap malalignment does not constitute a "preexisting condition" under the workers' compensation laws; and (2) even if her knee alignment could be regarded as a preexisting condition, the disputed surgery was not directed "solely" toward treating that condition.

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[1] The compensability of claimant's meniscus tear is not at issue in this proceeding, although the insurer has represented that this condition has since been accepted.

[2] We acknowledge that, pursuant to ORS 656.245(6), the Board lacks jurisdiction to consider disputes that concern only the compensability of medical services. See SAIF v. Shipley, 147 Or App 26 (1997) (Board lacks jurisdiction where the claimant seeks only medical services related to a compensable injury). In this case, however, in addition to asserting that her surgery is compensable, claimant also contends that her compensable injury was the major contributing cause of her current (combined) right knee condition. (See Tr. 2, 3.) Therefore, we retain jurisdiction. See, e.g., Richard L. Wheeler, 47 Van Natta 2011 (1995) (the Board retains jurisdiction to determine whether a claimant's condition is causally related to the compensable injury).

[3] This section provides, in pertinent part, as follows:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) * * * [W]ork conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition."

For the reasons that follow, we conclude that claimant's right knee condition is not compensable.

Despite Dr. Galt's characterization of claimant's malaligned kneecap as an unfavorable biomechanical "characteristic," we are persuaded that claimant's (pre-injury) right knee condition constitutes a "preexisting condition" under the statute. ORS 656.005(24) defines "preexisting condition" as "any injury, disease, congenital abnormality * * * or similar condition that contributes to or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury * * *." Here, claimant had both a malaligned knee cap and patellofemoral chondrosis in her right knee prior to her June 1994 injury.[4] When describing the anatomical condition of claimant's right knee, Dr. Galt testified that claimant's knee caps were "off to the side" and "did not track centrally." He explained that this biomechanical aspect made her knee caps less forgiving after an injury and could also lead to problems even without an injury or symptomatology, because the kneecaps carry pressures unevenly. Dr. Galt also reported that this was an "inherited" characteristic and a life long problem for claimant. (Ex. 25-5, 25-8). In light of this evidence, we conclude that claimant's malaligned knee cap is a "congenital abnormality * * * or similar condition" that predisposed her to disability of the right knee.

The medical evidence also establishes that claimant's compensable injury combined with her preexisting right knee condition to cause her disability and need for treatment. (See, e.g., Exs. 15-8, 16-2, 25-8). Therefore, even if claimant's surgery was not *solely* directed to her preexisting malalignment (in which case ORS 656.225 would be inapplicable), claimant must nevertheless establish that her compensable injury was the major contributing cause of her combined condition or need for treatment of the combined condition. See ORS 656.005(7)(a)(B).

The determination of major contributing cause requires a comparison of the relative contribution to the need for treatment of claimant's preexisting malalignment and chrondosis and the injury at work. See Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). The focus of this inquiry is to determine the *primary* cause of her disability/need for treatment of the combined condition. Id. Indeed, the fact that the work injury precipitated her disability/need for treatment does not necessarily mean that the work injury was the major contributing cause. Id.; see also Alec E. Snyder, 47 Van Natta 838 (1995).

Dr. Galt has opined that claimant's injury was the major contributing cause of her need for treatment. Dr. Donahoo, on the other hand, believes that claimant's preexisting patellar alignment and the wear and tear on the joint was the major cause. (See, e.g. Exs. 15, 16, 24). Where, as here, the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Medical opinions that are not based on a complete and accurate history are not persuasive. Miller v. Granite Construction, 28 Or App 473, 476 (1977).

In this case, we find persuasive reasons not to rely on Dr. Galt's opinion. Dr. Galt explained that both of claimant's knees have the same structural defects and have been subjected to the same general life experiences, except that the right knee was struck by the dishwasher door. He concluded the work injury was the major cause of the need for surgery for her combined condition because only claimant's right knee was symptomatic. (Ex. 24). With regard to the work incident, Dr. Galt understood that claimant sustained a "very distinct and clear injury" to the right patella, based on "objective findings of ecchymosis and swelling secondary to the direct blow to the patella."[5] He concluded that there was "a very clear mechanism of injury with objective findings of the severity of the injury that could clearly lead to problems that she is having." (Ex. 23-4, see also Ex. 25-6).

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[4] In addition to concurring with Dr. Donahoo's opinion in this regard (Exs. 15-8, 16), Dr. Galt also reported in October 1994 that claimant's "significant chronic patellofemoral malalignment and chondrosis [had] been exacerbated by the acute injury." (Ex. 9-3). In his deposition, Dr. Galt defined patellofemoral chondrosis as "symptoms affecting the kneecap that would include pain and popping and grinding" in the patella femoral joint. (Ex. 25-7).

[5] In his initial examination of claimant on July 27, 1994, Dr. Galt recorded a history of claimant "developing a small bruise and moderate soft tissue swelling" after being struck across the right patella with a door of a dishwasher. (Ex. 8-1). He noted no effusion on examination, however.

Contrary to Dr. Galt's understanding of claimant's injury, however, Dr. Heyerman found that claimant had "no obvious ecchymosis or swelling" and no redness around her right knee when she first sought treatment on July 5, 1994. (Ex. 3-1). The same was true on claimant's July 11, 1994 follow-up exam. Dr. Heyerman specifically noted "no obvious swelling or erythema." (Ex. 3-2). Further, on July 12, 1994, the physical therapist found no apparent contusion of the right knee and only mild effusion. (Ex. 4-1). Because Dr. Galt did not have a complete and accurate understanding concerning the objective findings and severity of claimant's injury, his opinion as to the cause of claimant's need for treatment is unpersuasive. See Miller, 28 Or App at 476.

Furthermore, even assuming Dr. Galt had an accurate history, we would find his analysis unpersuasive under the Dietz v. Ramuda standard. Dr. Galt acknowledged that the surgery was primarily directed at correcting claimant's patellar alignment, a condition which preexisted and even caused occasional symptoms prior to the work injury. (See Ex. 25-11). He opined that the work injury was the major cause because it triggered her symptomatology even though the injury did not have any perceivable effect on the biomechanics of her right knee. (See Exs. 24, 25-5). He also noted that claimant would likely not have needed surgery for her right knee condition if not for the work incident. (Ex. 25-9).

Because Dr. Galt essentially relies on the fact that claimant was consistently symptomatic after the work incident and reasons that she would not have needed treatment in the absence of the work incident, his opinion employs a "but for" analysis analogous to the "precipitating cause" analysis that was rejected by the court in Dietz v. Ramuda. See Alec E. Snyder, 47 Van Natta at 839; Cody L. Lambert, 48 Van Natta 115 (1996) (the physician employed a "but for" analysis rather than weighing the relative contribution of the different causes for the claimant's symptoms).

Consequently, we conclude that claimant has failed to establish by a preponderance of the evidence that her compensable injury was the major contributing cause of her need for treatment of her combined right knee condition. Accord Robinson v. SAIF, 147 Or App 157 (1997).[6] Moreover, the fact that Dr. Galt discovered and repaired a partially torn medial meniscus while performing the distal realignment of the extensor mechanism does not render the surgery compensable, even if the medial mensical tear is a compensable condition. See, e.g., Betty M. Tyre, 45 Van Natta 963 (1993) (where the primary purpose of surgery was to correct a noncompensable condition, the incidental repair of a compensable condition did not render surgery compensable).

ORDER

The ALJ's order dated January 17, 1997 is affirmed.

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[6] As in Robinson, this is not a case where there is a difference between the major contributing cause of the need for treatment of the combined condition and the major contributing cause of the combined condition itself. Compare SAIF v. Nehl, 148 Or App 101 (1997); see Gregory C. Noble, 49 Van Natta 764 (1997).

In the Matter of the Compensation of
EUGENIO SERRANO, Claimant
WCB Case No. 96-10083
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration declining to reclassify his claim for a sacral contusion injury from nondisabling to disabling. The insurer moves to strike claimant's reply brief as untimely. On review, the issue is claim classification.

We adopt and affirm the ALJ's order with the following change and supplementation. In the fourth paragraph on page 2, we delete the second sentence.

OAR 438-011-0020(2) allows an appellant to file a reply brief within 14 days after the date of mailing of the respondent's brief. The certificate of service from the insurer's attorney indicates that the respondent's brief was mailed to the Board on April 16, 1997. Thus, the respondent's brief was "filed" on April 16, 1997. See OAR 438-005-0046(1)(c). Although claimant's reply brief was dated April 24, 1997 and sent under a cover letter dated April 25, 1997 (which was within 14 days of the filing of the insurer's respondent's brief), the brief was received by the Board on May 29, 1997. The brief did not include a certificate of service from claimant's attorney. Under such circumstances, the brief is considered filed as of May 29, 1997. See OAR 438-005-0046(1)(c). The insurer moves to strike claimant's reply brief on the ground that it was untimely filed. We agree that claimant's reply brief was untimely and grant the motion.

ORDER

The ALJ's order dated February 7, 1997 is affirmed.

In the Matter of the Compensation of
SHAWN R. STONE, Claimant
WCB Case No. 96-02481
ORDER ON REVIEW
Cole Cary & Wing, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that upheld the insurer's denial of his consequential condition/reflex sympathetic dystrophy claim. In its respondent's brief, the insurer requested that this case be consolidated on review with WCB Case No. 96-06052, which concerns the extent of permanent disability arising from claimant's accepted right thumb injury. On review, the issues are consolidation and compensability.

We adopt and affirm the ALJ's order with the following supplementation on the motion to consolidate.

The insurer argues that, for purposes of judicial economy, this matter should be consolidated with WCB Case No. 96-06052 because the resolution of issues in one case may affect issues in the other. For the reasons set forth below, we deny the insurer's motion.

As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. See, e.g. Greg V. Tomlinson, 47 Van Natta 1085 (1995), aff'd 139 Or App 512 (1996). Here, although the two cases arise out of the same general circumstances (claimant's August 31, 1995 sliver injury of the right thumb), consolidation would not serve either interest. WCB Case No. 96-06052 is an "extent" proceeding. In such a proceeding, the admissible evidence is limited to that which was submitted on reconsideration and made part of the reconsideration record. ORS 656.283(7); Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996); Joe R. Ray, 48 Van Natta 325 (1996). Because we are statutorily prohibited in that case from considering any evidence that was not submitted at reconsideration in reviewing the determination of permanent disability, we find no compelling reason to review the two cases together.

ORDER

The ALJ's order dated October 7, 1996 is affirmed.

In the Matter of the Compensation of
VALERIE BARBEAU, Claimant
WCB Case No. 96-04426
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) found that claimant's right foot injury claim was not untimely under former ORS 656.265(4); (2) declined to consider the compensability of the claim on a "medical causation" basis; (3) set aside the insurer's denial; (4) assessed penalties for allegedly unreasonable claims processing; and (5) awarded an assessed attorney fee. Claimant has moved to dismiss the appeal on the basis that the insurer had accepted her claim. On review, the issues are dismissal, timeliness of claimant's claim, penalties and attorney fees.

We deny the motion to dismiss and adopt and affirm the ALJ's order with the following supplementation.

On May 9, 1997, following its appeal of the ALJ's Opinion and Order finding claimant's right foot injury compensable, the insurer issued a Notice of Claim Acceptance accepting claimant's right plantar fasciitis as a nondisabling injury. That same day, the insurer also issued a 1502 form, explaining that the claim had been "accepted through litigation order." Also, claimant concedes that approximately one month before the insurer's acceptance, the insurer issued a Notice of Closure, awarding temporary disability and noting that the compensation was stayed pending appeal pursuant to ORS 656.313(1).

As noted above, claimant argues that in light of the insurer's acceptance, the appeal must be dismissed. In response, the insurer contends that its appeal may go forward because the acceptance was made pursuant to the ALJ's order and contingent upon its appeal to the Board. We agree with the insurer.

A carrier that has been directed by litigation order to accept a claimant's claim may issue a "qualified" acceptance of the claim and continue to assert on appeal of that order that the claimant's condition is not compensable. Donna J. Calhoun, 47 Van Natta 454 (1996); Janice M. Hunt, 46 Van Natta 1145 (1994); compare SAIF v. Mize, 129 Or App 636 (1994) (where the carrier accepted the claimant's claim by a clear and unqualified Notice of Acceptance, the acceptance rendered moot any controversy over the compensability of the claimant's claim).

In Donna J. Calhoun, we held that where the employer issued a"1502" form explaining that the claim had been ordered accepted by a litigation order that was on appeal and also indicated on the Notice of Closure that it was appealing the ALJ's order, the employer's "acceptance" was not clear and unqualified and therefore not governed by ORS 656.262(6). If similarly, in Janice M. Hunt, we held that the insurer's notice of acceptance was not inconsistent with its position on appeal that the claimant's claim was disabling where it had issued a notice of acceptance accepting the claim as disabling, but had simultaneously notified the claimant of its intent to continue to challenge the ALJ's classification determination.

Here, unlike Calhoun, the insurer issued a Notice of Acceptance. At the same time, however, it also issued a 1502 form specifically explaining that the claim was accepted through a litigation order, an order which the claimant knew the insurer had already appealed. Further, like Calhoun, the insurer's "pre-acceptance" Notice of Closure referenced the appeal and also stated that temporary disability compensation had been stayed. Given the insurer's explanation on the 1502 for accepting the claim when the case was on appeal and its notation on the Notice of Closure, we cannot conclude that the insurer's acceptance was clear and unqualified. Rather, like Calhoun, we conclude that the insurer's "post-order" acceptance of claimant's claim was qualified by references in the 1502 form and the Notice of Closure and therefore the controversy between the parties regarding the compensability of the claim remains viable. Consequently, we deny claimant's motion to dismiss.

We turn to the merits of the insurer's appeal. Claimant experienced the onset of right foot pain while walking to the cashier location at work on April 15, 1995. The next day, she advised her supervisor that she had injured her foot. Claimant also mentioned the incident to her area manager, but was not provided with and did not complete a claim form.

Although claimant continued to work, her right foot pain continued. On April 19, 1996, more than a year after the initial onset of her pain, she ultimately sought medical attention. Her doctors diagnosed a bone spur and/or plantar fasciitis. Claimant filed a claim on April 23, 1996, which the employer denied on the grounds the claim was not timely under ORS 656.265.

The ALJ concluded that claimant's claim was timely under former ORS 656.265(4),[1] because she gave oral notice of her claim in a timely fashion and was prevented by the employer's actions from giving timely written notice of the claim. The ALJ further found no evidence of prejudice to the employer by claimant's delay in filing her claim.

On review, the insurer first asserts that the ALJ erred in declining to address the compensability of claimant's claim on a medical causation basis. Specifically, the insurer argues that it amended its denial to contest the causation of claimant's condition prior to the hearing, and therefore medical causation was at issue at hearing. We disagree.

It is evident from the file that the insurer's counsel did contest the causation of claimant's condition in a June 13, 1996 letter.[2] However, at the outset of the hearing, the ALJ stated that the issues before him arose from Exhibit 11, the insurer's April 29, 1996 denial. The ALJ noted that the basis for that denial was that the claim was untimely, and that the only issues were timeliness, and penalties and attorney fees arising from the denial. (Tr. 1). The insurer's counsel agreed with this statement of the issues (Tr. 1), and did not object when claimant's counsel stated that the matter was not proceeding on any issues "other than raised by the Denial." (Tr. 2). Although claimant's counsel specifically indicated that he was "not prepared to proceed upon any issue other than the issues raised by the Denial" and that claimant was "not consenting to the raising of any other issues other than issues raised by the Denial," the insurer's counsel did not protest nor ask that the causation issue (which was not raised by the April 29, 1996 denial) be preserved or bifurcated for later adjudication.

In determining whether a party has waived its right to assert a position, we must look to the "totality of circumstances." See Wright Schuchart Harbor v. Johnson, 133 Or App 680, 688 (1995) on remand, Connie M. Johnson, 48 Van Natta 239 (1996). Such waiver may be explicit or implicit.[3] Id. Here, because the insurer's attorney expressly agreed with the ALJ's statement of issues and did not respond to claimant's counsel's comments or declare on the record the insurer's intention to litigate the medical causation/compensability issue, we conclude the insurer implicitly waived this defense at hearing.[4] Consequently, the ALJ did not err in limiting the denial issue to the timeliness of claimant's

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[1] Former ORS 656.265 required that written notice of an accident resulting in an injury be given to the employer within 30 days. Former ORS 656.265(4) provided as follows:

"Failure to give notice as required by this section bars a claim under [the workers' compensation act] unless:

"(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice * * *."

Although amended ORS 656.265 was in effect at the time of the insurer's denial, the amended statute is not applicable to this claim because claimant's injury occurred prior to June 1995 legislative amendments. Pursuant to the express exception to retroactive application in Section 66(2) of the 1995 amendments, amended ORS 656.265 applies only to injuries occurring on or after the effective date of the Act. See Ronald E. Oachs, 47 Van Natta 1663 (1995).

[2] Although this letter arguably raised causation as an issue, it cannot be considered a formal, written amendment to the April 29, 1996 denial because it was not identified as such nor did it include the denial notice provisions required by the administrative rules.

[3] In Connie M. Johnson, we found "a beneficial policy in holding parties to implicit waiver since it will encourage them to declare any intention of litigating at hearing an issue raised pre-hearing." 48 Van Natta at 239.

[4] Although the insurer's counsel indicated in a post-hearing letter that it did not intend to waive all of its arguments with respect to compensability, we nevertheless conclude, based on the "totality of circumstances" (including the colloquy among the ALJ, claimant's attorney, and the insurer's attorney at the outset of the hearing) that the insurer implicitly waived its other defenses to the compensability of claimant's claim.

claim. See, e.g., Kenneth L. Devi, 49 Van Natta 108 (1997) (The ALJ properly did not address a "claim preclusion" theory where the issue was not placed before him on the record); see also Sonya G. Richardson, 48 Van Natta 1844 (1996) (where there was no evidence in the record that the parties expressly or implicitly agreed to expand the issues beyond the defense raised by the express language of carrier's denial, the ALJ should not have addressed a medical causation issue that was not raised at hearing).

On the timeliness issue, the insurer argues that claimant did not establish that her employer had knowledge of her injury and that it has shown that it was prejudiced by claimant's delay in submitting her claim form.[5] Like the ALJ, we find to the contrary.

Claimant testified at hearing that she advised her supervisor of her foot injury and asked for a claim form the day after her foot began hurting. Claimant also testified that she asked her supervisor and the area manager for a claim form on several occasions in the weeks that followed, but that she was not provided with the form until after she transferred to a different store and sought treatment for her ongoing pain in April 1996. There is no contrary evidence. On this record, we find that claimant has proven by a preponderance of the evidence that her employer had notice of her injury. In addition, because the employer presented no evidence on the issue,[6] we also find that the employer failed to establish that it was actually prejudiced by claimant's delay in filing her claim.

The insurer also challenges the ALJ's penalty award, asserting that it had a legitimate doubt about its liability for claimant's claim because the injury occurred more than a year before she filed her 801 form. We disagree.

The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991); 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 123, 126 n. 3 (1985).

As noted above, at the time the insurer denied claimant's claim on timeliness grounds, it should have known that the 1995 amendments to ORS 656.265[7] did not apply to the claim because claimant's injury reportedly occurred prior to the effective date of the Act. Because claimant's claim was not *automatically* time barred, the insurer had an obligation to investigate the claim to determine if and when the employer had knowledge of the injury or why claimant delayed making the claim. Since the record is devoid of any evidence concerning the insurer's investigation, we conclude its denial on timeliness grounds was unreasonable.

Finally, the insurer asserts that the ALJ's $3,000 attorney award (for prevailing over the insurer's denial) was excessive. We find to the contrary. 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 436-015-0010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue; (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 unrepresented party; and (7) and the risk that counsel may go uncompensated.

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[5] While claimant must prove the employer had knowledge, the burden is on the carrier to prove prejudice. Argonaut Ins. Co. v. Mock, 95 Or App 1, 4, rev den 308 Or 79 (1989).

[6] As claimant notes in her brief, statements and arguments of counsel are not evidence. The employer must offer facts to establish actual prejudice, not merely conclusory statements or speculation. See Aetna Casualty Co. v. Kupetz, 106 Or App 670, 675 (1991).

[7] Under amended ORS 656.265, the employer must have written notice of the claim within one year after the date of injury or the claim is barred.

Here, the issue in dispute was the timeliness of claimant's claim. Claimant had the burden of establishing that her employer had notice of her injury. Even though the hearing was relatively brief (claimant was the only witness who testified) and no depositions were performed, claimant's attorney (who has been litigating workers' compensation cases for many years) was successful in overturning the insurer's denial and establishing the compensability of claimant's plantar fasciitis condition, which had been chronic for more than a year. Further, although claimant prevailed over the timeliness denial, this case presented a significant risk that claimant's counsel's efforts might have gone uncompensated. After considering these factors, we find that $3,000 is a reasonable fee for claimant's counsel's services at hearing.

Because we have not disallowed or reduced the compensation awarded to claimant, her 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 $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the denial-related issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.[8]

ORDER

The ALJ's order dated January 29, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, payable by the insurer.

[8] Claimant's counsel is not entitled to an attorney fee for defending the ALJ's attorney fee award and penalty assessment. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Claimant is also not entitled to an award for her counsel's services regarding the unsuccessful motion to dismiss.

In the Matter of the Compensation of
WONDER WINDOM-HALL, Claimant
WCB Case No. 90-06799
ORDER OF ABATEMENT
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our June 26, 1997 Order on Remand that, on reconsideration from the Court of Appeals, reversed that portion of the Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's perilymph fistula condition and awarded an assessed fee of $5,000 to claimant's attorney for services concerning the compensability of the perilymph fistula. In her motion, citing OAR 438-015-0010(4) and the Court of Appeals' decision in Schoch v. Leupold & Stevens, 144 Or App 259 (1996), claimant contends that she is entitled to an assessed attorney fee award of $50,160.

In order to consider this matter, we withdraw our June 26, 1997 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM E. KANEHL, Claimant
WCB Case No. 96-08734
ORDER ON REVIEW
Bischoff & Strooband, 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) Livesley's order that: (1) affirmed that portion of an Order on Reconsideration that awarded 8 percent (12 degrees) scheduled permanent disability for loss of use or function of the right leg; and (2) increased claimant's unscheduled permanent disability for a low back condition from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to 25 percent (80 degrees). On review, the issues are extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Following an injury on June 23, 1995, SAIF accepted a claim for lumbar sprain and contusion. A May 31, 1996 Notice of Closure awarded only temporary disability. The Order on Reconsideration awarded 8 percent scheduled permanent disability and 14 percent unscheduled permanent disability. The ALJ affirmed the scheduled permanent disability award and increased the unscheduled permanent disability award to 25 percent. SAIF objects to both conclusions, asserting that claimant did not prove impairment due to the compensable injury.

Scheduled Permanent Disability

The Order on Reconsideration found that impairment was proved based on the report of Dr. Neumann, the medical arbiter, that found decreased muscle strength in the right hamstring muscle. The ALJ agreed. On review, SAIF argues that the ALJ based his award on finding that the compensable injury caused a low back herniated disc, which resulted in loss of strength to the right hamstring. SAIF further contends that, because it did not accept the herniated disc condition, it was improper for the ALJ to find claimant entitled to any award based on that condition.

The Order on Reconsideration based its award on former OAR 436-035-0230(9) (WCD Admin. Order 96-051), which provided that loss of strength in the leg "due to peripheral nerve injury is determined according to the specific peripheral nerve supply (innervating) the weakened muscle * * *." The rule also provided that the sciatic nerve relates to loss of strength in the hamstring. Consequently, there must be proof of injury to the sciatic nerve in order for the rule to apply.

In describing any muscle strength loss "due to the injury," Dr. Neumann reported that claimant showed 4/5 muscle strength in his right hamstring. (Ex. 25-4). Dr. Neumann did not indicate, however, that the loss of muscle strength was caused by injury to the sciatic nerve.

Moreover, the only evidence even referring to the sciatic nerve is from claimant's treating orthopedic surgeon, Dr. Peterson, who, on February 29, 1996 (before claimant was declared medically stationary), indicated that claimant's "past sciatica is now a minor component of his overall symptom complex." (Ex. 18). During the closing examination, Dr. Peterson found "no persistent neural tension signs" or any "evidence of persistent weakness from the L4 radiculopathy, which is largely resolved." (Ex. 21-3).

Based on such evidence, we find a lack of proof of, first, injury to the sciatic nerve and, second, that any such nerve injury caused a loss of strength in the right hamstrings. Consequently, we conclude that claimant is not entitled under the standards to a value based on Dr. Neumann's reference to loss of strength. Former OAR 436-035-0230(9). Thus, we agree with SAIF that claimant has not proven entitlement to scheduled permanent disability.

Unscheduled Permanent Disability

In increasing claimant's unscheduled permanent disability, the ALJ found that Dr. Neumann provided the most persuasive evidence concerning range of motion and Dr. Peterson was more reliable concerning adaptability. SAIF contends that both Dr. Peterson and Dr. Neumann found that the loss in range of motion was due to claimant's preexisting degenerative disc disease rather than the accepted conditions. SAIF also argues that claimant's adaptability should be based on a residual functional capacity of "medium" rather than "medium/light," resulting in an adaptability factor of 1.

We first address the range of motion issue. Range of motion is the only impairment found by the Order on Reconsideration and the ALJ and discussed by the parties. Thus, if we agree with SAIF concerning this issue, claimant is not entitled to an award of unscheduled permanent disability, no matter her adaptability factor. See OAR 436-035-0270(2).

On May 1, 1996, claimant underwent a physical capacities evaluation (PCE), to which Dr. Peterson concurred. (Ex. 19-3). The PCE provided range of motion for claimant's low back. (Id. at 2). In discussing the PCE, Dr. Peterson reported that "the inclinometer readings of the lumbar spine reflect the underlying degenerative changes noted on [claimant's] MRI and x-rays, and do not specifically reflect any decreased or altered range of motion due to his lumbar disc herniation." (Id. at 3). Dr. Peterson also indicated that lumbar disc degeneration was not "significantly related or contributed to by [claimant's] work exposure or work injury dated 6/23/95." (Id.)

Dr. Neumann also diagnosed preexisting degenerative arthritis of the spine. (Ex. 25-5). He similarly reported that claimant's lost range of motion was "secondary to age change, and his degenerative disease in his spine." (Ex. 25-5).

Based on such evidence, we find that claimant's lost range of motion is caused by his degenerative disc disease. Claimant contends that SAIF is liable under ORS 656.262(7)(b) for impairment caused by the degenerative condition even though its acceptance was limited to lumbar strain and contusion. Inasmuch as SAIF did not accept a combined condition, however, we conclude that ORS 656.262(7)(b) does not apply. Boyd K. Belden, 49 Van Natta 59, 62 (1997).

Under former OAR 436-035-0007(1), the worker is entitled to a value for impairment "that [is] permanent and ... caused by the compensable injury or disease including the compensable condition, a consequential condition and direct medical sequelae." Furthermore, "[u]nrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules." An exception to this rule (relied upon by the ALJ) is former OAR 436-036-0007(3), which provides that disability caused solely by a worker's preexisting condition "shall be rated completely if work conditions or events were the major contributing cause of a pathological worsening of the preexisting physical condition * * *."

Here, there is no evidence that claimant's preexisting degenerative disc disease was pathologically worsened or affected by claimant's work. Rather, as shown by Dr. Peterson, this condition was unrelated to claimant's employment. Consequently, we conclude that the loss of range of motion from claimant's degenerative disc condition constitutes an "unrelated or noncompensable impairment finding" and, thus, is excluded from consideration. Former OAR 436-035-0007(1).

Therefore, in the absence of any measurable impairment under the rules, claimant is not entitled to an award for unscheduled permanent disability. Former OAR 436-035-0270(2).

ORDER

The ALJ's order dated February 11, 1997 is reversed. In lieu of the ALJ's order and Order on Reconsideration awarding 8 percent (12 degrees) scheduled permanent disability, claimant is awarded no scheduled permanent disability. In lieu of the ALJ's order awarding 25 percent (80 degrees) and the Order on Reconsideration awarding 14 percent (44.8 degrees) unscheduled permanent disability, claimant is awarded no unscheduled permanent disability. The ALJ's attorney fee awards also are reversed.

In the Matter of the Compensation of
TERRY L. MASON, Claimant
WCB Case Nos. 96-07364 & 96-02372
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Agricomp Insurance Company (AIC) on behalf of its insured, Owen G. Froerer, requests review of that portion of Administrative Law Judge (ALJ) Peterson's order which set aside its denial of claimant's injury claim for a herniated disc at L4-5. On review, the issue is compensability.[1]

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

In his findings of fact, the ALJ found that claimant developed right leg pain within a couple of days of bending over and lifting a board at work on September 11, 1995, while the employer was insured by AIC. We agree with AIC that the contemporaneous medical records establish that claimant's lower extremity symptoms were limited to the left leg until late December 1995, when, according to claimant's testimony, he suddenly developed right-sided complaints, which ultimately led to surgery on January 30, 1996 for a herniated disc at L4-5 on the right. (Exs. 21, 25, 25A). Accordingly, we modify the ALJ's findings of fact. We now address the compensability of claimant's lumbar disc herniation.

Applying a material contributing cause standard, the ALJ determined that claimant had sustained his burden of proving that the L4-5 disc herniation was compensable. On review, AIC contends that the ALJ incorrectly applied a material causation standard, asserting that claimant must prove that the alleged September 11, 1995 incident was the major contributing cause of his L4-5 disc herniation under either ORS 656.005(7)(a)(B) or ORS 656.005(7)(a)(A). Arguing that the medical evidence does not satisfy claimant's burden of proof under a major causation standard, AIC contends that the ALJ improperly set aside its denial. For the following reasons, we disagree with AIC's contentions.

First, for ORS 656.005(7)(a)(B) to apply, an otherwise compensable injury must "combine" with a preexisting condition to cause or prolong disability or a need for treatment. Shirley Wilson, 49 Van Natta 304 (1997). We agree with the ALJ that this record does not establish the presence of a "combined" condition. Thus, we concur with the ALJ that the major contributing cause standard of ORS 656.005(7)(a)(B) is inapplicable.

Moreover, claimant contended that his herniated disc was the direct, though belated, result of the September 11, 1995 lifting incident. (Tr. 14). Therefore, we also conclude that the major causation standard of ORS 656.005(7)(a)(A) for "consequential conditions" is inapplicable. See Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992) (notwithstanding its belated onset, where a condition arises directly from an accident, the claimant need only establish that the condition was materially caused by the industrial accident).

Accordingly, we agree with the ALJ that the correct legal standard to apply in determining the compensability of the L4-5 disc herniation is whether the September 11, 1995 incident was a material contributing cause of the herniated disc. For the reasons cited by the ALJ, we agree that the medical evidence in this case is sufficient to satisfy claimant's burden of proof under that standard.

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 AIC. 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] The SAIF Corporation was also a party to the proceedings in connection with a compensable September 13, 1992 injury while it insured the employer. The ALJ upheld SAIF's compensability and responsibility denial of claimant's L4-5 herniated disc. AIC, however, does not contest the ALJ's determination that SAIF was not responsible for claimant's L4-5 disc herniation.

ORDER

The ALJ's order dated December 31, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by AIC.

In the Matter of the Compensation of
ZOE A. IRVIN, Claimant
WCB Case Nos. 95-05737 & 95-05736
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denials of claimant's bilateral shoulder injury claims. On review, the issue is compensability.

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

The ALJ relied on Dr. Erickson's opinion in finding claimant's shoulder conditions compensable. SAIF asserts that Dr. Erickson's opinion identifies the February 1994 and January 1995 injuries as precipitating causes of claimant's symptoms, but not major contributors to the shoulder conditions. On this basis, SAIF asserts that Dr. Erickson's opinion is unpersuasive. In Dietz v. Ramuda, 130 Or App 397, 401 (1994), the court held that a "precipitating" cause is not necessarily the major contributing cause.

Here, however, we are persuaded that Dr. Erickson considered the preexisting or underlying conditions and still believed that the injuries were the major contributing cause of the conditions. In addition, we are persuaded that Dr. Erickson's opinion as a whole establishes that the February 1994 and January 1995 injuries were considered the major contributing cause of the shoulder conditions, as well as the precipitating cause of those conditions.

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 attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 22, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

In the Matter of the Compensation of
JANET L. SUTTON, Claimant
Own Motion No. 97-0134M
OWN MOTION ORDER ON RECONSIDERATION
Hollander, et al, Claimant Attorneys

The self-insured employer requests that we "clarify" our March 21, 1997 Own Motion Order, in which we authorized the reopening of claimant's 1987 injury claim for the payment of temporary disability benefits. In that order, we also granted claimant's attorney an "approved fee" in the amount of 25 percent of the increased temporary disability compensation awarded under our order, not to exceed $1,050. The employer contends that it has already paid claimant's time loss (having processed the claim as an "aggravation claim" in error), and that no attorney fees were paid out of claimant's temporary disability compensation. In response to the employer's inquiry, claimant's attorney contends that, because of its processing errors, the employer, rather than claimant's counsel, should assume the burden of that error.

FINDINGS OF FACT

On July 1, 1987, claimant sustained a left carpal tunnel injury. Claimant's aggravation rights on that claim expired on April 18, 1993. Claimant filed a claim for right carpal tunnel syndrome in 1995. Claimant's right carpal tunnel claim was processed by the employer as an "aggravation" of the July 1, 1987 claim in error. Claimant's right carpal tunnel was accepted by the employer as a result of litigation in August 1996, and became a compensable component of her 1987 injury claim. The employer paid temporary disability compensation from June 13, 1996 through November 24, 1996.

On March 19, 1997, the employer submitted to the Board claimant's request for temporary disability compensation for her compensable right carpal tunnel condition and subsequent surgery. The employer recommended that the Board authorize the reopening of claimant's claim, beginning October 3, 1996, the date she entered the hospital for right carpal tunnel surgery.

On March 21, 1997, the Board issued an Own Motion Order which authorized time loss beginning October 3, 1996 under ORS 656.278(1)(a), and an approved attorney fee under OAR 438-015-0010(4) and OAR 438-015-0080. Our order instructed the employer to close claimant's claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

On March 26, 1997, the employer closed claimant's claim with an award of temporary total disability (TTD) from June 13, 1996 through October 16, 1996, and temporary partial disability (TPD) from October 17, 1996 through November 24, 1996. The employer declared claimant medically stationary as of December 23, 1996. Claimant has not appealed the Notice of Closure.

In an April 4, 1997 letter, the employer advised that, because this claim was reopened in error as an "aggravation claim," no monies were paid to claimant's attorney from claimant's temporary disability compensation. Furthermore, the employer requested clarification of the Board's March 21, 1997 order regarding the "approved" fee awarded by the Board to claimant's attorney. The employer asked whether our order awarded attorney fees "paid in addition to or out of [claimant's] time loss benefits." Finally, the employer inquired that if "attorney fees are payable out of the time loss benefits, please indicate if the attorney fees are due, since [claimant] was paid without offset for attorney fees."

On April 8, 1997, we abated our prior order to allow claimant sufficient time to file a response to the motion.

On April 15, 1997, claimant's attorney responded that he had received no approved attorney fee for his services culminating in claimant's Own Motion reopening. Citing Jane A. Volk, 46 Van Natta 681, on recon, 46 Van Natta 1017 (1994), claimant's attorney noted distinctions between claimant's case / claim and Volk, as well as procedures outlined for recovery of an attorney fee. Claimant's attorney requested the opportunity to receive claimant's response to his letter to claimant, in which he requested directly from claimant the payment of the approved fee.

In a June 24, 1997 letter, the Board again requested the parties' positions with respect to claimant's attorney's entitlement to an approved attorney fee.

In a June 26, 1997 letter, claimant's attorney notified the Board that, subsequent to his request to claimant that she pay the amount granted by our order out of her compensation, he had received no fee in this matter. Claimant's attorney noted that, inasmuch as the lack of payment of an attorney fee in this claim "originated with the Insurer's processing errors, it is only fair that it, rather than Claimant's counsel, assume the burden of that error." The employer has not responded further.

CONCLUSIONS OF LAW AND OPINION

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). ORS 656.386 provides the relevant statutory authorization for attorney fees in the present case. Attorney fees that are paid by the insurer are classified as "assessed" fees. ORS 656.386(1). Attorney fees that are paid out of the increased compensation secured by the attorney are classified as "approved" fees or "out-of-compensation" fees. ORS 656.386(2). OAR 438-015-0080 provides that attorney fees in Own Motion cases are to be paid out of the claimant's increased temporary disability compensation, which the claimant's attorney has been instrumental in obtaining for the claimant.

Our March 21, 1997 order awarded claimant's attorney an "approved" fee, payable by the employer directly to claimant's attorney. However, the employer had terminated claimant's time loss on November 24, 1996. The employer then closed the claim on March 26, 1997. Because claimant did not appeal the March 26, 1997 Notice of Closure, the employer had paid to claimant all of the time loss to which she was entitled during the reopened period. Claimant's attorney received no attorney fee for his services which resulted in claimant's receipt of temporary disability compensation during this reopening period.[1]

Claimant's attorney submitted a copy of a June 26, 1997 affidavit, in which he attested that he requested that claimant pay the unpaid attorney's fee from her temporary disability award. Claimant's attorney further stated that he had not received payment to date from claimant. Here, claimant's attorney has followed the procedure set forth in Jane A. Volk, 46 Van Natta at 1017. However, although having followed the Volk procedure, claimant's attorney also noted distinctions between the present case and Volk. Claimant's attorney asserted that, because claimant is not entitled to future permanent disability in her Own Motion claim, claimant's counsel would be unable to secure a lien against that disability. We agree with claimant's counsel's interpretation of the Volk holding as it pertains to this Own Motion claim.

However, our March 21, 1997 order awarded claimant's attorney an approved fee in the amount of $1,050, payable by the employer from claimant's compensation. In Clancy Whitten, 48 Van Natta 596 (1996), the Board awarded to the claimant's attorney an "approved" attorney fee consistent with ORS 656.386(2), payable directly from the employer to the claimant's attorney. In that order, the Board concluded that the carrier neglected to provide for payment of the claimant's attorney's fees through no fault of the claimant or the claimant's attorney. In Whitten, we reexamined our holding in Nancy E. O'Neal, 45 Van Natta 1490, on recon, 45 Van Natta 1743, on recon 45 Van Natta 2081 (1993), as well as the court's affirmation of our holding in SAIF v. O'Neal, 134 Or App 338 (1995). We concluded that the O'Neal rationale permitted the Board to require the carrier to pay the claimant's attorney directly and to recover that amount from the claimant's future compensation. As such, the Board ordered the carrier to pay the attorney fees directly to the attorney when the carrier's unnecessary and unilateral action made the "additional" payment necessary. SAIF v. O'Neal, 134 Or App at 338.

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[1] Claimant's attorney submitted a copy of a ledger sheet which indicates that he received "assessed" attorney fees for his services at hearing and at Board review. These attorney fees are separate fees for issues in this case which were resolved in different forums and under different statutory and administrative authority. See Robert S. Richey, 48 Van Natta 1875 (1996). Therefore, although claimant's attorney received assessed fees for his services in assisting claimant to receive other benefits in this claim, only the Board in its Own Motion authority, has jurisdiction to award temporary disability benefits under ORS 656.278. However, contrary to our order granting claimant's attorney an out-of-compensation fee for his services in assisting claimant to receive TTD under the Board's Own Motion authority, claimant's attorney was not compensated for these services.

Here, as in Whitten, we conclude that the current version of ORS 656.386(2) continues to mandate the payment of "out-of-compensation" attorney fees directly from a claimant's compensation. Furthermore, we continue to hold that the O'Neal rationale does not conflict with that statutory requirement, nor was it eliminated by the 1995 amendments to ORS 656.386(2). Because we agree that claimant's attorney is entitled to an approved fee for his services in securing temporary disability in this claim, and we are persuaded that claimant's attorney has followed those procedures for securing that fee as outlined in Jane A. Volk, 46 Van Natta at 681, we hold the employer responsible for correcting its error in processing the claim as an "aggravation" rather than a request to reopen the claim pursuant to ORS 656.278(1).

Accordingly, on reconsideration, we direct the employer to pay to claimant's counsel the attorney fee granted in our March 21, 1997 order. That fee shall be the sum of 25 percent of the total of temporary disability compensation awarded by the employer to claimant, or $1,050, whichever is the lesser amount. The employer is authorized to offset this payment against claimant's future temporary disability compensation in the manner prescribed in ORS 656.268(15)(a). See Clancy Whitten, 48 Van Natta at 598. We republish in its entirety our March 21, 1997 order, except as supplemented and modified herein. 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
RICHARD E. ANDERSON, Deceased, Claimant
WCB Case No. C701777
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On July 17, 1997, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 4 and 5, the CDA provides, in part: "The parties (claimants and insurer) separately have reached an agreement through which insurer's lien is released. The parties stipulate and agree that, reduced to present value, the value of insurer's lien, which separately is released contingent upon Board approval of this Claim Disposition Agreement is $309,719.40."

The CDA provides that the insurer's release of its $309,719.40 third party lien from the $3,000,000 third party settlement is contingent upon approval of the CDA.[1] In addition, the CDA provides for a consideration of $1. Because the release of the $309,719.40 third party lien is contingent upon approval of the CDA, we interpret the CDA as providing that, in addition to $1, the consideration for the CDA is the insurer's agreement to waive its $309,719.40 third party lien. See Bradford Sexton, Deceased, 49 Van Natta 740 (1997). Moreover, the CDA provides sufficient information regarding the third party settlement and the insurer's lien that we are able ascertain the value of the consideration flowing to claimant under the agreement. See Michael Salber, 48 Van Natta 757 (1996); Kenneth Hoag, 43 Van Natta 991 (1991).

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[1] It is not uncommon for the Board to receive CDAs which involve carrier approvals of claimants' third party settlements. When such circumstances arise, it is equally commonplace for all or a portion of the consideration for the CDA to be the carrier's full or partial waiver of its third party lien. Here, considering the parties' reference to a "contingent" waiver of the insurer's third party lien, we have interpreted the parties' CDA in a manner consistent with these more common CDAs.

As interpreted herein, the parties' CDA is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN DEATON, Claimant
WCB Case Nos. 94-04671, 94-04050 & 91-18480
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Frohnmayer, et al, Attorneys
Julene M. Quinn (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Deaton v. Hunt-Elder, 145 Or App 110 (1996). The court has reversed our prior order, Karen K. Deaton, 48 Van Natta 44 (1996), that affirmed an Administrative Law Judge's order that declined to award claimant's counsel a carrier-paid attorney fee under ORS 656.382(2). Determining that claimant is entitled to an attorney fee under ORS 656.382(2), the court has remanded for reconsideration.

We begin with a summary of the relevant facts. The noncomplying employer requested a hearing, raising issues regarding its compliance status and its objection to the SAIF Corporation's acceptance of claimant's right knee claim. Before the conclusion of the hearing, the parties negotiated a settlement and the employer withdrew its objection to SAIF's acceptance of the claim.

Claimant's counsel asked for an assessed attorney fee and submitted a letter attesting to 48 hours of legal services (39 hours at $175 per hour for one attorney and 9 hours at $150 per hour for another attorney), including preparation and review of exhibits, document review, preparation and review of memoranda, motions to dismiss, letter to clients and other parties, affidavits and other documents generated in the course of three days of hearing. The total requested fee was $8,175. (Record at 103-04).

SAIF challenged claimant's request, contending that claimant's attorney was not entitled to a fee under ORS 656.382(2) and, even if he was so entitled, an appropriate fee would be no more than $2,500. In this regard, SAIF contended that claimant's request was insufficiently detailed to support an $8,175 fee. (Record at 110-12; see also Record at 135).

The ALJ denied claimant's attorney fee request. The Board affirmed the ALJ's order on the ground that the stipulation did not address the merits of the case. The court reversed the Board's order, reasoning that the parties' Stipulated Settlement Order, approved and signed by the ALJ, was the equivalent of a finding on the merits that claimant's compensation should not be disallowed or reduced (and the remaining requirements of ORS 656.382(2) were satisfied). Deaton, 145 Or App at 118. Accordingly, we award an attorney fee on reconsideration.

In determining a reasonable attorney fee award, 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 employer's compliance status and the compensability of claimant's right knee condition. Approximately 40 exhibits were received into evidence. The hearing took place on three different days. The transcript consists of approximately 334 pages. Five witnesses, including claimant, testified. The issues presented legal, factual, and medical questions of a complexity greater than those generally submitted for ALJ 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 $6,000 is a reasonable attorney fee for claimant's counsel's services at the hearings level. In reaching this conclusion, we have particularly considered the time devoted at the hearings level to the compensability issue (as represented by the record, claimant's counsel's submission, and SAIF's objection), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant is not entitled to an attorney fee for services at hearing for defending the "noncomplying employer" order (because the order did not award compensation) or for services related to the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, on reconsideration, the ALJ's March 10, 1995 order is reversed. Claimant is awarded a $6,000 attorney fee, payable by the SAIF Corporation on behalf of the noncomplying employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
BETTY J. ELLINGSON, Claimant
WCB Case No. 96-07430
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
David J. Lefkowitz, Defense Attorney

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's claim for a costochondritis 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 the ALJ mistakenly found that the opinion of Dr. Fuchs, a consulting physician, was more persuasive than the remaining medical opinions in the record. Specifically, the employer contends that Dr. Fuchs' opinion was based on a misunderstanding that claimant had never experienced upper chest pain prior to the April 22, 1996 physical agility test at work. The employer relies on exhibits, however, which describe chest pain, but do not specifically provide that claimant experienced "upper" chest pain prior to the work incident. (Exs. B, H). Accordingly, because Dr. Fuchs was aware of claimant's prior history and because he focused on a specific finding of upper chest pain which was consistent with lifting activities, we do not agree that Dr. Fuchs had an erroneous history.

The employer also contends that Dr. Fuchs placed "undue weight" on claimant's pain reaction following palpation. Such an argument, however, is speculative where no other physician has rejected Dr. Fuchs' opinion on that basis. Under the circumstances, we decline to offer a lay opinion that Dr. Fuchs' reliance on claimant's reaction is either contrary to other evidence in the record or that too much emphasis was placed on such a finding. In any event, we note that Dr. Fuchs' palpation finding was only one of several reasons offered for his conclusion relating the condition to the work activity.

Finally, after comparing Dr. Fuchs' opinion to the remaining medical opinions, we agree with the ALJ's assessment that it is the most complete and well-reasoned opinion regarding causation of claimant's condition. Consequently, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated December 2, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
SHARON K. FALSETTO, Claimant
WCB Case No. TP-97003
THIRD PARTY DISTRIBUTION ORDER
Gaylord & Eyerman, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer, as paying agency, has petitioned the Board to resolve a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the insurer seeks to recover the sum of $8,121.99[1] as the present value of its reasonably to be expected future medical expenses. See ORS 656.591(1)(c). In her brief in opposition to the insurer's motion, claimant seeks sanctions pursuant to ORS 656.390, asserting that the insurer's petition is frivolous.

As set forth below, we conclude that the insurer has not established that it is reasonably certain to such future medical expenses. We also deny claimant's request for sanctions.

FINDINGS OF FACT

Claimant was compensably injured on July 14, 1992, when she was involved in a freeway motor vehicle accident. She sustained neck and left shoulder injuries, which were accepted by the insurer.

Claimant experienced continuing neck and bilateral upper extremity pain following the accident. She was diagnosed with cervical and thoracic strains superimposed on preexisting cervical spondylosis. After approximately five weeks of medical treatment and convalescence, claimant was released to work. She returned to her regular job on August 17, 1992.

Claimant's neck and back pain continued and, in November 1992, she was referred to Dr. Brett, who recommended a cervical myelography to assess the areas of neural impingement and to determine the necessity for surgical intervention. Claimant did not return to Dr. Brett for treatment. In January 1993, she saw Dr. Misko for a neurosurgical consultation. Dr. Misko found signs of cervical nerve root compression at C5-6 on the right and discussed the surgical procedure and alternative treatments with claimant.

In early April 1993, claimant was evaluated by Dr. Franks on referral from her family doctor. Following diagnostic testing which showed mild anterior defects at C5-6 and C6-7 and very minimal nerve root underfilling at the C7 level, Dr. Franks suggested a two level fusion (C5-6 and C6-7) if claimant could not tolerate her chronic pain. In December 1993, Dr. Franks noted that there had been no objective change in claimant's condition in the prior six months, that she had been tolerating her pain and that there was no reason to push her into surgery.

In February 1994, Dr. Franks reported that claimant was reluctant to consider surgery unless it was absolutely necessary. He further opined that since claimant had held off on surgery and had been tolerating her pain as much as possible with conservative nonsurgical treatment, the chances that her condition would worsen so that surgery would be necessary were low. He stated, however, that if claimant did worsen, either symptomatically or objectively, he would recommend two level fusion surgery at that time. Dr. Franks also reported that if surgery were performed, the cost of the surgery, post-operative and follow up treatments would be approximately $9,000 to $10,000.

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[1] This sum represents the balance of the settlement proceeds after payment of attorneys fees and costs, claimant's statutory recovery and reimbursement to the insurer for its incurred claim costs.

Claimant last sought treatment for her compensable injuries on March 31, 1995. On August 17, 1995, her family physician, Dr. Wilcox, reported that claimant was medically stationary with continued chronic symptoms, which tended to bother her more with increased activity. He also noted that claimant was at risk for re-injury and exacerbation of her symptoms as well as continuing degenerative changes exacerbated by the accident.

Claimant's claim was closed by Determination Order on October 4, 1995, with an award of temporary total disability and 15 percent unscheduled permanent disability.

In May 1996, claimant was evaluated by Dr. Podemski, who concluded that claimant was not in need of surgical intervention nor further treatment related to her injuries from the 1992 motor vehicle accident.

Meanwhile, in June 1994, claimant initiated a third party negligence action against the drivers of the other vehicles involved in the automobile collision.[2] On July 3, 1996, the day before the case was set for trial, claimant agreed to settle the third party action for $60,000. The insurer approved the settlement and was paid $17,930.93 as reimbursement for amounts it had incurred to date. After deducting the costs ($920.62) and attorney fee ($20,000) and paying claimant at least one third of the balance ($13,026.46), the parties agreed that the balance of the proceeds ($8,121,99) would be held in trust pending a determination as to whether and to what extent the insurer was entitled to a lien for future medical expenses.

CONCLUSIONS OF LAW AND OPINION

As noted at the outset, the insurer argues that it should be paid the balance of the settlement proceeds under ORS 656.593(1)(c) because it is reasonably likely to incur future medical costs in excess of that amount. In response, claimant asserts that it is not reasonably certain that she will need additional treatment and/or surgery for her compensable injuries and therefore the insurer is not entitled to a lien for future anticipated claim expenditures.[3]

ORS 656.593 sets forth the procedure when a worker elects to bring a third party action. If the worker or beneficiaries obtain a judgment for damages in a third party action, the recovery is to be distributed pursuant to the statutory formula set forth in ORS 656.593(1).[4] If, on the other hand, the worker or beneficiaries settle the third party case with the approval of the paying agency, the settlement proceeds are to be distributed pursuant to ORS 656.593(3). See, e.g. Denton v. EBI Companies, 67 Or App 339 n.1 (1984).

Under ORS 656.593(3), "the paying agency is authorized to accept such a share of the proceeds as may be just and proper" provided the claimant receives at least the amount to which he or she would be entitled if the proceeds were distributed under the statutory formula.[5] The amount that the agency

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[2] Pursuant to ORS 656.578, a worker who receives a compensable injury due to the negligence of a third party may elect to sue the third party for damages under ORS 656.154. Pursuant to ORS 656.580(2), the paying agency has a lien against the worker's cause of action, which is preferred to all claims except the cost of recovering the damages.

[3] In its reply brief, the insurer moves to strike excerpts of claimant's May 1996 deposition in the third party action, which were attached as Exhibit A to claimant's opposition brief. Alternatively, the insurer asks that claimant submit the entire deposition transcript, asserting that the partial transcript is "potentially misleading." We need not resolve the insurer's motion because we do not rely upon Exhibit A in denying the insurer's petition. The resolution of this third party distribution dispute is dependent upon the medical evidence concerning claimant's need for future medical treatment (see, e.g., Exs. 12, 13, 15, 18-25 and 28, submitted by the insurer) rather than claimant's credibility or prior admissions.

[4] Under ORS 656.593(1)(a), litigation costs and attorney fees are initially disbursed. Then, the worker receives at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency is paid the balance of the recovery to the extent that it is compensated for its expenditures for compensation and for the present value of its reasonably to be expected future expenditures for compensation. See ORS 656.593(1)(c). Any remaining balance is paid to the worker. ORS 656.593(1)(d).

[5] ORS 656.593(3) further provides that "[a]ny conflict as to what may be a just and proper distribution shall be resolved by the board."

is "authorized to accept" under ORS 656.593(3) is less precise than the amount of its lien under ORS 656.593(1)(c): "just and proper," as opposed to "its expenditures for compensation * * * and * * * the present value of its reasonably to be expected future expenditures for compensation." See Estate of Troy Vance v. Williams, 84 Or App 616 (1986).

Although ORS 656.593(1)(c) is not applicable when we are determining a "just and proper" distribution, that provision does provide some general guidance in determining what portion of the remaining balance of the third party settlement proceeds the paying agency may receive in satisfaction of its lien for future claim costs. See Mona R. Skelton, 47 Van Natta 882 (1995). To support a lien for anticipated future medical expenses, the paying agency must establish that it is reasonably certain to incur such expenditures. Id.

In Mona R. Skelton, we held that the paying agency was not entitled to recover its projected lien for anticipated future expenditures because the evidence established that future medical treatments were only a "possibility" rather than a reasonable certainty, especially in light of the claimant's treating doctor's report that no further treatment was necessary for the claimant's elbow injury. We reached the same conclusion in Cynthia G. Lavelle, 41 Van Natta 1399 (1989), where the medical evidence showed that the claimant's need for future surgery was speculative and that future treatments for her compensable back condition were neither expected nor necessary. Cf. David L. Whitlow, 41 Van Natta 1517 (1989) (holding that paying agency was entitled to a lien for expected future expenditures for claimant's herniated nucleus pulposus where the medical experts agreed that future conservative treatments, including physical therapy with manipulation and other modalities, would be necessary on a long term basis).

Here, despite the insurer's contention, we do not find that it is reasonably certain that the insurer will incur future expenses arising out of claimant's compensable injuries. Although both Dr. Brett and Dr. Franks discussed the possibility of fusion surgery to alleviate claimant's pain, neither physician concluded that such surgery was expected or necessary. Dr. Brett recommended a myelogram to verify the need for surgery. The myelogram and CT, which were ultimately ordered by Dr. Franks, showed only mild defects from spurring and no clear nerve root compression. Dr. Franks believed that surgery was an option but was not necessary if claimant could tolerate her chronic pain. In fact, Dr. Franks noted on two occasions in 1993 that claimant did not have fixed objective radiculopathy and that there was no need to "push her for surgery."

Similarly, in February 1994, Dr. Franks concluded that although fusion surgery would likely relieve claimant's chronic pain, claimant's desire to "avoid surgery at all costs" was reasonable because she did not harbor a fixed neurological deficit referable to her spinal cord and/or nerve roots. He further opined that the chances of claimant having objective deterioration and further spinal cord and/or nerve root compression were "low" and that changes in her current status were unlikely. More than two years later, Dr. Podemski found no change in claimant's status (other than some improvement in her arm symptoms) and opined that surgical intervention was not indicated by her chronic neck pain.

Although Dr. Wilcox reported that claimant's compensable injury put her at risk for reinjury and exacerbation, the potential for future injury or further cervical disc degeneration is insufficient to satisfy the "reasonably certain" standard. See Cynthia G. Lavelle, 41 Van Natta at 1400 (where future problems are possible but not necessarily expected, future expenditures are not reasonably certain).

Considering the expert medical opinion and claimant's stated desire to avoid surgery, we find that future surgery is only a possibility and not reasonably certain to occur. Moreover, since claimant remains medically stationary and there is no evidence indicating that other treatment for her compensable injuries is expected or necessary, we conclude that the insurer has not established that is reasonably certain to incur future expenditures for medical services.[6] Consequently, the insurer is not entitled to recover its projected lien for future anticipated claim expenses.

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[6] Furthermore, even if we were persuaded that claimant would need intermittent conservative treatment for her compensable injuries, the insurer has offered no evidence concerning the cost or frequency such treatments. Cf. David L. Whitlow, 41 Van Natta at 1518 (where the record established that the claimant would likely need long-term intermittent treatment on the frequency of 10 times per year at a cost of $43 a visit, paying agency was entitled to retain the $4,745 balance of the third party settlement as anticipated future medical expenditures).

With regard to claimant's request for an attorney fee as a sanction for a "frivolous" motion pursuant ORS 656.390, we question whether the statute is even applicable in this context. By its express terms, ORS 656.390 applies only to requests for hearing, requests for review of an ALJ's decision or appeals and motions to the Court of Appeals or Supreme Court. The statute does not specifically address third party petitions and/or conflicts as to what may be a just and proper distribution of third party settlement proceeds. We need not resolve whether the statute is applicable, however, because even if it were, we are persuaded that the insurer had at least a colorable argument for seeking to retain a lien for projected future expenses.

ORS 656.390(2) defines "frivolous" as a matter that is "not supported by substantial evidence" or that is "initiated without reasonable prospect of prevailing." See Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996). Here, although we have determined that the insurer has not established that it is reasonably certain to incur future expenditures, it did come forward with evidence showing at least the potential for future claim expenditures in excess of $9,000. Therefore, we cannot say that the insurer's petition was initiated without reasonable prospect of prevailing.

In conclusion, we hold that the paying agency is not entitled to recover the remaining balance ($8,121.99) of the third party settlement proceeds as its "just and proper" share for anticipated future expenditures. The balance of the third party recovery shall be paid to claimant. Claimant's request for sanctions pursuant to ORS 656.390 is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH E. GRUBB, Claimant
WCB Case No. 95-09110
ORDER ON REVIEW
Foss, et al, Claimant Attorneys
Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Baker's order which: (1) denied the insurer's motion to dismiss claimant's hearing request with prejudice for his allegedly unjustified failure to appear at a prior hearing; (2) awarded penalties and attorney fees for the insurer's allegedly unreasonable claim processing; (3) awarded an attorney fee for the insurer's allegedly unreasonable failure to provide timely discovery; and (4) admitted exhibits 20 and 21 into evidence. In his respondent's brief, claimant contests an apparent typographical error in the ALJ's order where it was stated that claimant's temporary disability was suspended on August 1, 1996, instead of August 1, 1995. On review, the issues are motion to dismiss, penalties, attorney fees and evidence. We modify in part and affirm in part.

FINDINGS OF FACT

Claimant sustained a disabling compensable injury on November 12, 1993. On July 18, 1995, the insurer wrote claimant that it had no information to indicate that he had received medical treatment since June 13, 1995. Advising claimant to return to his attending physician if he was still experiencing difficulty with his injury, the insurer stated that, if no response from was forthcoming from either him or his physician within two weeks of the date of the letter, it would be assumed that he had completely recovered from his injury and that actions would be taken to close the claim. (Ex. 8).

On August 3, 1995, the insurer wrote claimant to inform him that his temporary disability was suspended as of August 1, 1995, on the ground that his physician was not a qualified attending physician. (Ex. 9). This prompted claimant to request a hearing on August 7, 1995, raising the issues of penalties and attorney fees for unreasonable resistance to the payment of compensation. The case was set for hearing before ALJ Crumme on October 31, 1995.

On August 10, 1995, Dr. Silver, claimant's attending physician, forwarded to the insurer a copy of his most recent chart note of July 25, 1995. The date stamp on Dr. Silver's report indicated that the insurer received it on August 16, 1995. (Ex. 10).

Claimant's attorney forwarded a general discovery request on August 16, 1995. (Ex. 11). Enclosing updated discovery information, the insurer responded to claimant's discovery request on August 22, 1995 and advised claimant's attorney that it had previously provided discovery. In addition, the insurer stated that the letter to claimant regarding an unauthorized attending physician was a "misprint" and that the letter should have been a standard suspension letter based on a lack of "time loss information and no response to the 14 day notice letter." (Ex. 12).

On October 26, 1995, the parties advised the Hearings Division that their case had settled. However, on January 4, 1996, claimant's attorney requested that the case be reset for hearing after settlement negotiations failed to produce a stipulation acceptable to both sides. The case was once again scheduled for hearing on June 27, 1996, this time before ALJ Howell.

In the meantime, the claim was closed on April 16, 1996 with an award of temporary disability from June 10, 1994 through January 24, 1996. (Exs. 17, 18). Claimant's attorney noted on April 17, 1996 that the closure was based on a January 24, 1996 "IME" and Dr. Silver's March 10, 1996 concurrence, neither of which she alleged had been copied to her. (Ex. 19). Observing that the last transmittal of chart notes was December 5, 1995, claimant's attorney expressed frustration with "this continual violation of the [discovery] rules." Id. Claimant then filed another hearing request, raising the issue of failure to provide discovery.

On June 7, 1996, claimant's attorney notified the ALJ that she was withdrawing as counsel. (Ex. 22). That same day, claimant's counsel moved for a dismissal of the hearing request without prejudice. The insurer's counsel responded to the motion by requesting that the dismissal be with prejudice.

ALJ Howell advised the parties on June 14, 1996 that the matter would either be dismissed with prejudice or that claimant could attend the hearing on June 27, 1996. Claimant's counsel again confirmed on June 25, 1996 that she had withdrawn as counsel, but stated that she would continue efforts to contact claimant regarding the hearing. Claimant did not appear at the June 27, 1996 hearing.[1]

On July 1, 1996, ALJ Howell wrote the parties and stated that the insurer's attorney had advised him prior to the June 27, 1996 hearing that claimant did not wish to attend the hearing. However, the ALJ further stated that he was not told that claimant's nonappearance was conditioned upon agreement to the previously rejected stipulation. The ALJ then referred the case the docketing section to be reset for hearing with another ALJ.

The case was rescheduled for hearing on December 3, 1996 before ALJ Baker, but the parties agreed to submit the issues for resolution based on the documentary record. The insurer moved to dismiss claimant's hearing requests for lack of jurisdiction over the penalty and attorney fee issues. It also moved to dismiss claimant's hearing requests with prejudice based on claimant's failure to appear at the June 1996 hearing. The insurer also objected to the admission of two memorandums relating to conversations between personnel in the insurer's and claimant's attorney's offices regarding provision of discovery. (Exs. 20, 21). The issues to be decided on the merits were penalties and attorney fees for failure to provide discovery, unreasonable suspension of temporary disability and late payment of temporary disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ denied the insurer's motions to dismiss and admitted Exhibits 20 and 21. Finding that the insurer had suspended claimant's temporary disability on August 1, 1995 without reasonable justification, the ALJ assessed an attorney fee of $500 under ORS 656.382(1). The ALJ further concluded that claimant was entitled to a 25 percent penalty under ORS 656.262(11), finding that the insurer had unreasonably failed to timely pay temporary disability. Finally, the ALJ assessed another $500 attorney fee under ORS 656.382(1) for the insurer's allegedly unjustified failure to timely provide discovery.

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[1] It is not clear from the file exactly why claimant did not appear at the hearing. There is a hand-written memorandum of a conversation between ALJ Howell and the insurer's counsel. According to the ALJ's notes, the insurer's attorney stated that claimant's counsel's office had called to advise that claimant did not wish to attend the hearing, but wanted to sign the prior stipulation. The insurer's attorney apparently informed the ALJ that he was unsure if the prior settlement "offer" was still available, but that he did not believe claimant would appear at the hearing.

Motion to Dismiss

An ALJ shall dismiss a request for hearing if a claimant and his or her attorney fails to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). In this case, the insurer contends that the ALJ should have dismissed claimant's hearing requests because of claimant's failure to appear at the hearing scheduled on June 27, 1996, after ALJ Howell advised him to either attend the hearing or have his hearing request dismissed with prejudice. We disagree.

We find that "extraordinary circumstances" existed to justify postponement of the hearing before ALJ Howell. Claimant's counsel had withdrawn her representation prior to the scheduled hearing. Moreover, claimant was apparently under the impression that the case had been settled pursuant to the parties' stipulation. Given claimant's lack of legal representation and the uncertain status of the stipulation with the insurer, we conclude that extraordinary circumstances existed to justify the postponement and rescheduling of the hearing. The ALJ, therefore, properly declined to dismiss claimant's hearing requests.

Penalties and Attorney Fees

The ALJ assessed a $500 attorney fee pursuant to ORS 656.382(1), finding that the insurer had unreasonably suspended payment of temporary disability on "August 1, 1996."[2] The insurer contends that there is no evidence in the record that claimant's compensation was in fact suspended on August 1, 1995.

Our review of the payment records indicates that a full payment of temporary disability was made on August 3, 1995 for the period from July 15, 1995 to July 28, 1995. (Exs. 16-5, 15). Another payment was made for a two day period from July 29, 1995 to August 1, 1995 on August 17, 1995. (Exs. 16-4, 15). Four days later, on August 21, 1995, resumption of regular temporary disability payments occurred when the insurer made a regular payment for the period from August 2, 1995 to August 15, 1995. Id. Therefore, payment of temporary disability was suspended for four days.

We agree with the ALJ's finding that the "suspension" of temporary disability payments was unreasonable. In this regard, we note that the insurer wrote claimant on July 18, 1995 that he had two weeks to respond to its letter notifying him that the claim would be closed if he did not resume treatment. That letter did not propose any suspension of temporary disability; it merely stated that actions would be taken to close the claim if no response was received within two weeks. We recognize that the insurer subsequently informed claimant that it was suspending benefits as of August 1, 1995 because his physician was not a "qualified attending physician." The insurer subsequently admitted on August 22, 1995 that this was an erroneous basis for suspending compensation. While the insurer stated that the July 18, 1995 letter "should have been a standard suspension letter" to suspend temporary disability for lack of time loss information, we are not persuaded that the insurer's "after-the-fact" attempt to correct its error made its conduct reasonable when the July 18, 1995 letter provided insufficient justification to suspend compensation.

Considering the totality of circumstances, we agree with the ALJ that the insurer's brief suspension of temporary disability was unreasonable. Therefore, we conclude that the ALJ correctly awarded an attorney fee for unreasonable resistance to the payment of compensation under ORS 656.382(1).[3]

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[2] As claimant correctly notes, the ALJ's order contains an apparent typographical error in that the alleged date of suspension should be August 1, 1995.

[3] We recognize that a penalty pursuant to ORS 656.262(11) is being assessed that encompasses the same time period for which an attorney fee was awarded under ORS 656.382(1) (see discussion below). However, a separate attorney fee award under ORS 656.382(1) may be granted for separate unreasonable conduct that relates to a different factual basis. See, e.g., Corona v. Pacific Resource Recycling, 125 Or App 47 (1993). Accordingly, since the insurer's conduct in suspending payment of temporary disability and in untimely paying temporary disability constituted separate acts of unreasonable resistance to the payment of compensation, relating to different factual bases, claimant is entitled to penalty-related attorney fees assessed under ORS 656.382(1). See Lucille G. Major, 47 Van Natta 617, 619 (1995) (where a penalty was already assessed on amounts due, an attorney fee under ORS 656.382(1) was assessed for separate unreasonable conduct).

The ALJ also assessed a 25 percent penalty under ORS 656.262(11) for late payment of temporary disability, based on "late-paid periodic payments of time loss compensation." Although the ALJ's order implies that all temporary disability payments were untimely after the insurer's suspension of temporary disability, we find that, when the insurer received Dr. Silver's letter stating that he had treated claimant on July 25, 1995, claimant's temporary disability payments were resumed on August 21, 1995 and continued regularly thereafter. (Ex. 16-14). Under these circumstances, we limit the ALJ's penalty assessment to the untimely temporary disability payment made on August 21, 1995. The ALJ's order is modified accordingly.

Finally, the ALJ awarded an attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable failure to timely provide discovery.[4] Although the record does not indicate when discovery was provided to claimant, we conclude that there is sufficient evidence to establish that discovery was untimely provided.

Specifically, we note claimant's counsel's letter to the insurer after claim closure. (Ex. 19). It referred to the insurer's failure to provide a copy of an IME report, as well as a concurrence letter used to close the claim. Although there is no evidence that compensation was due at the time of the discovery violation, an attorney fee award pursuant to ORS 656.382(1) does not depend on amounts "then due." See Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989); Janice Talevich, 48 Van Natta 2318 (1996). Inasmuch as the insurer gave no reason for its failure to timely provide discovery, we conclude that the ALJ properly assessed an attorney fee under ORS 656.382(1).[5]

ORDER

The ALJ's order dated January 14, 1997 is modified in part and affirmed in part. That portion of the ALJ's order that assessed a 25 percent penalty on late-paid periodic temporary disability payments is modified. In lieu of the ALJ's award, the insurer is ordered to pay a 25 percent penalty based on the temporary disability due claimant on August 21, 1995. The remainder of the ALJ's order is affirmed.

[4] The insurer has objected to the admission of Exhibits 20 and 21, which pertain to the discovery issue. However, given our resolution of the issue, we need not determine whether the ALJ abused his discretion in admitting the documents.

[5] 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).

In the Matter of the Compensation of
JERILYN J. HENDRICKSON, Claimant
WCB Case No. 96-02463
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On June 30, 1997, we abated our May 30, 1997 Order on Review that adopted and affirmed the Administrative Law Judge's order that: (1) declined to award temporary disability benefits for the period of April 4, 1994 through October 13, 1994; and (2) declined to assess a penalty for the employer's allegedly unreasonable failure to pay those benefits. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

Claimant was hired by the employer as a painter-helper in June 1993. On September 2, 1993, she sought treatment for symptoms related to carpal tunnel syndrome (CTS) and was given a modified work release.[1] Claimant returned to work that day (or the next day) at a modified job at the same rate of pay, but was terminated prior to the end of her shift for reasons unrelated to her claim.

[1] Claimant was released for work with limitations on forceful, repetitive gripping with her right hand. She was also advised to use a brace at work.

On February 15, 1994, claimant underwent right carpal tunnel release surgery. On March 21, 1994, Dr. Ushman released claimant for modified work, with no repetitive bending of the right wrist and no lifting over 20 pounds. On October 13, 1994, Dr. Ushman found claimant medically stationary.

Meanwhile, claimant's CTS claim was found compensable by a February 17, 1994 Opinion and Order, which was affirmed on review on September 22, 1994. In response to the litigation order, the employer accepted the condition on April 4, 1994 and paid temporary disability benefits up to that date. The claim was closed by a November 6, 1995 Determination Order which granted temporary partial disability from September 2, 1993 through February 14, 1994, temporary total disability from February 15, 1994 through March 21, 1994 and temporary partial disability from March 22 through October 13, 1994. A March 6, 1996 Order on Reconsideration affirmed the temporary disability award and granted permanent partial disability.

Although the employer paid temporary disability benefits through April 3, 1994, it did not pay time loss for the period of April 4, 1994 though October 14, 1994 pursuant to the Determination Order and Order on Reconsideration. The employer took the position that claimant's rate of temporary partial disability for this time period was zero because claimant had returned to work at her at-injury wage and was then terminated for reasons unrelated to her claim. Claimant requested a hearing.

At hearing, claimant argued that the rate of her temporary partial disability benefits should be the same as her temporary total disability rate and also that the employer was precluded by issue and claim preclusion from contesting the temporary partial disability rate.[2] Relying on David L. Gooding, 47 Van Natta 1468 (1995), the ALJ determined that the rate issue had not been litigated previously and that the employer was not precluded from contesting the rate of claimant's temporary partial disability in this proceeding. The ALJ further found that, although the employer was obligated to pay temporary partial disability pursuant to the Order on Reconsideration, the rate of claimant's temporary partial disability benefits during the disputed time period (April 4, 1994 through October 13, 1994) was zero. We affirmed.

On reconsideration, claimant asserts that our decision is inconsistent with Deanna L. Rood, 49 Van Natta 285 (1997). In that case, we held that in order for a carrier to cease paying temporary total disability pursuant to ORS 656.325(5)(b),[3] the attending physician must approve that same modified job that would have been offered to the worker had the worker not been terminated. We found that it is not sufficient for the attending physician to merely release the worker to modified employment, the physician must review and consent to the specific modified job. Claimant argues that because her attending physician issued a general release to modified work but did not approve a specific modified job, the ALJ erred in relying upon ORS 656.325(5)(b).

We conclude that, although the ALJ cited to ORS 656.325(5)(b) and applied it by analogy, this case is not governed by that statute and therefore our determination is not inconsistent with Deanna L. Rood. ORS 656.325(5)(b) applies in the context of temporary total disability. When an injured worker who is otherwise entitled to temporary total disability is fired for violating a work rule or other disciplinary reasons, the carrier may cease paying temporary total disability and begin paying temporary partial disability under the circumstances discussed above. In this case, however, claimant was not entitled to (and the employer was not paying) temporary total disability benefits when she was fired for reasons unrelated to her claim. Therefore, the statute is not applicable.

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[2] In the prior litigation, we affirmed the ALJ's determination that claimant was entitled to interim compensation.

[3] This provision 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 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

At the time claimant was terminated, she was (at least theoretically) entitled to temporary disability benefits because she was partially disabled. Her physician had restricted her from repetitive gripping of the right hand. However, because she returned to a modified job at the same rate of pay prior to her termination, the rate of her temporary partial disability benefits equalled zero under ORS 656.212.[4] See former OAR 436-60-030(2); see also Alejandra R. Trevino, 48 Van Natta 399 (1996) (where the claimant's wages at modified work were the same as her at-injury wages, calculation of temporary disability benefits equals zero); Lonnie L. Dysinger, 47 Van Natta 2282 (1995). Furthermore, claimant's termination did not affect her (theoretical) entitlement to or the rate of her temporary partial disability because she was terminated for reasons unrelated to her claim. See former OAR 436-60-030(4)(b) (discharge for violation of normal employment standards not a withdrawal of a job offer which would allow resumption of temporary total disability); see also Dawes v. Summers, 118 Or App 15 (1993) (where the claimant was fired for non-claim related reasons and lost no wages because of her compensable injury, no temporary compensation was due following her termination); Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987) (where the claimant has not lost wages because of an inability to work as a result of his compensable injury, he is not entitled to temporary benefits).

The March 6, 1996 Order on Reconsideration has become final by operation of law and is enforceable.[5] See SAIF v. Roles, 111 Or App 597 (1991). That order granted claimant temporary *partial* disability benefits from September 2, 1993 and February 14, 1994, temporary *total* disability benefits between February 15, 1994 and March 21, 1994 (the period of time she was unable to work due to her carpal tunnel release surgery), and temporary *partial* disability benefits between March 22, 1994 (when she was released for modified work) and October 13, 1994 (her medically stationary date). We agree with the ALJ that the rate of claimant's temporary partial disability benefits during this latter period (March 22, 1994 to October 21, 1994) remains the same as the rate claimant was entitled to prior to her termination -- zero. This is so because there was no intervening event or circumstance to alter the temporary disability rate that was initially established pursuant to ORS 656.212 and former OAR 436-60-030(2).

In conclusion, like the ALJ, we conclude that although the employer is obligated to pay the temporary partial disability ordered by the March 6, 1996 Order on Reconsideration, the rate of this temporary partial disability is zero.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our May 30, 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] ORS 656.212(2) provides that temporary partial disability is calculated based on a comparison of the claimant's wages at modified employment and his or her at-injury wages.

[5] By arguing that her temporary partial disability rate should be equal to her temporary total disability rate, claimant is, in effect, seeking temporary total disability benefits for the time period in dispute instead of the temporary partial disability benefits awarded by the Determination Order and Order on Reconsideration. This constitutes an impermissible collateral attack on a final order. See, e.g. Monte W. Kentta, 46 Van Natta 1460 (1994); Mindi M. Miller, 44 Van Natta 2144 (1992) (on reconsideration).

In the Matter of the Compensation of
MICHAEL D. SAHM, Claimant
Own Motion No. 96-0434M
OWN MOTION ORDER DENYING RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 29, 1997 Second Own Motion Order on Reconsideration, in which we denied his request to reconsider our September 23, 1996 and November 21, 1996 orders that had declined to reopen his 1979 injury claim for the payment of temporary disability benefits. In denying reconsideration, we held that claimant had failed to establish good cause for his untimely request for reconsideration.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. Claimant's latest request for reconsideration was received on July 24, 1997, more than 30 days after the issuance of our May 29, 1997 order, but within 60 days after the mailing date of our order. Therefore, claimant must establish "good cause" for his untimely filing. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) or former ORS 18.160. Brown v. EBI Companies, 289 Or 455 (1980); Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); Hempel v. SAIF, 100 Or App 68, 70 (1990).

In our previous order, we concluded that claimant had not established good cause for his failure to request reconsideration within 30 days of our November 21, 1996 reconsideration order, nor had he established that extraordinary circumstances existed which prevented him from requesting reconsideration within 60 days of our final order. See OAR 438-012-0065(2) and (3); Larry P. Karr, 48 Van Natta 2182 (1996); Jay A. Yowell, 42 Van Natta 1120 (1990). We further concluded that claimant had failed to establish "due diligence" in providing information to the Board which had been available to him within 60 days after the issuance of our November 21, 1996 order. See Cogswell v. SAIF, 74 Or App at 234; Michael D. Sahm, 49 Van Natta 683 (1997).

In his recent undated letter, claimant blames his attorney's "negligence and lack of knowledge of the Own Motion Rules" for his prior untimely request. Claimant contends that he timely provided his attorney with his work history and W-4 forms, but that his attorney was "negligent in his duties to show the proof of my being in the work force at the time of disability." In short, claimant argues that his attorney neglected to timely request reconsideration of our orders denying temporary disability compensation in this claim.

It is well established that, even if a claimant's attorney was negligent in timely requesting appeal, the negligence of an attorney is not excusable neglect unless the attorney's reason for his action would be excusable had it been attributed to the claimant. Sekermestrovich v. SAIF, 280 Or 723 (1977); Jerry R. Testerman, 46 Van Natta 1443 (1994). The court has also previously established that good cause for an untimely filed hearing request is not established when a claimant's attorney charged with the responsibility to file such a request neglects to do so. Mendoza v. SAIF, 123 Or App 349 (1993).

Here, other than stating that his counsel did not return his telephone calls, claimant does not provide a reason for his attorney's apparent neglect to file a timely request for reconsideration of our prior orders. Under such circumstances, we are not persuaded that claimant has demonstrated good cause for his failure to request reconsideration of our prior order within 30 days of its issuance.

Finally, claimant does not contend that he did not receive a copy of our May 29, 1997 order, nor was claimant's copy of that order returned to the Board as undeliverable. In our order, we specifically recited that the appeal period for our orders was the 30-day period following the date of issuance. Furthermore, in all of our prior orders, we included a statement notifying the parties that a request for reconsideration of our orders must be filed with the Board within 30 days after the mailing date of the order. Therefore, we continue to conclude that claimant has not met his burden of proving "good cause," nor do we find reason to reach a different conclusion than what is contained in our prior orders.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD G. TOWNSEND, Claimant
WCB Case No. 96-04281
ORDER ON REVIEW
Swanson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) increased claimant's unscheduled permanent disability award from 3 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 5 percent (16 degrees); and (2) declined to award temporary disability benefits from May 2, 1994 through September 19, 1994. In his brief, claimant also contends that the ALJ erred in declining to admit Exhibit 48, a post-reconsideration report, into evidence. On review, the issues are extent of unscheduled permanent disability, temporary disability benefits, and evidence.

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

On review, claimant disagrees with the ALJ's finding that there were no objective findings to support claimant's headache condition. Claimant relies on Tony D. Houck, 48 Van Natta 2443 (1996), and argues that all of the doctors who have examined claimant have concluded that he suffers from post-traumatic headaches. Claimant also notes that doctors have prescribed medications for his headaches in order for him to be able to work.

We need not resolve the issue raised by claimant because we agree with the ALJ that claimant has not established permanent impairment due to the injury. ORS 656.214(5). In this regard, the medical arbiter, Dr. Farris, reported that claimant's headaches would gradually continue to improve, as they had done in the past. Dr. Farris further stated that claimant may "at some point have complete resolution of the headaches." (Ex. 44-5). Accordingly, we conclude that claimant has not established that his headache condition is permanent and, therefore, there is no basis for an award for that condition.

We also agree with the ALJ that claimant has not shown an entitlement to temporary partial disability benefits for the period of May 2, 1994 through September 19, 1994. On review, claimant argues that it was the employer's obligation to verify claimant's entitlement to temporary disability benefits. Claimant contends that his treating doctor, as shown by Exhibit 48, clearly authorized temporary disability benefits for that period of time. Finally, claimant argues that it was error for the ALJ to decline to admit Exhibit 48.

The ALJ found that the only evidence in the record supported a finding that claimant had been released to regular work during the time period in question. (Ex. 11). We agree. Consequently, claimant is relying on evidence not in the record to establish that temporary disability benefits were authorized during the relevant time period. Therefore, claimant's argument depends on whether the ALJ properly excluded Exhibit 48.

Here, the ALJ declined to admit Exhibit 48, which is a retroactive authorization of temporary disability benefits. Exhibit 48 was generated after the April 12, 1996 Order on Reconsideration. The ALJ reasoned that, because claimant requested reconsideration on the issue of temporary disability benefits, and claimant did not submit the report at the time of reconsideration, it could not subsequently be admitted for the first time at hearing. We agree.

We have previously held that, under ORS 656.283(7), evidence that is not submitted at reconsideration is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. The record of any subsequent hearing concerning the reconsideration order is limited to the reconsideration record that was developed by the Department. Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996); see also Precision Castparts v. Plummer, 140 Or App 227 (1996). Furthermore, we have extended our holding in Ray to include temporary disability benefits where the case underwent the same mandatory reconsideration procedure set forth in ORS 656.268. See Noel L. Baier, 49 Van Natta 290 (1997).

As in Baier, we conclude that the temporary disability issue in the present case involves "an issue regarding a notice of closure" within the meaning of ORS 656.283(7). Therefore, by its express terms, the statutory exclusion in ORS 656.283(7) applies to the hearing in this case. Accordingly, we conclude that the post-reconsideration evidence regarding temporary disability benefits was not admissible and was properly excluded by the ALJ. Therefore, we agree that claimant has not established an entitlement to temporary disability benefits.

ORDER

The ALJ's order dated January 29, 1997 is affirmed.

In the Matter of the Compensation of
LISA M. CHRISTIAN, Claimant
WCB Case Nos. 96-06518 & 96-06517
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that upheld the denial of Liberty Northwest, on behalf of employer Colvin Oil Company, of claimant's L3-4 disc injury claim.[1] On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, age 35 at the time of hearing, has a long history of low back problems, beginning with a December 1984 compensable injury. In 1986, she had a chemonucleolysus with chymodiactin of the L3-4 and L4-5 discs. Then, in 1987, claimant sustained another compensable low back injury, and underwent a percutaneous diskectomy at L5-S1. In September 1992, claimant suffered of L5-S1 disc condition, which was ultimately resolved through a Disputed Claim Settlement with SAIF.

Between November 1994 and April 1996, claimant continued to experience intermittent pain, but she did not seek treatment for her low back. In the meantime, in 1995, she began working for Colvin Oil as a gas station attendant.

While opening up the station on the morning of April 6, 1996, claimant experienced an acute increase in symptoms when she bent over, unlocked and lifted open a metal bay door. Later that day, claimant advised her supervisor, Jim Hiltbruner, that she had severe pain in her back, but did not describe the injurious incident. Claimant left work early because of her back and leg pain.

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[1] The ALJ also found that the SAIF Corporation, which accepted a 1987 injury to claimant's L5-S1 disc, was not responsible for claimant's L3-4 disc condition. Claimant does not challenge this aspect of the ALJ's order on review.

Two days later, on April 8, 1996, claimant sought treatment, complaining of a recent worsening of her low back pain. (Ex. 43). Although Dr. Foutz did not record a history of any specific injurious incident, claimant completed an 827 form indicating that she was injured while "bending over to pull a roll-up door up." (Ex. 44). Claimant then saw Dr. Dunn (who had treated her previous back injuries) on April 16, 1996. Dr. Dunn recorded a history of progressively increasing back and leg pain without any specific injurious incident. (Ex. 46). Based on a May 2, 1996 MRI which showed a large left posterior extrusion of the L3-4 disc, Dr. Dunn recommended an endoscopic diskectomy to remove the extruded fragment. On May 14, 1996, claimant related to Dr. Dunn that she felt a severe change in her symptoms on April 6, 1996 when she bent over to pull up the bay door at work.

In June 1996, claimant was examined by doctors Purtzer and Cronin. She gave a history of feeling "something give" in her lower back as she lifted the metal garage door on April 6, 1996. (Ex. 54-1). Similarly, in August 1996, claimant advised Dr. Donahoo that, for months prior to April 6, 1996, she experienced symptoms when she pulled open the garage door, but that "things went wrong" and her symptoms became severe when she opened the door that day.

CONCLUSIONS OF LAW AND OPINION

The ALJ was not persuaded that claimant experienced a specific incident at work on April 6, 1996, based on the lack of any reference to such an incident in the initial medical records and Mr. Hiltbruner's testimony that claimant did not report any incident to him. Because the ALJ was not persuaded such a specific, pain producing event occurred, he did not consider the expert medical causation opinions which relied on claimant's history of the incident.

On review, claimant argues the ALJ erred in concluding that she did not injure herself at work on April 6, 1996. Specifically, claimant argues that her testimony is credible, that she consistently reported that she experienced an exacerbation of her pain while lifting the metal garage door, and that she has proven the compensability of her L3-4 disc condition. We agree.

Where, as here, 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). While the initial medical reports of Drs. Foutz and Dunn do not record a history of an acutely painful door-lifting incident, claimant did state on the 827 form (completed April 8, 1996) that she was injured bending over and pulling the roll-up door. Claimant also described the door lifting incident on her 801 form, completed April 27, 1996. Under these circumstances, we do not find the absence of any reference to a specific injurious event in the first medical reports fatal to claimant's claim. Indeed, consistent with claimant's later testimony, both doctors noted that claimant had been dealing with chronic pain for some time and had experienced waxing and waning of her symptoms, but that her symptoms had worsened at work in the days just prior to seeking treatment. The doctors' failure to initially record exactly what claimant was doing at work when her pain worsened does not mean that the door lifting incident did not occur or that it was not the mechanism of her injury.[2]

Claimant has the burden of proving the compensability of her L3-4 disc injury[3] by a preponderance of the evidence. ORS 656.266. Unlike the ALJ, we find it more likely than not that claimant experienced an acute worsening of her low back and left leg pain as she bent over to lift up the bay door on April 6, 1996. As set forth below, we are also persuaded by the expert medical evidence that this work-related incident is the major contributing cause of claimant's L3-4 disc herniation.

Absent persuasive reasons to the contrary, we will generally defer to the opinion of the treating physician because of this physician's opportunity to observe the claimant over an extended period of time. Weiland v. SAIF, 64 Or App 810 (1983). When the medical evidence is divided, we will give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

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[2] The same is true to the extent Mr. Hiltbruner was unaware of any specific event. Although he did not believe that claimant injured herself at work, Mr. Hiltbruner was aware that claimant was in pain and in need of treatment for her back as of April 6, 1996. (Tr. 67, 70).

[3] The medical evidence establishes that claimant's L3-4 disc herniation results from a combination of the April 6, 1996 incident and her preexisting low back condition. (See, e.g. Exs. 47, 54-5, 57-13, 58-6). Therefore, we apply ORS 656.005(7)(a)(B).

Here, we find no persuasive reason not to rely on the opinion of Dr. Dunn, who has treated claimant's low back condition since 1986. When advised by claimant that her symptoms worsened when she bent over to pull up the door, Dr. Dunn opined that 51 percent of the cause of her symptoms was that incident rather than her preexisting low back condition. (Ex. 51). Dr. Dunn maintained this position during his deposition, explaining that her injury (a ruptured disk at L3-4) was consistent with bending over and lifting. (Ex. 63-14). He acknowledged that claimant's preexisting low back condition (including prior injuries to, and surgeries on, the two disks below L3-4) put an increased load on the L3-4 disk and predisposed claimant to a new disk bulge, but concluded that the work incident was the major cause because of the mechanism of injury (bending and lifting) and the force on the spine necessary to lift the weight of the garage door. (Ex. 63, pp. 20-21). Dr. Dunn further testified that his causation opinion was supported by his surgical findings of a "fresh" disc herniation instead of a calcified or hard fragment. Had he found the latter, he would have concluded that claimant a preexisting, chronic injury to her L3-4 disc.[4] (Ex. 63-11, 63-20).

While we have previously held that a simple "but for" analysis is unpersuasive under the major contributing cause standard,[5] see, e.g., Alec E. Snyder, 47 Van Natta 838 (1995), we find that Dr. Dunn's opinion in this case persuasively explains why the work incident is both the precipitating *and* primary cause of claimant's L3-4 disc injury and need for treatment after April 6, 1996. See Dietz v. Ramuda, 130 Or App 397(1994), rev dismissed 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more the claimed condition that all other causes or exposures combined). As noted above, Dr. Dunn evaluated the other (preexisting) factors that contributed to claimant's condition and explained why the work incident was, in his opinion, the major contributing cause of her recently herniated L3-4 disc.

After considering the record as a whole, we are persuaded that Dr. Dunn had a complete and accurate understanding of claimant's preexisting condition and the nature of the work incident on April 6, 1996. Based on his opinion and Dr. Donahoo's concurrence, we conclude claimant has established the compensability of her L3-4 disc herniation by a preponderance of the evidence. See Somers, 77 Or App at 263.

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 Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated January 10, 1997 is affirmed in part and reversed in part. That part of the order that upheld Liberty's denial is reversed and the denial set aside. Claimant's L3-4 disc injury claim is remanded to Liberty for processing according to law. For services at hearing and on review, claimant is awarded $4,000, payable by Liberty. The remainder of the ALJ's order is affirmed.

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[4] Dr. Donahoo, who examined claimant at Liberty's request, also opined that the April 6, 1996 door lifting incident was the major contributing cause, based on claimant's history of the incident and Dr. Dunn's surgical finding of a freshly extruded disc fragment. (See Ex. 67).

[5] At one point, Dr. Dunn testified that "but for [the door-lifting] incident," claimant would likely not have herniated her disc. (Ex. 63-21).

In the Matter of the Compensation of
ROBERT E. RALPH, Claimant
WCB Case No. 96-01973
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of his claim for a low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for the employer from early August until December 1995 as a car salesman. On November 28, 1995, claimant moved approximately 70 to 80 cars on the lot. After moving a good portion of the cars, claimant felt pain in his lower back and a popping sensation. (Tr. 11). Claimant's low back symptoms were worse by the following day and claimant went to work, but left because of back pain. Mr. Howell, a co-worker, took claimant from the lot to claimant's car in a golf cart. (Tr. 15; 85). That day, claimant sought treatment for his back pain from Dr. Bogard.

Claimant complained to Dr. Bogard of severe low back pain with spasm and pain radiating into both legs. (Ex. 10). Dr. Bogard subsequently diagnosed a herniated disc secondary to work injury. (Ex. 12). A CT scan showed a large herniated disc at L5-S1, a disc bulge at L4-5 and degenerative disc disease at L5-S1. (Ex. 13). Dr. Bogard referred claimant to neurologist Dr. Louie, for neurosurgical consultation.

Dr. Louie recommended a trial of epidural steroids and prescribed physical therapy. (Exs. 14; 15). Claimant returned to Dr. Bogard, who referred claimant to Dr. Tenckhoff, chiropractor, for chiropractic manipulation. In May 1996, after an MRI showed a worsening of the disc condition, Dr. Louie recommended surgery. (Ex. 34).

Claimant filed a workers' compensation claim for the November 28, 1995 injury which was denied by the insurer on January 31, 1996. (Ex. 22).

Claimant has been involved in at least three motor vehicle accidents occurring in 1976, 1983 and September 1992. The 1983 and 1992 accidents caused low back pain. (Exs. 4; 8). The 1992 accident also caused low back pain which radiated into claimant's right thigh. (Ex. 8-2).

In the winter of 1993, claimant, who was then working for a Coos Bay car dealership, hurt his back after slipping off a curb. Two or three weeks prior to the November 28, 1995 injury, Rudy Howell, a co-worker, observed claimant limping. Claimant told Howell that his back was hurting and that he had hurt his back when he slipped off a curb while working for a Coos Bay dealership. (Tr. 78-80). Claimant also mentioned the curb incident to others. Claimant told Mr. Murry, a former employer, that he had an injury stepping off a curb. (Tr. 68). Dave Gilman, the employer's general manager, also observed claimant limping on one occasion. Claimant told Gilman that he had slipped off a curb and hurt his back at a Coos Bay dealership. (Tr. 104).

Prior to the November 28, 1995 injury, claimant was physically active, jogging two to three times a week and doing pushups. (Tr. 20). At some point prior to November 28, 1995, Rudy Howell observed claimant doing one arm pushups. (Tr. 89).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had low back pain with occasional radiating pain into the legs prior to the November 28, 1995 injury. The ALJ further found that claimant's treating physicians did not have the history of prior low back symptoms with radiation. On this basis, the ALJ concluded that the treating physician's opinions were not persuasive and claimant had failed to establish compensability of his low back condition.

We agree with the ALJ's conclusion that claimant had low back pain with radiation into the legs prior to November 29, 1995. Witnesses Howell, Gilman and Murry observed claimant limping and were told by claimant about prior back problems and a "curb" incident. In addition, low back pain with radiation was noted after claimant's 1992 motor vehicle accident. Finally, claimant's former chiropractor noted prior back problems with some radiating pain into the legs and also mentioned the "curb" incident. To the extent that claimant denied prior low back and leg symptoms to his physicians and in his testimony, we do not find claimant to be a credible witness.

However, even if claimant is not a credible witness, it does not necessarily follow that he did not prove his claim. See Taylor v. Multnomah School District # 1, 109 Or App 499, 501 (1991). Here, based on the record, we conclude that claimant did sustain a compensable injury on November 28, 1995 and that his physicians ultimately were made aware of his prior low back and leg symptoms.[1] Moreover, based on the following reasoning, we find that the preponderance of the medical evidence supports a conclusion that the November 1995 injury is the major contributing cause of claimant's current back condition.

Several physicians offered opinions regarding the cause of claimant's current low back condition. At the insurer's request, Dr. Young, a radiologist, reviewed claimant's medical records and a December 1995 CT scan of claimant's lumbar spine and submitted a written report. In his report, Dr. Young summarized medical records regarding claimant's prior motor vehicle accidents and history of low back pain. Dr. Young opined that claimant's degenerative joint and disc disease at the L5-S1 level was long-standing in nature and preexisted claimant's November 28, 1995 injury. Dr. Young also opined that claimant probably aggravated his preexisting disc herniation on November 28, 1995, but that the aggravation was temporary and not permanent. Dr. Young explained that such temporary aggravations will generally subside within four to eight weeks and that the disc herniation would return to its pre-injury state. In conclusion, Dr. Young opined that the November 28, 1995 injury combined with claimant's preexisting degenerative condition to cause claimant's acute symptoms. However, Dr. Young opined that the major cause of claimant's low back condition was preexisting degenerative disc disease at the L5-S1 level, and not to the November 28, 1995 injury. (Ex. 28).

Claimant's former chiropractor, Dr. Harper, also submitted a report detailing claimant's history of low back problems prior to the November 28, 1995 incident. Dr. Harper indicated that he first saw claimant in February 1992. Claimant gave a history of low back problems on and off since a 1983 motor vehicle accident. In December 1993, Dr. Harper stated that claimant had radiating pain down one or both legs after a lifting incident followed by the incident in which claimant slipped abruptly off a curb and aggravated his back. Dr. Harper treated claimant in February, June and December 1994 and in February and May of 1995. In May 1995, Dr. Harper indicated that claimant had pain radiating down both legs. (Ex. 36).

Dr. Bogard, an osteopathic physician, is claimant's attending physician. Dr. Bogard was provided with Dr. Young's report and with medical records of claimant's 1992 motor vehicle accident. Dr. Bogard opined that claimant's disc herniation was not a consequence of the combining of the November 1995 injury and preexisting degenerative disc disease. Dr. Bogard believed that claimant's herniation was a direct result of the November 1995 injury. (Ex. 40). Dr. Bogard was also provided with Dr. Harper's report which detailed a history of prior low back problems preceding the November 1995 injury. Dr. Bogard was skeptical of Dr. Harper's report and indicated that Dr. Harper's report did not change his opinion regarding causation of claimant's current low back condition. (Exs. 44; 45). Dr. Bogard also indicated that he still believed that claimant's back pain, leg pain and ruptured disc were the result of his work injury. Dr. Bogard stated that claimant had "not been walking around with an 11 millimeter ruptured disc since 2-18-92." (Ex. 44).

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[1] We note that the non-medical evidence in the record supports the conclusion that claimant injured his low back on November 28, 1995. In this regard, Rudy Howell reported having seen claimant doing one arm pushups prior to his back injury. In addition, claimant was physically active prior to the injury and was able to jog two to three times a week and do pushups. After the November 28, 1995 injury, claimant was unable to walk and had to be driven from the lot in a golf cart. Finally, Rudy Howell testified that claimant appeared to be "in a lot of pain" and agreed that it was "something quite apart" from the day he had seen claimant limping prior to November 28, 1995.

Claimant was also evaluated by neurosurgeon, Dr. Louie. Initially, Dr. Louie did not attribute claimant's symptoms to the disc herniation because the herniation was primarily on the right and claimant's discomfort was primarily on the left. Dr. Louie opined that the major contributing cause of claimant's current condition was a mechanical strain secondary to a November 28, 1995 work injury. (Ex. 27). However, after a sudden increase in claimant's leg pain, Dr. Louie reported in May 1996 that claimant's MRI confirmed that the disc had completely extruded on the right causing root and cauda equina compression. Citing the progression of claimant's complaint from back pain and now right leg pain, Dr. Louie opined that it was reasonable to conclude that the bulging disc was a result of claimant's work injury. Dr. Louie's assessment was of right S1 radiculopathy secondary to extruded disc fragment secondary to work injury. Dr. Louie recommended surgery. (Ex. 34).

Dr. Louie later opined that claimant's disc herniation was the consequence of the combination of the November 28, 1995 injury and the preexisting degenerative disc disease and that the November 1995 injury was the major contributing cause of the herniated disc, as well as claimant's disability and need for treatment. (Ex. 39). Dr. Louie's opinions were given after reviewing Dr. Young's report which discussed claimant's history of prior motor vehicle accidents and prior low back problems.

Dr. Tenckhoff, a chiropractor, also rendered an opinion concerning the cause of claimant's low back condition. Dr. Tenckhoff opined that claimant's disc herniation was the result of the combining of claimant's November 28, 1995 injury with his preexisting degenerative condition and that the November 28, 1995 incident was the major contributing cause of claimant's herniated disc and his disability and need for treatment, including his need for surgery. Dr. Tenckhoff reviewed Dr. Young's report and did not agree with Dr. Young that claimant's low back condition was caused by preexisting degenerative disease. Dr. Tenckhoff opined that it would be impossible for an individual to demonstrate a herniation with thecal sac compression as demonstrated on the MRI exam and not have significant orthopedic and neurological symptomatology. (Ex. 41).

After reviewing the medical evidence, we are most persuaded by the opinion of Dr. Louie. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we rely on those medical opinions which are both well reasoned and based on complete information). Dr. Louie reviewed Dr. Young's reports and was aware that claimant had prior symptoms of low back pain with radiation into the legs prior to the November 28, 1995 injury. Thus, we are persuaded that Dr. Louie had a correct history of claimant's leg and back symptoms prior to November 28, 1995. Nonetheless, Dr. Louie concluded that claimant's current low back condition was the consequence of the combination of the November 28, 1995 injury and the preexisting degenerative disc disease and that the November 1995 injury was the major contributing cause of the herniated disc, as well as claimant's disability and need for treatment, including the need for surgery. Dr. Louie's opinion is supported by that of Dr. Tenckhoff, who also treated claimant. Based on these physician's persuasive opinions, we find claimant's current low back condition compensable under ORS 656.005(7)(a)(B) (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).

We are not persuaded by the contrary medical opinion of Dr. Young. Dr. Young indicated that the November 28, 1995 work injury aggravated, but was not the major contributing cause of claimant's low back condition. Dr. Young opined that the aggravation of claimant's disc condition was temporary and that the temporary aggravation would subside within four to eight weeks and that the disc herniation would return to its pre-injury state. Contrary to Dr. Young's expectations, however, the herniation worsened to the point where Dr. Louie recommended surgery. Thus, we do not find Dr. Young's opinion that the November 28, 1995 injury only caused a temporary worsening to be persuasive.

We likewise do not rely on the opinion of Dr. Bogard. Based on this record, we have concluded that claimant had at least sporadic symptoms of back pain with radiation into the legs prior to the November 1995 injury. However, Dr. Bogard is skeptical that claimant had such symptoms prior to November 28, 1995. Under such circumstances, we find that Dr. Bogard did not possess an accurate history regarding claimant's prior leg and back symptoms. Therefore, we find his opinion unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Finally, we accept Dr. Harper's reports of prior back symptoms to the extent that they are corroborated by other records and by the testimony of other witnesses. We note that Dr. Harper's record keeping practices were brought into question and that his original chart notes are not in the record. Dr. Harper did not give an opinion regarding the cause of claimant's current back condition, but only gave a summary of claimant's visits for low back/leg complaints.

To summarize, we are persuaded, based on this record, that Drs. Louie and Tenckhoff possessed an accurate history regarding claimant's low back and sporadic leg symptoms prior to the November 28, 1995 injury. In addition, we conclude based on the persuasive medical evidence that the November 28, 1995 injury was the major contributing cause of the disability and need for treatment of the combined condition.

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

ORDER

The ALJ's order dated August 12, 1996 is reversed. The insurer's denial is set aside and the claim remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,000, payable by the insurer.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that claimant's physicians possessed an accurate history concerning claimant's prior leg and back symptoms. It is clear that Drs. Louie, Tenckhoff and Bogard were not aware that claimant was having back and leg symptoms, manifested by limping, just weeks prior to the alleged injury at work. Witness Rudy Howell observed claimant limping two to three weeks prior to the alleged injury, and claimant told Howell and others that he hurt his back when he slipped off a curb while working for a previous employer. None of claimant's doctors had the history that claimant had previously injured his back and had been having symptoms of radiating pain into his leg prior to the work incident.

Claimant was not forthright with his doctors about his prior back and leg problems. His failure to tell his doctors about his history of prior back and leg pain has resulted, in my opinion, in unpersuasive medical evidence and a failure of proof. Because claimant's physicians lacked an accurate history of claimant's prior back and leg problems, I would affirm the ALJ's order upholding the denial.

In the Matter of the Compensation of
ANTONIO G. RODRIGUEZ, Claimant
WCB Case No. 96-08801
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that awarded claimant 10 percent (32 degrees) unscheduled permanent disability for his 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, with the following supplementation.

Claimant's accepted conditions are "contusion to chest wall, right side at rib 4, 5, 6" and "thoracic strain."

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the medical arbiter's opinion and found that based on the medical arbiter's "valid exam," the preponderance of the evidence established that claimant was entitled to an award for lost range of motion. The ALJ reasoned that, although the arbiter, Dr. Rand, had questioned the validity of the range-of-motion findings, the arbiter's "raw data" suggested that Dr. Rand did not intend to say that the findings were invalid. We disagree.

After reviewing the arbiter's report, we do not construe the arbiter's remarks as establishing that claimant's range-of-motion findings were valid. The arbiter specifically noted that the motor strength, sensation, and chest expansion findings appeared valid. However, with respect to range-of-motion testing, the arbiter stated that "[i]nclinometer range of motion testing of the thoracic spine is in some question, due to the claimant's pain behavior during testing today." (Ex. 15-5).

We find this case similar to our decision in Kathleen S. Schultz, 48 Van Natta 2518 (1996). In Schultz, we found that the arbiter's notations on the spinal range-of-motion form were within the validity criterion set forth in the Director's Bulletin 242. However, the arbiter had also questioned the validity of those findings based on the claimant's lack of effort. We noted that we had previously held that the determination regarding the validity of the testing must be made by the medical examiner performing the tests. Michael D. Walker, 46 Van Natta 1914 (1994). Accordingly, in Schultz, we concluded that regardless of whether the range-of-motion findings satisfied the Director's criteria, the arbiter had expressly questioned the validity of the findings and, therefore, those findings were not sufficient to establish permanent impairment. Schultz, 48 Van Natta at 2519. Also see Beverly L. Cardin, 46 Van Natta 770 (1994) (medical arbiter's report that range-of-motion findings were unreliable provided no evidence of impairment).

Finally, we find that our conclusion in this case is supported by the opinion of the treating physician, whose findings were consistent with those of the medical arbiter. Dr. Melson, claimant's treating doctor, also indicated that during the closing exam, he found abnormal thoracic findings which were "not reliable." Dr. Melson specifically responded that claimant's range-of-motion findings were not valid for purposes of rating, due to "interference with pain behavior and poor voluntary cooperation." (Ex. 13-4). Under the circumstances, we conclude that the arbiter's report is not sufficient to establish an award of permanent disability.

We also note that the medical arbiter, Dr. Rand, reported that claimant's findings were not due to the compensable injury. Rather, Dr. Rand noted that claimant's history included "old, healed fractures of the fourth and fifth ribs on the left posteriorly." (Ex. 15-4). Consequently, the arbiter found no permanent impairment due to the injury. Accordingly, for this additional reason, we find that Dr. Rand's opinion does not support an award of permanent disability. See ORS 656.214(2); ORS 656.266.

Therefore, the ALJ's award of 10 percent unscheduled permanent disability is reversed.

ORDER

The ALJ's order dated January 14, 1997 is reversed. The ALJ's award of 10 percent (32 degrees) unscheduled permanent disability and "out-of-compensation" attorney fee is reversed. The September 12, 1996 Order on Reconsideration is affirmed in its entirety.

In the Matter of the Compensation of
KENNETH R. SMITH, Claimant
WCB Case No. 96-03620
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's left hand/wrist/thumb condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated October 23, 1996 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

Board Member Haynes dissenting.

I disagree with the majority that claimant proved compensability. The ALJ, purportedly applying ORS 656.802 and relying on the opinion of the treating physician, Dr. Gill, found that claimant carried her burden of proof. For the following reasons, I dissent from this reasoning and conclusion.

In 1989, claimant began working for his present employer as a truck driver delivering paint. In November 1994, claimant was assigned a new tractor. Shortly after driving the new tractor, claimant began experiencing numbness, tingling and pain in his hands. In October 1995, claimant sought treatment.

Following a bone scan, claimant was diagnosed with osteoarthritis in the carpometacarpal joint of the left hand. In January 1996, the employer accepted tenosynovitis of the left wrist and thumb. In April 1996, the employer denied claimant's current condition and need for treatment.

The parties agree that the claim should be analyzed as one for occupational disease. In order to prove compensability, claimant must show that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If the claim is based on a worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

Numerous physicians provided opinions concerning claimant's left hand condition.[1] Dr. Gill found that claimant's work was the major contributing cause of his condition. According to Dr. Gill, the "heavy repetitive stresses" of claimant's work, including vibrations from the steering wheel and the "constant gripping" required by the driving and delivery duties, caused an inflammation in claimant's thumb joint, in turn resulting in the degeneration of the cartilage. (Ex. 24, 30, 36). Although acknowledging the possibility of congenital laxity in the thumb joints that predisposed claimant to injury, Dr. Gill indicated that claimant's "gripping and pinching" activities put pressure on the joint and, thus, were the major contributing cause of his condition. (Ex. 36-3).

Examining physicians Dr. Farris, neurologist, and Dr. Tesar, orthopedist, also diagnosed degenerative joint disease, but found that claimant exhibited "marked pain behavior." (Ex. 26-6). The panel further reported that it was "possible" that vibrations from the steering wheel made the condition symptomatic, but such a finding was contradicted by the fact that claimant continued to be symptomatic four months after not working. (Id.) According to the panel, the major contributing cause of claimant's need for treatment was the degenerative joint disease. (Id.)

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[1] This dissent does not summarize evidence from Dr. Sultany, examining rheumatologist, Dr. Mortimer-Lamb, who initially treated claimant, or Dr. Kappes, rheumatologist, because such evidence is not helpful in deciding causation.

Finally, Dr. Button, hand surgeon, examined claimant at the employer's request. Dr. Button agreed with the Farris/Tesar panel that claimant exhibited functional overlay or symptom magnification in that his subjective complaints did not correlate with the lack of instability or palpable inflammation in the joint found on clinical examination and minimal radiographic findings. (Ex. 33-5). Dr. Button also concluded that claimant's osteoarthritis in the left thumb joint was idiopathic and not caused by work activities. (Id. at 4). Dr. Button explained that claimant's condition was caused by "loading of the thumb joint" which did not occur when driving a truck and moving boxes or paint cans, when the grip was through the fingers and not the thumb. (Id.) For the same reason, Dr. Button discounted vibration as causing the condition. (Id. at 5-6).

In a subsequent deposition, Dr. Button added that the fact that claimant's condition had not improved while off work was additional evidence that it was idiopathic rather than work-related. (Ex. 37-26). Dr. Button further explained that stress was put on the carpometacarpal thumb joint when the hand performed a "tip pinch" and the tip of the thumb was pinched to the fingers. (Id. at 31-32). According to Dr. Button, the hand did not perform such a function when driving because the steering wheel was gripped with the fingers; the tip pinch also did not occur when lifting paint cans with wire handles or boxes since force was applied through the fingers. (Id. at 32-33).

I strongly disagree with the majority that Dr. Gill provided the most persuasive opinion. Although Dr. Gill is the treating hand surgeon, I find persuasive reasons not to defer to his opinion. See Weiland v. SAIF, 56 Or App 810 (1983). First, although Dr. Gill described how the inflammation process resulted in degeneration of the joint, he provided no specific explanation how claimant's work caused the inflammation. In this respect, his opinion is conclusory, especially in view of Dr. Button's detailed reasoning concerning the "tip pinch" and why claimant's driving and delivering activities did not involve such motion. Moreover, Dr. Gill did not explain why claimant's symptoms continued unabated despite the cessation of work; the Farris/Tesar panel and Dr. Button both found this fact supported their conclusion that the osteoarthritis was not caused by claimant's employment. Finally, Dr. Gill's inclusion of vibration as a factor in causing claimant's condition is inconsistent with his opinion that "gripping and pinching" resulted in degeneration; as explained by Dr. Button, vibration in no way involves the "tip pinch" motion leading to osteoarthritis of the thumb joint.

At hearing, claimant demonstrated the placement of his hands on the steering wheel and when delivering the paint cans and boxes. I agree with the ALJ that such testimony showed that the only time claimant may have used a "tip pinch" was when unloading the second level of the 5-gallon paint cans from the deck of the truck. (Tr. 41-42).[2] As shown by claimant's testimony, unloading the second row of the 5-gallon paint cans from the pallet constituted a small part of claimant's work; claimant also drove truck and unloaded boxes containing 1-gallon, pint, and half-pint cans of paint, placing the product on a hand truck to put in the store. Claimant's description of the latter activity did not involve a "tip pinch"; instead, claimant explained that he lifted and placed the paint buckets and boxes with his fingers and drove with his thumb on the outside rim of the wheel with his fingers wrapped around the wheel. (Tr. 37, 83, 88-90).

Even assuming that unloading the second row of the 5-gallon cans put the kind of stress on the thumb joint that Dr. Button described was necessary to cause osteoarthritis, such evidence does not prove compensability. Neither Dr. Gill nor Dr. Button indicated that such activity, by itself, was the major contributing cause of claimant's left thumb condition. Thus, it is only a matter of speculation whether either physician would consider this single activity as constituting the major cause of the condition or its worsening.

In sum, I find an absence of persuasive medical evidence establishing either that claimant's employment condition was the major contributing cause of his left thumb osteoarthritis condition or pathologically worsened it. Because the majority concludes to the contrary, I dissent.

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[2] Claimant explained that the 5-gallon paint cans were on pallets and stacked in three rows. (Tr. 40). When unloading, claimant took the first row of buckets and placed them next to the pallet on the deck of the truck. (Id. at 41). Claimant then stood on the ground to unload the second row of buckets; although claimant used his fingers to take the bucket off the pallet, the wire handle then transferred to the second joint of his thumbs when he lifted the bucket over his head. (Id. at 41-42). The wire handle then went back to the fingers while claimant set down the bucket. (Id.)

In the Matter of the Compensation of
SANDRA A. BURNS, Claimant
WCB Case Nos. 97-00864 & 96-04361
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease and aggravation claims for a right shoulder hypertrophic anterior acromial rim and subacromial impingement (HAARSI) condition; and (2) declined to assess a penalty for the employer's allegedly unreasonable denials. On review, the issues are compensability and penalties.

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

Claimant argues that her preexisting right shoulder type III acromion process is compensable under ORS 656.225,[1] because her work activities caused a pathological worsening of that condition.

Assuming, without deciding, that the statute applies in this case, we would reach the same conclusion because we agree with the ALJ that the medical evidence is insufficient to establish that claimant's work activities (or her compensable overuse syndrome condition) were the major contributing cause of the HAARSI condition.

ORDER

The ALJ's order dated February 7, 1997 is affirmed.

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[1] ORS 656.225 provides, in relevant part:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

"* * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

In the Matter of the Compensation of
BARBARA R. FLOYD, Claimant
WCB Case Nos. 96-06033, 96-04985 & 96-04984
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Reinisch, et al, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer, (Jeld-Wen), requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside Jeld-Wen's denial of an aggravation of claimant's accepted nondisabling low back injury; (2) set aside Jeld-Wen's responsibility denial of claimant's current low back condition; (3) upheld Crawford & Company's (Crawford's) responsibility denial of the same condition; and (4) assessed penalties and attorney fees against Jeld-Wen for unreasonable claims processing. In her respondent's brief, claimant seeks additional attorney fees pursuant to ORS 656.386(1) for her counsel's services at hearing. On review, the issues are aggravation, responsibility, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant began working for the employer in 1989. She compensably injured her back in July 1992 and the claim was eventually accepted by Crawford as a nondisabling low back strain.[1] Claimant missed no time from work because of this injury, although she continued to experience intermittent symptoms.

While tagging a load at work on September 22, 1995, claimant felt a pop in her left hip and immediate pain from her back to her toes. She sought treatment from Dr. Price, who diagnosed a back strain and sciatica and placed claimant on modified duty. On November 22, 1995, Jeld-Wen accepted the claim as a nondisabling back strain.

Claimant experienced an exacerbation of her low back pain at work on November 27, 1995, while lifting and stacking bundles of wood. She ultimately sought treatment for her worsened pain on January 2, 1996. Dr. Price completed a Notice of Aggravation form related to claimant's September 1995 claim, and referred claimant to Dr. Johnson, an orthopedist. Thereafter, on January 15, 1996, claimant filed a new 801 form arising out of the November 27, 1995 incident.

In February 1996, Dr. Johnson diagnosed chronic disc herniation with secondary mechanical joint derangement at L5-S1. He released claimant to work with restrictions on lifting, bending and twisting and recommended surgery to reduce claimant's chronic pain.

On April 1, 1996, Jeld-Wen issued a denial of claimant's new injury claim asserting that the injury did not arise in the course and scope of claimant's employment. On April 23, 1996, Jeld-Wen issued a second denial, amending the original denial. In its amended denial, Jeld-Wen denied responsibility for claimant's current condition and denied responsibility for an aggravation of claimant's accepted September 22, 1995 injury. The denial named Crawford as the other potentially responsible party.

In May 1996, claimant filed an aggravation claim with Crawford arising out of her 1992 injury. Shortly thereafter, Crawford denied both compensability and responsibility for claimant's current condition.

Claimant's attending physicians, Drs. Price and Johnson, reported that claimant's 1992 injury was the major contributing cause of her current condition. Dr. Johnson further reported that claimant's two injuries at work in the fall of 1995 contributed to her current condition.

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[1] The employer changed ownership in 1992, shortly after claimant's accepted injury.

CONCLUSIONS OF LAW AND OPINION

At hearing, the ALJ declined Jeld-Wen's oral request to amend its denial to deny the compensability of claimant's condition. The ALJ further found that Jeld-Wen's denial of an aggravation of claimant's September 22, 1995 nondisabling injury was procedurally improper and that Jeld-Wen should have referred the claim to the Department pursuant to ORS 656.277, because the claim was made within one year from claimant's accepted nondisabling injury.[2] On the merits, the ALJ determined that claimant's current condition was compensable and that Jeld-Wen was responsible for claimant's condition under the "last injury rule." In addition, the ALJ assessed a penalty against Jeld-Wen under ORS 656.262(11) based on unreasonable claims processing and awarded attorney fees pursuant to ORS 656.382(1), 656.386(1) and 656.308(2)(d).

Procedural Matters

Jeld-Wen challenges the ALJ's decision to set aside as improper that portion of its denial that denied an aggravation of claimant's September 22, 1995 injury. We adopt and affirm the ALJ's reasoning and determination on this issue.

Responsibility

On review, Jeld-Wen argues that the ALJ erred in finding it responsible for claimant's condition where a preponderance of the evidence establishes that claimant's 1992 injury (which was accepted by Crawford) was the major contributing cause of her current condition. Specifically, Jeld-Wen asserts that claimant's current condition is the same condition accepted by both it and Crawford and that it is entitled to shift responsibility for this condition back to Crawford pursuant to ORS 656.308(1).

We need not decide whether claimant's current condition (chronic disc herniation with mechanical joint derangement at L5-S1) is the "same condition" as the back strains accepted by Jeld-Wen and Crawford in 1995 and 1992, respectively, (in which case ORS 656.308(1) would be applicable) because even if it is the same condition, the statute does not permit Jeld-Wen to shift responsibility back to the prior carrier.

As the court explained in Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993), ORS 656.308(1) applies when the claimant seeks further compensable medical services and disability for a condition that has previously been processed as a part of a compensable claim. See also Sanford v. Balteau Standard, 140 Or App 177, 182 (1996). If the claim involves the "same condition," the statute assigns responsibility for that condition to the carrier with the *most recent accepted claim* involving that condition unless the claimant sustains a "new compensable injury." If a new compensable injury occurs, responsibility shifts *forward* to the carrier on the risk at the time of the new injury. Thus, in this case, Jeld-Wen would be responsible for claimant's current low back condition under ORS 656.308(1) because it is the carrier with the most recent accepted claim involving claimant's low back condition.[3]

Contrary to Jeld-Wen's contention, ORS 656.308(1) makes no provision for shifting responsibility *back* to the carrier with the original accepted injury when the medical evidence indicates that the original injury was the major cause (but not the sole cause) of claimant's current disability and need for treatment. Rather, where, as here, the medical evidence establishes that the most recent accepted injury

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[2] ORS 656.277 provides, in pertinent part, that if, within one year of a nondisabling claim, the insurer or employer receives notice or knowledge that the nondisabling injury has become disabling, the insurer or employer "shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268."

[3] ORS 656.308(1) was amended in 1995 to provide that "[t]he standards for determining 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." Although claimant experienced an exacerbation of her low back condition on November 27, 1995, we need not decide whether this incident constituted a "new compensable injury" under the statute because even if it did, Jeld-Wen would be responsible as the carrier on the risk at that time.

is related, at least in a material way, to claimant's disability and need for treatment subsequent to that accepted injury, responsibility remains with the carrier with the most recent accepted claim for that condition. See Sanford v. Balteau Standard, 140 Or App at 182.[4]

Even if claimant's accepted injuries involved the same body part (low back) but not the same condition (previously, a strain and currently, a chronic disc herniation with secondary joint derangement), then, as the ALJ found, Jeld-Wen is still responsible for claimant's current condition under the "last injury rule" of Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). See, e.g., Raymond H. Timmel, 47 Van Natta 31 (1995). Under the Kearns rule, the carrier with the last accepted claim involving the same body part (here, Jeld-Wen) is presumptively responsible for the claimant's current condition unless that carrier can establish that there is *no* causal connection between claimant's current condition and the last accepted injury. In this case, the medical evidence establishes that claimant's September 1995 accepted strain independently contributed to claimant's condition, even if that injury is not the major cause.[5] Therefore, Jeld-Wen has failed to rebut the presumption that it is responsible for claimant's current condition.

Consequently, we find that the ALJ properly assigned responsibility for claimant's current condition and need for treatment to Jeld-Wen.

Penalties

Jeld-Wen asserts that it did not act unreasonably in denying the aggravation of claimant's accepted injury or in processing claimant's claims. We disagree, and affirm and adopt the ALJ's decision to assess a penalty under ORS 656.262(11) (for the unreasonable aggravation denial) and a penalty-related attorney fee under ORS 656.382(1) for other unreasonable conduct in the processing of claimant's claims.[6] See, e.g. Lucille G. Major, 47 Van Natta 617, 619 (1995) (where a penalty was already assessed on amounts due, an attorney fee under ORS 656.382(1) may be assessed for separate unreasonable conduct).

Attorney Fees

Claimant asserts that the ALJ erred in failing to assess an attorney fee against Jeld-Wen under ORS 656.386(1). As set forth below, we agree that claimant is entitled to such an attorney fee award for his counsel's services at hearing.

ORS 656.386(1) provides for a reasonable attorney fee in cases involving "denied claims" where the claimant prevails over the denial. For purposes of this 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. See, e.g. Michael J. Galbraith, 48 Van Natta 351 (1996).

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[4] In Sanford, the claimant had a series of accepted back injuries dating back to 1984. SAIF had accepted a back strain in 1984 and an aggravation of that injury in 1988. In 1990 and 1991, the claimant experienced two additional back strains that were accepted by the employer who was, at that time, self-insured. The claimant's back went out again in 1993, and the medical evidence established that claimant's need for treatment in 1993 was caused in major part by his 1984 injury. The court held that if the back strains accepted by the employer in 1990 and 1991 involved the same condition that had been accepted by SAIF, then the employer would be responsible for claimant's 1993 need for treatment. If, however, the 1990 and 1991 accepted injuries did not involve the same condition as that accepted by SAIF, then SAIF would be responsible under ORS 656.308(1). The court then remanded the matter back to the Board for a determination as to whether claimant's accepted claims actually involved the "same condition." 140 Or App at 183.

[5] Although Dr. Johnson determined that claimant's 1992 injury was the major cause of her current condition, he explained that claimant's two injuries in the Fall of 1995 contributed to and "made a considerable change" in the status of her low back condition. (Ex. 88-20).

[6] Jeld-Wen is correct, however, that the 25 percent penalty assessed pursuant to ORS 656.262(11) applies only to "amounts then due" at the time of hearing and not to all compensation that may come due as a result of the ALJ's order.

Here, although Jeld-Wen did not issue a written compensability denial,[7] it did attempt to amend its denial at hearing to include a denial of compensability. (Tr. 8, 15). Jeld-Wen's counsel specifically questioned the causal relationship between claimant's accepted injury and her current condition, prompting claimant to request an assessed attorney fee against both Crawford and Jeld-Wen. (Tr. 13). Under these circumstances, we conclude that Jeld-Wen's position at hearing constituted a refusal to pay compensation on the express ground that claimant's current condition was not compensable. See, e.g. Emily M. Bowman, 48 Van Natta 1199 (1996) (finding a "denied claim" for purposes of ORS 656.386(1) where carrier's responded to a request for hearing by denying that the claimant sustained a work-related injury or occupational disease); Ronald E. Rogers, 48 Van Natta 2107 (1996). Consequently, we find that claimant's counsel is entitled to an assessed fee under ORS 656.386(1) for prevailing over Jeld-Wen's "denied claim" at hearing.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing with regard the compensability issue is $2,000, consisting of $1,000 payable by Crawford[8] and $1,000 payable by Jeld-Wen. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record at hearing), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. By virtue of the Board's de novo review authority of the ALJ's order (which decided both compensability and responsibility) and Jeld-Wen's appeal, the compensability of claimant's condition remained at risk on review. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252- 53 (1992), mod on recon, 119 Or App 447 (1993); Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by Jeld-Wen. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Jeld-Wen. 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.[9]

ORDER

The ALJ's order dated December 18, 1996 is affirmed in part and modified in part. In addition to the ALJ's $1,000 assessed fee award payable by Crawford, claimant is awarded an assessed fee of $1,000 for her counsel's services at hearing, payable by Jeld-Wen. The penalty assessed against Jeld-Wen pursuant to ORS 656.262(11) shall be 25 percent of the amounts due at the time of the ALJ's order. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by Jeld-Wen. The remainder of the ALJ's order is affirmed.

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[7] As noted above, Jeld-Wen originally asserted that claimant's November 1995 back injury did not arise in the course and scope of her employment, but subsequently issued an amended denial contesting only responsibility for claimant's current condition and an aggravation of her September 1995 accepted strain. Crawford formally denied both compensability and responsibility.

[8] Crawford does not contest this attorney fee award on review.

[9] Claimant is not entitled to an attorney fee on review for his counsel's services in securing the additional attorney fee award for her counsel's services at hearing. Dotson v. Bohemia, 80 Or App 233 (1986).

In the Matter of the Compensation of
PETER GEVERS, Claimant
WCB Case No. 95-10971
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration awarding no additional unscheduled permanent disability benefits beyond the 74 percent (286.8 degrees) awarded by a prior order. On review the issue is unscheduled permanent disability.

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

Claimant compensably injured both of his shoulders in 1988 in a fall from a collapsed scaffold. He subsequently underwent multiple shoulder surgeries and was declared medically stationary as of November 5, 1990. A February 22, 1992 Determination Order awarded claimant 74 percent unscheduled permanent disability for his shoulders and 19 percent scheduled permanent disability for loss of use or function of his left arm. The Determination Order was subsequently affirmed by an April 24, 1992 Order on Reconsideration.

The insurer accepted a claim for aggravation of claimant's left shoulder condition on December 1, 1992. Claimant underwent additional surgeries. An April 13, 1995 Determination Order awarded temporary disability but no additional permanent disability, on the grounds that claimant's left shoulder condition had not permanently worsened.

Claimant requested reconsideration. Following an examination by a medical arbiter panel, a September 15, 1995 Order on Reconsideration affirmed the Determination Order in all respects. The explanatory notes that accompanied the Order on Reconsideration indicated that claimant's award of unscheduled permanent disability had not been redetermined because there had been no permanent worsening of claimant's unscheduled condition. Relying on former OAR 436-35-005(9), the appellate reviewer found that an increase in impairment did not establish a permanently worsened condition unless that additional impairment reduced claimant's earning capacity.

On review, claimant contends that his condition has permanently worsened since his last award and that he is entitled to have the extent of his permanent disability redetermined under the standards. Specifically, claimant argues that his decreased range of motion and loss of strength findings are ratable under former OAR 436-35-350(3) and (5). In response, the insurer argues that even though claimant may have experienced an increase in impairment since his last award of compensation, he is not entitled to a redetermination of his permanent disability because he has not suffered a reduced earning capacity, as required by former OAR 436-35-005(9).

Like the ALJ, we conclude that claimant has not established that his unscheduled permanent disability is greater than the 74 percent award he received in 1992. Claimant's 74 percent unscheduled permanent disability award consisted of a 59 percent impairment value for the left shoulder,[1] combined with an 18 percent impairment value for the left shoulder (66 percent impairment value) added to an 8 percent value for age, education and adaptability.

In evaluating claimant's post-aggravation condition in September 1995, the medical arbiters found no change in claimant's right shoulder condition and a marked increase in his ability to repetitively use his left shoulder. The arbiters measured claimant's left shoulder range of motion as follows: Abduction 40 degrees, flexion 30 degrees, external rotation 0 degrees, internal rotation 45 degrees and adduction 5 degrees. The arbiters also found 3+/5 strength about the left shoulder, "due to perijoint fibrosis and not to any one specific nerve muscle or tendon unit." (Ex. 2-393).

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[1] Pursuant to former OAR 436-35-330 and former OAR 436-35-350(3), claimant was awarded 30 percent for his left shoulder total joint replacement, 15 percent for chronic dislocations of the left shoulder joint, 24 percent for reduced range of motion and 8 percent for loss of strength. (30 percent combined with 15 percent, combined with 24 percent, combined with 8 percent equals 59 percent).

Pursuant to former OAR 436-35-330, claimant is entitled to a value of 8 percent for loss of forward elevation, 2 percent for loss of backward elevation, 7 percent for loss of abduction, 1.5 percent for loss of adduction, 0 percent for loss of internal rotation and 9 percent for loss of external rotation. These impairment values are added for a total of 27.5 (rounded up to 28 percent). See former OAR 436-35-330(17). This 28 percent value for decreased range of motion is then combined with a value of 30 percent for the left shoulder joint replacement (former OAR 436-35-330(15)) and 15 percent for chronic dislocations (former OAR 436-35-330(16)) for an impairment value of 58 percent for the left shoulder.

Claimant argues that he is also entitled to additional impairment values pursuant to former OAR 436-35-350(3) and (5),[2] for 3/5 loss of strength in the following unilateral nerves: accessory, anterior thoracic, axillary, dorsal scapular, long thoracic, subscapular, suprascapular and thorcodorsal. Although the arbiters found 3/5 strength "about the left shoulder," the panel concluded that this decreased strength was not due to any one specific nerve muscle or tendon unit. Contrary to claimant's contention, we are unwilling to infer an injury to each named peripheral nerve set forth in former OAR 436-35-350(3) (or to any specific peripheral nerve that innervates the muscles of the left shoulder) in the absence of supporting medical evidence. See, e.g., Corinne M. Esperanza, 47 Van Natta 1915(1995) (Board is without expertise to infer an injury to a specific nerve in the absence of medical evidence). Here, the record establishes only that claimant's decreased strength is due to "perijoint fibrosis." We cannot logically infer from the arbiters' report any injury to a specific named peripheral nerve or any injury to a specific nerve muscle or tendon unit. Consequently, we conclude that claimant's decreased left shoulder strength is not ratable under the applicable standards.[3]

Combining claimant's left shoulder impairment (58 percent) with his right shoulder impairment (18 percent) equals impairment of 64 percent, 2 percent less than the 66 percent impairment value that was used to calculate claimant's total unscheduled permanent disability award in 1992. Further, because claimant was determined to have an RFC of "light" on the closure of his aggravation claim and in fact returned to his pre-aggravation job (a medium strength position as a hospital building maintenance worker), he has not established an adaptability factor in excess of the value determined in 1992. Accordingly, claimant has not established an entitlement to any additional unscheduled permanent disability by a preponderance of the evidence.

ORDER

The ALJ's order dated February 20, 1996 is affirmed.

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[2] Former OAR 436-35-350(3) applies to "[i]njuries to a unilateral specific named peripheral nerve with resultant loss of strength." Former OAR 436-35-350(5) provides that loss of strength due to muscle loss or disruption of the musclotendinous unit "shall be valued as if the nerve supplying that muscle or muscle group were impaired."

[3] As the ALJ noted, the record does not indicate that claimant requested the adoption of a temporary rule addressing loss of strength attributable to the formation of fibrous tissues.

Board Member Biehl specially concurring.

I agree that claimant has not established an entitlement to an award of additional unscheduled permanent disability under the standards. I write separately, however, to address the insurer's contention that claimant is not even entitled to a redetermination of his permanent disability based on the application of former OAR 436-35-005(9).

Former OAR 436-35-005(9) provides:

> "'Permanently worsened' is established by a preponderance of medical evidence concerning the worker's current injury-caused health condition compared to the worker's condition as it existed at the time of the last arrangement of compensation. A worker has permanently worsened when 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."

In addition, former OAR 436-35-007(7) provides, in pertinent part, that "[i]f the worker's condition has not permanently worsened, the worker is not entitled to have the extent of permanent disability redetermined under these rules."

For the reasons that follow, I believe that to the extent former OAR 436-35-005(9) requires proof of loss of earning capacity as an element of whether a claimant has "permanently worsened" (thereby entitling the worker to a redetermination of permanent disability benefits on closure of his or her aggravation claim), the rule is inconsistent with ORS 656.273. I also believe that, in this case, claimant has proven that he is "permanently worsened" so that he is entitled to a redetermination of his permanent disability under the appropriate standards, even though he has not proven that he is entitled to an additional award of permanent disability.

After closure of an initial injury or occupational disease claim, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury as provided in ORS 656.273. That additional compensation may include medical services, temporary disability, permanent disability, and benefits paid for death. Buddenberg v. Southcoast Lumber, 316 Or 180, 185 (1993). Following a compensable aggravation, an injured worker's additional award of permanent disability, if any, is determined in the same manner as an original claim for disability, *i.e.*, the entitlement to permanent disability benefits arises out of ORS 656.273(1), ORS 656.214 and ORS 656.206. The procedure for the determination of extent of permanent disability is set forth in ORS 656.268. See id. at 183 n 1 (a claim for aggravation is an independent "claim" as defined in ORS 656.005).

However, not every compensable aggravation claim results in a redetermination of permanent disability on claim closure. In Stepp v. SAIF, 304 Or 375 (1987), the Supreme Court held that, in order to obtain a redetermination of permanent disability on closure of an aggravation claim, a claimant is required to demonstrate a permanently worsened condition. Absent a permanent worsening, the court concluded, there is no entitlement to a redetermination even where a worker's earning capacity on closure of an aggravation claim is reduced below the level previously established on initial claim closure.

An examination of the facts in Stepp helps to illustrate the Court's rationale. The claimant in Stepp had received by stipulated order a prior award of 80 percent unscheduled permanent disability. Following a compensable aggravation claim, an ALJ ordered permanent total disability. On review, the Board reversed the permanent total disability award based on a finding that the claimant's injury-related conditions were no different than at the time of the prior 80 percent award.

The Court of Appeals affirmed the Board. 78 Or App 438 (1986). The court rejected the claimant's argument that once he proved a temporary worsening, he was entitled to a redetermination of the extent of his permanent disability, even though his compensable condition had not permanently worsened. The basis for the court's holding was that, absent a showing of a permanently worsened condition, the claimant, in effect, would be impermissibly relitigating the prior 80 percent stipulated final award. Id. at 442. By footnote, the court further explained that the claimant could "be understood to argue that he was, in fact, permanently and totally disabled when he stipulated to the permanent partial disability award. Without evidence of a permanent worsening since that time, he is bound by the stipulation." Id. at n 2.

On review to the Supreme Court, the claimant argued that he would not be relitigating an earlier claim closure because "[t]here is a new body of operative facts reflecting present inability to work, upon which the redetermination is based." The Supreme Court rejected the claimant's argument, noting that such a process "would result in employers and insurers paying for a host of disabilities (such as increasing age and other health conditions) that are unrelated to the earlier injury." The Court concluded that, absent proof of a permanent worsening of the injury-related condition itself, the claimant "is, in effect, seeking to reopen the 1979 hearing without proving a permanently worsened condition."

Stepp establishes that the requirement of proof of a permanent worsening in order to obtain a redetermination of permanent disability following a compensable aggravation does not arise directly from the statutory provisions of ORS 656.273. Rather, the threshold requirement of a permanent worsening is a judically-crafted doctrine designed to bar relitigation of a final order and to ensure that, on closure of an aggravation claim, carriers are not required to pay for noninjury-related disabilities such as increasing age. If a permanent worsening *has* been shown, the injured worker may -- or may not -- be able to establish entitlement to an actual award of additional permanent disability on redetermination of his or her permanent disability.

Assuming entitlement to a redetermination of permanent disability has been established (through medical evidence of a permanently worsened condition), then entitlement to an award of additional disability will depend on whether the permanently worsened condition has resulted in either permanent loss of use or function of a scheduled part of the body or, in the context of an unscheduled part of the body, a loss of earning capacity. ORS 656.214(2) and (5); Smith v. SAIF, 302 Or 396 (1986). Absent proof of a permanent worsening, a determination of greater permanent disability than the level found at the time of the prior award would necessarily result either from the fact that the prior award was incorrectly determined or would be based upon "a host of disabilities (such as increasing age and other health conditions) that are unrelated to the earlier injury." Stepp, 304 Or at 380. Consequently, the presence or absence of *reduced earning capacity* is irrelevant to the threshold question of whether the worker is entitled to have his or her permanent disability reexamined in the first place.

Turning to the dispute in this case, I believe that the Department erred in concluding that claimant had not established that his condition had permanently worsened based on former OAR 436-35-005(9) and the fact that he had returned to his pre-aggravation position as a hospital maintenance worker.[1] The proper focus is whether a preponderance of the medical evidence shows that the claimant's condition has permanently worsened[2] due to the compensable condition since the time of the last arrangement of compensation.

Here, given the medical arbiters' finding of less range of motion (particularly flexion and extension) and less strength about the left shoulder than claimant had at the time his claim was originally closed in February 1992, I am persuaded that claimant established a permanent worsening due to his compensable left shoulder injury, and that he is entitled to a redetermination of his permanent disability notwithstanding the language of former OAR 436-35-005(9). However, as discussed in the order, I am also persuaded that claimant's decreased left shoulder strength is not ratable under the applicable standards because the medical arbiters' did not identify any injury to a peripheral nerve or muscle or tendon unit. Therefore, I concur in the result in this case.

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[1] I recognize that the Board applied former OAR 436-35-005(9) in Gayle S. Johnson, 48 Van Natta 379, aff mem Johnson v. SAIF, 143 Or App 629 (1996), and held that the claimant was not entitled to a redetermination of her unscheduled permanent disability because she had not established a "permanent worsening," i.e., a reduction in earning capacity, even though she had experienced an increase in impairment of her compensable injury subsequent to her last arrangement of compensation. I believe, however, that our decision was in error because, as discussed above, under ORS 656.273 and the Stepp case, loss of earning capacity is irrelevant to the threshold issue whether a claimant is entitled to a redetermination in permanent disability.

[2] To prove an "actual worsening" of the compensable condition under ORS 656.273, there must be direct medical evidence that the condition has worsened. The Board may not infer a worsened condition from evidence of worsened symptoms. See SAIF v. Walker, 145 Or App 294 (1996).

In the Matter of the Compensation of
BONNIE C. THOMAS, Claimant
WCB Case No. 96-06742
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our July 8, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order upholding its denial of a consequential left knee condition. In its motion, the employer request reconsideration by the Board en banc and contends that our reliance on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), is no longer viable after the recent enactment of HB 2971. The employer further argues that, on the merits, claimant did not prove the compensability of her claim.

In order to consider this matter, we withdraw our July 8, 1997 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 will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELBA WALKER, Claimant
WCB Case No. 97-01094
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Howell's order that: (1) declined to address its partial denial of a "somatization phenomenon" because claimant had not made a claim for that condition; and (2) set aside its partial denial of claimant's current neck, shoulder and low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fifth paragraph on page 2, we change the last sentence to read: "Dr. Gerber reviewed Dr. Martin's report and commented that claimant was suffering from a pain syndrome that required treatment by Dr. Holmes. (Exs. 38, 65)." In the seventh paragraph on page 2, we change the last sentence to read: "Dr. Gerber and Dr. Doyle did not agree with the report from Drs. Hamby and Kirschner. (Exs. 44-58, 65, 66)."

Somatization Phenomenon

On May 6, 1996, the employer denied compensability of claimant's "somatization phenomenon," noting that it had received information that she was "in need of treatment for pain complaints which have been described as a somatization phenomenon." (Ex. 73). At hearing, claimant's attorney asserted that no claim had been made for somatization phenomenon and, therefore, the employer's denial was premature. (Tr. 2, 3). The ALJ declined to address the employer's partial denial of a somatization phenomenon because claimant had not made a claim for that condition.

The employer contends that claimant's ongoing medical services were due to a somatization phenomenon and, therefore, she is making a claim for that condition. We disagree.

In Vicki L. Davis, 49 Van Natta 603 (1997), we applied ORS 656.262(7)(a) and held that a carrier's precautionary partial denial of lumbar degenerative conditions was premature because the claimant had not filed a "new medical condition" claim for the conditions. Prior to the closure of the claimant's accepted injury claim for lumbar strain and rib contusion, an x-ray had shown, and several physicians (attending and examining) had diagnosed, degenerative disc disease/ arthritis conditions. Contending that the degenerative conditions were unrelated to the accepted lumbar strain injury, the carrier issued a "pre-closure" precautionary partial denial.

We held that the carrier's denial was premature because the claimant had not made a claim for her degenerative conditions. Relying on Ramona E. Hamilton, 48 Van Natta 2438 (1996), we reasoned that, because neither the claimant nor her physician made a "clear request" for a "formal written acceptance" of any degenerative conditions, there had not been a "new medical condition" claim under ORS 656.262(7)(a). Inasmuch as a denial issued in the absence of a claim is a nullity, we found that the carrier's denial had no legal effect.

We reach the same conclusion in this case. ORS 656.262(7)(a) requires a "clear request" for "formal written acceptance" of a new medical condition after claim acceptance and provides that new medical condition claims "are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition." (Emphasis added).

Here, the employer accepted a "contusion to the left elbow, hand and hip, and a cervical/lumbar strain." (Exs. 73, 85). Thereafter, neither claimant nor her physician made a "clear request" for a "formal written acceptance" of a somatization phenomenon. The employer does not contend otherwise. Therefore, we find no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Finally, since a denial issued in the absence of a claim is a nullity, we find that the employer's denial of the somatization phenomenon has no legal effect. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Vicki L. Davis, 49 Van Natta at 604.

Current Neck, Shoulder and Low Back Condition

We adopt and affirm the ALJ's reasoning and conclusion that the employer's preclosure denial was impermissible. See Elizabeth B. Berntsen, 48 Van Natta 1219 (1996).

Claimant's attorney is entitled to an assessed fee for services on review concerning the current neck, shoulder and low back condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 20, 1997 is affirmed. For services on review, claimant's attorney's is awarded $1,400, payable by the self-insured employer.

August 1, 1997 Cite as 49 Van Natta 1233 (1997)

In the Matter of the Compensation of
JESSE M. WRIGHT, Claimant
WCB Case No. 96-07498
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

Claimant requests reconsideration of our July 18, 1997 Order on Review. Claimant contends that certain findings of fact are incorrect, and that certain statements in our Order on Review are not supported by evidence in the record. Claimant requests that we make corrected findings of fact, as well as a new determination regarding whether claimant has proved his claim.

In order to fully consider this matter, we withdraw our July 18, 1997 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
HEIDI A. GREENWELL, Claimant
WCB Case No. 96-03945
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's aggravation claim for a low back injury. On review, the issue is aggravation.

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

As the insurer notes, Dr. Gambee's April 25, 1996 chart note appears to be inconsistent with the remainder of Dr. Gambee's opinions in the record, both before and after April 25, 1996. We note that, in his deposition testimony, Dr. Gambee persuasively explained the basis of his opinion that claimant's L5-S1 disc herniation was a reaggravation of claimant's March 21, 1995 compensable low back injury (accepted by the insurer as an L5-S1 disc bulge), rather than a new injury. Given Dr. Gambee's consistent opinions before and after the April 25, 1996 chart note, and his thorough explanation of the basis for his opinion, we are persuaded that the inconsistencies in the chart note represent a typographical error on Dr. Gambee's part. Thus, we do not find that the lone chart note renders Dr. Gambee's opinion unpersuasive. Because we find Dr. Gambee's opinion persuasive, we agree with the ALJ that claimant's worsened disc condition is materially related to the compensable injury and was not caused in major part by an off-work injury. See ORS 656.273(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 $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 20, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
JANICE D. KISER, Claimant
WCB Case No. 96-04461
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of her aggravation claim for a current low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In lieu of the ALJ's aggravation analysis, we apply the Court of Appeals' aggravation analysis in SAIF v. Walker, 145 Or App 294 (1996), rev allowed 325 Or 367 (1997), which issued shortly before the ALJ's order but was not applied in this case. In Walker, the court interpreted the "actual worsening" language in ORS 656.273(1) to require direct medical evidence that a condition has worsened. 145 Or App at 305. The court held that proof of a pathological worsening is now required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. Id. If an aggravation claim is based on increased symptoms, a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. Id.

Before applying the Walker analysis, we summarize the relevant facts. Claimant has an accepted claim for a lumbar strain she suffered in a slip and fall at work in October 1991. She has been treated by Dr. Counts, family physician, and Dr. Bert, treating orthopedic surgeon, for low back pain which initially involved the right leg down to the foot, then later involved the left leg and grew progressively worse. In March 1993, Dr. Bert performed low back surgery for an L4-5 disc protrusion, which did not significantly relieve claimant's low back and left leg pain. Her condition was found medically stationary, and her claim was closed by Determination Order in January 1994 with an award of 32 percent unscheduled permanent disability. The award was based on the surgery and reduced ranges of back motion.

Claimant continued to have low back pain which radiated into both legs, with intermittent numbness in the right foot. (Exs. 32, 33). An MRI scan in July 1994 showed degenerative changes with minimal disc bulging at L4-5, but no evidence of disc herniation. (Ex. 35). Dr. Bert interpreted the MRI as being unremarkable and concluded that claimant was having waxing and waning symptoms due to post-operative scar tissue and degenerative disc disease. (Exs. 33, 39).

Claimant filed an aggravation claim in mid-1994 for an alleged worsening of her condition. The claim was denied, and the parties entered into the Disputed Claim Settlement dated November 25, 1994 to settle the claim. The parties stipulated that the aggravation claim shall remain in denied status and that the insurer's denial shall be construed to include the contention, among others, that "claimant's condition has not pathologically worsened." (Ex. 40).

Subsequently, in January 1996, based on claimant's complaints of continued back pain, Dr. Bert ordered a repeat MRI scan. The scan showed: "Small right posterior disc herniation at L4-5 mildly indents the right anterior dural sac and may mildly impinge on the medial aspect of the right L5 nerve root." (Ex. 44). Dr. Bert interpreted the MRI as being unremarkable and recommended further conservative treatment. (Ex. 43). Claimant continued to see Drs. Bert and Counts with complaints of right leg sciatica and numbness in the right foot. She filed an aggravation claim which is the subject of this proceeding.

On review, both parties state that the "last award or arrangement of compensation" was the November 25, 1994 Disputed Claim Settlement (DCS) agreement. The Court of Appeals has held, however, that the proceeds from a DCS are not "compensation" within the meaning of ORS 656.005 because the proceeds are not benefits "provided for a compensable injury." Howard v. Liberty Northwest Ins., 94 Or App 283, 287 (1988). Inasmuch as the DCS is not an award or arrangement of compensation, we find that the "last award or arrangement of compensation" in this case was the January 1994 Determination Order. (Ex. 31). Nevertheless, by virtue of the DCS whereby the parties stipulated that claimant's condition "ha[d] not pathologically worsened" at the time of the DCS, claimant is precluded from asserting that her condition had pathologically worsened prior to the date of the DCS. Therefore, it is claimant's burden to prove by a preponderance of the evidence that her compensable back condition has pathologically worsened since the November 25, 1994 DCS. We conclude that she has carried her burden of proof.

Medical opinions on the worsening issue were offered by Dr. Bert, treating orthopedic surgeon, and Drs. Donahoo and Gardner, examining physicians.[1] Drs. Donahoo and Gardner opined that:

> "[Claimant's] current condition reflects a subjective worsening without objective findings which can be validated, indicating a worsening beyond the 32% awarded in January of 1994. Her sensory pattern is somewhat better, her motor function is about the same, her ranges of motion are somewhat better than demonstrated in 1994 overall, but neither is convincingly valid, and her straight leg validity tests are definitely not valid." (Ex. 47-6, emphasis supplied).

Dr. Bert concurred with Drs. Donahoo and Gardner's report and agreed that claimant's current right leg symptoms are substantially the same as they were in late 1994. (Ex. 49). In his deposition, however, Dr. Bert stated that claimant's condition was "more symptomatic" in 1996. (Ex. 52-10). In addition, when comparing the MRI films taken in July 1994 and January 1996, he stated that the disc herniation visible in January 1996 "may be a degree larger" than the disc bulge seen in July 1994. (Ex. 52-12). He later clarified that the disc herniation was "a degree or two worse" than the disc bulge in 1994. (Ex. 52-14). He also stated that claimant's complaints of symptoms in the right lower extremity were consistent with, and partially precipitated by, the change noted in the MRI's. (Ex. 52-13). He added that the post-operative epidural scarring was also a precipitating factor. (Id.)

After reviewing the medical evidence, we are most persuaded by the opinion of Dr. Bert. As claimant's treating orthopedic surgeon both before and after November 25, 1994 (the date of the DCS), he was in the best position to determine whether claimant's condition had worsened after that date. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986); Weiland v. SAIF, 64 Or App 810, 814 (1983). Although Dr. Donahoo, the examining physician, also saw claimant before and after November 25, 1994, he saw her only twice, whereas Dr. Bert saw claimant on numerous occasions over time and, thus, had a superior opportunity to evaluate claimant's condition.

We are mindful that Dr. Bert concurred with Drs. Donahoo and Gardner's report which described claimant's condition as a "subjective worsening without objective findings." We discount Dr. Bert's concurrence, however, because it is conclusory and inconsistent with his subsequent testimony that claimant's disc herniation in 1996 was visibly "worse" than the disc bulge in 1994 and that the disc change precipitated his increased symptoms in 1996. (Ex. 52, pp. 10, 12, 14).

We also discount the opinion of Drs. Donahoo and Gardner because their conclusion that there were no objective findings to support a worsened condition is inconsistent with the MRI's which document a pathological worsening of the L4-5 disc condition since 1994.

Finally, we reject the insurer's argument that the disc herniation may have occurred before the November 25, 1994 DCS. The parties expressly stipulated in the DCS that claimant's condition "ha[d] not pathologically worsened." (Ex. 40-2). When the stipulation is approved by an ALJ, it has the finality and effect of a judgment. Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993). We find

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[1] Dr. Counts, the attending physician, did not offer an opinion and, instead, deferred to the opinion of Dr. Bert. (Ex. 51).

no evidence in the record to contradict the parties' stipulation that there was no pathological worsening (i.e., disc herniation) as of the date of the DCS. We are therefore persuaded that the pathological change in the disc condition occurred after that date. In addition, we find that the MRI scans provided ample objective findings to support an "actual worsening" since the last arrangement of compensation. Accordingly, the aggravation claim is compensable, and the insurer's denial shall be set aside.[2]

Claimant's counsel is entitled to an assessed fee for prevailing against the denial. See 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 attorney fee for claimant's counsel's services at hearing and on review is $6,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel's services might have gone uncompensated.

ORDER

The ALJ's order dated January 16, 1997 is reversed. The insurer's denial of claimant's aggravation claim is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $6,000, to be paid by the insurer.

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[2] Because we find that claimant's compensable condition pathologically worsened after the November 25, 1994 DCS, the insurer's contention that the aggravation claim is barred by the settlement agreement is without merit and does not require discussion.

August 5, 1997 Cite as 49 Van Natta 1237 (1997)

In the Matter of the Compensation of
CHARLES BERTUCCI, Claimant
WCB Case No. 96-03524
ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

On July 22, 1997, we affirmed that portion of an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's partial denial of claimant's "post-retirement" hearing loss and vacated that portion of the ALJ's order that addressed claimant's medical services claim for hearing aids. In that decision, we concluded that, although we retained jurisdiction to resolve the parties' dispute regarding the compensability of his "post-retirement" hearing loss condition, we lacked authority to consider the parties' dispute regarding claimant's hearing aids claim.

On our own motion, we withdraw our prior order for further consideration of the jurisdictional issue posed by the court's holding in SAIF v. Shipley, 147 Or App 26 (1997). The parties are granted an opportunity to present their respective written positions regarding the Shipley decision and its effect on this case. To be considered, each of those positions must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHEAL H. McMURPHY, Claimant
WCB Case No. 96-08578
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that increased claimant's unscheduled permanent disability for a contact dermatitis condition from zero, as awarded by an Order on Reconsideration, to 15 percent (48 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's accepted contact dermatitis condition was the result of an allergic reaction and therefore was properly rated under OAR 436-035-0450. Based on claimant's attending physician's opinion that claimant cannot return to his regular job with the employer because of his allergy to epoxy resins, the ALJ found that claimant had 13 percent impairment under OAR 436-035-0450(1). The ALJ reasoned that claimant's impairment prevented most of his regular work activities. The ALJ further found, based on the parties' stipulation, that the value for non-impairment factors was 2. On this basis, the ALJ awarded 15 percent unscheduled permanent disability for claimant's contact dermatitis condition.

On review, the employer argues that the ALJ's conclusion that claimant's contact dermatitis should be rated under OAR 436-035-0450 improperly expands the employer's acceptance from "contact dermatitis" to "allergic contact dermatitis." We disagree.

The accepted condition is "contact dermatitis." The acceptance notice is not limited to any particular type of contact dermatitis. Thus, we find that the accepted condition is not limited only to non-allergic contact dermatitis.

The only medical opinion in the record is from Dr. Larsen, claimant's attending physician. Dr. Larsen diagnosed contact dermatitis and performed skin patch tests on claimant that were negative. Despite the negative patch tests, Dr. Larsen opined that claimant's contact dermatitis resulted from an allergic reaction to epoxy resins to which claimant was exposed at work. Under the disability rating standards, impairment from "contact dermatitis" which results from an allergic reaction is rated under OAR 436-035-0450.[1] See John S. Barna, 47 Van Natta 973 (1995). In the absence of any medical opinion to the contrary, we conclude that claimant's impairment caused by his allergic reaction to epoxy resins is "due to" his compensable injury and is ratable under OAR 436-035-0450. See ORS 656.214(5). However, for the following reasons, we disagree with the ALJ's conclusion that claimant's impairment prevented most of his regular work activities.

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[1] OAR 436-035-0450(1) provides:

"When exposure to physical, chemical, or biological agents has resulted in the development of an immunological response, impairment of the immune system shall be valued as follows:

"(a) 3% when the reaction is a nuisance but does not prevent most regular work related activities; OR

"(b) 8% when the reaction prevents some regular work related activities; OR

"(c) 13% when the reaction prevents most regular work related activities."

According to Dr. Larsen, claimant should not be exposed to any paint that contained an epoxy derivative. Other than exposure to epoxy, Dr. Larsen opined that claimant could work. (Ex. 18). Dr. Larsen indicated that he would classify claimant as having "Class 1, 3% impairment." (Ex. 22). There is no evidence in the record that most of claimant's regular work activities required exposure to epoxy or epoxy derivatives. Thus, we are not persuaded, based on this record, that claimant is completely unable to return to his regular work. However, Dr. Larsen has unequivocally restricted claimant from exposure to epoxy-based paints. Therefore, in accordance with Dr. Larsen's opinion, we find that claimant's reaction prevents some--but not most--work related activities.[2] Accordingly, we find that claimant has proven entitlement to 8 percent impairment under OAR 436-035-0450(1)(a). Moreover, the parties have stipulated that claimant is entitled to a nonimpairment value of 1 if the impairment value is between 5 and 9 percent. Therefore, claimant is entitled to an award totalling 9 percent unscheduled permanent disability.

ORDER

The ALJ's order dated December 31, 1996 is modified. In lieu of the ALJ's award of 15 percent unscheduled permanent disability, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability. The ALJ's award of an "out-of-compensation" attorney fee is modified accordingly.

[2] It appears that Dr. Larsen's statement regarding a "Class 1, 3% impairment" is a mistaken reference to OAR 436-035-0440.

In the Matter of the Compensation of
RICHARD M. MILLER, Claimant
WCB Case No. 97-00301
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that declined to award an assessed attorney fee based on the noncomplying employer's (NCE's) withdrawal of its hearing request concerning the SAIF Corporation's acceptance of claimant's injury claim for a right ankle fracture. In his reply brief, claimant moves to strike SAIF's respondent's brief, contending that it has no interest in this matter. On review, the issues are motion to strike and attorney fees.

We deny the motion to strike and, on the merits, adopt and affirm the ALJ's order with the following supplementation.

Motion to Strike

Contrary to claimant's contention, SAIF has an interest in this matter because of its status as the NCE's "assigned claims agent." Under ORS 656.054, the Director must refer injury claims involving NCE's to an assigned claims agent which is then responsible for processing the claim "in the same manner as a claim made by a worker employed by a carrier-insured employer," subject to one exception which is not at issue here.

Here, the Director referred claimant's claim to SAIF. As the NCE's claims agent, SAIF is charged with the duty to pay any costs of the claim, including attorney fees awarded to claimant. ORS 656.054(1). Reimbursement of those claim costs are ultimately recovered from the NCE pursuant to ORS 656.054(3).

Because claimant requested Board review seeking an award of an assessed fee payable by the NCE, SAIF, as the assigned agent responsible for processing the claim on behalf of the NCE, had an interest in defending against the fee request. Thus, we conclude that SAIF properly filed a respondent's brief on the NCE's behalf.

Attorney Fee

We begin with a brief summary of the relevant facts. Claimant filed a claim for a right ankle fracture suffered in July 1995. The employer was found to be noncomplying at the time of the claimed injury, and claimant's claim was referred to SAIF for processing. SAIF accepted the claim in November 1995 and the NCE requested a hearing contesting SAIF's acceptance. Claimant, through counsel, responded to the hearing request and requested an attorney fee award. A hearing was scheduled; however, prior to the date of hearing, the NCE, through counsel, withdrew its hearing request. Pursuant to the NCE's withdrawal, the ALJ dismissed the hearing request, but did not award claimant's attorney an assessed fee under ORS 656.382(2) for services rendered prior to the dismissal.

On review, claimant contends that he is entitled to an assessed fee under ORS 656.382(2). We disagree.

ORS 656.382(2) provides in part:

> "If a request for hearing...is initiated by the employer or insurer, and the Administrative Law Judge...finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge...for legal representation by an attorney for the claimant at and prior to the hearing...."

There are three prerequisites for an attorney fee award under this statute: (1) an employer or insurer must initiate a hearing request to obtain a disallowance or reduction in a claimant's compensation award; (2) the claimant's attorney must perform legal services in defense of the compensation award; and (3) the ALJ must find on the merits that the compensation award should not be disallowed or reduced. Deaton v. Hunt-Elder, 145 Or App 110, 114-115 (1996); Strazi v. SAIF, 109 Or App 105, 107-108 (1991).

The dispute in this case is over whether the third prerequisite has been satisfied, i.e., whether the ALJ found on the merits that claimant's injury claim should not be disallowed. Citing the court's opinion in Deaton, claimant argues that the ALJ's dismissal order made sufficient findings on the merits that claimant's claim should not be disallowed. However, the ALJ's sole "finding" was that the NCE, through counsel, withdrew its hearing request. See OAR 438-006-0071(1) (hearing request may be dismissed if the ALJ finds that the requesting party has abandoned the hearing request).

Moreover, claimant's reliance on Deaton is misplaced. In Deaton, the court was considering whether an ALJ's approval of a stipulated settlement order was equivalent to a finding on the merits that claimant's compensation should not be disallowed or reduced. Based on the Board's rule, former OAR 438-09-005(4) (since renumbered OAR 438-009-0005(4)), which stated that an ALJ's order approving a settlement stipulation is a "determination of all matters" included within the terms of the stipulation, the court concluded that the ALJ's approval of the stipulated settlement amounted to a decision "on the merits" of the claim for compensation. The court therefore reversed the Board's order which declined to award an assessed fee under ORS 656.382(2).

Unlike Deaton, this case does not involve an ALJ's approval of a settlement stipulation. For that reason, the Deaton holding is inapposite here. A closer case is Donna J. Spencer, 47 Van Natta 117 (1995). In Spencer, the ALJ dismissed an NCE's hearing request after it was withdrawn. We held that, because the NCE withdrew its hearing request, the ALJ's dismissal was not a finding "on the merits" of the claimant's claim. Therefore, we held, the claimant's attorney was not entitled to an assessed fee under ORS 656.382(2). See Kenneth J. Short, 45 Van Natta 342 (1993).

This case is controlled by our holding in Spencer. Because the ALJ dismissed the NCE's hearing request based one the NCE's withdrawal of its request, there has been no decision on the merits of the claim. Under such circumstances, claimant is not entitled to an assessed fee under ORS 656.382(2).

ORDER

The ALJ's order dated March 13, 1997 is affirmed.

In the Matter of the Compensation of
ROGER L. ODOM, Claimant
WCB Case No. 96-10206
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that awarded 10 percent (19.2 degrees) scheduled permanent disability for loss of use or function of the right arm, whereas an Order on Reconsideration awarded claimant 15 percent (28.8 degrees) scheduled permanent disability. On review, the issue is extent of scheduled permanent disability.

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

On review, claimant argues that, because the insurer requested a reduction in claimant's scheduled permanent disability award, it has the burden of proof. Additionally, claimant contends that the insurer has not met its burden of proving that claimant was not entitled to a chronic condition award.

We agree that the insurer has the burden of proof in this matter. See Roberto Rodriguez, 46 Van Natta 1722 (1944). However, after reviewing the record, we conclude that it has met its burden of proving that the standards were incorrectly applied with regard to claimant's chronic condition award. ORS 656.283(7).

ORDER

The ALJ's order dated March 10, 1997 is affirmed.

In the Matter of the Compensation of
GARY M. EMMERSON, Claimant
WCB Case No. 96-06224
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Claimant requests reconsideration of our July 17, 1997 Order on Review which reversed the Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's left foot and ankle injury claim. Claimant contends that we incorrectly determined that he failed to sustain his burden of proving legal and medical causation. For the following reasons, we disagree with claimant's contention.

In our previous order, we concluded that claimant failed to prove legal causation because the medical evidence did not establish that the alleged incident of injury (stepping off a loader) could have caused his injury. Noting that the usual exertion in a worker's job is sufficient to establish legal causation, claimant asserts that he sustained his burden of proof because there is no dispute that the alleged incident of injury occurred on the job while he was performing the normal functions of his job.

Claimant is correct that there need not be unusual exertion in order to establish legal causation. See Coday v. Willamette Tug & Barge, 250 Or 39 (1968) (an injured worker's usual exertion sufficient to establish legal causation). However, the medical evidence from Dr. Holmboe and Dr. Burton proves that the alleged incident of injury could not have caused claimant's left foot and ankle injury. (Exs. 23, 26). Moreover, as we noted in our initial order, even if claimant did establish legal causation, those same medical opinions preclude claimant from establishing medical causation, i.e., that the alleged incident of injury in fact caused his left foot and ankle injury.

Claimant contends, however, that, because the medical causation issue is not complex, he need not have produced any expert medical evidence to prove medical causation. Claimant cites Michael J. Coomer, 49 Van Natta 247 (1997), where we held that expert medical evidence was not required regarding the cause of the claimant's back strain.

However, unlike Coomer, where there was no expert medical evidence that the alleged work events could not have caused the claimant's injury, 49 Van Natta at 249, here there are medical reports from Drs. Burton and Holmboe that indicate that the alleged incident of injury could not have caused claimant's injury. (Exs. 23, 26). Therefore, we conclude that Coomer is not controlling and once again find that the medical causation issue in this case was complex, requiring expert medical evidence for its resolution. See also Barnett v. SAIF, 122 Or App 279 (1993).

Accordingly, we withdraw our July 17, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our July 17, 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
ANTHONY J. McKENNA, Claimant
WCB Case No. 95-01946
ORDER ON REVIEW
Bottini, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Thye's order that: (1) found that claimant's request for hearing regarding claim classification was not precluded by the Director's order dismissing the insurer's reclassification review request as untimely; (2) found that claimant's right knee injury claim was properly classified as nondisabling; (3) declined to award temporary disability (interim compensation) for three hours on May 29, 1990; (4) upheld the insurer's partial denial of claimant's aggravation claim; (5) found that claimant's right knee crepitus condition was not compensable; and (6) declined to award penalties or sanctions for allegedly unreasonable claim processing and allegedly frivolous or bad faith litigation. In his brief, claimant: (1) requests remand for admission of his May 14, 1997 affidavit and supporting documents; (2) requests remand for admission of evidence offered to impeach the employer's bookkeeper's credibility; and (3) argues that the insurer's July 13, 1995 denial was precluded by the Director's order requiring the insurer to issue an acceptance.[1] In its brief, the insurer moves to strike claimant's affidavit and supporting documents. On review, the issues are remand, motion to strike, res judicata, temporary disability, claim classification, aggravation, compensability, penalties and sanctions.

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

Remand

Claimant requests remand for admission of his May 14, 1997 affidavit and supporting documents, contending that the alleged content of unrecorded proceedings (concerning the admissibility of independent medical reports, as discussed in the affidavit) would establish the compensability of his right knee crepitus condition and a reasonable expectation of permanent disability. We consider the proffered evidence and argument only for the purpose of determining whether remand is appropriate.[2]

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 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. For a compelling reason to exist, the proffered evidence must be reasonably likely to affect the outcome. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

In this case, we would reach the same result even without considering the independent medical reports which claimant contends were the subject of unrecorded proceedings discussed in his affidavit. In other words, without considering independent medical reports,[3] we would still find that claimant's

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[1] Claimant also continues his objection to the ALJ's admission of medical evidence after September 20, 1995, when he contends that the medical record was frozen. Although the medical record was frozen on that date, the action was taken with regard to claimant's prior low back claim, not his current right knee claim. See 9/20/95 Tr. 5-6, 20-21, 151-152; see also 5/2/96 Tr. 117-121). Consequently, the ALJ did not err in admitting evidence regarding the knee claim after September 20, 1995.

[2] We acknowledge the insurer's motion to strike claimant's affidavit and supporting documents on the ground that the proposed documents constitute improper argument and an attempt to supplement the record. The insurer's motion is denied for the following reasons. First, the insurer does not explain why it believes that claimant's argument is "improper." Second, "post-hearing" submission of proposed evidence may be a basis for remand, as explained herein. Moreover, because we have considered the proffered documents only for the purpose of evaluating claimant's motion to remand, there is no reason to strike them.

[3] We acknowledge claimant's contention that the ALJ erred in admitting independent medical reports, (Exs. 12Ca, 13Ca, 131A), because the reports issued following "unlawful" medical examinations and the insurer had no right to require such examinations under threat of suspending claimant's compensation. However, because we have determined that we would reach the same result on the merits in this case without considering those reports, we need not address claimant's contention in this regard.

right knee crepitus condition is not injury-related; there is no reasonable expectation of injury-related right knee permanent disability; and claimant has not proven a worsening of his compensable right knee condition.

In addition, we acknowledge claimant's request for remand for admission of evidence offered at hearing for the purpose of impeaching the employer's bookkeeper's credibility.[4] We further acknowledge claimant's motion to strike or exclude the time cards submitted by the insurer, because they are admittedly incomplete and allegedly inaccurate.

We do not rely on the bookkeeper's testimony, or on the time cards admitted at hearing, in evaluating claimant's contention that he left work on May 26, 1990 before he finished working.[5] Under these circumstances, we cannot say that the evidence offered to impeach the bookkeeper would likely affect the outcome of this case. Id. Accordingly, we conclude that the record in this case has not been improperly, insufficiently, or incompletely developed and the motions to remand are denied. Finally, because we do not rely on the time cards, there is no reason to "strike or exclude" them.

Res Judicata

We agree with the ALJ that the Director's findings regarding claimant's alleged lost work time have no preclusive effect on the current classification and time loss issues because they were not necessary to the Director's holding that the request for reclassification was untimely. Accordingly, we adopt the ALJ's opinion on this issue.

On review, claimant contends that the insurer's July 13, 1995 denial and all subsequent denials are precluded by the Director's February 28, 1996 Final Order dismissing the insurer's request for reclassification review. In this regard, claimant contends that, because the insurer had an opportunity to litigate the aggravation issue (including whether claimant's crepitus was compensable) before the Department, its subsequent denial is precluded by claim preclusion. However, because the Department lacks jurisdiction to address such issues, we find that the insurer did not have an opportunity to litigate them at the Department. Consequently, the insurer's denial is not precluded.

Penalties

Claimant seeks penalties on numerous bases. He argues that the insurer unreasonably denied his right knee condition after the Director ordered it to issue an acceptance. However, because the compensable condition is a right knee contusion (only), we do not find the insurer's partial denial of claimant's current claim for crepitus to be unreasonable.

Claimant also argues that the insurer's denial was unreasonable, because it was statutorily defective and therefore "invalid." We disagree, because the record is well-developed regarding the denial and claimant had ample opportunity to submit evidence concerning the denied claims. See

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[4] Claimant contends that the proffered evidence would impeach the bookkeeper's statement that she had never signed a false statement regarding claimant. Because the bookkeeper's testimony addresses claimant's and other employee's work hours in the spring of 1990 and particularly on May 26, 1990, claimant apparently believes her alleged lack of credibility would support his claim for lost work time. However, because we do not rely on the bookkeeper's testimony, no compelling reason exists to remand on this basis. (See n. 5, ante).

[5] Claimant argues that he worked less than a full shift on May 26, 1990, based on his testimony that other employees worked after he stopped working and went to the emergency room. The insurer responds that claimant was finished working when he left work. We agree with the insurer. In reaching this conclusion, we first note that claimant does not explain how other employees' work hours or time cards for May 26, 1990 (or any other day) would support his position. It is undisputed that all employees worked irregular hours on Saturdays and there is no suggestion that everyone stopped working at the same time. Moreover, we do not see how claimant would have been in a position to know whether anyone continued working after he left the workplace that day. In any event, considering the complete lack of medical evidence suggesting that claimant was restricted from working that day (or any time) due to his right knee condition, we are not persuaded that claimant left work on May 26, 1990 due to his May 25, 1990 knee injury.

Anthony J. McKenna, 49 Van Natta 96, 102 (1997) (Where the record was sufficiently developed and the claimant had ample opportunity to submit evidence, the denial and subsequent proceedings afforded claimant due process).[6]

Claimant also seeks penalties based on the insurer's allegedly unreasonable failure to accept the claim as disabling, nonpayment of time loss, and its failure to provide claimant with complete payroll records.

We find that no penalties are appropriate on these bases because we agree with the ALJ that the claim is properly classified as nondisabling, no time loss is due, and there are no other amounts due under the claim. See McKenna, 49 Van Natta at 103.

Finally, claimant requests penalties based on the insurer's allegedly untimely payment of medical bills. (See Exs. 2D-5, 2DA-2-3). Although we can determine from the record that the bills in question were submitted to the insurer by the provider and paid by the insurer, we cannot determine when the insurer received them. Consequently, we cannot say that the bills were paid late and no penalty may be assessed on this basis.

Sanctions

The ALJ found that claimant was not entitled to sanctions under ORS 656.390 because the insurer did not request a hearing. Claimant argues that the insurer's pursuit of its "current condition denial" theory at hearing and on review amounts to initiating litigation on that issue and effectively perpetuating it without a formal cross-request for review. Further, contending that the insurer had no reasonable prospect of prevailing because the Board lacks jurisdiction over a current condition denial, claimant renews his request for sanctions.

We need not determine whether the insurer's pursuit of its current condition denial theory satisfies the statute. Even if it does, we do not find that the "current condition denial" theory constitutes frivolous or bad faith litigation. Assuming (without deciding) that the insurer has denied claimant's current right knee condition, we do not find that we lack jurisdiction over a compensability issue raised by such a denial. Moreover, because we find no medical evidence relating any right knee condition which claimant may now have to the 1990 compensable injury, we cannot say that the insurer would have no reasonable prospect of prevailing if claimant requested a hearing and/or review from a current condition denial. Accordingly, we decline to award sanctions based on the insurer's pursuit of its "current condition denial" theory.[7]

Finally, we conclude that claimant is not entitled to sanctions for the insurer's attorney's allegedly violent conduct or threats at hearing, because the statute does not provide for sanctions related to conduct of any type at hearing.

Claimant is not entitled to an attorney fee for the 12 hours of attorney services claimed, because claimant has not prevailed on a denied claim. ORS 656.386(1).

ORDER

The ALJ's order dated February 27, 1997 is affirmed.

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[6] In the same vein, claimant seeks a penalty based on the insurer's alleged failure to provide sufficient notice of the claim's nondisabling status. Even assuming (without deciding) that the insurer's notice of acceptance was defective, no penalties may be assessed on this basis because there are no amounts due under the claim. We further find that claimant has not been prejudiced by lack of notice of classification, because the status of the claim has been fully litigated.

[7] Moreover, because the insurer accepted claimant's injury claim for a right knee contusion (and it has not since denied the accepted condition), we find that the current denial is properly characterized as a partial denial and there is no "back up" denial issue in this case.

In the Matter of the Compensation of
YVETTE A. ALLEN, Claimant
WCB Case No. 96-11486
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Neal's order that upheld the self-insured employer's denial of her right wrist aggravation claim. In its respondent's brief, the employer requests review of that portion of the ALJ's order that declined to award sanctions pursuant to ORS 656.390 for an allegedly frivolous request for hearing. On review, the issues are aggravation and sanctions.

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

We do not adopt the final sentence of the second paragraph of the Findings of Fact.

Citing SAIF v. Walker, 145 Or App 294 (1996) ("actual worsening" under ORS 656.273(1) requires more than symptomatic worsening), the ALJ upheld the employer's aggravation denial. The ALJ reasoned that claimant failed to carry her burden of proof because the medical record did not establish her condition by objective findings or establish that her compensable condition had actually worsened pursuant to ORS 656.273(1).

On review, noting that the Supreme Court has accepted review in Walker, 325 Or 367 (1997), claimant requests that we stay further proceedings until the court reviews the aggravation issue decided in Walker. The employer has not responded to claimant's request, but has addressed the merits of claimant's aggravation appeal and seeks sanctions for allegedly frivolous requests for hearing and review.

In the absence of the parties' agreement to do otherwise, we decline to hold a matter in abeyance indefinitely pending resolution of a court appeal in another case. See Carl L. Gruenberg, 49 Van Natta 750 (1997). Turning to the merits of the aggravation issue, we adopt the ALJ's conclusion that claimant's aggravation claim is not compensable.

We now turn to the employer's request for sanctions pursuant to ORS 656.390. The ALJ declined to award sanctions for a frivolous hearing request, reasoning that the Walker decision could be overturned by the Court and, thus, claimant could reasonably expect to prevail in the future. The employer contends that the aggravation issue does not turn on the Walker case, but rather that claimant's request for hearing was frivolous because the aggravation claim was not supported by "objective findings."

ORS 656.390(1) allows an ALJ or the Board to impose an appropriate sanction against an attorney who files a frivolous request for hearing or review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see Westfall v. Rust International, 314 Or 553, 559 (1992) (defining "frivolous" under former ORS 656.390).

Here, claimant's request for hearing and request for review were not frivolous. We find that both requests raised arguments that were sufficiently developed so as to create a reasonable prospect of prevailing on the aggravation claim. See Gerard R. Schiller, 48 Van Natta 854 (1996). Moreover, Dr. Takacs, claimant's attending physician explained that claimant's accepted condition, right wrist tendonitis, is often not accompanied by what is generally considered "objective findings." (Exs. 43-1, 56-2). Dr. Takacs has not questioned the validity or work-relationship of claimant's symptomatology. (Exs. 48, 54, 56-2). Under these circumstances, we agree with the ALJ that the employer's request for sanctions at hearing should be denied. Furthermore, we deny the employer's request for sanctions based on claimant's request for review.

ORDER

The ALJ's order dated March 26, 1997 is affirmed.

In the Matter of the Compensation of
DANIEL E. BRADFORD, Claimant
WCB Case No. 96-10252
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's injury claim for a low back condition/herniated disc at L4-5. On review, the issue is compensability.

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

The ALJ found that claimant and his wife were credible witnesses, both as to demeanor and the substance of their testimony. Relying on their testimony and the medical opinion of Dr. Lewis, the ALJ found that claimant suffered a compensable low back injury on August 30, 1996, which was the cause of his L4-5 disc herniation.

Despite the ALJ's finding that claimant was credible based on demeanor, the insurer argues on review that claimant's testimony concerning the incident on August 30, 1996 is not to be believed. It is well settled that, unless the substance of the witness' testimony and other inconsistencies in the record raise such doubt that we are unable to conclude that the material testimony is credible, we will generally defer to the ALJ's finding that the witness is credible. See, e.g., Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Gail A. Albro, 48 Van Natta 41 (1996); David A. Peper, 46 Van Natta 1656 (1994). In this case, we find no persuasive reason to overturn the ALJ's demeanor-based credibility determination.[1]

Claimant has the burden of proving the compensability of his low back condition by a preponderance of the evidence. ORS 656.266. Like the ALJ, we accept claimant's history of the August 30, 1996 incident. Claimant's testimony, which was independently corroborated by his wife, indicates that he experienced a "tweak" in his low back while bending and turning to stack boards at work on the morning of August 30, 1996. Moreover, claimant's corroborated testimony indicates that he was reluctant to file a workers' compensation claim, as he thought he would get better, did not want to reveal his inability to write, and did not want to cause the loss of the "no work time lost" raffle.

Attorney Fees

Claimant's counsel submitted a statement of services documenting 8.5 hours for services before the Board and requesting an attorney fee of $1,500. The insurer, which has no objection to the number of hours, contends that $1,500 is excessive and that a fee of $1,300 is more appropriate. We disagree.

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[1] We note that, although the insurer argues that claimant failed to give his doctors a history of his prior low back claims, claimant reported to Dr. Breitkreuz that he had had an occasional sore back and had seen a chiropractor about 10 years earlier. (Ex. 5A). Claimant also reported to his physical therapist, Ms. Welch, a past medical history of a disc problem five to six years earlier, with no symptoms over the last few years. This information was provided to Dr. Breitkreuz in an October 4, 1996 letter. (Ex. 6A). In both cases, claimant received chiropractic treatment for two weeks and lost no time from work. We conclude that the witness's subsequent failure to report these relatively minor incidents that occurred 15 and seven years earlier is insufficient to undermine the evidence in support of claimant's assertion that the injury occurred in the manner he described.

We consider the amount of claimant's counsel's attorney fee for services on review 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.

As compared to typical compensability cases, the issue here was somewhat above average complexity. The claim's value and the benefits secured are of above average proportions, consisting of substantial medical services and disability, including potential permanent disability. As represented by his respondent's brief, claimant's counsel devoted a number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Finally, although there was a decided risk that claimant's counsel's efforts might have gone uncompensated, counsel's skill and time was spent in reducing that risk through preparation. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996) (the risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)).

After considering these factors, we conclude that $1,500 is a reasonable assessed attorney fee for claimant's counsel's services on Board review. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding, the skill of the attorneys, the time devoted to the case, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated February 25, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the insurer.

In the Matter of the Compensation of
JACQUELINE J. ROSSI, Claimant
WCB Case Nos. 95-09628 & 95-08655
ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On July 25, 1997, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's partial denial of her right knee condition, involving congenital/developmental bilateral patella alta with lateral subluxation, poor patellar tracking and loss of articular cartilage. In that decision, we concluded that the Hearings Division retained authority to consider the parties' compensability dispute, notwithstanding their stipulation that the real dispute centered on claimant's need for surgery for her current right knee condition.

On our own motion, we withdraw our prior order for further consideration of the jurisdictional issue posed by the court's holding in SAIF v. Shipley, 147 Or App 26 (1997). The parties are granted an opportunity to present their respective written positions regarding the Shipley decision and its effect on this case. To be considered, each of those positions must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY S. DAYE, Claimant
WCB Case No. 96-09718
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's claim for swelling of hands, joint pain and knots at joints; and (2) assessed a penalty for the employer's allegedly unreasonable denial of claimant's condition. On review, the issues are compensability and penalties.

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

The ALJ determined that claimant's bilateral hand swelling, joint pain and knots on the joints were compensable as an accidental injury under ORS 656.005(7)(a). On review, the employer and claimant argue that the claim should be analyzed as an occupational disease because hand symptoms are a foreseeable result of using vibrating or jolting power tools, such as those claimant used while working in the employer's "prepaint" department.

In determining the appropriate standard for analyzing compensability, the focus is whether claimant's bilateral hand pain and swelling was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson, 56 Or App at 187 ("sudden in onset" does not have to be "instantaneous").

In this case, as the ALJ found, claimant's bilateral hand pain arose during a short, discrete period: those days that she worked in the prepaint department during May and June 1996. Nevertheless, as the parties note, hand pain and swelling are not an unexpected result of claimant's employment conditions, considering the inherent hazard of repetitive hand activity as a driller and bolter.

We need not decide whether the ALJ erred in analyzing the claim as an accidental injury, because even if claimant's condition is an occupational disease, we are persuaded by the expert medical evidence that her employment activities were the major contributing cause of her condition. See ORS 656.802(2)(a).

As the ALJ noted, both Dr. MacKay, claimant's treating doctor, and Dr. Dordevich, who examined claimant at the employer's request, opined that claimant's pain and inflammation was most likely due to her heavy, repetitive hand activity of drilling and monobolting cabs in the prepaint department. (See Exs. 1, 3, 10-6). Dr. Dordevich explained that this activity resulted in flexor and extensor strains in claimant's wrists and hands. (Ex. 10-5). Neither doctor found any evidence of preexisting, underlying degenerative arthritis which would have contributed to claimant's condition. (Exs. 10-4, 11-2). Although Dr. MacKay determined that claimant was physically unable to perform the monobolting job and that her symptoms resulted from "some combination of physical predisposition and lack of work hardening," he did not identify the predisposition or preexisting condition. In the absence of any further evidence on this point, we conclude that claimant's claim is not based on the worsening of a preexisting disease or condition[1] and does not involve a "combined condition" under ORS 656.005(7)(a)(B). See ORS 656.802(2)(b). Because both medical experts cite to claimant's work activity in

[1] "Preexisting condition" is defined in ORS 656.005(24) as "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of the initial claim for an injury or an occupational disease . . . ."

the prepaint department as the primary (if not only) cause of her bilateral hand pain and swelling, we conclude that claimant has sustained her burden of proof under ORS 656.802(2)(a), as well as under ORS 656.005(7)(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 regarding the compensability issue is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 28, 1997 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
JOSEPH E. BRIDWELL, Claimant
WCB Case No. 96-07849
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On July 14, 1997, we awarded claimant interim compensation and assessed a penalty for the self-insured employer's unreasonable failure to pay interim compensation. Raising several challenges to our conclusion that its failure to pay interim compensation had been unreasonable, the employer seeks reconsideration of our penalty assessment. In response, claimant contends that the employer's request should be denied. Claimant has responded, contending that the employer's request should be denied.

In order to further consider this matter, we withdraw our July 14, 1997 order. In addition, the following supplemental briefing schedule is implemented. The employer's response to claimant's position shall be due 14 days from the date of this order. Claimant's reply shall be due 14 days from the date of mailing of the employer's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID L. GLENN, Claimant
WCB Case No. 96-04402
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that awarded 11 percent (35.2 degrees) unscheduled permanent disability for a thoracic strain injury, whereas an Order on Reconsideration had 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, except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on January 30, 1995. On May 1, 1995, the insurer accepted a right sided lower thoracic sprain. (Ex. 21). On February 1, 1996, a Determination Order awarded claimant temporary disability, but no permanent disability. (Ex. 31). The October 22, 1996 Order on Reconsideration did not award permanent disability. (Ex. 37).

Based on the reports of Drs. Hartkop and Kirkpatrick, the ALJ concluded that claimant was entitled to an award of 5 percent for a chronic condition. The insurer relies on the medical arbiter's opinion to argue that claimant does not have any permanent impairment as a result of the accepted claim.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Former OAR 436-35-007(9) (WCD Admin. Order No. 6-1992) provided that, where a medical arbiter is used on reconsideration, impairment was determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. Rather, we rely on the most thorough, complete, and well- reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994). In order to be entitled to an unscheduled chronic condition impairment award, a preponderance of medical opinion must establish that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. Former OAR 436-35-320(5).

Claimant relies on the opinion of his attending physician, Dr. Hartkop, to establish that he is entitled to a chronic condition award.

On March 29, 1995, Dr. Hartkop agreed with Dr. Kirkpatrick's recommendation that claimant should change to work not involving heavy lifting. (Exs. 15, 19-1). Dr. Hartkop concurred with the April 24, 1995 report from Drs. Potter and Melson, who examined claimant on behalf of the insurer. (Ex. 24). Drs. Potter and Melson recommended that claimant be limited to 25 pounds lifting with no repetitive bending and that he be limited to sitting, standing and walking for one hour without positional change. (Ex. 20-5). The panel reflected the opinion of Dr. Kirkpatrick that claimant should be restricted in his lifting and should not do heavy lifting. (Id.) Drs. Potter and Melson noted, however, that if claimant "takes care of his back, the pain will resolve." (Id.) They felt that claimant should enter a work hardening program. (Ex. 20-6).

Approximately one-and-one-half years later, on September 21, 1996, Dr. Sukin, medical arbiter, examined claimant and measured ranges of motion for his thoracic spine. (Ex. 36-3). Dr. Sukin reported, however, that the range of motion testing was invalid due to a lack of effort by claimant. (Ex. 36-4). Dr. Sukin determined that claimant did not have a limited or partial loss of ability to use his spine due to a permanent medical condition and he opined that claimant did not have any limitations in residual functional capacity due to the accepted condition. (Ex. 36-4, -5).

In this case, we find that Dr. Sukin, the medical arbiter, provided the most persuasive medical opinion addressing claimant's permanent impairment. The medical arbiter's examination was conducted closer in time to the reconsideration order and his report is a thorough and well-reasoned evaluation of claimant's permanent impairment. Further, Dr. Hartkop's concurrence with Drs. Potter and Melson took place more than six months prior to claimant becoming medically stationary. Therefore, we rely on the arbiter's findings over those of Dr. Hartkop. Based on Dr. Sukin's report, we conclude that claimant is not entitled to a chronic condition award. Consequently, we reverse the ALJ's order and affirm the Order on Reconsideration that awarded no permanent disability.

ORDER

The ALJ's order dated January 21, 1997 is reversed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

In the Matter of the Compensation of
LESLIE C. BURBANK, Claimant
WCB Case No. 96-02952
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) admitted Exhibit 4 (a laboratory report) into the record; and (2) upheld the self-insured employer's denial of her right wrist injury claim. On review, the issues are evidence and compensability.

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

Based on the substance of claimant's testimony at hearing, we conclude that she is not credible regarding the circumstances of her injury. In this regard, claimant testified that she was aware that her employer would require an alcohol and drug test following her injury. Nevertheless, claimant alleged that after her 7:00 a.m. injury she consumed approximately eight ounces of wine while waiting in the hospital emergency room to be seen by a physician. Then, according to claimant's testimony, within one-half hour she approached a nurse in the emergency room and volunteered to take a drug and alcohol test even though the nurse supposedly informed claimant that she need not take the test at that time. Claimant's rendition of these events is not credible.

Claimant's credibility is further placed in question because she did not initially report her consumption of the wine while waiting in the hospital emergency room. Rather, claimant's boyfriend telephoned the employer to inform the employer of the emergency room alcohol consumption on the same day that claimant learned the positive results of the alcohol testing. These facts lead us to conclude that it is more likely than not that claimant either did not drink any wine while in the hospital but stated that she did so in order to explain an anticipated positive alcohol test, or that claimant purposefully drank wine in the hospital in anticipation of the alcohol test and in order to mask the amount of her consumption prior to her injury. In either event, claimant is not a credible witness with regard to the events that transpired the evening before and the morning of her injury.

Claimant's lack of credibility is important as it relates to her explanation of the events leading up to her injury. Although claimant testified that she was performing her work in the appropriate manner when injured and that it was her working partner who mistakenly mishandled the door that led to her injury, we are unable to accept this testimony. Because we reject claimant's explanation of the events leading to her injury, we also reject her challenge to the ALJ's findings regarding the injury.

ORDER

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

In the Matter of the Compensation of
MARVIN J. GREGORY, Claimant
WCB Case No. 96-08994
ORDER ON REVIEW
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) did not address the compensability of claimant's left elbow condition (epicondylitis); (2) awarded interim compensation from August 2, 1996 through September 5, 1996; and (3) declined to assess penalties for an allegedly unreasonable denial. With his appellate briefs, claimant submits additional written material and a "post-hearing" medical report. We treat these submissions as a motion to remand to the ALJ for the taking of additional evidence. ORS 656.295(5); Judy C. Britton, 37 Van Natta 1262 (1985). The insurer cross-requests review of that portion of the ALJ's order which set aside its denial insofar as it pertains to claimant's cervical/left arm injury claim. On review, the issues are remand, compensability, interim compensation and penalties. We deny claimant's motion and reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, a long-haul truck driver, alleged that, on or about July 10, 1996, he sustained a left arm injury loading a shipment of chairs weighing 50 to 75 pounds. Claimant first received medical treatment on August 6, 1996 from Dr. Luty, who diagnosed a "possible" cervical strain with unlikely but possible nerve root involvement. (Ex. 3-2). Dr. Luty noted visible swelling in the forearm and triceps area. Id. Placing claimant on modified work, Dr. Luty reported that claimant was a poor historian and that it was difficult to believe claimant's history. Id. On an August 7, 1996 form 827, Dr. Luty listed "objective findings" as decreased left biceps strength, decreased left wrist extensors, decreased biceps reflex and decreased brachioradialis reflex. (Ex. 4).

On August 9, 1996, Dr. Luty again examined claimant and reported that he had left arm pain "possibly" related to cervical strain or nerve root impingement. (Ex. 6-2). However, reflex testing did not support the diagnosis. Dr. Luty wrote that "there may be another etiology to the left arm pain that I am unaware of or this may be a hysterical conversion reaction." Id.

On August 23, 1996, another physician, Dr. Yarusso, examined claimant, who reported pain along the dorsal lateral aspect of the left elbow. (Ex. 10-1). Noting a positive hyperextension test, Dr. Yarusso diagnosed lateral epicondylitis. Id. Dr. Yarusso's report indicates that he performed a corticosteroid injection after apprising claimant of the underlying pathology and treatment options and obtaining claimant's consent. (Ex. 10-2). According to Dr. Yarusso's records, claimant was released to full duty as of the August 23rd visit. (Ex. 9).

On September 3, 1996, claimant wrote Dr. Yarusso, alleging that Dr. Yarusso had released him for work without examining him and that Dr. Yarusso had given him an injection without permission. (Ex. 12a-1). That same day, claimant wrote Dr. Luty and accused him of "slipping a ringer doctor to sign a work release." (Ex. 12b). Claimant also wrote the employer to object to returning to work before his injury had healed. (Ex. 12c).

On September 5, 1996, the insurer denied the claim on the ground that claimant's condition did not arise out of and in the course of employment. Claimant requested a hearing.

Subsequently, on September 6, 1996, Dr. Yarusso confronted claimant regarding his allegation of misconduct. Diagnosing "multiple symptoms," Dr. Yarusso noted that there was a "possible intentional desire to deceive." (Ex. 14).

On December 16, 1996, Dr. Luty agreed that it was highly unlikely that claimant's lone objective finding (absent biceps reflex) was related to the alleged July 10, 1996 injury. (Ex. 15-1). Dr. Luty also agreed that claimant's subjective complaints did not correlate with any anatomical abnormalities. Id. That same day, Dr. Yarusso also agreed that he could not relate any of claimant's symptoms to the alleged July 10, 1996 injury. (Ex. 16). Finally, Dr. Yarusso specifically denied claimant's allegations regarding his treatment of claimant. (Ex. 17).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial, reasoning that claimant had satisfied his burden of proving that he sustained a compensable injury because he had reported his alleged injury to the employer and had evidence of objective findings on examination. The ALJ also determined that claimant was entitled to interim compensation from August 2, 1996 through September 5, 1996 because the form 801 showed that the employer had knowledge of the claim on August 1, 1996 and the claim was not denied until September 5, 1996.[1] Finally, the ALJ declined to award penalties for an unreasonable denial, finding that the insurer had sufficient doubt about its liability when it issued its denial.

Remand

As previously noted, claimant has submitted additional evidence not considered by the ALJ. This material includes a May 1997 medical report from Dr. Mysliwiec, an osteopath who opined that claimant has a chronic work-related epicondylitis condition and a median neuropathy in the left arm. Because our review is confined to the record developed before the ALJ, we treat claimant's submission as a motion to remand for the taking of additional evidence. See ORS 656.295(5); Chris G. Clausen, 49 Van Natta 167 (1997).

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, we are not persuaded the additional documents submitted by claimant are likely to affect the outcome of this case. In this regard, we note that Dr. Mysliwiec has opined that claimant has work-related epicondylitis. However, at hearing, claimant, through counsel, withdrew any claim for left epicondylitis. (Tr. 9). Inasmuch as claimant's left elbow condition is not at issue in this case, Dr. Mysliwiec's opinion that claimant has a work related epicondylitis condition has no bearing on the issues to be decided in this case.[2] Although Dr. Myslilwiec also diagnosed left median neuropathy, he did not relate this condition to claimant's employment, nor did claimant ever make a claim for this condition at hearing. Id. Moreover, claimant provides no explanation as to why the additional evidence he has submitted was not obtainable with due diligence at the time of hearing. Therefore, we find no compelling reason to remand and consequently deny claimant's motion for remand.[3]

Compensability

The insurer contends that the ALJ incorrectly set aside its denial because there is no affirmative evidence supporting the compensability of claimant's alleged injury of July 10, 1996. We agree.

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] The parties stipulated that the insurer had paid interim compensation from August 9, 1996 to August 23, 1996. (Tr. 10). The ALJ gave the insurer a credit for the temporary disablity paid during this period.

[2] If claimant desires to pursue a left elbow claim, he, of course, is free to do so. Should the insurer deny the left elbow claim, claimant could then request a hearing regarding the compensability of that condition. However, given that claimant's attorney withdrew any claim for the left elbow at the hearing, any evidence that claimant has submitted regarding a left elbow condition is not relevant to these proceedings.

[3] To the extent that claimant is raising "post-hearing" claim processing issues, those questions are not an issue in this case.

Here, the circumstances of claimant's injury claim are complicated. According to claimant, his symptoms appeared while loading a shipment on or about July 10, 1996. (Tr. 24). There is no evidence of a preexisting left arm/cervical condition. Claimant testified that he attempted to promptly report his alleged injury, although those efforts were complicated by the fact that the alleged injury occurred while claimant was on the road and claimant had difficulty determining to whom he should report the injury. (Tr. 24-27). However, claimant did not receive medical treatment until August 6, 1996, nearly one month after the alleged injury. In addition, Dr. Yarusso could not relate claimant's symptoms to the alleged July 10, 1996 injury. (Ex. 16-1).

Under these circumstances, we find that this case presented a complex medical causation issue and, thus, that claimant was required to produce expert medical evidence linking claimant's cervical/left arm condition to the July 10, 1996 incident. As the insurer correctly observes, there is no affirmative evidence that does so. As previously noted, Dr. Yarusso agreed that he could not relate claimant's symptoms to the alleged injury.[4] (Ex. 16). Dr. Luty initially diagnosed only a "possible" strain while, at the same time, stating it was difficult to believe claimant's history. Dr. Luty raised the possibility of another etiology of claimant's complaints. Dr. Luty also agreed that it was "highly unlikely" that claimant's absent biceps reflex was related to the alleged injury. (Ex. 15). Because there was no persuasive medical evidence relating claimant's condition to the alleged work incident, we disagree with the ALJ's decision to set aside the insurer's denial. We, therefore, reverse.[5]

Interim Compensation

Interim compensation is due and payable if the carrier does not accept or deny the claim within 14 days of notice or knowledge, whether or not the claim eventually is found to be compensable. E.g., Jones v. Emanuel Hospital, 280 Or 147 (1977); Gene T. Lapraim, 41 Van Natta 956 (1989) (carrier is obliged to pay interim compensation for noncompensable claims from date carrier received notice of disability). Here, although we have determined that claimant's claim is not compensable, claimant is still entitled to interim compensation.

The ALJ awarded claimant interim compensation from August 1, 1996, the date the employer indicated that it had knowledge of the claim until the date of the September 5, 1996 denial. However, no temporary disability was authorized until August 6, 1996, when Dr. Luty restricted claimant to modified work. (Ex. 3-3). Interim compensation is due and payable beginning 14 days after the date upon which the employer receives notice or knowledge of the claim and verification from the attending physician as to the worker's injury-related inability to work. ORS 656.262(4)(a); Stephen M. Snyder, 47 Van Natta 1956, 1958 (1995). Under these circumstances, claimant's interim compensation was due no earlier than August 6, 1996. Because claimant was not totally disabled after the injury, we conclude that temporary disability should not have commenced until after the 3 day waiting period in ORS 656.210(3) had expired.[6] Thus, the insurer properly waited until August 9, 1996 to commence payment of interim compensation. Moreover, Dr. Yarusso released claimant to regular work on August 23, 1996. (Ex. 9). Because there was no longer an authorization of temporary disability, claimant's entitlement to interim compensation ended on that date. ORS 656.262(4)(f).[7] Inasmuch as the insurer had already paid

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[4] Claimant has submitted additional information (including an audio tape) which challenges the foundation and persuasiveness of Dr. Yarrosso's opinion. As noted above, we treat such a submission as a motion to remand. We find no compelling reason to remand because, even if these materials were considered and even if Dr. Yarosso's opinion was rejected, the record would still lack sufficient medical evidence to relate claimant's condition to his work.

[5] Because we have reinstated the insurer's denial, we need not address the issue of whether it was unreasonably issued.

[6] ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period."

[7] 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."

interim compensation from August 9, 1996 to August 23, 1996, claimant was not entitled to additional temporary disability. Accordingly, we reverse the ALJ's decision to award additional interim compensation.

ORDER

The ALJ's order dated March 6, 1997 is reversed in part and affirmed in part. That portion which set aside the insurer's denial of claimant's cervical/left arm claim is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. That portion of the ALJ's order that awarded additional interim compensation and an "out-or-compensation" attorney fee from August 1, 1996 to August 9, 1996 and from August 24 to September 5, 1996 is also reversed. The remainder of the ALJ's order is affirmed.

August 8, 1997 Cite as 49 Van Natta 1256 (1997)

In the Matter of the Compensation of
JEFFREY C. MICHAEL, Claimant
WCB Case No. 95-07698
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Michael v. Blue Mountain Asphalt Co., 146 Or App 179 (1997). The court reversed our prior order, Jeffrey C. Michael, 48 Van Natta 929 (1996), which upheld the insurer's denial of claimant's aggravation claim for a low back condition. Citing Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996) (Messmer II), the court has remanded for reconsideration.

FINDINGS OF FACT

We continue to adopt the ALJ's "Findings of Fact," but not the "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the pertinent facts. In April 1993, claimant developed low back and left leg pain while lifting. Dr. Gamber diagnosed lumbosacral strain with probable disc involvement. (Ex. 2). Results of an April 1993 MRI of claimant's lower back revealed a small disc herniation at L4-5 and no evidence of disc herniation at L5-S1. (Ex. 3).

In May 1993, Dr. Flaiz became claimant's attending physician and diagnosed "mechanical back pain." (Ex. 6). On referral from Dr. Gamber, Dr. Washington diagnosed claimant's condition as lumbosacral strain with a small disc herniation at right L5. (Ex. 8-3). On July 1, 1993, the insurer accepted a lumbar strain. (Ex. 10).

In January 1994, examining physicians, Drs. Marble and Rich, evaluated claimant's low back condition and diagnosed "history of lumbar strain." (Ex. 12). They later confirmed that claimant had reduced range of motion in the low back due to the compensable injury, but that it was of "little functional significance." (Ex. 14). A Determination Order then closed claimant's claim in April 1994, awarding 5 percent unscheduled permanent disability based on reduced range of motion in claimant's low back. (Ex. 16).

On February 21, 1995, Dr. Flaiz reported that claimant "had a recurrence of his back pain." (Ex. 17). Drs. Peterson and Reimer then performed an insurer- arranged examination in March 1995 and diagnosed "history of lumbar strain with L4-5 disk herniation." (Ex. 20-5). The examiners stated that claimant's current condition "appeared" to be more than a simple waxing and waning of symptoms contemplated by claimant's prior permanent disability award. (Ex. 20-6). However, because of claimant's considerable pain behavior, the examiners requested another MRI in order to objectively substantiate claimant's condition. The panel stated that if the new MRI showed no appreciable change

from claimant's April 1993 MRI, they would feel comfortable stating that claimant's condition had remained stable and there would be no need for additional treatment.

On March 29, 1995, Dr. Flaiz concurred with the Peterson/Reimer medical report. (Ex. 23). A MRI performed in May 1995 revealed degenerative disc disease, mild disc herniation at L4-5 and slight to mild disc herniation at L5-S1. (Ex. 25). On June 19, 1995, Dr. Peterson interpreted the May 1995 MRI as showing a "small change" at L5-S1 and no change at L4-5. (Ex. 26). Dr. Peterson stated that the "small change" at L5-S1 may have been present in April 1993, but that he could not be certain unless he was able to view claimant's April 1993 MRI. Dr. Peterson recommended conservative treatment.

On June 20, 1995, the insurer issued a denial of claimant's aggravation claim. (Ex. 27). Claimant appealed the denial.

Relying on the opinion of Dr. Flaiz that claimant had a recurrence of low back pain, the ALJ found that claimant proved a worsened low back condition that was attributable to his compensable injury. Therefore, the ALJ set aside the insurer's aggravation denial.

On review, we reversed the ALJ's order. Jeffrey C. Michael, 48 Van Natta at 930. In doing so, we found no persuasive medical evidence that claimant's current condition was attributable to his compensable lumbar strain. We reasoned that, while Dr. Flaiz, who treated claimant both before and after claimant's claim was closed, had reported that claimant "had a recurrence of back pain," such a statement did not persuasively relate claimant's current condition to his compensable lumbar strain, particularly where the MRI revealed degenerative disc disease and mild herniations.

Further, assuming that Dr. Flaiz's report did relate claimant's current condition to his compensable condition, we determined that there was no persuasive evidence in the record relating claimant's "small change" at L5-S1 to his compensable lumbar strain condition or establishing that his current condition represented a pathological worsening of his compensable strain or was more that just a waxing and waning of symptoms contemplated by claimant's prior permanent disability award.

Claimant requested review of our order before the Court of Appeals. As previously noted, the court has reversed our prior order and remanded for reconsideration, citing Messmer II.

In Messmer II, the court determined that former ORS 656.262(10) did not effectively overrule its prior decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (Messmer I). Messmer, 140 Or App at 556. In Messmer I, the court had held that an employer's failure to appeal a Determination Order that awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease, precluded the employer from contending later that the condition was not part of the compensable claim. The court reasoned that the result was not that the degenerative condition had been accepted, it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. 130 Or App at 258.

Here, claimant contends that the award of permanent disability in April 1994 was based on a disc herniation and degenerative disc disease. Therefore, claimant argues that, when the insurer failed to appeal the 5 percent disability award in the Determination Order, it became responsible for those conditions under Messmer. Moreover, claimant asserts that, since the medical evidence establishes a pathological worsening of the accepted conditions, he established a compensable aggravation claim. For the following reasons, we disagree with claimant's assertions.

As previously noted, the April 1994 Determination Order's permanent disability award was based on reduced range of motion, as indicated by the accompanying worksheet. The Determination Order's range of motion findings were based on the examination findings of Drs. Marble and Rich, with which Dr. Flaiz concurred. (Ex. 12-3). However, there is no indication in the Marble/Rich report that the range of motion findings were due to a disc herniation or degenerative disease. Drs. Marble and Rich diagnosed only a history of a lumbar strain. Although they commented that, if one "assumes" that the L4-5 disc protrusion was related to compensable injury, that would be the residual level of impairment (Ex. 12-6), the Marble/Rich panel never stated that the disc protrusion was responsible for claimant's reduced range of motion on examination. Inasmuch as there is no evidence that the

Determination Order awarded permanent disability for a disc herniation or degenerative disease, we disagree with claimant's assertion that the insurer is responsible for those conditions under Messmer.[1]

Even assuming that permanent disability was awarded for a disc protrusion at L4-5, claimant's current condition involves a "small change" at L5-S1. According to the Dr. Peterson, there has been no change at L4-5. (Ex. 26). There is no evidence that relates the current disc abnormality at L5-S1 to the accepted lumbar strain or to the L4-5 disc condition.

Therefore, we adhere to the finding in our previous order that there is insufficient evidence that claimant's current low back condition is related to the compensable lumbar strain. Moreover, despite claimant's references to various examination findings, such as muscle spasm, reduced range of motion and radiating pain, there is no medical opinion that establishes that claimant's compensable low back condition has pathologically, as opposed to symptomatically, worsened. SAIF v. Walker, 145 Or App 294 (1996) ("actual worsening" in ORS 656.273(1) was not intended to include a symptomatic worsening). Therefore, even if we assumed that claimant's L4-5 disc abnormality is a part of the accepted claim, the medical evidence indicates there has been no pathological change in that condition. (Ex. 26).

In conclusion, on remand, we continue to find that claimant failed to prove a compensable aggravation claim. Accordingly, as supplemented herein, we adhere to and republish our prior order dated April 26, 1996.

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[1] Former ORS 656.262(10) provided that payment of permanent disability benefits pursuant to a closure notice, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein. As previously noted, the court in Messmer II held that this statutory language did not overrule the court's holding in Messmer I. Messmer, 140 Or App at 556. The 1997 legislature recently amended ORS 656.262(10) to provide that "the failure to appeal or seek review of such an order or notice of closure" also shall not preclude a carrier from contesting the compensability of a condition rated therein. HB 2971, 69th Leg., Reg. Sess. (July 25, 1997). We need not determine the effect of this amendment on this case because we have determined that Messmer is inapplicable.

In the Matter of the Compensation of
ANTHONY D. SHERMAN, Claimant
WCB Case Nos. 96-07731 & 96-05313
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of his left elbow injury claim. On review, the issue is compensability.

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

The sole issue on review is whether claimant established a compensable left elbow injury supported by objective medical findings. We agree with the ALJ that the record fails to demonstrate the requisite objective medical findings.

In order to establish a compensable injury, claimant must prove, by a preponderance of the evidence, that his work injury was at least a material contributing cause of his disability or need for medical treatment. ORS 656.005(7)(a). In addition, claimant must establish his compensable condition by medical evidence supported by objective findings. Id. ORS 656.005(19) provides:

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In Jairo J. Garcia, 48 Van Natta 235 (1996), we decided the issue of whether the claimant's subjective pain complaints were sufficient to constitute "objective findings" under ORS 656.005(19). Citing Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992), and Suzanne Robertson, 43 Van Natta 1505 (1991), we stated that, under former ORS 656.005(19), a worker's description of pain (supported by a physician's indication that the worker was experiencing such symptoms) was sufficient to constitute "objective findings." However, since the 1995 legislature amended the definition of "objective findings," we found it necessary to interpret the phrase "verifiable indications of injury or disease" in ORS 656.005(19). We found that language ambiguous and turned to the legislative history. After reviewing that history, we concluded that the statutory amendments were clearly intended to overrule the Suzanne Robertson holding. Consequently, we determined that a physician's indication that the worker experiences pain, standing alone, is no longer sufficient to constitute "objective findings."

In Garcia, the claimant's attending physician reported that the claimant had pain, but he characterized the findings of pain as subjective and not objective. The attending physician reported that there were no "objective findings" of injury. 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).

In Tony D. Houck, 48 Van Natta 2443 (1996), we examined the issue of whether a claimant's subjective responses to physician testing constituted "objective findings" under ORS 656.005(19). Based on both the language of ORS 656.005(19) and the legislative history, we concluded that, although the legislature rejected a physician's mere adoption of a worker's complaint of pain, it intended that a physician's interpretation of a worker's verifiable subjective response to clinical testing be relied on, provided it was "reproducible, measurable or observable." 48 Van Natta at 2448-49. 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 Houck, the claimant responded positively to clinical tests used in diagnosing his bilateral carpal tunnel syndrome and left epicondylitis conditions. Specifically, these tests included Tinel's and Phalen's tests and clinical testing involving resisted extension and flexion of the wrist. Id. at 2449. Applying the above standard, we concluded that claimant's positive responses to clinical testing constituted verifiable subjective responses to pain that were reproducible and came within the definition of "objective finding."

Here, claimant was terminated on March 8, 1996. On March 27, 1996, claimant first sought treatment from Dr. Reynolds, treating physician, for left elbow pain. (Ex. 1). At that time, claimant reported a February 29, 1996 industrial injury in which he struck his left elbow. (Exs. 1, 2). Dr. Reynolds indicated that claimant's physical examination was "not remarkable," finding good range of motion, no neurological deficit, and noting that supernation and pronation were "not remarkable." (Ex. 1). He noted that "there is tenderness over the lateral condyle of the elbow, just lateral to the radial head." (Ex. 1). Dr. Reynolds' assessment was "contusion to left elbow. a) Rule out possible chip fracture (doubt)." (Ex. 1). To rule out a possible chip fracture, Dr. Reynolds ordered an x-ray, which was normal. (Exs, 1, 3, 4).

On April 23, 1996, claimant returned to Dr. Reynolds, who reported that claimant "continues to note discomfort about the lateral aspect of the elbow." (Ex. 4). The record contains no indication of any other medical treatment regarding the left elbow.

Claimant argues that Dr. Reynolds' notation of "tenderness over the lateral condyle of the elbow, just lateral to the radial head" in his March 27, 1996 chart note and his notation of "over radial head, lt." in the "objective findings" section of the 827 form of the same date establish the requisite objective medical findings. In support of this argument, claimant relies on Naomi Whitman, 48 Van Natta 605 (1996), Rosalie A. Peek, 47 Van Natta 1432 (1995), and James S. Jones, 49 Van Natta 226 (1997).

Rosalie A. Peek was issued before our decision in Jairo J. Garcia in which we concluded that a physician's indication that the worker experiences pain, standing alone, is no longer sufficient to constitute "objective findings." In addition, although we noted in Peek that the claimant there had "reproducible tenderness," and indicated that this finding was not excluded as an objective finding under ORS 656.005(19) because "this physical finding or subjective response to a physical examination

was reproducible," we also noted that the claimant had "bruising and reduced range of motion which are verifiable, observable indications of injury." 47 Van Natta at 1433 (footnote omitted). Because the bruising and reduced range of motion satisfied the requirements of ORS 656.005(19), the discussion of "reproducible tenderness" is dicta and is not controlling here.

Claimant's reliance on Naomi Whitman is also misplaced. There, although we noted that a chart note mentioned tenderness, our holding was based on our finding that claimant had "measurable " reduced range of motion and "observable" paraspinous spasm, both of which constituted "objective findings" under ORS 656.005(19). 48 Van Natta at 607.

Here, Dr. Reynolds provides a thorough listing of his findings regarding claimant's physical examination, which he indicated was "not remarkable," with "good range of motion." (Ex. 1). Although diagnosing "contusion of the left elbow," Dr. Reynolds makes no finding of any bruising in his objective findings. Id. Therefore, unlike the claimants in Rosalie A. Peek and Naomi Whitman, claimant does not have any abnormal findings outside of a report of "tenderness."

Finally, claimant notes that, in James S. Jones, 49 Van Natta 226 (1997), which cited Tony D. Houck and Rosalie A. Peek, we found that physicians' findings of tenderness in the low back constituted "objective findings" under ORS 656.005(19). Yet, the "tenderness/objective findings" statement in James S. Jones is inconsistent with our holdings in Jairo J. Garcia, 48 Van Natta at 237 (a physician's indication that the worker experiences pain, without more, is no longer sufficient to constitute "objective findings") and Tony D. Houck, 48 Van Natta at 2448-49 (a physician's interpretation of a worker's verifiable subjective response to clinical testing constitutes "objective findings," provided it is "reproducible, measurable or observable").

Moreover, the facts of the present case are more similar with Garcia. In this regard, in his March 27, 1996 chart note, Dr. Reynolds reported that claimant had tenderness over the lateral condyle of the elbow. (Ex. 1). Although Dr. Reynolds obviously considered claimant's report of tenderness valid, he did not indicate that it was the result of claimant's verifiable subjective response to clinical testing or that it was "reproducible, measurable or observable." In addition, in his follow-up exam on April 23, 1996, Dr. Reynolds no longer indicated that claimant had tenderness; instead, he reported that claimant "continues to note discomfort." (Ex. 4). Given the statutory changes in the law, Dr. Reynolds' indication of tenderness, without more, is not sufficient to establish "objective findings" under ORS 656.005(19). Jairo J. Garcia, 48 Van Natta at 237.

ORDER

The ALJ's order dated December 20, 1996 is affirmed.

August 7, 1997 Cite as 49 Van Natta 1260 (1997)

In the Matter of the Compensation of
CINDY L. KEEN, Claimant
WCB Case No. 96-02120
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Claimant requests reconsideration of our July 11, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding the insurer's denial of her aggravation/current condition claim for a low back condition. Asserting that our compensability analysis under ORS 656.005(7)(a)(B) is inconsistent with the approach set forth in SAIF v. Nehl, 148 Or App 101, on recon, 149 Or App 309 (1997), claimant seeks reconsideration.

In order to further consider this matter, we withdraw our July 11, 1997 order. The insurer is granted an opportunity to respond. To be considered, that response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGIA BARKLOW, Claimant
WCB Case No. 96-05710
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's low back injury claim, concluding that claimant had satisfied her burden of proof under ORS 656.005(7)(a)(B).[1] In reaching this conclusion, the ALJ relied on the medical opinion of claimant's attending neurologist, Dr. Curran, who opined that a December 16, 1995 low back injury was the major contributing cause of claimant's need for treatment of the combined condition (consisting of a December 1995 injury and preexisting facet joint arthritis).

On review, the employer contends that the ALJ failed to evaluate the medical evidence correctly and improperly set aside its denial. For the following reasons, we conclude that claimant did not satisfy her burden of proof under ORS 656.005(7)(a)(B).

We begin by briefly summarizing the factual background of the claim. On December 16, 1995, claimant allegedly wrenched her low back when she slipped on a wet floor. Claimant advised the employer of the injury on the day of the incident, but did not file a claim until March 15, 1996, after she advised the employer that she was terminating her employment.

Claimant first sought treatment from Dr. Snyder on March 18, 1996. Noting a "very, very hard spasm" of the left paraspinous muscle on the left, Dr. Snyder diagnosed low back pain. (Exs. 3, 6). Dr. Snyder eventually referred claimant to Dr. Curran, who first examined claimant on May 10, 1996. Dr. Curran reported that claimant had a lot of severe pain, but little in the way of MRI findings. (Ex. 9). However, Dr. Curran did interpret claimant's MRI scan as showing "fairly significant" arthritic changes in the facet joints, most pronounced at L3-4. Id.

The employer denied the claim on June 11, 1996, on the ground that claimant's low back condition did not arise out of and in the course of employment. (Ex. 17).[2] Claimant requested a hearing.

On August 23, 1996, Dr. Curran responded to an inquiry from claimant's attorney. Dr. Curran concluded that the December 1996 injury was the "cause" of claimant's current need for treatment. (Ex. 19-2). Dr. Curran reasoned that, since claimant was not having back problems prior to the injury, the injury was the source of the "pain problem." Id.

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[1] That statute provides:

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

[2] The denial was orally amended at hearing without objection to include lack of medical causation as a basis for the denial. (Tr. 4).

On September 6, 1996, Dr. Battalia conducted a records review for the employer. (Ex. 20). Dr. Battalia concluded that, while claimant probably had a strain at the time of the December 16, 1995 incident, the preexisting bony and degenerative disc disease were the major contributing factor in claimant's continued pain.

The claim is governed by ORS 656.005(7)(a)(B), because the medical evidence establishes that claimant's preexisting degenerative arthritis condition "combined" with the alleged December 16, 1995 incident to cause claimant's need for treatment. (Ex. 21-11). Therefore, to establish medical causation, claimant must prove that the December 16, 1995 incident was the major contributing cause of her disability and need for treatment of the "combined" condition. Ramona Andrews, 48 Van Natta 1652 (1996).[3]

Considering the presence of claimant's preexisting degenerative condition, the determination of the major cause of claimant's low back condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons to do otherwise.

As previously noted, Dr. Curran opined that the December 1995 injury was the "cause" of claimant's need for treatment since claimant was not having back problems before the work incident and developed them afterwards. In his deposition, Dr. Curran stated: "she told me her back was fine until she wrenched around at work and then had the problem, and that's what I based my opinion on." (Ex. 21-17). Later, when asked why he believed the December 16, 1995 injury was the major contributing cause of claimant's need for treatment, Dr. Curran explained: "This is a lady whose back was comfortable as far as I know, until she wrenched around at work. Then she developed the pain following that, and that is the information upon which I would base my opinion." (Ex. 21-19).

Based on our review of Dr. Curran's medical reports and deposition testimony, we conclude that Dr. Curran's causation opinion relies on a temporal relationship between claimant's symptoms and the alleged injury and does not sufficiently weigh the relative contributions from the preexisting degenerative condition and the alleged injury to claimant's low back condition. See Dietz v. Ramuda, 130 Or App 397 (1994) (the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"); see also James S. Modesitt, 48 Van Natta 2542 (1996); Alec E. Snyder, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).[4] Therefore, we find that it does not satisfy claimant's burden of proving medical causation.

Since Dr. Battalia opined that claimant's preexisting degenerative condition was the major contributing factor in her low back condition, it follows that claimant failed to sustain her burden of proof under ORS 656.005(7)(a)(B). Accordingly, we reverse the ALJ's order that had set aside the employer's denial.

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[3] The employer alleges the claim is not supported objective findings and that claimant's testimony is unreliable. Given our disposition of the claim, we need not address those contentions.

[4] In SAIF v. Nehl, 148 Or App 101 (1997), the court discussed the application of ORS 656.005(7)(a)(B). It stated that, "regardless of the extent of claimant's underlying condition, if the immediate cause of claimant's need for treatment is an on-the-job accident, the treatment is compensable." We concluded that the court's analysis in Nehl did not overturn the Dietz analysis regarding the determination of the major contributing cause. Gregory C. Noble, 49 Van Natta 764 (1997). Instead, we determined that Nehl held that a claimant is not required to prove that an injury is the major contributing cause of the combined condition; rather, he or she must prove that the work injury is the major contributing cause of the need for treatment of the combined condition. In making that compensability determination, we stated that the standard for proving major contributing cause as articulated in Dietz and its progeny remains unchanged. Nothing in the court's recent reconsideration of Nehl causes us to alter our analysis in Noble. See SAIF v. Nehl, 149 Or App 309, opinion adhered to as modified on reconsideration (1997) ("combined condition" is compensable under ORS 656.005(7)(a)(B) if a claimant's work injury, when weighed against a preexisting condition, is the major contributing cause of the claimant's need for treatment).

ORDER

The ALJ's order dated February 20, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the employer's denial is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

August 11, 1997 Cite as 49 Van Natta 1263 (1997)

In the Matter of the Compensation of
DWAYNE R. DeWOLF, Deceased, Claimant
WCB Case No. C701005
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Bock and Moller.

On April 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 beneficiaries of the deceased worker's estate) releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

On May 6, 1997, the Board wrote the parties requesting: (1) postcards announcing CDA approval, as required by OAR 438-009-0028(1); (2) a fully executed document with original signatures, as required by OAR 438-009-0025(1); (3) the correct provision at the conclusion of the document prescribed by the Board, rather than the Director, as required by OAR 438-009-0020(3); and (4) additional information regarding the deceased worker's beneficiaries.

On June 10, 1997, the Board reminded the parties that they had not responded to the Board's prior letter. Unless the prior deficiencies were corrected within 21 days, the parties were notified that the Board might disapprove the proposed CDA. See OAR 438-009-0020(4)(b).

To date, the parties have not submitted the requested addendum. Under the circumstances, we find that the proposed disposition is unreasonable as a matter of law. See OAR 438-009-0020(4)(b). Accordingly, we disapprove the agreement.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of any survivor benefits that were stayed by submission of the proposed disposition. See OAR 436-060-0150(4)(i) and (6)(e).

IT IS SO ORDERED.

In the Matter of the Compensation of
SAMUEL C. FIELDS, JR., Claimant
WCB Case No. 95-13300
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's claim for a low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a stacker in a wood products factory. In March 1994, claimant experienced an off-the-job injury while performing heavy lifting on his ranch. He reported low back pain that extended into his left leg. He was diagnosed with an acute low back strain that resulted in approximately one week off work.

Claimant again experienced a nonwork-related low back injury in January 1995. At that time, claimant reported right lumbar discomfort and pain radiating to the right buttock and down the right thigh. The incident resulted in time loss from work. Medication and home physical therapy were prescribed. Claimant was seen by Dr. Hearne following each of these incidents.[1]

Between June 10 and August 27, 1995, claimant made nine skydiving jumps. Also during the summer of 1995, claimant lifted and stacked approximately 40 bales of hay weighing a total of one ton.

On September 22, 1995, claimant had a particularly busy work shift. The following morning, claimant awoke with a sore back. He had no lower extremity symptoms at that time. He next reported for work on September 26 and told his supervisor about his sore back. He continued to work and did not seek medical treatment until October 9, at which time he was diagnosed with a herniated disc. Subsequent surgery revealed a large herniated disc at S1.

When claimant first sought medical treatment on October 9, 1995 he reported an acute exacerbation of his low back pain -- extending down his right leg -- during the preceding weekend while making several nonwork-related motor vehicle trips between Coquille and Roseburg. The pain became so intense during these trips that claimant was forced to lay down in the back of the pickup truck in which he was riding.

During the time period between the onset of his low back pain and his first medical visit on October 9, possibly during the period October 3 to October 6, claimant and his wife moved a washer and dryer as part of a change of residence.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's work exposure on September 22, 1995 was the major contributing cause of a combined low back condition requiring medical treatment for a herniated disc. The employer disagrees, arguing that claimant has failed to sustain his burden of proof by a preponderance of the persuasive medical evidence. Following our de novo review of the medical evidence, we agree with the employer.

The only medical evidence directly addressing causation is from Dr. Miller, neurosurgeon, who did not see claimant until November 14, 1995, approximately two months after the allegedly injurious work exposure and following claimant's surgery. (Ex. 15). For this reason, as well as the fact that the issue in this case requires expert medical analysis rather than benefiting from an extended period of observation, Dr. Miller's opinion is entitled to no special deference. See Weiland v. SAIF, 56 Or App 810 (1983).

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[1] In contradiction to Dr. Hearne's contemporaneous chart notes, claimant testified that he did not remember seeing Dr. Hearne in January 1995 and that he did not remember experiencing any right-sided pain prior to September 22, 1995. Claimant's unreliable memory regarding these prior events significantly diminishes the persuasiveness of the medical opinions that depend upon his accuracy as an historian.

Dr. Miller's first report acknowledged claimant's two prior episodes of low back pain in March 1994 and early 1995, characterizing them as "significant" and finding that claimant had "an underlying degenerative condition[.]" (Ex. 18-1). According to Dr. Miller, the "degenerative condition combined with an injury on September 22 to create his disk herniation and ultimately his need for surgery." In terms of causation, Dr. Miller opined that "[w]ithout his injury on September 22, he would not have required surgery. I therefore think the major contributing factor is the injury of September 22." (Id. at 2).

Significant problems exist with regard to Dr. Miller's history of the alleged "incident" that led to the onset of claimant's symptoms. As noted by the ALJ, Dr. Miller's initial opinion regarding causation relied, in part, on the history claimant provided to Dr. Serbu, consulting neurosurgeon. In this regard, Dr. Serbu noted a history of claimant "pulling a heavy sheet of veneer at which time he developed some acute low back pain. The next morning, his pain became markedly more severe." (Ex. 9-1). Dr. Miller's own history was that claimant "was doing some heavy work and pulled a heavy sheet of veneer. He felt a twinge in his back, but was not overly concerned. His pain really started the next morning." (Ex. 18-1).

By contrast, Dr. Hearne's understanding from claimant was that claimant experienced no specific incident on the day in question and that he noted no problems when he left work. (Ex. 5-2). Claimant similarly testified at hearing that he did not experience any particular incident at work. He subsequently explained his reported history that he "hurt himself on the 22nd" on the basis that "the only thing that's constant in the whole thing is the stacker. That is -- that was my job, and that's the only thing that could've done it."

During his deposition, Dr. Miller testified that his opinion relied on a history that claimant felt the onset of pain while pulling on a heavy sheet of veneer at work. (Ex. 20-9, 20-10). When presented with the history that claimant testified to at hearing, *i.e.*, no specific incident, Dr. Miller responded that "[i]t gets more complicated" and was "possible" that claimant sustained a work-related injury. (Id. at 12). Dr. Miller also stated that, "if nothing happened to [claimant] at work, then there would be no reason to suspect that this was a work-related injury and it ought to be something that was unrelated." (Id. at 24).

When questioned by claimant's attorney, Dr. Miller explained that, in the absence of an "obvious incident," claimant's condition was "more of an occupational thing." (Id. at 36). In attributing the degenerative condition to work activities, Dr. Miller pointed to claimant's "heavy labor" and specifically "the repetitive and abstained [sic] bending postures where you put a tremendous stress load on the disk[.]" (Id. at 41).

We find Dr. Miller's opinion to be unclear and internally inconsistent. At the end of the deposition, Dr. Miller continued to insist that claimant had experienced the onset of symptoms following a specific event at work. (Id. at 44-45). Dr. Miller also explained that he relied on a history that claimant's radicular symptoms began the day following the September 22 work activity. (Id. at 20-21). Both assumptions were contrary to claimant's testimony that he "felt fine" after working on September 22 and felt no lower extremity symptoms when he awoke with back pain. (Tr. 19-20). Consequently, Dr. Miller's opinion in this regard is unpersuasive because it is based on an inaccurate history. Furthermore, during the deposition, Dr. Miller continued to characterize the "work injury" as an initiating event, which is not sufficient to show that it was the major contributing cause of the need for treatment of a combined condition under Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995).

Any attempt to use Dr. Miller's opinion to prove a compensable occupational disease also fails. Dr. Miller indicated that he based claimant's history on notes from Dr. Serbu, who previously saw claimant, and a discussion with the employer's attorney. (Id. at 6-7). Dr. Serbu, however, recorded information concerning claimant's job activities on the day of the alleged injury. (Ex. 9-1). It appears that the employer's attorney provided no information about claimant's employment duties. (Ex. 41-B). According to claimant's testimony at hearing, during the two years he worked for the employer, he performed "pretty much every job at that mill except for out in the barker yard and the finish end," including jitney driver, which claimant stated required no repetitive motions. (Tr. 8-9).

Consequently, Dr. Miller also incorrectly understood claimant's employment conditions. Moreover, his opinion is expressed in conclusory terms without any adequate explanation. As such, his opinion also is not sufficiently persuasive to prove that work was the major contributing cause of -- or pathologically worsened -- the degenerative condition. ORS 656.802(2).

Therefore, we conclude that the medical evidence is insufficient to prove compensability. ORS 656.005(7)(a)(B), 656.802.

ORDER

The ALJ's order dated October 14, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
VANXAY KHONGSAVANH, Claimant
WCB Case No. 96-10712
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) assessed a penalty for an allegedly unreasonable denial. Contending that the insurer's appeal is frivolous, claimant seeks sanctions under ORS 656.390(1). On review, the issues are aggravation, penalties and sanctions.

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

On page 4, we delete the third paragraph and replace it with the following:

"ORS 656.273(8) provides that where a worker has received a permanent disability award, an aggravation is established if it is shown "that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." Claimant was not awarded any permanent disability. (Ex. 9). Nevertheless, even if we assume that waxing and waning of symptoms was contemplated, Dr. Verzosa's opinion establishes that claimant's worsened condition was more than waxing and waning of symptoms."

Sanctions

Claimant contends that the insurer's request for review is frivolous, in that the request for review was not supported by substantial evidence and/or this matter was initiated without a reasonable prospect of prevailing.[1]

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).

Here, we find that the insurer's challenges to claimant's aggravation claim involved questions of fact, which are colorable on the record. The insurer's arguments are 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). Under these circumstances, we are not persuaded that the insurer's request for review was frivolous. Accordingly, claimant's request for sanctions is denied.

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[1] We note that claimant raised this argument in a separate letter and did not raise the argument in the respondent's brief.

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

ORDER

The ALJ's order dated March 28, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
MONICA K. LOMAS, Claimant
WCB Case No. 95-13454
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of her occupational disease claim for a mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 2, at the end of the last paragraph, we add the following sentence: "In May 1994, claimant returned to work for the employer as a radiographer A." In the first sentence of the third paragraph on page 3, we change the date to "July 1995."

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of a mental disorder, claimant must prove that employment conditions were the major contributing cause of the mental disorder. ORS 656.802(2)(a). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment, or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

Claimant began working for the employer in September 1986 and has performed several different jobs. (Tr. I-83). She transferred to the x-ray department in November 1988, after taking an x-ray class for level one radiographers. (Tr. I-84). Claimant was involved in a special transfer program. (Id.) Her goal was to work as a film interpreter. (Tr. I-85). Claimant started as a dark room helper and eventually became a radiographer A, step five, in November 1991. (Tr. I-89). She had not progressed past radiographer A, step five. (Tr. I-88). In order to apply for the film interpreter position, she had to reach the position of radiographer A, step 6. (Id.)

Claimant testified that she received performance reviews every 6 months, until June 1992. (Tr. I-97). She did not receive a performance review in November 1992. (Tr. I-99).

In January 1993, claimant voluntarily accepted a layoff and went to work for another employer. (Tr. I-99, -100). In May 1994, she returned to work for the employer as a radiographer A. (Tr. I-100). Since she returned to work, she continually requested performance evaluations from her various supervisors. (Tr. I-99, -106). Claimant has not received a performance evaluation since she returned to work for the employer.

On July 5, 1995, claimant and her domestic partner, who also worked for the employer, requested permission to take September 5, 1995 as a vacation day. (Tr. I-120). The supervisor, Mr. Hartley, denied the vacation request, saying that either of them could have the day off, but not both of them. (Tr. I-121, -148). Claimant later asked her supervisor to reconsider, but her request was denied. (Tr. I-178).

Claimant's domestic partner was investigated by the employer for an alleged incident of physical abuse of claimant while at work. Her partner was suspended pending investigation on August 7, 1995. Claimant's last day of work was August 7, 1995. (Tr.1-181).

Claimant sought medical treatment for her stress symptoms from Dr. Miller on August 7, 1995. (Ex. 11-8). She was subsequently treated by Drs. Hadeed and Perkins.

In closing argument at hearing, the employer conceded that there was a diagnosis of a mental or emotional disorder that was generally recognized in the medical or psychological community. The ALJ found, among other things, that claimant had three primary stressors at work: she did not receive performance reviews, she did not receive the promotion she wanted and she was not allowed to have a day off with her domestic partner, who also worked for the employer. The ALJ determined that the employer's failure to provide claimant with performance evaluations was unreasonable. In addition, the ALJ found that the medical opinions that related claimant's condition to her work all depended to some degree on the employer's refusal to allow claimant and her partner to have the same day off. However, the ALJ found that the employer's actions regarding the "day-off" conflict were reasonable and the stress that resulted from that conflict could not be considered in the analysis of compensability. The ALJ concluded that, because the "day-off" conflict was an inextricable part of the theory of causation, her claim was not compensable.

Claimant argues that the ALJ erred by concluding that the "day-off" conflict was a significant factor in causing her mental disorder. Rather, claimant contends that the medical evidence and testimony shows that the employer's failure to provide performance evaluations was the primary cause of her stress.

Although we agree with the ALJ that claimant's mental disorder is not compensable, we reach our decision based on the following reasoning. We are not persuaded that the employment conditions which allegedly caused claimant's condition were conditions other than those "generally inherent in every working situation." See ORS 656.802(3)(b). Conditions "generally inherent in every working situation" are those common to all employment, not merely the specific occupation involved. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). We are authorized to determine what conditions are common to all employment on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

Claimant contends that the medical evidence and testimony shows that the employer's failure to review her performance was the primary cause of her stress and she argues that the failure to provide performance reviews is not generally inherent in any working situation. In her closing argument, claimant contended that her failure to obtain regular performance reviews led to her inability to advance, which was a genuine source of the frustration that led to her emotional condition.

Claimant's position before leaving work in August 1995 was Radiographer A, step five. The record is not clear as to whether claimant was to receive performance evaluations every six months or every year.[1] However, for purposes of our analysis, that factor is not critical. Claimant was evaluated in June 1992, but was not evaluated again before her January 1993 layoff. She returned to work for the employer in May 1994 and her last day was August 7, 1995. During that time period, she would have been entitled to either an annual review in May 1995 or six-month reviews in November 1994 and May 1995, depending on the required frequency of her evaluations. Claimant testified that her stress symptoms began in spring 1995. (Tr. I-166).

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[1] Claimant testified that she was to have a performance evaluation every six months. (Tr. I-97; II-229). Similarly, one of claimant's supervisors, Mr. Hartley, testified that reviews were to be every six months and upon request. (Tr. I-43). On the other hand, Mr. Scott, another one of claimant's supervisors, testified that, at step five, performance reviews were to be given every 12 months. (Tr. II-101). Mr. Damien, vice-president of human resources, testified that the policy was annual performance appraisals. (Tr. II-128, -164). However, Mr. Damien said it was possible that the employee handbook indicated that employees below step six should have performance reviews every six months. (Tr. II-170).

Mr. Damien explained that, when he became vice president of human resources in July 1995, only 16 percent of employees had been reviewed on a timely basis as a result of downsizing and changes in and loss of supervisors. (Tr. II-125, -158, -159). Mr. Damien was not surprised that claimant had not received a performance evaluation since June 1992. (Tr. II-128). He explained that previously the company had one supervisor for every 18 employees and now they had one supervisor for every 45 employees. (Tr. II-159). The company had made a tremendous effort in the past year to get their on-time performance reviews up to 100 percent, and they were now 93 percent on time. (Tr. II-128, -159).

Mr. Damien's testimony is supported by that of other witnesses. Ms. Laws, a coworker, had worked for the employer for almost nine years. Since November 1991, she had received one evaluation, although she noted that did not work for the employer from April 1993 to September 1994. (Tr. I-204). Ms. Green, a coworker, testified that she had a difficult time getting a raise because "it seemed like every time I walked in the door, we had a new boss, who had a new way." (Tr. II-24). Claimant testified that, on more than one occasion, she had asked for a review from her then-current supervisor, who would refer her to someone else or leave the company. Claimant said that, when she started working at the titanium plant in January 1995, her supervisor was Mr. Reid. (Tr. I-113). Although she spoke to him about a review, he left the business. (Id.) She then wrote to Mr. Standish, but he also left the company. (Tr. I-113, -116).

We conclude that claimant's performance evaluations were delayed due to downsizing and turnover among the supervisors. In Karen M. Colerick, 46 Van Natta 930 (1994), we held that the problems cited by the claimant, i.e., changes in procedures, turnover in personnel, understaffing, altered job descriptions and decreased patient care, constituted conditions generally encountered in every working situation. Similarly, in Gary W. Helzer, 47 Van Natta 143 (1995), we concluded that new management and administrative procedures are generally inherent in every working situation.

Here, in light of the testimony regarding the late performance evaluations for most of the employees, we are not persuaded that claimant was "singled out" in having a delayed performance review.[2] We conclude that claimant's delay in performance reviews, caused by downsizing and turnover of supervisors, was reasonable under the circumstances and was a condition generally inherent in every work situation. ORS 656.802(3)(b). Furthermore, we conclude that the employer's delayed performance reviews constituted an "employment decision attendant upon ordinary business or financial cycles." Id. Consequently, we conclude that claimant's delayed job performance evaluations may not be considered in the analysis of compensability of the claim.

As we mentioned earlier, claimant contended in closing argument that her failure to obtain regular performance reviews led to her inability to advance, which was a genuine source of frustration that led to her emotional condition. Claimant apparently assumes that she would have received a promotion or a raise if she received a performance evaluation. Claimant testified that she could still seek a promotion if she was on a resolution plan.[3] (Tr. I-164).

However, Mr. Damien, Mr. Scott (one of claimant's supervisors), Mr. Runyan (same), Ms. Laws (coworker) and Ms. Green (coworker) testified that employees on resolution plans were not eligible for salary increases or promotions. (Tr. I-199, II-29, -96, -97, -159-167, -184). Mr. Damien and Mr. Runyan both testified that an employee on a resolution plan could bid on a job, but would not be qualified for the position. (Tr. II-167, -185). Mr. Runyan said that he had never promoted anyone while on a resolution plan. (Tr. II-184). Mr. Damien testified that claimant's resolution plans would have retarded her ability to get promoted. (Tr. II-168). We conclude that, although claimant could "bid" for a promotion while she was on a resolution plan, she would not have been eligible for a promotion or a salary increase during the time she was on a resolution plan.

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[2] Since it is not clear whether claimant's performance reviews were due every six months or every year, we note that it is possible her evaluation was only two to three months late as of August 1995.

[3] Mr. Hartley testified that a "resolution plan" meant that there was something in the employee's performance that required improvement. (Tr. I-48). He said that claimant wanted to be evaluated so that she could be promoted. (Tr. I-50).

Claimant was on several "resolution plans" for attendance problems from May 1991 until her voluntary layoff in January 1993. (Exs. 4, 5, 7, 8). One of claimant's earlier supervisors, Mr. DeSousa, said that before her layoff, claimant was close to being terminated for attendance problems. (Tr. II-202). In addition, claimant was placed on a resolution plan in November 1992 for wasting time at work. (Ex. 9). Claimant returned to work for the employer in May 1994. A "resolution plan" dated May 5, 1995 indicated that claimant's attendance did not meet the attendance guidelines. (Ex. 12). She was allowed three to six months for improvement. (Id.) Claimant testified that her stress symptoms began in spring 1995. (Tr. I-166). Thus, at the time claimant's stress symptoms occurred, she was not eligible for a promotion or raise.

An individual's inability to obtain a desired job is not, in and of itself, an "employment condition" within the meaning of ORS 656.802. Mary A. Murphy, 45 Van Natta 2238, 2240 (1993). Here, claimant asserts that her failure to obtain performance reviews led to her inability to advance, which in turn led to her emotional condition. Claimant did not identify the resolution plans as a source of stress. Because claimant was not eligible for a promotion at the time her stress symptoms occurred due to being on a resolution plan, we are not persuaded that the gap in performance evaluations was the cause of her failure to obtain a promotion or a raise during that time. Furthermore, although we agree that the failure to receive a raise or a promotion may be stressful, we are not persuaded that the employer's policy that employees on resolution plans were not eligible for a promotion was unreasonable.

We conclude that, although claimant's failure to receive performance evaluations and/or promotions or raises may have contributed to her stress, those conditions are generally inherent in every working situation. Therefore, we may not consider those factors in evaluating the compensability of claimant's psychological condition.

Furthermore, we agree with the ALJ that the employer's actions regarding claimant's "day-off" conflict were reasonable. Claimant testified that one cause of her stress was not being able to take a vacation day off that she requested in July 1995. (Tr. I-131, -132). On July 5, 1995, claimant and her domestic partner, who also worked for the employer, requested permission to take a day off in September 1995. (Tr. I-120). The supervisor denied the vacation request, saying that either of them could have the day off, but not both of them. (Tr. I-61, -121, -148). Mr. Hartley, claimant's supervisor, testified that he could only give one or the other the day off because of limited resources that would be available for the job. (Tr. I-59). At hearing, claimant agreed that vacations there were not planned at the beginning of the year were allowed on a first-come, first-serve basis. (Tr. I-148). She also agreed that her supervisor had the discretion to schedule a vacation day based on work needs. (Id.) Under these circumstances, we are not persuaded that the employer's refusal to grant both employees the same day off was unreasonable. The conflict regarding vacation time was a condition generally inherent in every working situation. Consequently, any contribution to claimant's mental disorder resulting from the "day-off" incident may not be considered in determining compensability.

Claimant also testified that her stress was caused by supervisor harassment and differential treatment. (Tr. I-131, -132). Claimant asserted that, among other things, her supervisor, Mr. Hartley, followed her and watched her and she was denied break privileges allowed to other employees.

On this record, we are not persuaded that claimant was harassed by her supervisors and received differential treatment.[4] Nevertheless, even if we assume that she was harassed by her supervisors and received differential treatment, none of the medical opinions establish that those particular factors were the major contributing cause of claimant's emotional disorder. See Robert A. Jarvill, 47 Van Natta 221 (1995) (the medical evidence did not sufficiently identify the purportedly unreasonable conduct, or factor out those actions in the process of ascertaining the cause of the claimant's psychological condition). Rather, the medical opinions on causation referred to claimant's "employment conditions" generally.

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[4] Our order is not intended to suggest whether or not any "harassment" claimant received would satisfy the requirements for a separate legal cause of action against the employer or any of its employees. Our review is confined solely to the issue of whether claimant's mental disorder claim satisfies the statutory requirement of the workers' compensation law.

Dr. Hadeed treated claimant on three occasions. In a report on causation, Dr. Hadeed reported that he had not taken an extensive history from claimant and his opinion was based on limited information. (Ex. 27-1). He concluded that claimant's "employment conditions" were the major contributing factors in her mental condition and disorder. (Ex. 27-2). In a deposition, Dr. Hadeed testified that claimant's work stressors included harassment, not having a review and pay raises, problems with her supervisors and the termination of her fiance/domestic partner. (Ex. 29-9). Dr. Hadeed agreed that claimant's condition was "related to her work," although he indicated he would reach a different conclusion based on the employer's hypothetical.[5] (Exs. 29-21, -33). We are not persuaded by Dr. Hadeed's opinion since it was based on limited information of claimant's work history. Moreover, since Dr. Hadeed attributed claimant's condition to "work" and "employment conditions" generally, his opinion does not establish that supervisor harassment and differential treatment were the major contributing cause of claimant's emotional disorder.

Claimant was also treated on three occasions by Dr. Perkins. Dr. Perkins reported that claimant's diagnosis related to "employment upset." (Ex. 26-2). In a deposition, Dr. Perkins testified that she did not take claimant's history as part of the first session and the history was taken from "various comments" that claimant made. (Ex. 30-7, -8). Dr. Perkins "was able to get a bit of the history of what happened at work but it's in fragments." (Ex. 30-8). Although Dr. Perkins concluded that claimant's "work" was the major contributing cause of her condition, she did not have an opportunity to inquire about non-work stressors. (Ex. 30-18, 19). Dr. Perkins felt that claimant's underlying personality traits were another cause of her condition. (Ex. 30-14). We are not persuaded by Dr. Perkins' opinion because her understanding of claimant's work history was inadequate. Moreover, she did not describe what work conditions caused claimant's condition and she did not consider claimant's non-work stressors. Dr. Perkins' opinion is not sufficient to establish compensability.

Dr. Turco examined claimant on behalf of the employer. Dr. Turco testified that claimant's stress was caused by work-related concerns about not being reviewed, being harassed, not being treated properly and not being promoted on time. (Ex. 26A-13, -14). He felt that those factors were the major contributing cause of claimant's condition. (Ex. 26A-14). He testified, however, that his conclusion was based exclusively on claimant's history, and he would reach a different conclusion based on the employer's hypothetical. (Ex. 26-18, -20). Dr. Turco subsequently reviewed claimant's personnel records and additional medical records. Dr. Turco did not find any justification for claimant's complaints that she underwent prejudicial behavior or was "singled out." (Ex. 28-2). Dr. Turco believed that claimant was treated as any employee would be with regard to reasonable supervision. (Id.) Dr. Turco's opinion does not support the compensability of claimant's condition. Since none of the medical opinions are adequate to support compensability, we conclude that claimant has failed to establish the compensabiity of her mental disorder claim.

ORDER

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

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[5] The employer's attorney asked Dr. Hadeed to assume, among other things, that after moving to the titanium plant, claimant's performance became poor to very poor and was characterized by tardiness and absence; claimant was not regularly evaluated during the last four years she worked for the employer because she was on probation five times and the company does not evaluate or promote people on probation; the relationship between claimant and her fiance was disruptive to workers; and the vacation dispute was a matter of a late request or low seniority. (Exs. 29-20, -21).

In the Matter of the Compensation of
RICHARD C. PURDY, Claimant
WCB Case No. 96-04364
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of his current low back 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 49 at the time of hearing, worked as a maintenance engineer for a medical clinic. On October 21, 1995, while helping another person lift an x-ray machine, he felt a "pop" in his low back and the acute onset of pain radiating down both legs. Claimant sought treatment on October 23, 1995, and was diagnosed with a lumbosacral strain and preexisting degenerative disc disease at L4-5 and L5-S1. The insurer accepted claimant's lumbar strain condition on January 31, 1996, but later issued a denial contending that claimant's accepted strain was no longer the major cause of his current need for treatment and disability.

Claimant began treating with Dr. Warburton, who opined that claimant had suffered an acute lumbar strain superimposed on lumbar spondylosis. In February 1996, claimant was examined by Dr. Scheinberg at the insurer's request. Dr. Scheinberg opined that claimant's strain was likely to have resolved within eight weeks and that after that time, claimant's symptoms were primarily related to his preexisting, underlying degenerative disc disease rather than the compensable strain injury. (Ex. 14). Dr. Warburton did not concur.

In April 1996, claimant began treating with Dr. Davis, who opined that claimant's preexisting condition was, at most, a minor contributing factor in his disability and need for treatment. In the fall of 1996, claimant saw Dr. Bert, a physician in the same group as Dr. Davis. Dr. Bert also offered a report on claimant's behalf.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Scheinberg and rejecting the opinions of Drs. Warburton, Davis and Bert, the ALJ concluded that claimant's current (combined) condition was not compensable. The ALJ found that the opinions of Drs. Warburton, Davis and Bert demonstrated that claimant's work injury precipitated his current disability and need for treatment, but did not persuasively establish that the work injury was the major contributing cause of his combined condition or need for treatment of the combined condition under ORS 656.005(7)(a)(B).

On review, claimant asserts that the opinions of claimant's treating doctors, Drs. Warburton, Davis and Bert should not have been rejected. We agree.

Claimant has the burden of proving that his current low back condition is compensable by the preponderance of the medical evidence. ORS 656.266. To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributes more to his current low back condition and need for treatment than all other factors combined. See, e.g. McGarrah v. SAIF, 296 Or 145, 146 (1983). The persuasive medical opinion must evaluate the relative contribution of different causes and explain why the work injury contributes more to the claimed condition than all other causes or exposures combined. See Dietz v. Ramuda, 130 Or App 397 (1994).

Drs. Warburton, Davis and Bert all opined that claimant's work injury combined with his preexisting low back condition to cause or prolong his disability. Drs. Davis and Bert specifically determined that claimant's work injury remained the major cause of his combined condition and need for treatment of that condition as of August and October 1996, respectively. We note that both Dr.

Davis and Dr. Bert had an accurate understanding of claimant's preexisting asymptomatic degenerative conditions as well as the mechanism of his work-related injury. Both doctors explained that although claimant had degenerative changes prior to his work-related injury, the work injury was the primary reason for his ongoing low back symptoms. (Exs. 28, 29, 31).

On this record, we find that Drs. Davis and Bert evaluated the relative contribution of the different causes for claimant's current disability in identifying the work injury as the major contributing cause. We further find that their opinions are sufficient to sustain claimant's burden under ORS 656.005(7)(a)(B). Contrary to the insurer's contention, Dr. Davis' and Dr. Bert's opinions are not based solely on the temporal relationship between claimant's work injury and the onset of symptoms, but upon claimant's medical history, their clinical examinations of claimant and their expertise regarding the mechanism of claimant's combined condition. See Bronco Cleaners v. Velazquez, 141 Or App 295 (1996) (evidence of causation that goes beyond a chronological connection is legally sufficient to sustain claimant's burden under ORS 656.266).

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

ORDER

The ALJ's order dated January 29, 1997 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for further processing according to law. For services at hearing and on review, claimant's counsel is awarded $4,000, payable by the insurer.

Board Member Haynes dissenting.

At issue in this case is whether claimant's current low back condition results primarily from his October 21, 1995 accepted lumbosacral strain or from his underlying degenerative arthritis and degenerative disc disease at L4-5 and L5-S1. Because I believe that claimant has failed to prove that his accepted strain remains the major cause of his current disability and need for treatment, I respectfully dissent.

The majority relies on the causation opinions of Drs. Davis and Bert. I find their opinions too conclusory to be persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). As the majority notes, the determination of major contributing cause involves evaluating the relative contribution of different causes of the condition and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397 (1994). Although Drs. Davis and Bert relate claimant's continued symptoms to his work injury, I see no evidence that these physicians actually weighed the relative contribution of claimant's underlying degenerative condition against his on-the-job injury. Both doctors pointed out that claimant was asymptomatic before the injury and remained symptomatic thereafter, but neither explained how or why the injury was the major cause of claimant's continuing symptoms and current condition. Like the ALJ, I believe that these opinions establish only that claimant's work injury precipitated his current disability and need for treatment, which is insufficient under the Dietz standard.

Furthermore, neither Dr. Davis nor Dr. Bert address Dr. Scheinberg's determination that claimant's musculoligamentous strain should have resolved within eight weeks and therefore any continuing problems would be related to claimant's preexisting degenerative conditions.[1] Dr. Scheinberg saw claimant four months after his injury, and opined that, based on the history provided, claimant's strain should have resolved by that time. Although Dr. Scheinberg only examined claimant on one occasion, it is evident that his report is based on a complete and accurate history of claimant's low back problems. It is also apparent that Dr. Scheinberg evaluated the relative contributions of claimant's preexisting conditions versus the compensable injury in concluding that claimant's preexisting conditions were the major cause of his current condition.

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[1] Dr. Williams, the first physician to treat claimant's low back pain in October 1995, concurred with Dr. Scheinberg's report.

Considering the divided evidence and the lack of any well-reasoned opinion explaining why claimant's injury contributed more to his ongoing disability than his preexisting degenerative conditions, I would conclude that claimant has not sustained his burden of proof under ORS 656.005(7)(a)(B) and 656.266.

In the Matter of the Compensation of
FINIS O. ADAMS, Claimant
Own Motion No. 97-0181M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys
Liberty Northwest, Insurance Carrier

Contending that the insurer's attempt to recover a 1986 alleged "overpayment" of temporary disability compensation from claimant's current temporary disability award is "unlawful," claimant requests that the Board determine whether the insurer is entitled to that recovery. The insurer requests that the Board allow the deduction of 25 percent of each of claimant's temporary disability payments under ORS 656.268(15)(a) so that "the overpayment or at least part of the overpayment may be recovered."

FINDINGS OF FACT

On February 12, 1975, claimant sustained a disc herniation injury at the L3-S1 levels of his low back. Claimant's aggravation rights expired on August 25, 1983.

On August 7, 1985, the Board reopened claimant's claim under our Own Motion jurisdiction for the payment of temporary disability compensation. On January 28, 1987, the Board issued an Own Motion Determination Order, which granted claimant temporary disability compensation from July 9, 1985 through May 1, 1986 and from October 10, 1986 through November 3, 1986, less time worked. Our order indicated that the deduction of overpaid temporary disability, if any, from unpaid permanent disability was approved.

The insurer's February 3, 1987 file audit of claimant's claim determined that, although the insurer paid claimant time loss benefits as granted in the Board's January 28, 1987 order, it also paid temporary disability compensation from May 2, 1986 through October 9, 1986 and from November 4 - 13, 1986. The audit also reflected that claimant was self-employed during that time. Based on that audit, the insurer calculated that claimant received an overpayment of $6,646.21.

On May 7, 1997, we issued an Own Motion Order reopening the claim and authorizing temporary disability compensation beginning with claimant's hospitalization for low back surgery. Following issuance of our order, the insurer notified claimant that it was withholding 25 percent of his temporary disability award to recover some of its prior overpayment.

In response to the insurer's announcement, claimant petitioned the Board for a ruling. Claimant asserted that the insurer's attempt to recover a "decade old" overpayment (if one existed) was unlawful.

Thereafter, the Board acknowledged claimant's petition and implemented a briefing schedule. In response to the Board's announcement, the insurer submitted claims information documenting the periods it paid temporary disability, which included periods that did not coincide with the periods awarded in the Board's 1987 order. Relying on "the most recent law changes," the insurer contended that it was entitled to recover its overpayment against claimant's current temporary disability payments (25 percent of each installment). Claimant did not reply to the insurer's response and submission.

CONCLUSIONS OF LAW AND OPINION

The 1995 Oregon Legislature amended ORS 656.268 to add ORS 656.268(15)(a). That statute provides that:

> "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."

In a May 20, 1997 letter, the insurer notified claimant of its discovery of its alleged outstanding overpayment. The insurer further notified claimant that it had reduced claimant's current benefits by 25 percent, and would continue to do so in order to recover the amount claimant owed. Claimant requests that the Board disallow the recovery of the overpayment, contending that an overpayment which is "more than a decade old, if it indeed exists, is unlawful, both procedurally and substantively."[1]

In our January 28, 1987 determination order, we approved an offset of any overpaid temporary disability compensation. Although our order indicates that the offset is to be made against any future permanent disability award, as of January 1, 1988, claimant was no longer entitled to an increased permanent disability award. See Independent Paper Stock v. Wincer, 100 Or App 625 (1990). Consequently, as a practical matter, the only disability benefits from which an "overpayment" could be withheld would be temporary disability benefits as awarded by the Board under ORS 656.278.

Amended ORS 656.268(15)(a) provides that recovery of an overpayment must be from "a claim with the same insurer or self-insured employer" and that it may be withheld from "any compensation payable to the worker." The statute neither prohibits an insurer from recovery of an overpayment which existed prior to the 1995 amendments, nor does it set a time frame within which the recovery may take place. Because ORS 656.268(15)(a) specifically and unqualifiedly designates temporary disability as a benefit from which an overpayment may be withheld, we find no statutory prohibition that would preclude a carrier from recovering an overpayment from the temporary disability granted by a Board's Own Motion order under ORS 656.278.

We turn to the question of whether the insurer has established the existence of an overpayment. The insurer has documented its "overpayment" through an audit of claimant's claim on February 3, 1987, and has submitted those documents to the Board for consideration. Those documents reflect that the Board's Own Motion Determination Order approved TTD for the periods of July 9, 1985 through May 1, 1986, and from October 10, 1986 through November 3, 1986, less time worked (the insurer's audit document indicates that claimant worked October 20 - 23, 1986). The insurer's unrebutted submission further indicates that it paid temporary disability benefits for the period of May 2, 1986 through October 9, 1986 and from November 4 - 13, 1986. Our order did not approve an award for those periods. Therefore, we conclude from the unrebutted evidence, that the insurer made an "overpayment" of TTD to claimant for the periods of May 2, 1986 through October 9, 1986 and from November 4 - 13, 1986.

Finally, we conclude that the carrier's failure to apply its overpayment in subsequent claim reopenings or to seek further Board authorization to do so, does not preclude it from applying the overpayment at this time. ORS 656.268(15) permits offsets without Board authority. See also OAR 436-060-0170; Harris v. Ireland Trucking, 115 Or App 692 (1992) (the failure by a carrier to previously assert an overpayment did not preclude the carrier from later asserting an offset pursuant to former OAR 436-60-170). In addition, the record supports the overpayment in this claim. The insurer has submitted records to substantiate its claim that it paid TTD for those periods when the Board did not approve TTD; claimant does not rebut the insurer's submission, except to assert that any overpayment which might exist is "unlawful." Yet, claimant cites no authority for this assertion, nor does he submit any evidence which would rebut the existence of this overpayment (including its amount and dimension).

Consequently, we are persuaded that an overpayment in the amount of $6,646.21 was made to claimant in 1986, and that the insurer is not precluded from recovering its overpayment from claimant's current temporary disability benefits. Accordingly, the insurer is entitled to offset 25 percent of claimant's current and future temporary disability awards paid on this claim until such time as it has recovered its $6,646.21 overpayment.

IT IS SO ORDERED.

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[1] A claimant's procedural entitlement to temporary disability benefits is for all periods during an open claim. OAR 436-030-0036(2). Claimant's claim is currently in reopened status. Therefore, claimant's current entitlement to procedural temporary disability compensation beginning May 7, 1997 would be affected by the insurer's overpayment recovery request.

In the Matter of the Compensation of
JODY CROMPTON, Claimant
Own Motion No. 95-0287M
OWN MOTION ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

The self-insured employer requested reconsideration of our June 18, 1997 Own Motion Order, in which we directed it to pay temporary disability compensation pursuant to our June 12, 1996 order reopening claimant's claim for the payment of temporary disability compensation. Our June 18, 1997 order further assessed a 25 percent penalty under ORS 656.262(11)(a) of the amounts "then due" claimant beginning the date she underwent surgery, payable in equal shares to claimant and her attorney. Contending that claimant's alleged "double recovery" of sick leave and temporary disability compensation should not be allowed, the employer moves the Board to reconsider its decision to enforce our June 12, 1996 order.

On July 15, 1997, we issued an Own Motion Order of Abatement, in which we requested that claimant respond to the employer's motion within 14 days of the date of that order. Claimant's response has been received. On reconsideration, we continue to find that our jurisdiction encompasses our authority to award temporary disability compensation under ORS 656.278 as well as our authority to enforce our orders. See Lee R. Parker, 48 Van Natta 2473 (1996); Larry P. Karr, 48 Van Natta 2183 (1996); Thomas L. Abel, 45 Van Natta 1768 (1993); David L. Waasdorp, 38 Van Natta 81 (1986). In this regard, we issued our Own Motion Order reopening this claim for the payment of temporary disability compensation on June 12, 1996. The employer did not comply with our order, nor did it timely request reconsideration of our June 12, 1996 order.

The employer submits no new evidence with its motion to support its position that claimant is not entitled to temporary disability in this claim. It argues, however, that the Board's reliance on Garry W. Rodgers, 43 Van Natta 1233 (1991), "is contrary to the impartial and balanced manner envisioned by the Legislature." We conclude that the employer's "double recovery" argument was adequately addressed in our initial Own Motion Order. In other words, if the employer had concerns regarding the temporary disability award granted by our June 12, 1996 order, it should have sought reconsideration of our decision rather than unilaterally failing to comply with the express directive made in our order. We continue to find refusal to abide by our unappealed temporary disability award to have been unreasonable.[1] Thus, we find no reason to reach a different conclusion than what is contained in our prior order.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 18, 1997 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We would reach this conclusion whether a carrier was an insurer or self-insured employer. Regardless of the carrier's status, it is obligated to comply with a final, unappealed Board order that awards compensation to a worker.

In the Matter of the Compensation of
JAN M. EDDINGS, Claimant
WCB Case Nos. 96-08293 & 96-07753
ORDER ON REVIEW
Foss, Whitty, 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) Mongrain's order that upheld the SAIF Corporation's denials of claimant's right carpal tunnel syndrome. On review, the issue is compensability.

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

As a preliminary matter, we note that the ALJ's order states that Exhibits 1 through 22 were admitted into the record. However, upon review of the transcript, it is evident that Exhibits 1 through 25 were admitted into the record. (Tr. 2). Accordingly, the ALJ's order is corrected to reflect that Exhibits 1 through 25 and Exhibit A were admitted into evidence.

With the exception of Exhibit 24, Dr. Whitney's opinions regarding the cause of claimant's right carpal tunnel syndrome are somewhat conclusory. In Exhibit 24, Dr. Whitney explained his opinion that claimant's work activities were the major contributing cause of a worsening of claimant's preexisting right carpal tunnel syndrome. He explained: "This patient had symptoms with carpal tunnel difficulty in her previous employment. She had a period where she was asymptomatic while she was off work. She then began working at the job in the bar and said that immediately upon starting this, she started to get symptomatology. This would be very indicative that work activity, no matter what it is, puts her over the top. Certainly, she probably has some predisposition to the carpal tunnel syndrome, however, work clearly seems to be the triggering factory [sic], especially repetitive work."

After reviewing the totality of Dr. Whitney's opinions, we agree with the ALJ's assessment that Dr. Whitney's opinion that claimant's work was the "triggering factor" that "puts her over the top" suggests that claimant's work activities were a precipitating factor to claimant's right carpal tunnel symptoms. We further agree with the ALJ that while Dr. Whitney noted that claimant had preexisting symptoms of carpal tunnel syndrome, he failed to analyze the contribution from claimant's preexisting carpal tunnel syndrome. Based on this record, we are not persuaded that Dr. Whitney weighed the relative contributions from the preexisting condition and the work activities to determine which was the primary cause. See Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995) (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). Lacking such a weighing of the different causes of claimant's right carpal tunnel syndrome, we agree with the ALJ that Dr. Whitney's opinion is insufficient to establish compensability under the standard set out in Dietz. Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated February 27, 1997 is affirmed.

In the Matter of the Compensation of
CRAIG A. FRAUSTO, Claimant
WCB Case No. 96-09474
ORDER ON REVIEW
Thomas J Dzieman, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration that awarded 5 percent (7.5 degrees) scheduled permanent disability bilaterally for a bilateral wrist condition. On review, the issue is extent of scheduled permanent disability.

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

On review, claimant argues that his claim should be rated under former OAR 436-035-0110,[1] "Other upper extremity findings," rather than "loss of strength" based upon the 5/5 testing provided in former OAR 436-035-0007(18).[2] Claimant contends that, pursuant to this rule, the Physical Capacities Evaluation (PCE) supports an additional award of 11 percent impairment for each wrist for the nerve involvement. We disagree.

The Director's rules provide that when a medical arbiter is used on reconsideration, impairment is established by the medical arbiter, unless a preponderance of medical opinion establishes a different level of impairment. Former OAR 436-035-0007(13). Impairment findings made by a consulting physician or other medical providers may be used only if the attending physician concurs with those findings. Former OAR 436-035-0007(12). Otherwise, only the attending physician at the time of claim closure may make impairment findings. ORS 656.245(2)(b)(B).

The Director's rules further provide that methods used by the examiner for making impairment findings shall be the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., Rev. 1990). Former OAR 436-035-0007(6).

As the ALJ found, claimant's attending physician, Dr. Webb, did not concur with the PCE. Therefore, the PCE may not be used in determining impairment. ORS 656.245(2)(b)(B); former OAR 436-035-0007(12). In addition, as the ALJ found, the PCE did not comply with the rules requiring use of the 0 to 5 international grading system and the 0 to 5 method in the AMA Guides. Former OAR 436-035-0007(18). Moreover, both the medical arbiter and Dr. Webb indicated claimant's muscle strength is 5/5. (Exs. 10-2, 22-3). Claimant's reliance on former OAR 436-035-0110(8) is not well taken, since that rule incorporates the 0 to 5 grading system under former OAR 436-035-0007(18).

ORDER

The ALJ's order dated February 12, 1997 is affirmed.

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[1] Claimant's claim was closed by Notice of Closure on May 16, 1996. Therefore, the applicable standards for rating claimant's disability are set forth in WCD Admin. Order 96-051. OAR 436-035-0003(2). Former OAR 436-035-0110(8) provides, in part, that "[l]oss of strength in the arm, forearm or hand due to a peripheral nerve injury is rated based upon the specific peripheral nerve, which supplies (innervates) the weakened muscle(s), * * * as modified pursuant to [former] OAR 436-035-0007(18)."

[2] Former OAR 436-035-0007(18) provides, in part, that "[t]o determine impairment due to loss of strength, the 0 to 5 international grading system and 0 to 5 method as noted in the AMA Guides to the Evaluation of Permanent Impairment, 3rd. Ed. Revised, 1990 shall be used."

In the Matter of the Compensation of
ROY D. HODGKIN, Claimant
WCB Case Nos. 96-07532 & 96-04123
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation, on behalf of Roy's Preferred Painting (Roy's), requests review of those portions of Administrative Law Judge (ALJ) Schultz' order that: (1) set aside its denial of claimant's occupational disease claim for lead poisoning and toxic encephalopathy; (2) upheld its denial, on behalf of Roko Associates, Inc. (Roko), of claimant's current condition; and (3) assessed a "penalty-related" attorney fee for its allegedly untimely denial. On review, the issues are responsibility and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

Claimant first sought treatment for symptoms of lead poisoning in March 1985.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a painter since 1954. Over the years, claimant worked with oil-based paint, latex, epoxy, hot synthetic enamel, and lacquer. Since 1972, about 60 percent of claimant's work time involved paint preparation, using grinders outside and palm sanders inside. He usually wore a respirator for this work. Otherwise, claimant's work since 1972 involved paint application without protection.

Claimant worked for Roko, with workers' compensation coverage provided by SAIF, between April 1, 1978 and April 1, 1985. Thereafter, claimant was self-employed for several years. By August 26, 1994, claimant worked for Roy's and SAIF again provided coverage.

Claimant's first serious medical problems surfaced in 1984, when he awoke with vertigo and episodic vomiting. An inner ear infection was diagnosed and treated. He was evaluated by a number of physicians, including a hematologist who discovered a high level of lead in claimant's blood.

In 1985, claimant was admitted to a hospital for chelation treatment.

Claimant filed occupational disease claims with SAIF, based on exposure to lead during his employment with Roy's and Roko. SAIF denied the claims on behalf of both employers.

Threshold issues: Subjectivity and Timeliness

A threshold issue in this case is whether claimant, a corporate officer of Roko's, was a covered subject worker when his claim with Roko arose.[1] See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614 (1994).

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[1] We note that Roy's (not Roko) initially denied the claim on the basis that claimant had not elected personal coverage when he first sought treatment for lead poisoning. (Ex. 61). The ALJ did not address whether claimant was a covered subject worker for Roy's or Roko. We determine herein that claimant was a subject worker when employed at Roko. We need not determine whether claimant was a subject worker at Roy's, because, even if he was, responsibility does not shift from Roko to Roy's, as explained infra.

In March 1985, when claimant first sought treatment for lead poisoning, former ORS 656.027(8) provided that corporate officers with substantial ownership in the corporation were not subject workers, absent written election of coverage pursuant to ORS 656.039.[2] Until at least April 30, 1985, when Roko renewed its workers' compensation coverage with SAIF, Hiroko Minami owned 100 percent of the Roko corporation. (See Ex. H, see also Ex. C-A). See ORS 656.419(3). Thus, although claimant was Secretary of the corporation when the claim for lead poisoning arose, he was not a substantial owner. Under such circumstances, former ORS 656.027(8) did not exclude him from workers' compensation coverage. Accordingly, we conclude that claimant was Roko's subject worker for purposes of this claim.

A second threshold issue[3] in this case is whether claimant's occupational disease claim with Roko was timely filed. The ALJ found that claimant's claim with Roko was untimely because it was filed over a year after claimant knew he had lead poisoning. See ORS 656.807(1). We disagree.

Occupational disease claims are void if they are filed more than a year from the date that the worker first discovered, or in the exercise of reasonable care should have discovered, the disease. Id. However, under applicable law,[4] Roko must prove that it was prejudiced by failure to receive timely notice of the claim, in order to establish a late filing defense. See Joanne C. Rockwell, 44 Van Natta 2290, 2292 (1992). Because there is no showing of prejudice by Roko in this case, we conclude that the claim is not time-barred.[5]

Responsibility

We apply the last injurious exposure rule (LIER) to determine responsibility in this case.[6] The rule provides that, where a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984), rev den 299 Or 203 (1985). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

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[2] Former ORS 656.027 provided that all workers were subject to ORS Chapter 656, with enumerated exceptions, including: "A corporate officer who is also a director of the corporation and has a substantial ownership in the corporation, regardless of the nature of the work performed by such officer."

[3] The parties do not raise this issue on review. However, because the issue was litigated at hearing and addressed by the ALJ, it is within the proper scope of our review under ORS 656.295(5)&(6). See Destael v. Nicolai Co., 80 Or App 596, 600-601 (1986) (The scope of the Board's de novo review encompasses all issues considered by the ALJ; it is not limited to issues specifically raised on review); Joseph M. Doolittle, 41 Van Natta 211 (1989) (same). Moreover, because our "first task is to determine which provisions of the Workers' Compensation Law are applicable," and provisions other than those applied by the ALJ compel a different result, we conclude that the timeliness issue must be addressed. See Daniel S. Field, 47 Van Natta 1457, 1458 (1995) (quoting Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Sheridan v. Johnson Creek Market, 149 Or App 44 (1997) ("Arguments not raised in an administrative forum will not be considered on judicial review unless they concern errors apparent on the face of the record.").

[4] The claim is controlled by the time limitation in effect when the claim was filed. See SAIF v. Scott, 111 Or App 99, 104 (1992); Melvin L. Gordon, 48 Van Natta 1275 (1996). As of the June 7, 1995 amendments to ORS Chapter 656, the prejudice requirement was eliminated. However, this change applies only to injuries occurring on or after June 7, 1995. 48 Van Natta at 1275.

In this case, the record does not reveal exactly when claimant filed his claim with Roko. However, there is no indication that the claim was filed before June 7, 1995. (See Ex. 66). Accordingly, because claimant's "injury" occurred by 1985, the former law applies and the claim is not time-barred absent a showing of prejudice due to late filing. 48 Van Natta at 1276; see Robinson v. State Acc. Ins. Fund Corp., 69 Or App 534, 539 n. 3 (1984) (Where no specific prejudicial event was shown, there was no need to decide when the statutory time period commenced running).

[5] We need not determine whether claimant's claim with Roy's was timely filed because, even if it was, responsibility does not shift from Roko to Roy's, as explained herein.

[6] Where there is no accepted claim, ORS 656.308 does not apply. SAIF v. Yokum, 132 Or App 18, 23 (1994).

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

On this record, we find that claimant first sought treatment for symptoms of lead poisoning in March 1985, while employed at Roko and covered by SAIF. (See Ex. E; see also Exs. F, G, 60-2-4). Consequently, presumptive responsibility is assigned with Roko under LIER.

In order to shift responsibility to Roy's, the later employer, Roko must show that the latter employment actually contributed to a worsening of the condition. See Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992).

There is evidence of continued work exposure to lead during the years after claimant's Roko employment. However, there is also evidence indicating that claimant's lead poisoning condition did not actually worsen once established. In fact, despite the immediate "dose/response" relationships suspected, neither exposure nor variations in blood lead concentrations likely correlated with a worsening of claimant's pathology. (Tr. 58-67, 101-105; see Exs. 64-14, 67). Under these circumstances, we cannot say that claimant's "post-Roko" work exposure actually contributed to a worsening of his lead poisoning. Accordingly, we conclude that responsibility does not shift from Roko to Roy's. See Lott, 115 Or App at 74. Finally, because Roko has not established that it was impossible for its workplace conditions to have caused claimant's disease or that the disease was caused solely by prior employment conditions, we further conclude that Roko remains responsible for claimant's condition. See FMC Corporation v. Mutual Ins. Co., 70 Or App 370 (1984).

Penalties and Attorney Fees

The ALJ assessed a $500 "penalty-related" attorney fee against Roy's for its untimely denial. On review, Roy's argues that the fee assessment was inappropriate, because claimant was unable to attend an independent medical examination (IME) between October 9, 1995 and January 19, 1996 because he was confined to a wheelchair during that time. Even assuming that claimant could not attend an IME for a period of time after filing this claim (as Roy's asserts), we find the fee proper in this case. The claim with Roy's was filed on September 26, 1995. Roy's offers no explanation for failing to accept or deny the claim until March 5, 1996, over six weeks after claimant attended Dr. Burton's January 19, 1996 examination in a wheelchair. (See Ex. 60-13). Under these circumstances, we agree with the ALJ that the denial was late and Roy's conduct in this regard amounted to unreasonable resistance to the payment of compensation. Accordingly, we affirm the ALJ's $500 assessed attorney fee under ORS 656.382(1), payable by Roy's. See Larry S. Karnoski, 46 Van Natta 2526 (1994).

The ALJ also assessed a $5,000 attorney fee for claimant's counsel's services at the hearings level, payable by Roy's. Because we determine herein that Roko, rather than Roy's, is responsible for claimant's current condition, we modify the ALJ's order to indicate that the latter fee is payable by Roko.

Finally, claimant is entitled to an attorney fee for his counsel's services on review regarding the denial issue. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by Roko. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. Dotsun v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 6, 1996 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial, on behalf of Roy's Preferred Painting, is reversed. The denial is reinstated and upheld. That portion of the order that upheld SAIF's denial, on behalf of Roko Associates, is reversed. The denial is set aside and the claim is

remanded to SAIF/Roko for processing according to law. The ALJ's $5,000 assessed attorney fee is modified so that it is payable by SAIF/Roko rather than SAIF/Roy's. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded $500, to be paid by the SAIF Corporation, on behalf of Roko.

In the Matter of the Compensation of
GREGORY P. JEFFRIES, Claimant
Own Motion No. 97-0237M
OWN MOTION ORDER
United Pacific Insurance Co., Insurance Carrier

Claimant requests temporary disability compensation for his April 1996 ventral hernia condition. We grant claimant's request for Own Motion relief.

FINDINGS OF FACT

Claimant sustained a compensable epigastric hernia injury on January 20, 1987. Claimant's aggravation rights expired on May 1, 1992.

On or about April 1, 1996, claimant underwent surgery for his current ventral hernia condition. On June 6, 1996, claimant requested temporary disability compensation following surgery for his ventral hernia condition. On June 18, 1996, the insurer issued a Carrier's Own Motion Recommendation. In its recommendation, the insurer reported that it was "exercising our 90-day investigative period." However, in that "recommendation," the insurer advised that the Board deny the reopening of the claim on the grounds that: (1) claimant's current condition was not causally related to the compensable injury; (2) it was not responsible for claimant's current condition; and (3) surgery or hospitalization was not reasonable and necessary for claimant's compensable injury.

On October 2, 1996, the insurer notified claimant that it had accepted his current recurrent ventral hernia condition. In a March 28, 1997 letter, the insurer advised claimant that its records indicated that he had not sought further medical treatment since June 1996. On April 25, 1997, the insurer issued a Notice of Closure (Form 2066), which closed claimant's claim without a temporary disability award. The insurer declared claimant medically stationary as of April 11, 1997.

On May 12, 1997, the Board received the insurer's June 18, 1996 recommendation to deny reopening of claimant's 1987 claim. That recommendation was forwarded to the Board from the Department of Consumer and Business Services.

On June 24, 1997, we issued an Interim Own Motion Order, in which we: (1) set aside the insurer's Notice of Closure as invalid; (2) required the insurer to send copies to claimant of documents it used in making its recommendation and in closing the claim; and (3) allowed claimant 21 days from the insurer's submission to respond.

The insurer responded by forwarding a copy of the record with its letter explaining its account of the events which transpired in this claim. The insurer also subsequently submitted an "amended" Own Motion Recommendation, in which it agreed that: (1) claimant's current condition required surgery or hospitalization; (2) claimant's current condition is compensably related to the accepted injury, the condition is the responsibility of the insurer and surgery or hospitalization is reasonable and necessary; and (3) claimant was in the work force at the time of disability.

CONCLUSIONS OF LAW AND OPINION

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

Here, the insurer initially indicated that claimant's current condition required surgery or hospitalization. No operative report is in the record. However, the record contains a May 26, 1996 Medical Records Review report, in which Dr. Heinonen, examining physician, reported that claimant had undergone surgery for a hernia condition. Dr. Heinonen noted that:

> "According to the records, while unloading a pallet pulling backwards, the pallet stopped suddenly, putting a strain on [claimant's] stomach and back. [Claimant] was evaluated by Dr. John Sandilands, who found symptomatic recurrent ventral incisional hernia. The operative findings were three separate small recurrent ventral hernias above the umbilicus. The hernias were in the area of the previous closure, one beneath it and one at the level of the umbilicus. These were closed and also mesh was placed to prevent further hernias."

Additionally, the record contains a June 26, 1996 transcribed interview in which claimant stated that he underwent the hernia surgery during "probably the first of April" in 1996. Finally, Ms. MacArthur, the claims examiner who interviewed claimant, asked claimant whether he returned to work after his surgery. Claimant answered that he returned back to regular duty after his two-week recuperation.

Here, the insurer accepted claimant's recurrent ventral hernia as disabling. The insurer also agrees that claimant's compensable condition required surgery and that claimant was in the work force at the time of disability. Finally, the insurer has now recommended that claimant's claim be reopened for the payment of temporary disability compensation.[1]

The issue is whether claimant's compensable condition has worsened requiring surgery or hospitalization. See ORS 656.278(1)(a). After considering the aforementioned evidence and the insurer's position, we conclude that the claim satisfies the statutory prerequisite. Consequently, we find that claimant is entitled to temporary disability compensation for his compensable ventral hernia condition and ensuing surgery. Such benefits should continue until the date claimant's compensable condition became medically stationary.

Accordingly, we authorize the reopening of claimant's claim for the payment of temporary disability compensation beginning on the date in April 1996 when he underwent hernia repair surgery. The insurer shall close the claim pursuant to OAR 438-012-0055, with temporary disability terminated effective the date claimant's compensable condition became medically stationary.

IT IS SO ORDERED.

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[1] The insurer noted in its August 6, 1997 cover letter that "an actual aggravation form was not filed by the worker" in this claim. Because claimant's aggravation rights have expired in his 1987 injury claim, his claim is not processed as an "aggravation" claim, and no "aggravation form" is required to be submitted. Furthermore, OAR 438-012-0020(3) states that "[a]n insurer is deemed to have notice of an own motion claim for temporary disability compensation when one of the following documents is submitted to the insurer by or on behalf of the claimant after the expiration of aggravation rights: (a) [a] written request for temporary disability compensation or claim reopening; or (b) [a]ny document that reasonably notifies the insurer that the claimant's compensable injury requires surgery or hospitalization."

In the Matter of the Compensation of
YVONNE PARAZOO, Claimant
WCB Case No. 96-09797
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that increased claimant's scheduled permanent disability for the loss of use or function of the left foot from 17 percent (22.95 degrees), as awarded by an Order on Reconsideration, to 30 percent (40.5 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted left foot injury claim. A July 1996 Notice of Closure awarded 18 percent scheduled permanent disability. Based on a medical arbiter examination, the Order on Reconsideration decreased the award to 17 percent.

The ALJ agreed that the medical arbiter, Dr. Neumann, provided the most persuasive findings for range of motion and a chronic condition. The ALJ found the treating physician, Dr. Laubengayer, however, was more reliable concerning claimant's inability to walk or stand for more than two hours during an 8-hour period. Consequently, the ALJ found claimant entitled to greater impairment. On review, the insurer challenges only that portion of the order awarding impairment based on the ALJ's finding that claimant proved an inability to walk or stand for two hours during an 8-hour period.

When a worker has sustained a severe injury to the foot or ankle and "objective medical evidence establishes an ability to walk or stand for a cumulative total of two hours or less, in an 8-hour period, the award shall be 15% of the foot/ankle[.]" Former OAR 436-035-0200(4)(a) (WCD Admin. Order 96-051). Impairment is determined by a medical arbiter where one is used "except where a preponderance of medical evidence establishes a different level of impairment." Former OAR 436-035-0007(13). "Preponderance of medical evidence" is "the more probative and more reliable medical opinion based upon factors including, but not limited to, the most accurate history, the most objective findings, sound medical principles or clear and concise reasoning." Former OAR 436-035-0005(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).

After finding claimant medically stationary on June 5, 1996, Dr. Laubengayer indicated "YES" to the insurer's question whether claimant could "stand or walk for a cumulative total of two hours or more, in an 8 hour shift." (Ex. 21) (emphasis in original). Subsequently, in response to claimant's attorney's questionnaire and also based on the June 5, 1996 examination, Dr. Laubengayer stated "yes" to whether claimant had a "two hour cumulative limit in an 8-hour period" and added "may walk frequently but only for very short periods & not to exceed two hours in an 8 hour day." (Ex. 23-2).

Dr. Neumann examined claimant on September 21, 1996 and found that claimant was "not permanently precluded from walking or standing for two hours or less, cumulative, in an eight hour shift." (Ex. 26-5).

We agree with the insurer that Dr. Laubengayer provided inconsistent opinions by first agreeing that claimant could stand or walk for "two hours or more" and then indicating that claimant could not exceed two hours when she walked or stood. Furthermore, Dr. Laubengayer's responses were conclusory and based on an examination that occurred over three months before Dr. Neumann's examination. Thus, because Dr. Laubengayer's opinion was inconsistent, lacked clear and concise reasoning and was not based on a more recent examination, we find that his opinion does not constitute

a preponderance of medical evidence. See former OAR 436-035-0005(10). Consequently, we rely on the medical arbiter's opinion that claimant is not precluded from walking or standing for two hours or less during an 8-hour period and she is not entitled to additional impairment. See former OAR 436-035-0007(13), 436-035-0200(4)(a).

As stated above, the parties do not dispute that, based on range of motion and a chronic condition, claimant is entitled to 17 percent scheduled permanent disability, as awarded by the Order on Reconsideration.

ORDER

The ALJ's order dated March 6, 1997 is modified. In lieu of the ALJ's award of 30 percent (40.5 degrees) scheduled permanent disability and "out-of-compensation" attorney fee, the Order on Reconsideration, which awarded 17 percent (22.95 degrees) scheduled permanent disability, is affirmed.

August 13, 1997 Cite as 49 Van Natta 1285 (1997)

In the Matter of the Compensation of
JAMES M. BENEDICT, Claimant
WCB Case Nos. 96-03511 & 95-12812
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denial, on behalf of Point Adams Packing Company, of claimant's injury claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, except for the last paragraph of the section entitled "Conclusions of Law and Opinion." In addition, we offer the following supplementation.

Claimant argues that he need only prove that his July 12, 1995 injury with SAIF's insured was a material contributing cause of his need for surgery for a herniated C5-6 disc, because he does not have a "combined condition" under ORS 656.005(7)(a)(B). Alternatively, assuming that he does have a "combined condition," claimant argues that he may prevail by establishing that the July 12, 1995 work incident caused his recent need for treatment (without necessarily proving that the work incident caused the cervical condition itself). See SAIF v. Nehl, 148 Or App 101 (1997) mod on recon 149 Or App 309 (1997); see also Robinson v. SAIF, 147 Or App 157, 162 (1997).

We find that claimant has not proven that the July 1995 work incident caused his need for treatment (even if the standard of proof is "material contributing cause"). Dr. Mawk, treating surgeon, provides the only medical evidence arguably supporting the claim.[1] However, Dr. Mawk was expressly unable to determine whether claimant's 1995 work injury caused the herniated disc which recently required surgery. (See Exs. 85-26; 85-32; 85-34). Under these circumstances, we agree with the ALJ that the claim must fail.

ORDER

The ALJ's order dated February 10, 1997 is affirmed.

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[1] Dr. Mawk favored a theory of traumatic causation. However, claimant did not tell Dr. Mawk about the incident in question and it is not clear when Dr. Mawk first became aware of that event. (See Exs. 85-21-22; -24-25).

In the Matter of the Compensation of
GERARDO V. BUENTELLO, Claimant
WCB Case No. 96-07275
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that affirmed an Order on Reconsideration that increased his award of scheduled permanent disability for loss of use or function of the left arm from 7 percent (13.44 degrees), as granted by a Notice of Closure, to 15 percent (28.8 degrees). On review, the issue is scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant had post-traumatic degenerative arthritis of the left elbow resulting from a 1969 injury. On October 2, 1994, claimant slipped and fell at work, suffering compensable injuries to his left elbow and left knee. The SAIF Corporation accepted a left elbow contusion and left knee contusion. (Ex. 3).

In April 1995, claimant underwent a left elbow arthrotomy. (Ex. 5). On May 26, 1995, an examining physician, Dr. Keenan, concluded that claimant's preexisting left elbow osteoarthritis was the major contributing cause of claimant's disability and need for medical treatment. (Ex. 6-5). Dr. Ruggeri, claimant's attending physician, concurred with that opinion. (Ex. 8-1). In a subsequent report on October 13, 1995, Dr. Ruggeri estimated that claimant had 25 percent impairment of the left elbow due to the preexisting condition and 25 percent due to the October 1994 injury. (Ex. 9-2).

On December 1, 1995, Dr. Peterson, another examining physician, evaluated claimant's left elbow condition. (Ex. 10). He opined that the major contributing cause of claimant's current disability and need for treatment was the preexisting degenerative condition. (Ex. 10-7). Dr. Peterson further stated that no more than 50 percent of claimant's lost range of motion of the left elbow was due to the current injury. (Ex. 10-8). Dr. Ruggeri concurred with the Peterson report. (Ex. 12).

On January 4, 1996, SAIF denied the compensability of claimant's degenerative post-traumatic left elbow arthritis. (Ex. 13). There is no indication that claimant appealed the denial.

On January 19, 1996, Dr. Peterson responded to SAIF's inquiry regarding impairment due to loss of strength. Dr. Peterson indicated that loss of strength in claimant's left arm was due to the preexisting arthritis. However, elsewhere in the report, Dr. Peterson specifically attributed 25 percent of claimant's strength loss to the compensable 1994 injury. (Ex. 14-1). Finally, Dr. Peterson graded claimant's strength loss as "4/5." (Ex. 14-2). Dr. Ruggeri concurred with Dr. Peterson's impairment assessment. (Ex. 15).

A February 26, 1996 Notice of Closure awarded 7 percent scheduled permanent disability for claimant's left elbow injury. (Ex. 16-1). After the closure notice was corrected on March 15, 1996 with respect to claimant's award of temporary disability (Ex. 17), claimant requested reconsideration, including scheduling of a medical arbiter examination. (Ex. 18).

A panel of medical arbiters, consisting of Drs. Gancher, Bald and Stanford, examined claimant on June 4, 1996. The panel rated claimant's muscle strength as "4/5" in the left arm. (Ex. 19-3). Moreover, the panel attributed 75 percent of claimant's impairment to the compensable injury and 25 percent decreased range of motion as due to the preexisting degenerative arthritis. (Ex. 19-4).

An Order on Reconsideration awarded claimant 15 percent scheduled permanent disability for his compensable left elbow contusion. This award, which represented an increase of 8 percent over the scheduled award in a Notice of Closure, was based on the range of motion and "chronic" condition findings of the panel of medical arbiters. (Ex. 20-5).

CONCLUSIONS OF LAW AND OPINION

At the hearing, claimant sought an impairment rating for loss of strength in the left arm based on the panel's finding that claimant had 4/5 strength in the left arm muscles due to "pain radiating into his left elbow." (Ex. 19-3). The ALJ declined to make an additional scheduled permanent disability award based on this finding. The ALJ reasoned that the relationship between claimant's radiating pain into his left elbow and his compensable injury was not clear from the report. Instead, the ALJ found that claimant had no loss of strength due to his compensable injury. In reaching this conclusion, the ALJ relied on the opinion of an examining physician, Dr. Peterson, with whom claimant's attending physician (Dr. Ruggeri) had concurred, and who attributed claimant's strength loss to arthritis of the elbow, the condition that SAIF had denied. Finding no evidence that the denial had been appealed, the ALJ determined that any impairment resulting from the denied condition should not be rated.

On review, claimant contends that he is entitled to additional scheduled permanent disability based on the impairment rating in the arbiters' report. He particularly notes the panel's conclusion that 75 percent of his impairment is due to his compensable injury and 25 percent of his decreased range of motion is related to his degenerative arthritis. (Ex. 19-4). For the following reasons, we find that claimant is entitled to an increase in his scheduled permanent disability.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Orfan A. Babury, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but, rather, we rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

In this case, we find that the medical arbiter panel provided the most thorough, complete and well-reasoned persuasive medical opinion addressing claimant's permanent impairment. Because permanent disability is rated at the time of the July 10, 1996 reconsideration order, the arbiter panel's June 4, 1996 evaluation of claimant's permanent impairment is more probative than that of Dr. Ruggeri, who concurred with the January 19, 1996 impairment findings of Dr. Peterson in February 1996. Moreover, Dr. Peterson's impairment rating was done in a summary fashion and is internally inconsistent in that he attributed claimant's loss of strength to preexisting arthritis, but in the same report attributed 25 percent of claimant's left arm strength loss to the October 1994 injury. (Ex. 14-1). Dr. Ruggeri's concurrence also provided no explanation of his agreement with the inconsistent report from Dr. Peterson. Under these circumstances, neither Dr. Peterson's nor Dr. Ruggeri's impairment assessment is persuasive.

In contrast to those evaluations, the medical arbiter report is well reasoned and directly answers the question posed by the Department, i.e. what percentage of impairment was due to the compensable injury. (Ex. 19-4). The medical arbiters rated claimant's impairment due to injury as 75 percent and provided an explanation of their opinion. Id. On this record, the medical arbiters' opinion is most persuasive. We, therefore, use it to rate claimant's permanent impairment due to loss of strength.

As previously noted, the medical arbiter panel graded claimant's loss of strength in the left arm muscles as "4/5." See OAR 436-035-0007(18). Accordingly, we rate claimant's impairment based on that grading of claimant's strength loss. The arbiter panel determined that claimant's strength loss affected the muscles in claimant's left biceps and left triceps, as well as those involved in left wrist flexion, left wrist extension and left grip. (Ex. 19-2).

Pursuant to OAR 436-035-0110(8), 4/5 strength in the biceps muscle equals 5 percent impairment of the arm. Likewise, 4/5 strength in the triceps muscle also equals 5 percent impairment. Id. The wrist extension muscle finding equals 10 percent impairment under OAR 436-035-0007(19). Since both the triceps muscle and the wrist extension muscles are innervated by the radial nerve, the wrist extension and triceps findings are averaged, which equals 7 and one-half percent impairment (rounded to 8 percent). Id. The wrist flexion muscles are innervated by the median nerve and claimant's

impairment would equal 8.8 percent impairment (rounded to 9 percent). OAR 436-035-0110(8). The muscles affecting grip are innervated by the ulnar nerve and claimant's impairment equals 6.2 percent (rounded to 6 percent). Id. The above impairment values (5, 8, 9, 6) are combined for a total of 25 percent impairment due to loss of strength.

Inasmuch as we have determined that 75 percent of claimant's loss of strength impairment is due to his compensable injury, his total strength loss impairment (25 percent) is multiplied by 75 percent which equals 18.75 or 19 percent. OAR 436-035-0007(14). When that value is combined with the other, undisputed impairment factors (11 percent impairment for loss of range of motion and 5 percent for a chronic condition), the total impairment value is 32 percent. This represents a 17 percent increase in claimant's scheduled permanent disability. The reconsideration order is modified accordingly.

Because we have increased claimant's scheduled permanent disability award from 15 to 32 percent, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order (the 17 percent increase between the 15 percent Order on Reconsideration award and our scheduled permanent disability award), not to exceed $3,800, payable directly to claimant's counsel. See ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated December 18, 1996 is modified. In addition to the Order on Reconsideration award of 15 percent (28.8 degrees) scheduled permanent disability, claimant is awarded 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of the left arm, for a total award to date of 32 percent (61.44 degrees). Claimant's counsel is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order, not to exceed $3,800, payable directly to claimant's counsel.

August 13, 1997 Cite as 49 Van Natta 1288 (1997)

In the Matter of the Compensation of
TWILA P. COLEMAN, Claimant
WCB Case No. 95-13301
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scheminske, 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) Herman's order that: (1) set aside its denial of claimant's claim for a bilateral foot condition; and (2) awarded claimant's counsel an assessed attorney fee of $4,500. The employer also contends that the ALJ erred in admitting Exhibit 13, the Metropolitan Insurance Company's weight and height table, into evidence. On review, the issues are evidence, compensability and attorney fees.

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

On review, the insurer argues that the ALJ incorrectly admitted Exhibit 13, the Metropolitan Life Insurance Company's weight and height table, into evidence. The insurer argues that claimant sought to have the table admitted based on Dr. Gambee's reliance on the chart, yet Dr. Gambee eventually testified that he did not actually rely on the table.

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 ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

Despite Dr. Gambee's statement that he did not rely on the table, as noted by the ALJ, Dr. Gambee testified that he used a "rule of thumb" to determine whether claimant was overweight, and that rule of thumb was derived from the table. (Ex. 14-21). Additionally, despite his statement that he did not rely on the table, prior to his deposition, Dr. Gambee specifically referred to the table in a medical report discussing claimant's weight. (Ex. 12-2). Under the circumstances, we do not find that the ALJ abused her discretion by admitting Exhibit 13 into evidence.

Claimant's attorney is entitled to an attorney fee for services on review concerning the issue of compensability. 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, 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 issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 11, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the self-insured employer.

In the Matter of the Compensation of
MICHAEL R. DOWELL, Claimant
WCB Case No. 96-09074
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of his injury claim for left eye, headache and dizziness conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the pertinent facts. Claimant, a 22 year old laborer in the employer's lumber mill, was pulling lumber off the "green chain" on June 7, 1996, when a 2x4 struck him in the left temple. Dr. Gamelin provided claimant's initial medical treatment on June 17, 1996, when he presented with complaints of blurred and lost vision in the left eye. (Ex. 2). Dr. Gamelin diagnosed acute loss of vision in the left eye and referred claimant to an ophthalmologist at Oregon Health Sciences University, Dr. Berner.

In a June 22, 1996 report, Dr. Berner reported that his examination had revealed changes in the retina of claimant's eye called "angioid streaks." (Ex. 5). According to Dr. Berner, the angioid streaks were due to a condition called pseudoxanthoma elasticum (PXE). Dr. Berner surmised that claimant's vision loss was coincidental with his trauma because there was no sign of recent injury on examination. Id.

On July 9, 1996, an osteopath, Dr. Herscher, reported that claimant had been experiencing headaches for the previous three weeks. (Ex. 9). In August 1996, claimant consulted a specialist in PXE, Dr. Neldner, a professor of dermatology at a medical school in Texas. Dr. Neldner confirmed the diagnosis of PXE and opined that claimant's injury caused his vision loss. (Ex. 11-6).

On August 30, 1996, claimant began treating with Dr. Marjanovic, complaining of dizziness, headaches and fainting spells. (Ex. 14A-1). Dr. Marjanovic ordered diagnostic tests, including a CT scan of the brain that was normal. (Ex. 15).

An examining ophthalmologist, Dr. Romanowski, evaluated claimant's eye condition on September 23, 1996. (Ex. 16). Dr. Romanowski agreed that claimant did have the ophthalmological condition known as angioid streaks as a result of PXE. Dr. Romanowski concluded, however, that it was not medically probable that trauma caused claimant's vision loss, but rather that claimant's vision loss was due to preexisting PXE. (Ex. 16-6).

On September 24, 1996, the insurer denied the left eye injury claim. (Ex. 18). Claimant requested hearing.

In a November 17, 1996 letter to claimant's counsel, Dr. Neldner stated that he could not apportion the percentage of causation of claimant's left eye condition between the PXE and the June 1996 trauma. (Ex. 22). However, Dr. Marjanovic opined that the June 1996 trauma was the more significant factor in claimant's vision loss. Dr. Marjanovic concluded that the June 1996 trauma was the major contributing cause of claimant's central vision loss, headaches, and dizziness. (Ex. 24).

The ALJ upheld the insurer's denial of claimant's vision loss, concluding that claimant had failed to sustain his burden of proof under ORS 656.005(7)(a)(B).[1] In reaching this conclusion, the ALJ found the medical opinions of Dr. Neldner and Dr. Marjanovic insufficient to prove that the June 1996 trauma was the major contributing cause of claimant's left eye vision loss. Finally, the ALJ determined that claimant's headaches and dizziness conditions were not compensable, finding that the only opinion directed to the causation of those conditions (Dr. Marjanovic's) did not establish that the June 1996 blow to the head was a material contributing cause of those conditions.

On review, claimant concedes that he must establish that his left eye vision loss is compensable under ORS 656.005(7)(a)(B). However, claimant asserts that he sustained his burden of proof based primarily on the medical opinion of Dr. Neldner, and to a lesser extent on that of Dr. Marjanovic. Claimant also contends that Dr. Marjanovic's opinion establishes the compensability of his headache and dizziness conditions.

Vision Loss

The parties agree, and we find, that claimant's June 6, 1996 trauma "combined" with a preexisting PXE condition 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 June 6, 1996 injury was the major contributing cause of the need for treatment of claimant's left eye vision loss. SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309 (1997); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).

In satisfying the "major contributing cause" standard, claimant must establish that the compensable injury contributed more to his left eye condition or 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 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).

Claimant has the burden of proving that his left eye 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).

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[1] The ALJ referred to the statute as ORS 656.005(7)(a)(A).

Dr. Neldner is an expert in the diagnosis and treatment of PXE. (Ex. 22-2). Dr. Neldner explained that PXE is a hereditary disorder of abnormal calcification of the elastic fibers which are normally present in the skin, eye and cardiovascular system. PXE causes angioid streaks in the retina of the eye. (Ex. 12-2). However, according to Dr. Neldner, the angioid streaks did not cause claimant's vision loss; rather it was the result of the blow to claimant's left temple which produced either a small retinal hemorrhage (RH) or a sub-retinal membrane which in turn caused the vision loss. Id. Although Dr. Neldner declined to attribute the exact percentage of causation attributable to claimant's preexisting PXE and that due to the June 1996 blow to claimant's head, Dr. Neldner opined that claimant's injury caused the loss of vision. (Ex. 11-16). Dr. Neldner emphasized that anyone who receives sufficient direct trauma to an eye can develop RH and have permanent central vision loss. (Ex. 22-2).

Dr. Neldner's opinion is supported by that of Dr. Marjanovic, who agreed that claimant would still have normal vision in his left eye had the June 1996 trauma not occurred. (Ex. 24-1). Dr. Marjanovic noted that the absence of vision loss in claimant's right eye (even though PXE was present in that eye) also supported her position, as well as the fact that a higher percentage of blindness caused by RH follows trauma. Dr. Marjanovic also agreed that it was rare for a man of claimant's age (22) to suffer central vision loss due to PXE alone. According to Dr. Marjanovic, the June 1996 trauma was the major contributing cause of claimant's left central vision loss. Id.

Because they are well-reasoned, based on an accurate history and weigh the relative contributions of the potential contributors to claimant's vision loss, the opinions of Drs. Neldner and Marjanovic are persuasive. See Somers v. SAIF, 77 Or App 259 (1986); Dietz, 130 Or App at 401-02 . Moreover, we find them more persuasive than those of Drs. Romanowski and Berner.

Dr. Romanowski concluded that PXE was the major contributing cause of claimant's eye condition. (Ex. 16-6). However, Dr. Romanowski's qualifications with respect to diagnosis and treatment of PXE are unclear. On this record, we are persuaded that Dr. Neldner has superior expertise in dealing with this condition. Thus, we find his opinion more persuasive. See Abbott v. SAIF, 45 Or App 657, 661 (1980).

In addition, Dr. Romanowski does not sufficiently weigh the relative contributions of the potential contributors to claimant's vision loss. Dr. Romanowski reasoned that, because a person without PXE would not have been expected to develop vision loss as a result of the trauma that claimant sustained, PXE was the major contributing cause of claimant's eye disorder. However, we find such a "but for" analysis unpersuasive in light of Deitz.

Finally, we do not find that Dr. Romanowski adequately considered the fact that claimant had normal vision prior to the June 1996 trauma and developed left eye problems a short time thereafter. While it is improper to rely exclusively on the temporal connection between the trauma and claimant's vision loss to establish causation, see Allie v. SAIF, 79 Or App 284 (1986), we nevertheless believe that Dr. Romanowski's failure to factor this into his causation opinion lessens the probative value of his opinion.

Finally, Dr. Berner opined that it was not clear whether the June 7, 1996 trauma was coincidental with claimant's vision loss. (Ex. 5). However, Dr. Berner "thought" the trauma was coincidental because of the lack of evidence of recent injury to the eye. We do not find Dr. Berner's opinion sufficient to overcome those of Drs. Neldner and Marjanovic. First, Dr. Berner's opinion is equivocal. Thus, we find that it is entitled to little weight. Gormley v. SAIF, 52 Or App 1055 (1981). Moreover, there is no indication that Dr. Berner, a resident in ophthalmology, has any expertise in diagnosis and evaluation of PXE.

In summary, we find that claimant sustained his burden of proving by a preponderance of the evidence that the June 1996 trauma was the major contributing cause of the need for treatment of claimant's left central vision loss. Thus, we find that claimant established a compensable eye claim under ORS 656.005(7)(a)(B). Because the ALJ concluded otherwise, we reverse.

Headaches and Dizziness

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

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of his vision loss. 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 Board review is $4,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated January 21, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the insurer's denial of claimant's left eye condition is reversed. The insurer's denial to the extent that it denies claimant's left eye vision loss is set aside and the left eye claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
CARLA J. FOSTER, Claimant
WCB Case Nos. 96-10627 & 96-09723
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) upheld St. Paul Fire & Marine's denial of the same condition. Submitting a "post-hearing" surgical report, claimant also seeks remand for the introduction of new evidence. On review, the issues are remand, compensability and, potentially, responsibility. We deny the request for remand, affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 37 at the time of hearing, has worked as a hairdresser for approximately 16 years. In 1993, she began working for Great Clips dba Smooth Sailing, a hair salon that serviced men, women and children on a walk-in basis. Her work activity included combing, cutting, blow drying, shampooing, setting and styling hair. On October 13, 1995, claimant treated with a chiropractor for neck and back pain. The chiropractor also noted claimant complained of numbness in the fingertips from the mid-knuckle down.

Over time, claimant's hand symptoms worsened, and she began to drop things at work. She also experienced numbness and pain when she first awoke in the morning.

During the spring of 1996, claimant was terminated from Smooth Sailing and began working for Shear Precision, Inc., another Great Clips franchise. At Shear Precision, claimant performed her customary haircutting and hairstyling activities, but also worked as a manager.

Claimant's symptoms continued to worsen, prompting her employer to suggest that she seek medical attention. On June 16, 1996, claimant's symptoms became so severe that she was unable to

finish her shift. Later that day, she sought treatment for bilateral pain and numbness. She demonstrated a positive bilateral Tinel's sign and swollen fingers. The diagnosis was "repetitive movement injury/carpal tunnel syndrome."

Claimant eventually began treating with Dr. Tongue, an orthopedic and hand surgeon, who diagnosed bilateral carpal tunnel syndrome with key pinch weakness. Dr. Tongue treated claimant with steroid injections, which provided relief and allowed claimant to return to her regular work.

On September 3, 1996, claimant returned to Dr. Tongue, complaining of a recurrence of symptoms after an extraordinarily busy week at work. Dr. Tongue diagnosed "right arm median and ulnar nerve neuropraxias and musclotendinitis secondary to repetitive use, chronic, recurrent."

That same day, claimant was examined by Dr. Nye at the request of SAIF/Shear Precision. Although he initially related claimant's symptoms to her work activity, Dr. Nye ultimately concluded that claimant did not have carpal tunnel syndrome because of the absence of any objective evidence of median nerve compression. On November 11, 1996, claimant was examined by Dr. Button at the request of St. Paul/Smooth Sailing. Dr. Button also questioned the diagnosis of carpal tunnel syndrome and concluded that claimant was fabricating her symptoms.

On January 15, 1995, Dr. Tongue performed a right carpal tunnel release. Post operatively, claimant experienced a decrease in her right sided-symptoms, including no numbness and tingling. Her left wrist, however, continued to be painful and numb.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

As noted above, claimant moves for remand to the ALJ for admission of reports concerning a surgery that was performed shortly after the ALJ closed the record. Claimant submitted a surgical report from her left carpal tunnel release, performed by Dr. Tongue on February 5, 1996 (13 days after the hearing and two days after the record formally closed).

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).

Here, the proffered evidence relates to claimant's bilateral carpal tunnel syndrome and therefore concerns her disability. Moreover, since the surgery did not take place until after the hearing, the proffered evidence 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.

As explained below, we adopt and affirm the ALJ's conclusion that claimant does, in fact, have bilateral carpal tunnel syndrome. Therefore, the primary issue on review is whether claimant's carpal tunnel syndrome was caused in major part by her work. Although the proffered evidence pertains to claimant's diagnosis, it does not address the causation of her condition. Because the document does not tend to prove or disprove her position that her occupational disease was caused in major part by her work activities, we find no reasonable likelihood that the submitted evidence will affect the outcome of the hearing.

Consequently, lacking a compelling reason, we conclude that remand is not warranted.

Compensability

The ALJ determined, based primarily on the opinion of Dr. Tongue, that claimant did, in fact, have carpal tunnel syndrome but that she had failed to prove by a preponderance of the evidence that

her condition was caused in major part by her work activities. Specifically, the ALJ concluded that there was no persuasive evidence that claimant's symptoms were the disease.[1]

On review, claimant argues that Dr. Tongue's chart notes and reports persuasively establish the requisite causal connection between her bilateral carpal tunnel syndrome and her work activities as a hairstylist. We agree.

As a preliminary matter, we adopt and affirm the ALJ's determination that Dr. Tongue provides the most persuasive opinion regarding claimant's diagnosis and the ALJ's conclusion that claimant has carpal tunnel syndrome. Dr. Tongue specifically opined that claimant has the condition notwithstanding her normal electrodiagnostic studies. As the ALJ noted, all of the medical experts in this case agreed that normal nerve conduction test results did not necessarily rule out carpal tunnel syndrome. Further, both Dr. Tongue and Dr. Nye agreed that claimant's positive response to the steroid injections were diagnostic of the condition.

In order to establish an occupational disease claim, claimant must establish that her employment conditions were the major contributing cause of her bilateral carpal tunnel syndrome. ORS 656.802(2)(a). In this case, we need not address whether claimant's symptoms are the "disease" because, even if we assume that her symptoms were not the disease, we are persuaded by Dr. Tongue's opinion that claimant's work activities were the major contributing cause of her carpal tunnel syndrome, both the symptoms and pathology.

Dr. Tongue, who has treated claimant since July 1996, has opined on more than one occasion that claimant's condition was caused in major part by her work as a hairdresser. (See Exs. 27-1, 27-6). He later explained that this opinion was based on his understanding of claimant's particular work activities as well as his past experience treating other patients who cut hair. (Exs. 44, 46). In response to counsel's question concerning the nature of carpal tunnel syndrome, Dr. Tongue opined that it "is a constellation of three basic symptoms: pain, numbness and weakness with different patterns for different patients, hence the term syndrome." He further explained that the "basic pathology [of carpal tunnel syndrome] consists of extrinsic pressure on the nerve causing a loss of blood supply within the nerve itself." (Ex. 46-2).

As discussed above, Dr. Tongue also explained that claimant's normal nerve conduction studies were not inconsistent with his diagnosis of carpal tunnel syndrome, and that in clinical testing, claimant showed both median and ulnar nerve symptoms. Dr. Tongue also reported that, during her course of treatment, she did not exaggerate her symptoms or exhibit obvious signs of functional overlay. (Exs. 44, 46).

Both Dr. Button and Dr. Nye disputed the diagnosis of carpal tunnel syndrome, but neither doctor specifically opined that claimant's problem was not caused by her work or that work as a hairdresser was not the type of activity that could cause carpal tunnel syndrome. Indeed, Dr. Nye acknowledged that claimant's occupation was hand and arm intensive, and could lead to the nerve irritation claimant exhibited on clinical examination. (Ex. 34-3).

On this record, we find no persuasive reason not to rely on Dr. Tongue's causation opinion, as it is based on a complete and accurate history. Accordingly, we conclude that claimant has established the compensability of her carpal tunnel syndrome by a preponderance of the evidence.

Responsibility

Claimant argues that responsibility for her condition should be analyzed under the last injurious exposure rule. We agree. The last injurious exposure rule provides that when a worker proves that an occupational disease was caused by work conditions that existed at two or more places of employment, 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

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[1] Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. See Weller v. Union Carbide, 288 Or 27 (1980). However, if the medical evidence establishes that the claimant's symptoms are the disease, a worsening of symptoms that is caused, in major part, by work conditions, may be compensable. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, although claimant's chiropractor noted in October 1995 (when claimant was still employed by St. Paul's insured, Smooth Sailing) that claimant was experiencing numbness in her fingertips, he did not diagnose nor treat this symptom. Therefore, this medical visit did not constitute "medical treatment" for the compensable condition. See, e.g. Michael J. Joseph, 47 Van Natta 2043 (1995). Rather, claimant first sought treatment for her carpal tunnel syndrome in June 1996, when she was employed by SAIF's insured, Shear Precision. Therefore, SAIF is assigned responsibility under the last injurious exposure rule.[2]

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for finally prevailing over SAIF's denial of her carpal tunnel syndrome. ORS 656.386(1); 656.308(2)(d). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 3, 1997 is reversed in part and affirmed in part. That part of the order that upheld SAIF's denial is reversed. SAIF's denial is set aside in its entirety, and the bilateral carpal tunnel claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded $4,000, payable by SAIF. The remainder of the order is affirmed.

[2] Because the record does not establish that it was impossible for claimant's work activities at Shear Precision to have caused her bilateral carpal tunnel syndrome or that her disease was caused solely by her work conditions at her previous employment, SAIF is responsible for claimant's condition. See Roseburg Forest Products v. Long, 325 Or 305 (1997).

In the Matter of the Compensation of
HELEN L. GOOD, Claimant
WCB Case No. 96-08930
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the SAIF Corporation's denial of her left ankle fracture. On review, the issue is whether claimant's injury arose out of and in the course and scope of her employment. We reverse.

FINDINGS OF FACT

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

At all pertinent times, claimant worked as an accounting technician in the employer's accounting department. On the morning of July 26, 1996, claimant went to a co-worker's cubicle to speak with him about a work-related matter. As she walked out of the co-worker's cubicle after finishing the conversation, claimant made a slight pivot, her left ankle turned and she felt immediate pain. She was thereafter diagnosed with an undisplaced fracture of the base of the 5th metatarsal in the left ankle.

Claimant was wearing low-heeled sandals on the day of the incident. She did not recall tripping on the carpet nor slipping out of her sandal before the injury. July and August are the busiest months of the year for claimant at work, as her employer operates on a fiscal year basis.

CONCLUSIONS OF LAW AND OPINION

Citing to James D. Johnson, 48 Van Natta 303 (1996),[1] and James R. Montoya, 48 Van Natta 1841 (1996), the ALJ determined that claimant could not show that her ankle injury arose out of her work because she identified no risk of employment to cause the injury. The ALJ reasoned that neither the medical evidence nor claimant's testimony pointed to any work-related reason for the fracture.

On review, claimant argues that her injury resulted from risks associated with her employment. We agree.

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." Norpac Foods Inc. v. Gilmore, 318 Or 363, 366 (1994). If there is no causal connection between the claimant's injury and his or her work activities other than the fact the injury occurred at work, the injury is not compensable. Johnson v. Beaver Coaches, Inc., 147 Or App at 235. However, where the claimant's injury results from either an employment-related risk or a neutral risk that the employment put the claimant in a position to be injured, the injury is compensable under ORS 656.005(7)(a). See, e.g., Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994) (worker's injury when she stepped out of an elevator while attempting to leave the building for a lunch break was in the course and scope of employment); Pamela M. Ahlstrom, 48 Van Natta 1665 (1996) (the claimant's knee injury, which occurred as she bent over to pick up merchandise off the floor, was within the course and scope of employment). Moreover, where a specific work activity is part of a claimant's job, the risk of injury from that activity is a risk of that job. Folkenberg v. SAIF, 69 Or App 159, 165 (1984).

Unlike the ALJ, we find that claimant's ankle injury resulted from a risk associated with her employment. Claimant testified that July and August were the busiest times at work. (Tr. 13). She also testified that she had gone to speak to the co-worker about a matter that was "somewhat urgent" and that she was in a rush as she left his cubicle because she was working on something that needed to be taken care of as soon as possible. (Tr. 15-19). Under these circumstances, we conclude that claimant's injury occurred because she was hurrying to complete her work. Although there is no evidence that claimant slipped or tripped on the carpet, we conclude that walking to and from another worker's work station and rushing to complete a task during the busiest time of the year are conditions of claimant's employment that put her in a position to be injured.[2] Consequently, we find a sufficient causal connection between claimant's injury and her employment to conclude that her injury is compensable.

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

ORDER

The ALJ's order dated January 17, 1997 is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded $4,000, payable by SAIF.

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[1] Subsequent to the ALJ's order, the Court of Appeals affirmed James D. Johnson in a per curiam decision. Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997).

[2] The dissent contends that our decision is inconsistent with the Johnson and Montoya holdings. We disagree. In those cases, the Board found the only work connection to be that the claimants' injuries had occurred on work premises during work hours. Here, in contrast to the factual findings in those cases, we have found a sufficient causal nexus between claimant's injury and her employment; i.e., during a busy period at her employment, she was responding to a "somewhat urgent" matter by walking to/from a co-worker's cubicle to complete a work-related assignment.

Board Member Haynes dissenting.

I do not agree with the majority's conclusion that claimant's injury occurred in the course and scope of employment. Because I find insufficient evidence that claimant's injury occurred because she was busy at work or because of any risk associated with her employment, I respectfully dissent.

As the majority notes, to satisfy the "arising out of employment" element of ORS 656.005(7)(a), the claimant must show a causal link between the occurrence of the injury and a risk connected with employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994); Phil A. Livesley Co. v. Russ, 269 Or 25, 29 (1983). The mere fact that the injury occurred on the employer's premises during working hours is insufficient to prove compensability. James D. Johnson, 48 Van Natta 303 (1996), aff'd Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997); James R. Montoya, 48 Van Natta 1841 (1996).

Here, as in James D. Johnson and James R. Montoya, the parties agree that claimant's injury occurred in the course of employment. Their dispute is whether the injury arose out of her employment. Claimant testified that her ankle twisted and she felt the acute onset of pain as she took her second step upon leaving her co-worker's cubicle. (Tr. 14). This second step was not a complete 180 degree turn, but a slight pivot. (Tr. 19). Claimant testified that she did not trip on the carpet, slip on anything on the floor or slide out of her sandal. (Tr. 26). She could not identify any particular cause or reason for her ankle to twist. Similarly, at the emergency room on the day of the incident, claimant gave a history of twisting her left ankle at work. She reported that she was "walking out of a co-worker's cubicle when her left foot bent inwards." (Ex. 1).

Unlike the majority, I cannot conclude that claimant's injury resulted from any risk associated with her employment. Although claimant testified that July and August were her busiest months at work, and that she was generally rushed and pressured to complete her fiscal year-end tasks, she did not contend that these employment conditions had anything to do with her injury.[1] For example, had the record established that claimant was walking faster than usual because of an impending deadline, that she was preoccupied with thoughts about work and not watching her step, or that she bumped into a wall, furniture or another person along the way, I might be willing to conclude that her employment conditions put her in a position to injure her ankle. None of these scenarios are established by the record in this case, however.

Consequently, I would find this case indistinguishable from Johnson and Montoya. In Johnson, the claimant was injured when he stopped to speak to a coworker about a work-related subject. When he took a step to return to his task, he left knee buckled and popped. The floor of the shop where the claimant worked was level, and there was no evidence that he slipped or tripped over anything on the floor. The claimant was later diagnosed with a medial meniscus tear. The Board concluded that the claimant failed to show that his left knee condition arose out of his employment because there was not causal connection between the injury and his work activities other than the mere fact that the step occurred at work. The court affirmed. Johnson v. Beaver Coaches, 147 Or App at 235.

In Montoya, the claimant felt the acute onset of sharp burning pain in the back of his left heel while climbing a flight of stairs at work. A month later, he was diagnosed with a rupture of the Achilles tendon, which required surgical repair. The Board concluded, as it had in Johnson, that the record did not sufficiently establish a causal connection between the injury and a risk associated with the claimant's employment. There, as in Johnson and the case at hand, the claimant did not slip or trip over anything, and the only connection between the injury and employment was the fact that the injury occurred on work premises during working hours. 48 Van Natta at 1842.

Because I find the record devoid of evidence of a causal connection between claimant's left foot fracture and a risk or condition of her employment, I would affirm the ALJ's order upholding the employer's denial.

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[1] As the ALJ found, claimant did not contend that she injured her ankle while rushing out of the coworker's cubicle. Rather, she told the emergency room physician (and testified at hearing) that she was walking when her left foot bent inwards. (Ex. 1, Tr. 26-27).

In the Matter of the Compensation of
CHARLES D. GREENOUGH, Claimant
WCB Case No. 96-10574
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that reduced his scheduled permanent disability award for loss of use or function of the left arm from 18 percent (34.56 degrees), as awarded by an Order on Reconsideration, to 10 percent (19.2 degrees). In its respondent's brief, the SAIF Corporation contends that claimant's award should be further reduced to 2 percent. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

An October 25, 1996 Order on Reconsideration awarded claimant 18 percent (34.56 degrees) scheduled permanent disability for the left arm. (Ex. 26). The award included 2 percent for reduced range of motion and 16 percent for loss of sensation. (Ex. 26-5).

At hearing, SAIF challenged only the portion of the award for loss of sensation. (Tr. 4). The ALJ concluded that the arbiter panel found "less than normal" sensation in the tips of the digits of the left hand. The ALJ modified the award for loss of sensation to 8 percent, for a total scheduled permanent disability award of l0 percent.

Claimant argues that his scheduled permanent disability award should be increased to the 18 percent award as determined by the Order on Reconsideration. He contends that he is entitled to compensation for the loss of sensation in all of the digits of his left hand.

SAIF contends, among other things, that the arbiter panel's report does not meet the criteria for an award for loss of sensation. SAIF argues that, since claimant's discrimination was "less than" 7 millimeters, the arbiters' findings do not qualify for an award of permanent impairment.

The extent of claimant's permanent disability is determined by an application of the standards adopted by the Director. Claimant's claim was closed by a July 10, 1996 Notice of Closure. (Ex. 22). Accordingly, the disability standards contained in Workers' Compensation Department Administrative Orders No. 96-051 apply to claimant's claim. OAR 437-035-0007(13) provides, in part:

> "On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence."

Claimant's treating physician, Dr. Nye, found that claimant was medically stationary on June 25, 1996. (Ex. 21). Dr. Nye reported that claimant's sensory loss was "normal" in "all areas." (Ex. 21-2).

Claimant was examined by a medical arbiter panel on October 4, 1996. The panel reported "[t]wo-point discrimination of the tips of all digits of the right hand is less than 6 mm and in the left hand, it is less than 7 mm." (Ex. 24-3).

Under OAR 436-035-0110(1), loss of palmar sensation in the hand, fingers or thumb is rated according to the location and quality of the loss, and is measured by the two point discrimination method. OAR 436-035-0110(1)(a) provides:

"If enough sensitivity remains to distinguish two pin pricks applied at the same time (two point), the following shall apply:

Finding	Grade of Sensation
6 millimeters apart or less	normal
7-10 millimeters	less than normal
11-15 millimeters	protective sensation
Greater than 15 millimeters	total loss"

Here, the arbiter panel reported that claimant's two point discrimination in the left hand was "less than 7 mm." (Ex. 24-3). Under OAR 436-035-0110(1)(a), the grade of sensation must be at least 7 millimeters to be considered "less than normal." Under these circumstances, the arbiter panel's findings do not qualify for an award of permanent impairment for loss of sensation. Therefore, we reduce claimant's scheduled permanent disability award to 2 percent.[1]

ORDER

The ALJ's order dated February 18, 1997 is modified. Claimant's previous awards of scheduled permanent disability for loss of use or function of the left arm are reduced to 2 percent (3 degrees).

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[1] In light of our conclusion, we do not address claimant's argument that he is entitled to compensation for the loss of sensation in all of the digits of his left hand, rather than just the tips of the fingers. Similarly, we do not address SAIF's alternative argument that the arbiter panel's report is not persuasive because they failed to identify which nerve was injured, i.e., the ulnar or median nerve.

In the Matter of the Compensation of
GARY A. HARVEY, Claimant
WCB Case No. 96-09865
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant became medically stationary as of March 18, 1996, whereas an Order on Reconsideration found that he was medically stationary on February 29, 1996; and (2) awarded 6 percent (19.20 degrees) unscheduled permanent disability for a low back condition, whereas the Order on Reconsideration awarded no permanent disability. On review, the issues are medically stationary date and extent of unscheduled permanent disability. We reverse.

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 compensably injured his low back on August 11, 1995. The employer accepted a disabling lumbar strain, and claimant was off work from August 18, 1995 to October 16, 1995.

Claimant returned to work, but continued to experience symptoms. On February 29, 1996, his attending physician, Dr. Rabie, opined that his back injury was medically stationary and that no further curative forms of treatment were recommended. On March 7, 1996, claimant returned to Dr. Rabie complaining of a severe headache and vomiting. Dr. Rabie diagnosed a post-epidural injection headache, and authorized time loss through March 17, 1996. Claimant was released to return to regular work on March 18, 1996.

On April 5, 1996, claimant was examined by Dr. Bald at the employer's request. Dr. Bald tested claimant's lumbar ranges of motion and agreed that claimant was medically stationary on February 29, 1996. Dr. Bald further opined that claimant had experienced spinal type headaches for a two-week period in early March 1996, that was a direct result of his most recent epidural steroid injection. Dr. Rabie concurred with Dr. Bald's report.

Claimant's claim was closed by a July 15, 1995 Determination Order, which set February 29, 1996 as his medically stationary date, and awarded temporary disability compensation for the period of August 18, 1995 to October 16, 1995 and 6 percent unscheduled permanent disability.

Claimant requested reconsideration and was examined by a medical arbiter. An October 11, 1996 Order on Reconsideration reduced claimant's unscheduled disability award to zero and affirmed the Determination Order in all other respects.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

The ALJ found that although claimant's low back injury was medically stationary on February 29, 1996, he was "overall" not medically stationary until March 18, 1996 because of his spinal-type headaches. We find to the contrary.

As a preliminary matter, we note that in requesting reconsideration of the July 15, 1996 Determination Order, claimant did not assert that the claim was prematurely closed nor did he disagree with the medically stationary date. (Ex. 6). Rather, the only issues raised by claimant in his request for reconsideration concerned the extent of unscheduled permanent disability. (Exs. 6, 10-4). Pursuant to ORS 656.283(7), "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." Therefore, claimant was precluded from contesting the medically stationary date at hearing and on review. See William T. Masters, 48 Van Natta 1788 (1996) (where issue was not raised at the time of reconsideration, the claimant was precluded from raising the issue for the first time at hearing).

Even assuming that claimant had properly preserved the issue, we agree with the employer that there is no medical evidence supporting the ALJ's finding.[1] Dr. Rabie specifically found claimant medically stationary on February 29, 1996 and recommended no further curative forms of treatment. (Ex. 3-2). In addition, after examining claimant on March 11, 1996, Dr. Rabie did not indicate that claimant's medical status had changed. Rather, he stated that the treatment necessitated by claimant's post-epidural headache was palliative and that no further treatment was anticipated. (Ex. 3B-2). In April 1996, Dr. Bald expressly agreed that claimant was and had remained medically stationary since February 29, 1996. (Exs. 3C-4, 3F-1).

Consequently, on this record, we conclude that claimant has failed to prove that he was not medically stationary on February 29, 1996.

Extent of Unscheduled Disability

The ALJ found that claimant established entitlement to an award of 6 percent unscheduled permanent disability by a preponderance of the evidence. Citing to the findings of the medical arbiter and the findings of Dr. Rabie on the day he declared claimant medically stationary, the employer argues that claimant has not proven that he is entitled to an unscheduled permanent disability award as a result of his compensable injury. We agree.

Permanent impairment is established by a preponderance of the medical evidence, considering the arbiter's examination as well as any prior relevant impairment findings. See Raymond L. Owen, 45 Van Natta 1528 (1993), aff'd Roseburg Forest Products v. Owen, 129 Or App 442 (1995). In evaluating claimant's permanent disability, 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).

Here, when he examined claimant on February 29, 1996, Dr. Rabie measured claimant's lumbar motion and found "full and normal" movement. He noted that claimant could squat with ease and rise independently to a standing position, and that the straight leg raising test was carried out "easily and smoothly" and without referred low back pain. (Ex. 3-1). Based on claimant's range of motion and neurological examination, Dr. Rabie concluded that claimant had no functional impairment and was capable of returning to his regular work. (Ex. 3-2).

Six weeks later, claimant was evaluated by Dr. Bald. Dr. Bald found no objective measurable neurological defects and slightly reduced lumbar range of motion, although he did not indicate whether claimant's range of motion findings met the validity criterion required by the administrative rules. (Exs. 3C-4, 3F-3). Dr. Rabie concurred with Dr. Bald's findings and recommendations. (Ex. 3D).

The medical arbiter, who examined claimant on September 21, 1996, also found slightly reduced lumbar range of motion but reported that the findings were invalid because they did not meet the straight leg raising validity check. (Ex. 9-3). The medical arbiter also found, among other things, some magnification of symptoms. Id. The arbiter concluded that claimant showed no evidence of objective abnormality as a result of his compensable injury.

Considering Dr. Rabie's report that claimant had "full and normal" range of motion and no functional impairment at the time he became medically stationary and the medical arbiter's determination several months later that claimant had no objective abnormality and that, to the extent claimant exhibited reduced motion, his examination findings were invalid, we conclude that claimant has not established his entitlement to an unscheduled permanent disability award by a preponderance of

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[1] Claimant has the burden of proving that he was not medically stationary on February 29, 1996. See, e.g. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

the evidence. Both the attending physician and the medical arbiter offered complete and well-reasoned evaluations of claimant's injury-related impairment and neither physician's findings support an award for loss of lumbar motion.[2] Consequently, we reverse the ALJ's finding to the contrary.

ORDER

The ALJ's order dated January 30, 1997 is reversed. The October 11, 1996 Order on Reconsideration is reinstated and affirmed in its entirety.

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[2] Although Dr. Rabie later concurred with Dr. Bald's report (finding reduced lumbar range of motion), this concurrence does not create a preponderance of medical opinion establishing a different level of impairment from that found by the medical arbiter, especially since Dr. Bald did not apply OAR 436-035-007(27) and did not comment on the validity of claimant's range of motion findings.

In the Matter of the Compensation of
LINDA L. LEBLANC, Claimant
WCB Case No. 96-07211
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denials of her injury and occupational disease claims for a low back condition. On review, the issue is compensability.

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

On review, claimant contends there is no medical evidence to support the ALJ's finding that her disability and need for treatment following the April 25, 1996 incident at work were due to a "combined condition." We disagree. An MRI scan showed mild degenerative changes in the facets at L3 through S1, with mild disc bulging, and Tarlov cysts. (Ex. 6). It is undisputed that the degenerative changes preexisted the April 1996 incident.

In addition, claimant had a four-year history of low back symptoms prior to the April 1996 incident. (Tr. 7, 10). She described the preexisting symptoms as intermittent low back aching related to increased activity. (Tr. 10-11).

Finally, in addition to evidence of a preexisting pathology and symptoms in the low back, there are medical opinions indicating the preexisting condition combined with the April 1996 incident to cause disability and the need for treatment. Dr. White, examining neurosurgeon, opined that the major contributing cause of claimant's current low back pain is the preexisting degenerative condition. (Ex. 10-4).

Dr. MacRitchie, treating physician, disagreed with Dr. White's opinion, and opined that the April 1996 incident was the major cause of claimant's symptoms. (Ex. 13). At the same time, however, Dr. MacRitchie did not rule out the preexisting condition as a contributing factor. Rather, she indicated that claimant's work exposure probably was "a major cause" of the degenerative changes "or at least causing them to be symptomatic and requiring treatment." (Ex. 11). By stating that work probably caused the preexisting degenerative changes to become symptomatic and require treatment, Dr. MacRitchie appeared to suggest that there was a combination of the preexisting condition and work exposure. Thus, even Dr. MacRitchie's opinion supports the finding that claimant's need for treatment following the April 25 incident was the result of a "combined condition."

Claimant cites to Dr. Blair's diagnosis of an "acute lumbosacral strain [with left] sciatic radiculitis" on April 26, 1996 (one day after the work incident) and argues that she has established a compensable claim based on that diagnosis of an acute injury. (Ex. 3). However, Dr. Blair's diagnosis was made without the benefit of the June 19, 1996 MRI scan which revealed the multi-level degenerative changes in the spine. (Ex. 6). There is no indication in the record that Dr. Blair was ever aware of claimant's preexisting degenerative condition. Thus, we cannot determine whether Dr. Blair's diagnosis would remain the same had he known of the preexisting condition. For this reason, Dr. Blair's diagnosis is unpersuasive.[1]

Based on this record, therefore, we agree with and adopt the ALJ's finding that claimant's current low back condition is a "combined condition," and that claimant must prove her injury claim under the "major contributing cause" standard in ORS 656.005(7)(a)(B). For the reasons discussed by the ALJ, we also agree that claimant has not carried her burden of proof by a preponderance of the evidence.

ORDER

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

[1] Similarly, we are unpersuaded by Dr. Hirons' early diagnosis of "[l]ow back pain, related to stooping injury at work," (Ex. 2), which was also made before the degenerative changes in claimant's lumbar spine were discovered.

In the Matter of the Compensation of
KATHY L. PAUL, Claimant
WCB Case No. 96-04559
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) declined to admit certain exhibits; and (2) affirmed an Order on Reconsideration awarding 25 percent (80 degrees) unscheduled permanent disability for an upper back condition. In her brief, claimant also challenges that portion of the ALJ's order concerning unscheduled permanent disability, asserting that she is entitled to a greater award. On review, the issues are evidence and extent of unscheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

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

The parties submitted the issue of extent of unscheduled permanent disability to the ALJ based on the record without a hearing. After the employer submitted exhibits, claimant submitted additional documents for inclusion in the record. Neither party objected to the exhibits submitted to the ALJ.

In his order, the ALJ decided that a portion of Exhibits 45 and 53, as well as Exhibits 47, 51, and 54, which had been submitted by the employer, were not admissible because they had not been provided to the Department during reconsideration. In making this decision, the ALJ cited to the "Explanatory Notes" accompanying the Order on Reconsideration.

The employer moved to abate and reconsider the ALJ's order. The employer argued that some of the exhibits found inadmissible by the ALJ had been submitted on reconsideration and accompanied its motion with a certified copy of the reconsideration record. The ALJ denied the motion on the basis that the submitted record at hearing should have been verified as having been submitted on reconsideration before the ALJ closed the record and issued his order.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable claim for thoracic strain. In February 1996, the employer issued a Notice of Closure that awarded temporary disability and 13 percent unscheduled permanent disability. On April 29, 1996, an Order on Reconsideration increased claimant's unscheduled permanent disability award to 25 percent. The employer requested a hearing, asserting that claimant was not entitled to the amount awarded by the Order on Reconsideration.

Evidence

The ALJ refused to admit the following disputed documents. Pages 9 through 22 of Exhibit 45 includes a job analysis report, claimant's treating physician's approval of the report, and documents pertaining to vocational assistance; all documents were dated before April 9, 1996. Page 2 of Exhibit 53 is a handwritten response from Dr. Cade to the employer's attorney. Exhibit 54 is a letter dated March 8, 1996 from the employer's attorney to Dr. Cade with Dr. Cade's signature of concurrence with the contents.

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."

Under this statute, evidence that was not previously offered on reconsideration is inadmissible at hearing. Precision Castparts v. Plummer, 140 Or App 227 (1996).[1]

Here, the certified reconsideration record submitted by the employer shows that all the documents described above were part of the record on reconsideration and, thus, were submitted on reconsideration.[2] Consequently, we conclude that ORS 656.283(7) does not prohibit their admission at hearing. Inasmuch as the excluded documents are part of the file on review, we consider them in conducting our review. E.g., Verda K. Harmon, 46 Van Natta 2307 (1994).[3]

Extent of Unscheduled Permanent Disability

The employer asserts that claimant is not entitled to more than the 13 percent unscheduled permanent disability awarded by the Notice of Closure. Specifically, the employer challenges the factors of education and adaptability.

Education

The education factor is determined according to the worker's formal education and the highest Specific Vocational Preparation (SVP) of the employment performed during the five years preceding the time of determination. Former OAR 436-35-300(3) (WCD Admin. Order 93-056). SVP is determined

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[1] The court recently considered the application of ORS 656.283(7) where the claimant's testimony that was not submitted during reconsideration was admitted at hearing without objection but then challenged on review before the Board. The court held that, based on the Board's "well-established practice" not to consider issues that were not raised at hearing, "[b]ecause employer did not object to claimant's testimony at hearing, the Board should not have entertained employer's argument, first made to the Board, that the evidence was not admissible." Fister v. SAIF, 149 Or App 214 (1997). Here, unlike Fister, because the evidence issue was raised before the ALJ, we find it appropriate to address the matter.

[2] We may take official or administrative notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned." E.g., Rodney J. Thurman, 44 Van Natta 1572 (1992). An act of a state agency is one category of "fact" which satisfies the aforementioned criteria. Phyllis Swartling, 46 Van Natta 481 (1994). Here, because the certification of the reconsideration record is an act of state agency, we may take administrative notice of the fact that the disputed documents were part of the reconsideration record.

[3] Because we can consider on review the documents excluded by the ALJ, we need not address whether he abused his discretion in denying the employer's motion for abatement and reconsideration. See OAR 438-007-0025(1) (providing that an ALJ may reopen the record and reconsider his or her decision upon a party's motion showing "error, omission, misconstruction of an applicable statute or the discovery of new material evidence").

according to the applicable DOT code. Former OAR 436-35-300(3)(a). "When a combination of DOT codes most accurately describes a worker's duties, the highest SVP shall apply if the worker has met the specific vocational preparation training time for that specific code." Id.

The parties agree that claimant is entitled to 0 for her formal education. The Order on Reconsideration based the education factor of 4 on finding that claimant's work fit under Packager, DOT 920.587-018,[4] which has an SVP of 2. The employer asserts that SVP should be based on Patcher, DOT 769.684-030,[5] which is classified with an SVP of 3, resulting in an education factor of 3.

Claimant submitted a written statement on reconsideration explaining that she worked at a wood door manufacturing plant and her "main position" was as a wrapper. (Ex. 52B-1) Claimant further stated that she also performed "fill-in work as a patcher" and this job required the use of various hand tools, including orbital sanders, sliver saws, wood welders, belt sanders, handsaws, chisels and putty knives. (Id. at 1-2).

This description of claimant's job is consistent with medical reports. Dr. Cade, claimant's treating general practitioner, recorded that claimant "has a job where she is finishing doors" where she "has to sand, fix and tape doors, lift doors, etc." (Ex. 11-1). Dr. Cade also reported that claimant "works in two different positions; one for five hours and the other for three hours[.]" (Id.) Dr. Belza, who also treated claimant for a short time, indicated that claimant "works as a door wrapper/patcher." (Ex. 17-1). The Form 801 lists claimant's job as "Packager" but states that claimant felt her back hurting while "patching doors." (Ex. 3).

The Order on Reconsideration apparently based SVP on the "Packager" job because the employer's claims examiner provided job analyses to Dr. Stewart, claimant's treating physical medicine specialist, for "Packager/Wrapper," DOT 920.587-018, asking Dr. Stewart if claimant could be released to her "regular work." (Exs. 45, 49). An eligibility evaluation report for vocational services also stated that claimant's position was a "Packager/Wrapper," DOT 920.587-018. (Ex. 45-19).

We find more persuasive the evidence showing that claimant's job was a combination of "Packager" and "Patcher." Such evidence came either directly from claimant, as from her written statement submitted on reconsideration, or obtained from claimant by her treating physicians. As discussed above, when a combination of DOT codes most accurately describes the worker's job, the highest SVP applies. Former OAR 436-35-300(3)(a). Consequently, claimant's SVP is 3, resulting in a value of 3. Former OAR 436-35-300(4). Thus, claimant's education value is 3. Former OAR 436-35-300(6).

Adaptability

Adaptability is determined by comparing the worker's Base Functional Capacity (BFC) with the maximum Residual Functional Capacity (RFC). Former OAR 436-35-310(2). RFC is the worker's "remaining ability to perform work-related activities despite medically determinable impairment

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[4] The Packager position is defined as follows:

"Packages materials and products manually, performing any combination of following duties: Cleans packaging containers. Lines and pads crates and assembles cartons. Obtains and sorts product. Wraps protective material around product. Starts, stops, and regulates speed of conveyor. Inserts or pours product into containers from spout or chute. Weighs containers and adjusts quantity. Nails, glues, or closes and seals containers. Packs special arrangements or selections of product. Inspects materials, products, and containers at each step of packaging process. Records information, such as weight, time, and date packaged. * * *"

[5] A Patcher is defined as:

"Repairs defects in surfaces of finished lumber, wood doors, veneer sheets, and plywood panels to improve appearance and increase market value, performing any combination of following tasks: Examines material to be repaired to determine type of repair needed. Mixes specified amounts of colored putties or patching compound with paint thinner to obtain workable consistency and fills defects, such as cracks, splits, and crevices with mixture, using putty knife. Cuts defective sections from material, using portable router or saw. Glues and sets shims, or trims and inserts wood patches in locations where defects have been cut out, using glue and hammer. Brushes water on dents and raises grain in dent with hot iron. Smooths patched areas, using hand sander. Stacks patched material on conveyor for movement to next processing station. * * *"

resulting from the accepted compensable condition." Former OAR 436-35-310(3)(b). The employer does not challenge the Order on Reconsideration's finding that claimant's BFC is medium.[6] The employer disagrees, however, with the order's finding that claimant's RFC is sedentary/light. The employer contends that RFC should be found to be medium with restrictions.

On January 23, 1996, Dr. Stewart approved the job analysis for "Packager/Wrapper," with the provisions that claimant "have help with lifting weight over 40 pounds" as well as "assistance with changing the 25 pound shrink wrap rolls[.]" (Ex. 45-8). On February 20, 1996 (apparently because the modified Packager/Wrapper job was not available), Dr. Stewart approved a job analysis for "Woodworking Machine Feeder/Off-Bearer." (Ex. 45-12). On February 26, 1996, however, Dr. Cade restricted claimant to "pure light duty," with no lifting over 10 pounds. (Ex. 52). On March 8, 1996, Dr. Cade concurred with a letter written by the employer's attorney stating that Dr. Cade would "defer to Dr. Stewart on the question of claimant's release for work" and that such deferral "nullifies the work release that you filled out on February 26, 1996." (Ex. 54).

Because Dr. Stewart approved the "Woodworking Machine Feeder/Off-Bearer" position and Dr. Cade ultimately deferred to Dr. Stewart concerning the work release issue, we consider the job analysis for the approved position as representing claimant's treating physicians' opinions of her "remaining ability to perform work-related activities." We also consider such evidence to be more persuasive than the medical arbiter's indication that claimant's RFC was sedentary/light, (Ex. 56). Claimant had extensive contact with her physicians, as opposed to the sole examination with the arbiter. Furthermore, the arbiter's recitation in its report of the medical reports ends with Dr. Cade's restriction to sedentary work, indicating that the arbiter was unaware of Dr. Stewart's subsequent approval of the "Woodworking Machine Feeder/Off-Bearer" position and Dr. Cade's deferral to Dr. Stewart's opinion.

The job analysis for "Woodworking Machine Feeder/Off-Bearer" includes the requirement of frequent lifting and carrying of various items from 1 to 10 pounds and occasional lifting and carrying of product weighing up to 35 pounds. (Ex. 45-11). Based on this evidence, claimant falls in the medium/light category. Former OAR 436-35-310(3)(g).[7] We further find that claimant has restrictions since the job analysis provides for no climbing, crawling, or balancing. Former OAR 436-35-310(3)(l)(C). Because claimant's RFC fall between two categories and she also has restrictions, her RFC is light. Former OAR 436-35-310(7). Comparing the RFC of light to the BFC of medium results in an adaptability value of 3. Former OAR 436-35-3310(6).

The employer does not challenge the factor of 1 for age. Adding the age and education factors results in a value of 4 (1+ 3). Multiplying that value with the adaptability factor results in 12 (4 x 3). The employer also does not challenge the impairment value of 5 percent which, added to 12, results in 17 percent unscheduled permanent disability.

ORDER

The ALJ's order dated December 6, 1996 is reversed in part and modified in part. That portion of the order finding inadmissible a portion of Exhibits 45 and 53, as well as Exhibits 51 and 54, is reversed. In lieu of the ALJ's order, the Order on Reconsideration's award of 25 percent (80 degrees) unscheduled permanent disability is reduced to 17 percent (54.4 degrees) unscheduled permanent disability. The Order on Reconsideration's "out-of-compensation" attorney fee is modified accordingly. The ALJ's attorney fee award is reversed.

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[6] In her brief, claimant contends that her BFC is heavy, thus entitling her to a greater adaptability factor and an award of 35 percent unscheduled permanent disability. Inasmuch as claimant asserts for the first time on review that she is entitled to a greater permanent disability award, we do not consider it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

[7] "Light" is defined as requiring the ability to occasionally lift 20 pounds and frequently lift or carry objects weighing 10 pounds. Former OAR 436-35-310(3)(f). "Medium" means the worker can occasionally lift 50 pounds and frequently lift or carry objects weighing up to 25 pounds. Former OAR 436-35-310(3)(h). "Medium/Light" means the worker can do more than light activities but less then the full range of medium activities. Former OAR 436-35-310(3)(g). Because the job analysis provides for occasional lifting and carrying of up to 35 pounds, although limited to frequent lifting of 10 pounds, we find that claimant can do more than light activities but less than what is required for medium work.

In the Matter of the Compensation of
ROBERT S. WIGGET, Claimant
WCB Case No. 96-08995
ORDER ON REVIEW
Robert J Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its denial of claimant's current low back condition; (2) set aside its denial of claimant's aggravation claim; (3) assessed a penalty for an allegedly unreasonable denial; and (4) awarded claimant's counsel a fee in the amount of $5,000 for services at hearing. On review, the issues are compensability, aggravation, penalties and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the first sentence of the first finding of ultimate fact, and with the following correction.

On March 4, 1992, the insurer denied claimant's 1991 injury claim on the ground that it was not work-related and that responsibility rested with the prior carrier.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation to address the insurer's contention that ORS 656.005(7)(a)(B) is applicable in this case.

The ALJ found that claimant's degenerative disc disease (DDD) was an accepted component of his 1991 claim with the insurer and, under the doctrine of res judicata, concluded that the insurer is barred from attempting to litigate an issue which was fully litigated in a prior proceeding. The insurer contends that, under the provisions of ORS 656.005(7)(a)(B), it is not precluded from denying claimant's DDD and, on the merits, that condition is not compensable.

In order for ORS 656.005(7)(a)(B) to apply, a compensable injury must combine with the preexisting condition. Based on the following reasoning, we hold that, even if res judicata did not preclude the insurer's denial, the aforementioned statute has no application to this case.

Here, claimant's DDD was ordered accepted by a July 31, 1992 litigation order which was affirmed by the Board and not appealed further. (Ex. 25-6). Thus, there is no preexisting condition; only claimant's DDD, which is compensable as a matter of law. Moreover, there is no evidence that the compensable DDD combined with any other preexisting condition.[1] Consequently, ORS 656.005(7)(a)(B) does not apply to this case. See James M. King, 47 Van Natta 1563 (1995); (neither former nor amended ORS 656.005(7)(a)(B) applicable where claimant's preexisting coronary artery disease was found compensable by the court); Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (same in regard to preexisting osteomyelitis condition); Joyce E. Soper, 46 Van Natta 740 (1994) (former ORS 656.005(7)(a)(B) not applicable where the claimant's preexisting degenerative arthritis condition was ordered accepted by a prior litigation order).[2]

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[1] We note that claimant has been diagnosed with bilateral spondylolysis and spondylolysthesis at L5-S1, which preexisted his 1989 low back injury. (Exs. 4, 9, 10, 35, 40, 42, 47, 63). However, there is no medical evidence that these conditions have combined with claimant's degenerative disc disease. Claimant has also been diagnosed with Scheuermann's disease. (Exs. 47, 63). Although this condition may have disposed claimant to the premature development of degenerative disc disease, Dr. Young indicated that the condition is healed. (Ex. 63).

[2] ORS 656.262(6)(c) provides that a carrier is not precluded from later denying a "combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition." However, as with ORS 656.005(7)(a)(B), a "combined" condition is a prerequisite for application of this statutory provision. As noted in our order, claimant's degenerative disc condition is the compensable condition and has not combined with any other preexisting condition or disease. Consequently, ORS 656.262(6)(c) is likewise not applicable to this case.

Aggravation

The ALJ found that claimant established a compensable aggravation, based on the opinion of Dr. Gallo, claimant's long-time treating physician. The insurer contends that the ALJ erred in declining to consider the limiting effects of claimant's prior noncompensable aggravation claim, and that claimant failed to establish that his condition actually worsened. We interpret the insurer's first contention as an assertion that claimant's prior aggravation claim establishes the baseline for determining a worsening. We do not agree.

Claimant filed an aggravation claim on May 11, 1994, which was denied by the insurer. A January 19, 1995 Opinion and Order, affirmed by the Board, found that claimant's condition had not worsened and upheld the denial. On September 16, 1996, claimant filed another aggravation claim, which is the subject of the present dispute.

We addressed the effect of a prior noncompensable aggravation claim in Caroline F. Wood, 46 Van Natta 2278 (1994). In Wood, the insurer argued that issue preclusion changes the baseline for determining a worsening from the last arrangement of compensation to the last order regarding a prior aggravation claim. We concluded that, although issue preclusion would prevent claimant from relitigating the determination that she had not established a compensable aggravation as of the prior order, it does not change the statutory baseline for the determination of a worsening regarding any future aggravation claims.

ORS 656.273(1) provides that claimant must prove a worsening "[a]fter the last award or arrangement of compensation." Here, therefore, the ALJ properly determined that claimant must prove that his compensable condition worsened since the last arrangement of compensation, which is the September 14, 1992 Notice of Closure.

We now turn to the insurer's assertion that claimant failed to establish an actual worsening. 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." The term "actual worsening" may be established by direct medical evidence of a pathological worsening, or, for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that symptoms have increased to the point that it can be said that the condition has worsened. SAIF v. Walker, 145 Or App 294, 305 (1996). Absent such evidence, it is no longer permissible for the fact finder "to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim." Id.

As discussed above, claimant's compensable condition is his DDD. Thus, the question is whether claimant's degenerative condition has actually worsened since the September 14, 1992 Notice of Closure, which awarded no permanent disability. We conclude that it has not.

In October 1991, an MRI revealed a decrease in height of the interspace and progression of disc dessication changes at L5-S1, which Dr. Gallo treated with a course of epidural steroid injections, physical therapy and a brace. (Ex. 15-1, 23-2). On May 28, 1992, Drs. Barth and Duff examined claimant, who complained of low back pain and intermittent left posterior leg pain, usually to the knee, but on occasion to the heel of his left foot. (Ex. 23-3). The doctors found no weakness or numbness in the legs, no tenderness or muscle spasm in the low back. Claimant had normal reflexes (knee and ankle jerks at 2+), strength, sensation, and range of motion. The doctors declared claimant medically stationary; Dr. Gallo concurred in their report. (Exs. 23-4, -5 -6; 24).

In January 1996, claimant returned to Dr. Gallo for treatment, complaining of low back and right leg pain which had been worsening over time. Dr. Gallo continued to treat claimant over the year. On September 16, 1996, Dr. Gallo requested claim reopening and arthrodesis surgery at L5-S1. (Id.) However, Dr. Gallo did not indicate that claimant's degenerative condition had pathologically worsened. Nor did she conclude that claimant's symptoms had increased to the point that she could say the condition had worsened.[3] To the extent Dr. Gallo addressed this question, she stated that: "[claimant] has suffered a downhill course of progressively worsening low back symptoms" but that she could not "reinforce this opinion with any of his radiographic studies." (Ex. 64).

[3] Moreover, her request for arthrodesis surgery does not prove a worsening. See ORS 656.273(1)(b).

Dr. Young, radiologist, performed a records review for the insurer. Dr. Young compared the 1996 studies, which showed moderate degeneration, annular fissuring and a full thickness annular tear in the posterior lateral aspect on the right, associated with a minor annular bulge, at L5-S1, with those of 1991 and 1994. Dr. Young assessed claimant's clinical presentation as "chronic intermittent back pain since his 1989 surgery, associated with 'radicular type' symptoms involving both legs, with pain predominately in the low back and not the legs." Dr. Young opined that, because the disc remained morphologically (structurally) unchanged, that claimant's current symptoms were no more than the normal progression of his degenerative condition.

Because neither Dr. Gallo nor Dr. Young concluded that claimant's degenerative condition had "actually worsened," we find that claimant has failed to establish his aggravation claim.

Penalties

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

Attorney Fees

The ALJ awarded claimant's counsel a $5,000 insurer-paid attorney fee for finally prevailing over the insurer's denials of claimant's current condition claim and aggravation claim. Inasmuch as we have upheld the insurer's aggravation denial, we must modify the ALJ's attorney fee award. In addition, because claimant has successfully defended the ALJ's compensability decision regarding the current condition issue, claimant is entitled to an attorney fee for services on review devoted to that 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 at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to these issues (as represented by the hearing record and claimant's respondent's brief), the complexity of the issues, and the value of the interests involved. No attorney fee is awarded for claimant's counsel's services at hearing/review regarding the aggravation issue or on review regarding the penalty/attorney fee issues.

ORDER

The ALJ's order dated March 12, 1997, is affirmed in part, reversed in part and modified in part. That portion of the ALJ's order that found claimant's aggravation claim compensable is reversed and that portion of the insurer's denial is reinstated and upheld. That portion of the ALJ's order awarding claimant's counsel an attorney fee of $5,000 is modified. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $3,500 for services at hearing and on review regarding the compensability issue, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

August 13, 1997 Cite as 49 Van Natta 1309 (1997)

In the Matter of the Compensation of
SHAWN R. STONE, Claimant
WCB Case No. 96-02481
ORDER OF ABATEMENT
Cole, Cary & Wing, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

On July 25, 1997, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's consequential condition/reflex sympathetic dystrophy claim. We have since received the insurer's announcement that the parties have settled their disputes in this case, as well as WCB Case No. 96-06052, a case which is currently pending review. In light of such circumstances, we interpret the insurer's action as a motion to withdraw our July 25, 1997 order to enable us to retain authority to consider their forthcoming settlement.

Accordingly, we grant the motion and withdraw our July 25, 1997 order. On receipt of the parties' proposed settlement, we will proceed with our reconsideration. In the meantime, the parties are requested to keep us apprised of any further developments regarding this case.

IT IS SO ORDERED.

August 13, 1997 Cite as 49 Van Natta 1310 (1997)

In the Matter of the Compensation of
PETER G. WYLIE, Claimant
WCB Case No. 96-03042
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its partial denial of claimant's current right knee condition. On review, the issue is compensability.

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

The insurer argues that only chondromalacia is at issue in this case, not claimant's "current" right knee condition. However, because the persuasive medical evidence indicates that the compensable strain injury combined with claimant's preexisting chondromalacia "to cause or prolong disability or a need for treatment," this is a claim for a current combined condition under ORS 656.005(7)(a)(B). Compare Reynolds Metals v. Thrasher, 133 Or App 30, 33 (1995) (Where the issue was a partial denial of chondromalacia only, the Board erred in addressing the compensability of the current resulting condition).

In addition, because we agree with the ALJ that the opinion of Dr. Lipp, treating surgeon, persuasively establishes that the accepted 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," we also conclude that the insurer's partial denial of claimant's current right knee condition must be set aside. See ORS 656.005(7)(a)(B); Robinson v. SAIF, 147 Or App 157 (1997).

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

ORDER

The ALJ's order dated January 24, 1997 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

In the Matter of the Compensation of
WILLARD A. HIRSCH, Claimant
WCB Case Nos. 96-08306 & 96-02836
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order which: (1) upheld Liberty Northwest Insurance Corporation's denial, issued on behalf of Western Foundry, of claimant's occupational disease claim for a bilateral hearing loss condition; and (2) upheld Liberty's denial, issued on behalf of Varicast, of claimant's occupational disease claim for the same condition. On review, the issue is compensability.

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

On review, claimant contends that, in determining whether his hearing loss claim is related in major part to noise exposure at work, we should not weigh the relative contribution of presbycusis as a causative factor. Claimant acknowledges that his contention is inconsistent with our analysis in a similar hearing loss case, Henry F. Downs, 48 Van Natta 2094, recon 48 Van Natta 2200 (1996). He requests, however, that we reconsider our analysis in Downs. We decline to do so. Like the claimant in Downs, claimant's "disease" is his entire bilateral hearing loss. In order to establish the compensability of the hearing loss as an occupational disease under ORS 656.802(2)(a), claimant must prove that "employment conditions were the major contributing cause of" his entire hearing loss.

As in Downs, it is immaterial whether claimant's presbycusis is a "preexisting condition" within the meaning of ORS 656.005(24) or whether claimant's hearing loss is a "combined condition" within the meaning of ORS 656.005(7)(a)(B) or ORS 656.802(2)(b).[1] Claimant must prove that work exposure was the major contributing cause of his hearing loss. The greater weight of the medical evidence establishes that claimant's hearing loss was caused in major part by age-related presbycusis, not noise exposure. Drs. Hodgson and Bakos, both otolaryngologists, opined that the major contributing cause of claimant's hearing loss was presbycusis. (Exs. 11-4, 13, 17).

Dr. Edgerton, audiologist, disagreed. He opined that claimant's noise exposure prior to his employment with Varicast beginning in 1984 "had a much greater impact" than age on his hearing. (Ex. 14). However, Dr. Edgerton subsequently agreed that he could not say with reasonable medical probability what percentage of the noise exposure related to work and what percentage related to off-work exposures such as firearms and chainsaws. (Ex. 21-1). He also agreed that he could not say with reasonable medical probability whether work was the major contributing cause of claimant's hearing loss. (Id.)

In the light of Dr. Edgerton's uncertainty regarding the major cause of claimant's hearing loss, and Drs. Hodgson and Bakos' opinion that the hearing loss is primarily age-related, we agree with the ALJ that there is a failure of proof.

ORDER

The ALJ's order dated February 26, 1997 is affirmed.

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[1] Given our conclusion that the "combined condition" analysis under ORS 656.005(7)(a)(B) is not dispositive of this case, we reject claimant's contention that the Court of Appeals' interpretation of ORS 656.005(7)(a)(B) in SAIF v. Nehl, 148 Or App 101 (1997), is supportive of his claim. The Nehl court did not address the "major contributing cause" standard in the occupational disease statute, ORS 656.802(2)(a). Thus, the analysis in Nehl is not applicable here.

In the Matter of the Compensation of
JEANNE E. WHEELER, Claimant
WCB Case No. 96-09320
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denial of her occupational disease claim for left carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer as a legal secretary in 1985. Her work involved hand intensive activity associated with typing and handling papers. In 1992, claimant sought treatment for aching in her neck, back, shoulders, arms and hands, and was diagnosed with early carpal tunnel syndrome and overuse syndrome. (Ex. 1).

Claimant continued to have hand, wrist and shoulder pain. In November 1994, claimant underwent nerve conduction testing which was normal on the left but revealed slowing on the right side, indicative of carpal tunnel syndrome of moderate severity. (Exs. 2, 5). She was given a Cortisone injection of the right carpal canal which provided temporary relief.

Claimant experienced an increase in her right-sided symptoms when she engaged in heavy computer keyboard use in June 1995. She made a claim for right sided carpal tunnel syndrome on July 19, 1995. (Ex. 7). On July 20, 1995, Dr. Welch found bilateral numbness and tingling, worse on the right side. He diagnosed right carpal tunnel syndrome and noted that claimant's left-sided symptoms may be compensatory for avoidance of use of her right hand. (Ex. 8).

SAIF accepted claimant's right wrist carpal tunnel syndrome in August 1995. (Ex. 11). Dr. Welch opined that claimant's work activity was the major cause of her need for treatment. (Ex. 12). On September 21, 1995, claimant underwent a right carpal tunnel release. (Ex. 15). On October 2, 1995, Dr. Welch noted that claimant showed right-sided improvement since the surgery but that she continued to be having left-sided symptoms. (Ex. 17).

Claimant returned to modified work following her surgery and was released for full duty work on December 20, 1995. (Exs. 19 -22). At work, claimant continued to favor her right hand and her left-sided symptoms worsened. (Tr. 17). Her right carpal tunnel syndrome claim was closed by a Notice of Closure dated February 13, 1996. (Ex. 25).

Meanwhile, claimant was terminated from her employment on February 29, 1996. (Tr. 17). Although some of her arm pain resolved, claimant still noted pain in her left wrist and numbness in her hand and fingers. (Tr. 18). On May 14, 1996, claimant sought treatment from Dr. Long, complaining of left forearm and hand pain and numbness. Dr. Long performed diagnostic tests and diagnosed, among other things, bilateral carpal tunnel syndrome with clear median compression neuropathy in the left palm. (Ex. 27).

Claimant was examined by Dr. Hill on May 21, 1996, who diagnosed symptomatic left-sided carpal tunnel syndrome related to her previous occupation as a legal secretary. (Ex. 29). Claimant was seen by Dr. Button at SAIF's request on July 24, 1996. Dr. Button diagnosed carpal tunnel syndrome related to idiopathic factors. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

The ALJ rejected all of the expert medical opinions and concluded that claimant failed to prove the requisite causal connection between her work activities and her left carpal tunnel syndrome. On review, claimant urges us to rely on the causation opinions of Drs. Long and Hill and find that she has established the compensability of her left carpal tunnel syndrome by a preponderance of the evidence.

In order to prove the compensability of her left carpal tunnel syndrome as an occupational disease, claimant must show that "employment conditions were the major contributing cause of the disease or its worsening." ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. See Dietz v. Ramuda, 130 Or App 397 (1994); McGarrah v. SAIF, 296 Or 145, 166 (1983).

Here, four doctors have expressed opinions concerning the cause of claimant's left carpal tunnel syndrome. Drs. Hill and Long have opined that claimant's occupation as a legal secretary is the major contributing cause of her condition, whereas Drs. Button and Radeki (who reviewed claimant's medical records at SAIF's request) relate her condition to other factors, including her weight, gender and age.

In evaluating medical evidence concerning causation, we give the most weight to those opinions which are both well- reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). Absent persuasive reasons to do otherwise, we generally give greater weight to the conclusions of a claimant's treating physician. Weiland v. SAIF, 64 Or App 810 (1983).

As evidenced by his report, Dr. Long took a detailed history of claimant's symptoms and work activities when he examined her on May 14, 1996. He noted that claimant had developed bilateral carpal tunnel symptoms over time, which were clinically noticeable as of July 1995, and that her right-sided symptoms were generally more severe. He reported that after claimant returned to work following her right carpal tunnel release surgery, her symptoms persisted on the left side. Dr. Long also noted that diagnostic testing showed a deterioration in claimant's left median function between November 1994 and May 1996. (Ex. 27). He concluded that, like her right sided carpal tunnel syndrome, claimant's left carpal tunnel syndrome was related to her 10 year history of work as a legal secretary. (Exs. 27, 36).

Dr. Long also responded to the contrary opinions of Drs. Button and Radeki. Dr. Long specifically disputed Dr. Radeki's theory that claimant's carpal tunnel syndrome related primarily to her age, sex and body mass index. Dr. Long cited to medical literature documenting an increased incidence and prevalence of carpal tunnel syndrome in individuals who do hand intensive work. He determined that claimant developed median compression in her palms as a result of her occupation, and that she had bilateral carpal tunnel syndrome, right worse than left, when she was examined by Dr. Welch in July 1995. Dr. Long explained that claimant's work as a legal secretary was somewhat more intensive on her dominant right hand than on the left which is why she developed right-sided symptoms sooner and more severely. He concluded claimant's left median compression progressed as she favored her right hand and maximized the use of her left hand in the 18 months between November 1994 and May 1996.

Like Dr. Long, Dr. Hill opined that claimant's occupation was the major contributing cause of her left carpal tunnel syndrome. (Ex. 29). Dr. Hill expressly disagreed with Dr. Button's report, explaining that claimant was having symptoms of left sided carpal tunnel syndrome related to her work activity prior to her right carpal tunnel release which became more symptomatic as she favored her right hand after the surgery. (Ex. 33).

After reviewing the medical evidence, we find no persuasive reason not to rely on the causation opinions of Drs. Long and Hill, who treated claimant's condition. Both doctors had a complete and accurate understanding of claimant's work activities and symptom history and both concluded that her condition was caused in major part by her occupation as a legal secretary. Consequently, we conclude that claimant has established the compensability of her left carpal tunnel syndrome by a preponderance of the evidence.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,500, 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 and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 10, 1997 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded $5,500, payable by SAIF.

In the Matter of the Compensation of
JOSE L. VILLEGAS, Claimant
WCB Case No. 96-09207
ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our July 21, 1997 Order on Review, which affirmed the Administrative Law Judge's (ALJ's) order finding that the Hearings Division had jurisdiction to determine the rate of claimant's temporary disability.

In order to consider this matter, we withdraw our July 21, 1997 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 will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLIFFORD C. BENSON, Claimant
WCB Case No. 96-08204
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that he sustained a compensable low back injury on March 15, 1996 which combined with a preexisting condition. Relying on the opinion of his treating orthopedic surgeon, Dr. Johnson, claimant further argues that he proved that the compensable injury is the major contributing cause of the combined condition, thus satisfying the compensability standard under ORS 656.005(7)(a)(B). SAIF responds that claimant did not show that he sustained an injury and, in any case, Dr. Johnson's opinion is not sufficiently persuasive to carry claimant's burden of proof.

According to Dr. Johnson, claimant sustained an acute low back strain that was "superimposed on his degenerative spondylolysis." (Ex. 9-1). Dr. Johnson also stated that the major contributing cause of the need for treatment and disability was the work injury. (Id.) Dr. Johnson added that "after a six month time period [claimant's] strain should have resolved and the ongoing complaints [claimant] would have after that period of time would most likely be relatable to degenerative arthrosis rather than the acute strain portion of his combined injury." (Id. at 1-2). Dr. Johnson's report is dated October 2, 1996.

The remaining medical opinion is from Dr. Ireland, who also treated claimant on referral from Dr. Johnson. Dr. Ireland concurred with a "check-the-box" report stating that, if claimant sustained a strain at work, "it combined with the preexisting osteoarthritis but the preexisting condition remained the major contributing cause of the disability and need for treatment." (Ex. 10A).

Absent persuasive reasons to do otherwise, we defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Johnson's opinion. First, it is internally inconsistent. The report was written nearly seven months after the alleged work injury, putting claimant beyond the six-month period that, according to Dr. Johnson, was necessary for the strain to resolve. Dr. Johnson, however, did not follow this statement with the opinion that, unlike the norm, claimant's strain did not resolve within six months or otherwise explain why claimant's ongoing complaints were not caused by the preexisting condition. At minimum, we find Dr. Johnson's opinion confusing, lessening its persuasiveness. The persuasiveness of Dr. Johnson's opinion is further undermined by the opinion of Dr. Ireland, a physician to whom Dr. Johnson referred claimant, who attributed the major contributing cause of claimant's disability and need for treatment to his preexisting condition.

Consequently, whether or not claimant proved legal causation, we agree with the ALJ that the medical evidence is insufficient to prove medical causation.

ORDER

The ALJ's order dated January 3, 1997 is affirmed.

In the Matter of the Compensation of
PATRICIA L. BOWSER, Claimant
WCB Case No. 96-09415
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesley'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 order of the ALJ, with the following supplementation.

On review, the insurer argues that the present case is similar to our decision in James D. Johnson, 48 Van Natta 303 (1996). In Johnson, we concluded that the claimant had not established the required causal connection between his injury and a risk associated with his employment. There, when the claimant took a step at work on the level floor of the plant, his knee buckled, resulting in a torn meniscus. There was no evidence that the claimant slipped, twisted or tripped over anything on the floor. The claimant's doctors related the knee injury to work, but gave no explanation of how the work environment or activities contributed to the injury. The medical evidence established no causal connection between the injury and employment other than the fact that the injury occurred at work and during work hours. We concluded that the evidence was insufficient to carry the claimant's burden of proving that his injury arose out of employment. The court recently affirmed our decision. Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997).

In the present case, claimant reported that her knee either gave out" or "buckled." At the time her knee gave out, claimant was turning to reach for fries to fill a customer's order, while working at the employer's fast food restaurant. With respect to the medical evidence, claimant's treating physician, Dr. Hill, agreed that claimant's history of injury was consistent with her symptoms. Dr. Hill also checked a box indicating that the work injury was the major cause of claimant's right knee condition.

We find the present case to be distinguishable from Johnson. In Norpac Foods, Inc. v. Gilmore, 318 Or 363, 368 (1994), the court held that the claimant must show a causal link between the occurrence of the injury and a risk connected with his or her employment. Here, claimant's job required her to turn to fill orders by turning from the counter to the food line. Consequently, the risk that claimant would sustain a knee injury from twisting or turning to fill orders was a risk connected with her employment. Accordingly, we conclude that claimant established that her knee injury arose out of her employment.

Claimant's attorney is entitled to an 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 $650, to be paid by the insurer. 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 January 29, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $650, to be paid by the insurer.

In the Matter of the Compensation of
PATRICK E. LEWIS, Claimant
WCB Case No. 96-08450
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the insurer's denial of his injury claim for a right hand fracture. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. On page 2, we change the sixth sentence to read: "Gershawn spit on claimant."

CONCLUSIONS OF LAW AND OPINION

Claimant fractured his right hand at work on July 4, 1996 during an altercation with a customer. He contends that his injury occurred "in the course of" and "arose out of" his employment. Additionally, claimant asserts that his claim is not precluded under ORS 656.005(7)(b)(A), because he was not an active participant in the assault. We agree.

For an injury to be compensable under workers' compensation law, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1993). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. Id. In assessing the compensability of an injury, neither element is dispositive. Id.

We agree with the ALJ that claimant was injured in the course of employment because he was injured in an altercation during working hours while on the employer's premises.

The insurer argues that claimant's injury did not arise out of employment because the injury resulted from a personal dispute with a former friend and it asserts that the injury just happened to occur at claimant's work. We disagree.

Claimant was employed as a gas station attendant. He had been friends with Mr. Gershawn in 1993 and saw him socially for six to seven months, but stopped seeing him in early 1994 because he thought that Gershawn had taken something from his mother's home. Claimant confronted Gershawn, who denied it. Claimant subsequently saw Gershawn on the street, but did not meet or talk to him during the following approximately two years.

On July 1, 1996, or July 2, 1996, Gershawn came to the station where claimant worked. Claimant thought Gershawn was intoxicated because he was rude, loud and demanded that claimant serve him. (Tr. 8). Claimant told him that if he was rude, he did not have to pump his gas. (Id.) In orientation, claimant was told that he had the right not to serve customers who were rude or intoxicated.[1] (Tr. 5). Since Gershawn only wanted a small amount of gas, claimant went ahead and pumped his gas anyway to avoid any problems. (Tr. 9). Claimant told Gershawn that if he came back intoxicated or was rude to him, he would not pump his gas. (Tr. 9). On July 2, 1996, or July 3, 1996, Gershawn drove through the gas lot so that claimant would notice him and he then drove away. (Tr. 10).

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[1] Claimant's manager also testified that employees may refuse to serve unruly persons and may call the police or threaten to call the police in order to try to avoid a conflict. (Tr. 30).

On July 4, 1996, claimant was at work when Gershawn and two other men came into the station. Gershawn wanted gas. (Tr. 18). Gershawn was loud and appeared to be intoxicated. Gershawn told claimant that he wanted to fight, but claimant said that he was at work and did not want to fight. (Tr. 12). Claimant walked away from Gershawn many times. (Tr. 44). Claimant moved to another island. Gershawn's friends advised him that claimant was not going to fight him and that they should leave. (Tr. 12). Gershawn spit on claimant. Claimant then walked into the store and called two friends. Claimant went back outside and the cashier called the police.

After claimant returned outside, Gershawn was still loud and yelling, but claimant continued to pump gas. Gershawn approached claimant. Claimant was between the car he was servicing and the gas pump. (Tr. 13). Claimant was further confined by the gas hose stretching between the pump and the car. While claimant was backing up, Gershawn swung at him, grazing claimant's chin. Claimant then struck Gershawn with his right fist. He then immediately hit him again, knocking Gershawn to the ground. The whole incident took about 20 to 30 minutes with the altercation itself lasting only a few seconds. The police came within a few seconds, arrested Gershawn and took him to the detox unit, but did not cite claimant.

In Barkley v. Corrections Div., 111 Or App 48 (1992), the claimant, a convenience store clerk, was sexually assaulted while working alone late at night. Reasoning that the work environment increased the claimant's exposure to people who might commit violent crimes, the court concluded that there was a sufficient relationship between the assault and a risk connected to the employment to conclude that the injury arose out of and in the course of her employment. In reaching its decision, the court stated that "an assault by a third person is deemed to arise out of a claimant's employment when the assault is the result of the nature of the work or when it originates from some risk to which the work environment exposes the employee." 111 Or App at 52.

Here, we find a sufficient relationship between claimant's injury and a risk connected with claimant's employment to conclude that the injury arose out of and in the course of his employment. As in Barkley, claimant's position as a gas station attendant subjected him to unavoidable and indiscriminate contact with the general public. Behavior of irate gas station customers was a hazard of his employment, as evidenced by the existence of an employer policy on dealing with troublesome customers.

Moreover, we are not persuaded that claimant's injury resulted from a personal relationship. During the encounter of July 1 or 2, 1996, the conversation between claimant and Gershawn concerned claimant's job duties and the fact that Gershawn wanted gas. There is no evidence of a discussion regarding their former friendship or any personal matters from two years earlier. On July 4, 1996, when Gershawn came into the station asking for gas, he became aggressive and told claimant he wanted to fight. Claimant testified that he did not know why Gershawn wanted to fight. He thought it was related to the time when Gershawn came into the station on July 1 or 2, 1996, when claimant told him he would not serve him again if he was rude or intoxicated. (Tr. 12). Under these circumstances, we conclude that the conflict between claimant and Gershawn was not personal. Rather, we find that the conflict was related to claimant's job duties and his injury arose out of a risk to which his employment exposed him.

Next, we must determine whether claimant was an "active participant" in the conflict that resulted in his injuries. 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 voluntarily 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).

Here, claimant attempted to avoid an altercation with Gershawn by refusing to fight for approximately 20 minutes and by retreating into the store. Although Gershawn told claimant that he wanted to fight, claimant said that he was at work and did not want to fight. (Tr. 12). Claimant moved to another island to get away from Gershawn. He walked into the store to avoid Gershawn and he stayed in the store for a couple of minutes before returning to his job duties. (Tr. 12-13). After claimant returned outside, Gershawn was still loud and yelling, but claimant continued to pump gas. There is no evidence that claimant confronted Gershawn or attempted to re-initiate the conflict. Rather, claimant was attempting to perform his job duties when Gershawn cornered him in a confined space, swung at him, and grazed his chin. Claimant then struck Gershawn with his right fist.

We find that Gershawn initiated the conflict and escalated the conflict by following claimant to a different island and continuing to yell at him. After claimant returned outside after being in the store, Gershawn re-initiated the conflict by yelling at claimant while he was performing his job duties. Mr. Irvine, an employee who witnessed the altercation, testified that claimant walked away many times and said there was nothing more claimant could have done to avoid the altercation. (Tr. 44). Irvine testified that it was "more just one person yelling at the other." (Tr. 39). Under these circumstances, we conclude that claimant did everything he could possibly do, short of leaving work, to avoid the confrontation with Gershawn. We conclude that claimant did not assume an active role in the confrontation. Compare G. J. Trenchard, 47 Van Natta 2323 (1995) (the claimant was an active participant because he threw a wrench in the direction of his supervisor), aff'd mem 142 Or App 311 (1996); Ronald A. Smith, 47 Van Natta 807 (1995) (the claimant found to be active participant because he prepared to actively participate in the conflict between himself and his assailant), aff'd mem 138 Or App 704 (1996); Hope C. Panages, 47 Van Natta 626 (1995) (the claimant was an active participant after she followed a store patron into the parking lot and participated in a fight). Moreover, when Gershawn approached claimant while he was backing up and swung at him, we find that claimant did not have sufficient opportunity to withdraw from his confrontation with Gershawn. See Herbert J. Logsdon, 48 Van Natta 56, aff'd mem 144 Or App 495 (1996).

Accordingly, ORS 656.005(7)(b)(A) does not exclude claimant's injuries from compensability. Consequently, the ALJ's order is reversed and the insurer's denial is set aside.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 17, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services on review and at hearing, claimant's attorney is awarded $3,500, payable by the insurer.

In the Matter of the Compensation of
JERRY L. BLISS, Claimant
WCB Case No. 96-09525
ORDER OF ABATEMENT
Neil Jackson & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of our July 22, 1997 Order on Review that increased claimant's unscheduled permanent disability award for a dermatitis condition from 13 percent (41.6 degrees) to 23 percent (73.6 degrees). Contending that we erroneously rejected its assertion that its acceptance was limited to a transient skin disorder concerning claimant's bilateral forearms and lateral neck and that our $1,000 attorney fee award was excessive, the insurer seeks reversal or modification of our decision.

In order to further consider the insurer's arguments, we withdraw our July 22, 1997 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 will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY E. PACE, Claimant
WCB Case No. 96-09392
ORDER ON REVIEW
Anita Smith, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that affirmed an Order on Reconsideration which awarded claimant an additional 2 percent (3.84 degrees) for the right arm beyond the 19 percent (36.48 degrees) she had previously received pursuant to a prior final order. On review, the issue is extent of scheduled permanent disability.

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

Claimant compensably injured her right forearm in May 1991 and was diagnosed with deep vein thrombophlebitis. The claim was originally closed in March 1992 with an award of 19 percent scheduled permanent disability of the right arm. The permanent disability award consisted of 5 percent for a chronic condition and 15 percent for a class 2 vascular condition.

In April 1996, claimant experienced a recurrence of her thrombophlebitis condition. The employer accepted her aggravation claim. Before declaring claimant medically stationary, claimant's treating physician, Dr. Origer, referred her for a physical capacities evaluation. He later accepted the findings of the evaluator as a basis for his recommendations regarding claimant's future restrictions. (Ex. 11-10).

On September 12, 1996, the employer reclosed the claim, awarding claimant temporary disability and an additional 2 percent scheduled permanent disability. An October 14, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects.

At hearing, claimant asserted that her vascular disorder should be classified as class 3 (as opposed to class 2) and that her total scheduled disability award should be 40 percent. The ALJ concluded that claimant's physical findings fell within the class 2 category. On review, claimant again argues that she has established a class 3 vascular impairment. We disagree.

In evaluating claimant's impairment, we consider the findings of claimant's attending physician as well as any findings or reports with which claimant's physician has concurred.[1] ORS 656.245(2)(b)(2); OAR 436-035-0007(12). Reports of insurer-arranged medical examiners are not admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician. Tektronix, Inc. v. Watson, 132 Or App 483 (1995). Here, in the absence of any evidence indicating that Dr. Origer concurred with the findings of Dr. Acker (who examined claimant at the employer's request), we do not consider Dr. Acker's report in determining claimant's impairment. We do, however, consider the findings from claimant's physical capacities evaluation, as Dr. Origer concurred with and relied upon that report.

Pursuant to OAR 436-035-0110(6)(b), claimant is entitled to a class 2 rating for her vascular condition if she "experiences intermittent pain with **repetitive exertional activity**; or there is **persistent moderate** edema . . . ." For a class 3 rating, claimant must prove that she "experiences intermittent pain with **moderate** upper extremity usage; or there is a **marked** edema." See OAR 436-035-0110(6)(c).

Dr. Origer repeatedly noted that claimant had pain and chronic swelling of 2 to 3 cm of her right arm, but characterized this swelling as "mild." (See Ex. 11, pp. 2-8). Like the ALJ, we consider this degree of swelling as falling within the class 2 category ("persistent moderate edema") rather than class 3 ("marked edema").

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[1] Claimant was not evaluated by a medical arbiter during the reconsideration process.

With regard to her activity level, Dr. Origer determined that claimant had some intermittent swelling and pain with *moderate to heavy* activity. (Ex. 11-10). After reviewing the PCE findings, Dr. Origer concluded that claimant was "basically able to work in the light capacity with lifting of 20-25 lbs. occasionally and 10 to 15 lbs. frequently." Id.

The PCE evaluator concluded that claimant could not tolerate frequent use of her right arm in a manner that requires materials handling, but that she basically demonstrated the ability to work in the light physical demand range. (Ex. 15-3). She reported that claimant should avoid overhead reaching with her right arm "on a frequent basis" and that claimant could tolerate light manipulation of moving objects on a regular basis throughout the day, but could not tolerate (on a frequent or continuous basis) activities that involve force with grasping or pinching. Dr. Origer concurred with these findings.

On this record, we agree with the ALJ that claimant has established that she experiences "intermittent pain with repetitive exertional activity" but that she has not proven by a preponderance of the evidence that she experiences "intermittent pain with moderate upper extremity usage," so as to place her in the class 3 category. In this regard, we note that claimant's aggravation claim stemmed from her repetitive, excessive activities as a cook. Both Dr. Origer and the PCE evaluator opined that claimant would continue to experience pain with that level of activity on a frequent basis, but did not report that claimant would have problems with more moderate usage. (See, e.g. Exs. 11, 15-3). Consequently, we agree that claimant's vascular condition was correctly classified as class 2.

ORDER

The ALJ's order dated February 20, 1997 is affirmed.

August 18, 1997 Cite as 49 Van Natta 1321 (1997)

In the Matter of the Compensation of
TERESA McPHERSON, Claimant
WCB Case No. 95-10760
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our July 23, 1997 Order on Review which affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the insurer's denial of claimant's current neck condition; and (2) upheld the insurer's denial of claimant's aggravation claim for the same condition. Contending that we improperly discounted his attending physician's opinion, claimant seeks reconsideration of our decision. Responding that the preponderance of the evidence neither establishes that her current condition is causally related to her compensable injury nor that her compensable condition has actually worsened, insurer argues that we should continue to affirm the ALJ's order.

In order to further consider this matter, we withdraw our July 23, 1997 order. After completing this additional review of the record and the parties' positions, we will then issue our reconsideration order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MIKE FREEMAN, Claimant
WCB Case No. 96-06919
ORDER ON REVIEW
Robert J. Guarassi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) found that claimant was not entitled to temporary disability benefits after May 7, 1996; (2) declined to award a penalty for an allegedly unreasonable failure to pay temporary disability benefits; and (3) declined to award a penalty for an alleged failure to provide discovery. On review, the issues are temporary disability benefits and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant was compensably injured on March 13, 1996. Following emergency care for his mid-back pain, claimant returned to work.

On March 15, 1996, claimant treated with Dr. Laudenschlager for mid-thoracic pain. Dr. Laudenschlager took claimant off work for four days and then released him to light duty work.

On April 10, 1996, claimant was seen by Dr. Adams on referral from Dr. Laudenschlager. Dr. Adams recommended exercises, but discontinued claimant's passive physical therapy. Dr. Adams also released claimant to work.

On April 10, 1996, claimant completed a Change of Attending Physician form, naming Dr. Adams as his attending physician.

In April 1996, claimant requested a referral to Dr. Hacker, neurosurgeon. On May 7, 1996, Dr. Hacker advised Dr. Laudenschlager that further studies were needed. Dr. Hacker also reported that he would provide follow-up.

On May 8, 1996, claimant treated with Dr. Laudenschlager for continuing mid-thoracic pain. On the same date, claimant completed a Form 827. Dr. Laudenschlager also completed the form and indicated that claimant's care had been referred to Dr. Adams. Dr. Laudenschlager further noted that claimant had been referred to Dr. Hacker for another opinion and an MRI.

On May 22, 1996, the insurer accepted claimant's claim as a nondisabling thoracic strain. On the same date, Dr. Hacker referred claimant to Dr. Karasek for nerve block treatment, with follow-up by Dr. Hacker. On that same day, Dr. Hacker filled out a supplemental medical report and indicated that claimant was released to modified work, as of May 22, 1996.

On July 2, 1996, claimant treated with Dr. Laudenschlager for allergic rhinitis and sinusitis. Dr. Laudenschlager reported that claimant's work injury continued to be followed by Dr. Hacker.

On July 3, 1996, claimant treated with Dr. Karasek, who recommended a cervical MRI and nerve blocks.

On July 26, 1996, the insurer notified Dr. Adams that, pursuant to the employer's use of an MCO, it was necessary for Dr. Adams to review a Primary Care Verification form and to complete the form with documentation.

On July 27, 1996, claimant underwent a left thoracic block administered by Dr. Karasek. Dr. Karasek also prescribed physical therapy and a follow-up in six weeks.

On August 16, 1996, Dr. Laudenschlager signed a Primary Care Physician Verification form and returned it to the insurer. Dr. Laudenschlager signed a statement that he qualified "as the primary care physician and have attached documentation verifying that the above named worker had an established history of treatment, prior to the work related injury date."

On September 23, 1996, claimant returned to Dr. Karasek who recommended thoracic epidurals and continued use of steroids.

On September 26, 1996, claimant underwent an epidural steroid injection, administered by Dr. Karasek. That same day, claimant signed a Form 823. The form was also signed by Dr. Karasek as attending physician. Dr. Karasek authorized light duty work for July 3, 1996 through October 15, 1996.

On October 9, 1996, the insurer notified claimant that Dr. Karasek did not meet the criteria of an attending physician pursuant to the MCO rules and statutes. The letter instructed claimant that, in order to obtain temporary disability benefits, claimant needed to select either a new attending physician from an MCO list, or a qualified primary care physician.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

Relying on Dr. Adams' authorization of benefits, the ALJ found that claimant was entitled to temporary disability benefits from March 19, 1996 through May 7, 1996. However, on review, claimant argues that the ALJ erred in finding that Dr. Adams, rather than Dr. Laudenschlager, was his attending physician for purposes of authorizing temporary disability benefits. We agree that Dr. Laudenschlager is claimant's attending physician.

Here, as the ALJ noted, temporary disability benefits must be authorized by the worker's attending physician. ORS 656.262(4)(a), (f). However, as the ALJ also reasoned, because claimant's employer participates in an MCO (managed care organization), the statutory definition of "attending physician" does not apply. ORS 656.005(12)(b). In an MCO situation, workers must treat with physicians who are members of the MCO, unless a nonmember primary care physician's medical records show that treatment has been provided to the worker prior the date of injury. OAR 436-015-0070(2). Additionally, if an injured worker has selected a primary care physician through a private health plan prior to the date of injury, the nonmember physician may qualify as an attending physician. OAR 436-015-0070(2).

The insurer contends that there is no evidence in the record that Dr. Laudenschlager treated claimant prior to the injury. The insurer also contends that, at the time he signed the verification form and returned it to the insurer, Dr. Laudenschlager failed to provide documentation of such a prior relationship. Consequently, the insurer argues that, pursuant to the rules, Dr. Laudenschlager cannot qualify as an attending physician for purposes of authorizing temporary disability benefits.

We conclude that Dr. Laudenschlager's signature on the Primary Care Physician Verification form is sufficient. By signing the form, Dr. Laudenschlager agreed that he qualified as the primary care physician. (Ex. 30C).

In addition, although Dr. Laudenschlager may not have attached documentation regarding a history of treating claimant prior to the work injury, the rules themselves do not actually require the doctor to provide such information. Rather, the rules state that, to qualify as a primary care physician, the doctor must "maintain" the worker's medical records and "[h]ave a documented history of treatment of that worker." OAR 436-015-0070(1)(a)-(c). Here, Dr. Laudenschlager has signed the insurer's primary care physician verification form and essentially agreed that he is in compliance with the rules. His compliance in this regard has not been rebutted.

Finally, the record as a whole shows that Dr. Laudenschlager remained claimant's attending physician, as the other doctors who treated claimant did so primarily at Dr. Laudenschlager's request. Under the circumstances, we conclude that, for purposes of authorizing temporary disability benefits, Dr. Laudenschlager qualifies as claimant's attending physician.

Accordingly, because the insurer's sole challenge to claimant's claim is based on Dr. Laudenschlager's status as attending physician, we find that claimant is entitled to temporary disability benefits beginning March 16, 1996.

Penalties

We adopt the ALJ's Conclusions on the penalty issues.

ORDER

The ALJ's order dated December 23, 1996 is reversed in part and affirmed in part. The insurer is directed to pay claimant temporary disability benefits beginning March 16, 1996, and continuing until such benefits may be terminated according to law. Claimant's counsel is awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
ELIZABETH NIMMO-PRICE, Claimant
WCB Case No. 95-00779
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's injury claim for thoracic strain/sprain, myofascitis, myospasms, left arm numbness, left hip pain, thoracic outlet syndrome, rotator cuff tear, and cerebral hematoma conditions; and (2) awarded a $1,750 attorney fee for claimant's counsel's services related to the insurer's pre-hearing acceptance of claimant's claim for headache and post-concussive syndrome conditions. On review, the issues are compensability and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

On March 16, 1994, claimant slipped and fell at work, injuring her head, left shoulder, arm, hip, and her back. Her emergency room diagnosis was fractured left shoulder bone; head, left shoulder and left hip contusions; and a black eye.

Dr. Hardiman, orthopedist, treated claimant's left shoulder from March 23, 1994 through September 15, 1994.

Claimant began treating with Dr. Siegfried, chiropractor, on October 27, 1994.

Dr. Knox, neurologist, examined claimant on December 12, 1994, diagnosed a concussion and post-concussion syndrome, and referred claimant to Dr. Kurleychek, neuropsychologist.

The employer accepted: left shoulder contusions/nondisplaced fracture; left face and knee contusions; fracture of the greater tuberosity, left humerus; left shoulder adhesive capsulitis; cervical strain; closed head injury without loss of consciousness, but including post-concussive syndrome, and headaches. (Exs. 5, 17, 28). The employer denied: post traumatic cervical and thoracic strain/sprain (it later accepted the cervical strain, Ex. 28); myofascitis, myospasms, left arm numbness and tingling (except as due to left shoulder fracture or adhesive capsulitis), low back pain, left hip pain, cerebral hematoma, thoracic outlet syndrome, and rotator cuff tear. (Ex. 19A).

The ALJ found the denied conditions compensable, except for the low back pain,[1] based on claimant's credible testimony and the opinion of Dr. Siegfried, chiropractor.

The employer argues that the denied conditions are not compensable, because claimant does not have the conditions, or because Dr. Siegfried's opinion relating them to the work injury is not persuasive. We agree in part.

Dr. Siegfried first examined claimant seven months after her work injury. He diagnosed numerous conditions and indicated that diagnoses of rotator cuff tear, thoracic outlet syndrome and cerebral hematoma conditions should be ruled out. (Exs. 11B-1, 12, 13A). The remainder of the medical record indicates that these diagnoses have been eliminated. Claimant does not have these conditions. (Exs. 7-9, 13B, 24-2, 26-8, 29-2; see Ex. 26C). Consequently, the employer's denial of rotator cuff tear, thoracic outlet syndrome and cerebral hematoma conditions is upheld.

With regard to the left arm numbness and tingling (which the employer does not deny as it is related to her accepted fracture of the left humerus or her adhesive capsulitis), we find no evidence of a left arm condition separable from the accepted conditions. Under these circumstances, we find that the employer's attempted partial denial of a left arm condition is not valid. See Darrell D. Hendrix, 46 Van Natta 421, 422 (1994) (Where the employer did not deny a specific, unrelated condition, its "partial denial" was not valid).

We find the remaining denied conditions, including thoracic strain/sprain, left hip pain and generalized pain complaints (with related myospasms), to be compensable.

Dr. Siegfried provides the primary discussion of claimant's thoracic strain/sprain diagnosis. Dr. Siegfried first diagnosed a post-traumatic thoracic strain/sprain when he examined claimant on October 27, 1994. (Ex. 11B-1). Claimant credibly testified that she felt pain throughout her back immediately following her work injury. (Tr. 17). Dr. Siegfried opined that claimant's diagnoses, including the thoracic strain/sprain, were directly related to claimant's slip-and-fall accident at work. (Ex. 22-1). There is no evidence that claimant had any prior difficulties with her upper back.[2] (Tr. 18). Under such circumstances, it is claimant's burden to establish, by a preponderance of the evidence, that her work injury was a material contributing cause of her disability or need for medical treatment due to the thoracic strain/sprain. ORS 656.005(7)(a).

Here, only Dr. Siegfried's opinion addresses the cause of claimant's thoracic strain/sprain and need for treatment for that condition. Dr. Siegfried opined that claimant's diagnosis was directly related to her accident at work. The remaining orthopedic medical opinions do not even acknowledge the existence of a thoracic strain/sprain. However, claimant credibly testified that Dr. Hardiman, who provided initial orthopedic treatment, did not listen to claimant's complaints of back pain. (Tr. 20-21). Moreover, Dr. Siegfried pointed out that the examining physicians, Drs. Sanford and Reimer, did not take into account the progress claimant had made under Dr. Siegfried's treatment. (Ex. 21). Based on claimant's testimony and Dr. Siegfried's response to the IME report, we find that Dr. Siegfried was in the best position to establish the existence of claimant's upper back problems. Therefore, with respect to the thoracic strain/sprain condition, we give no weight to those medical opinions that failed to identify the condition. Accordingly, we find that, based on Dr. Siegfried's opinion, claimant has established the compensability of a thoracic strain/sprain condition.

The employer argues that claimant's remaining problems do not exist separately from the accepted conditions because they are documented only by Dr. Siegfried and Dr. Siegfried's opinion is not persuasive. We disagree.

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[1] Claimant does not challenge the ALJ's conclusion that her low back pain is not compensable.

[2] The ALJ found, based on Dr. Siegfried's comment that claimant had preexisting scoliosis and degeneration (Ex. 22-1), as well as claimant's testimony that she had a long-standing low back problem prior to the March 1994 work injury (Tr. 16-17), that claimant's low back injury combined with her preexisting low back condition to cause her current low back disability and need for treatment. However, there is no evidence that claimant had a preexisting upper back condition that could have arguably combined with her work injury to cause her disability or need for treatment.

Claimant has a compensable post-concussion syndrome condition, for which she has treated with Dr. Knox, neurologist. Due to claimant's continuing problems, including persistent pain, Dr. Knox authorized ongoing chiropractic treatment and referred claimant to Dr. Kurleychek for neuropsychometric testing. (Exs. 19D, 22A). Dr. Kurleychek examined claimant, reviewed her history, and administered numerous tests. His diagnostic impressions included mild resolving post-concussion syndrome, "pain disorder associated with both psychological factors and a general medical condition," and "adjustment disorder with mixed anxiety and depressed mood." (Ex. 23A-6). Dr. Kurleychek opined that, although claimant's underlying encephalopathy had resolved, "her psychological adjustment difficulties related to the perceived cognitive difficulties [associated with the head injury], along with distraction from chronic pain, have exacerbated and maintained her cognitive difficulties." (Id., emphasis added).

Dr. Kurleychek further opined "that the nature of [claimant's] injury produced her initial symptoms and that difficulties with adjustment and the pain disorder contributed to their continuance." (Ex. 27-1). Dr. Kurleychek also stated that the work injury was the major contributing cause of claimant's symptoms as of his examination and explained:

> "I would also want to emphasize that, while I state that psychological factors were the major deficits demonstrated, that these are real and persistent problems. I would not want it implied that because she has psychological adjustment difficulties that this is due to some character flaw or pre-existing personality disorder. As do most individuals who suffer physical injury that is characterized by persistent discomfort, she is psychologically affected by this." (Id. at 1-2).

Dr. Binder, neuropsychologist, examined claimant for the employer and reviewed her history. Dr. Binder's diagnoses were "cognitive deficits, secondary to head injury, mild (mild post-concussive syndrome)" and "status post mild head injury." (Ex. 26-6). Dr. Binder offered no opinion regarding claimant's pain complaints (other than headaches, which "appear to be a reasonable sequel to her injury"),[3] but opined that the conditions he diagnosed were attributable to the work injury. (Ex. 26-7-8).

Dr. Kurleychek reviewed Dr. Binder's report and agreed with Dr. Binder's diagnostic impression regarding claimant's mild post-concussive syndrome, but also stated: "I would still maintain that the persistent pain condition merits a diagnostic acknowledgment." (Ex. 26A-1).

We read the opinions of Drs. Siegfried, Kurleychek, and Binder as consistent with one another.[4] Considering these opinions in light of claimant's undisputed credibility and her consistent clinical presentation, we conclude that claimant's ongoing pain complaints (whether diagnosed as myofascial or as chronic pain disorder) result from her work injury, directly or indirectly.[5] Consequently, they are compensable conditions under ORS 656.005(7)(a).

Attorney fees

The employer argues that the ALJ erred in awarding claimant a $1,750 attorney fee for services related to obtaining a pre-hearing rescission of the partial denial of claimant's headache and post-concussive syndrome conditions. Specifically, the employer argues that claimant's attorney was not

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[3] We note Dr. Binder's comment that he lacked "expertise" regarding the denied conditions other than post-concussive syndrome, cerebral hematoma, and headaches. (See Ex. 26-8).

[4] Dr. Hardiman is the only doctor who suggested that claimant does not have injury-related myofascitis, myospasms, or left hip pain. (See Ex. 35). In this regard, Dr. Hardiman reasoned that claimant does not have these conditions because he did not diagnose them before September 15, 1994, when he last saw claimant. Considering claimant's credible reporting that Dr. Hardiman only evaluated her left shoulder condition (even though claimant apprised him of multiple additional problems), we find that Dr. Hardiman was not in the best position to evaluate claimant other than with regard to her left shoulder. Accordingly, we conclude that Dr. Hardiman's rather conclusory opinion concerning claimant's subsequent diagnoses is less persuasive than those of Drs. Siegfried and Kurleychek (which are based on recent examinations of claimant).

[5] Insofar as claimant's chronic pain or myofascial conditions are indirectly related to the work injury, we find Dr. Kurleychek's opinion sufficient to carry any burden claimant may have under ORS 656.005(7)(a)(A). (See Ex. 27).

instrumental in obtaining acceptance of these conditions, because he provided no relevant services since the Interim Order,[6] which directed the employer to pay a stipulated attorney fee for services related to the acceptance of the cervical strain and closed head injury claims.

Claimant responds that the Interim Order settled nothing with regard to denials other than those it specifically addressed and therefore its attorney fee award was not for services related to subsequent acceptances. We agree and conclude that the ALJ properly awarded claimant a $1,750 attorney fee for services in obtaining the employer's "post-Interim Order" acceptance of claimant's headache and post-concussion syndrome conditions. We adopt the ALJ's opinion in this regard, with the following supplementation.

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 in obtaining the pre-hearing acceptance of the headache and post-concussion syndrome conditions is $1,750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record)[7], the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

The ALJ awarded a $3,000 attorney fee for services at the hearings level related to the claims for thoracic strain/sprain, myofascitis, myospasms, left arm numbness, left hip pain, thoracic outlet syndrome, rotator cuff tear, and cerebral hematoma conditions. Because we are reinstating the employer's denials of the thoracic outlet syndrome, rotator cuff tear, and cerebral hematoma conditions, we reevaluate the fee for services at the hearing level as follows.

Claimant's attorney is entitled to an assessed fee for services at hearing regarding the myofascitis, myospasms, left arm numbness, left hip pain claims. 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 regarding these conditions is $2,300, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, claimant is entitled to an assessed fee for services on review in successfully defending the ALJ's compensability decision regarding claimant's thoracic strain/sprain, myofascitis, myospasms, left arm numbness, and left hip condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding these issues is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and claimant's counsel's fee request), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 29, 1997 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the self-insured employer's partial denial of claimant's claims for thoracic outlet syndrome, rotator cuff tear, and cerebral hematoma conditions is reversed.

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[6] We take administrative notice of the April 14, 1995 Interim Order which directed the employer to accept claimant's cervical strain and closed head injury claims and pay a $1,750 attorney fee for services related to obtaining that acceptance (pursuant to the parties' stipulations).

[7] We note that the Interim Order assessed an attorney fee (pursuant to the parties' agreement) in part for services associated with the employer's acceptance of claimant's "closed head injury without loss of consciousness but with post-concussive symptomatology." (Interim Order at p. 2). After the Interim Order, but before the hearing on the remaining denied conditions, the employer accepted claimant's headache and post-concussive syndrome conditions. Although the employer had already accepted at least some of claimant's post-concussive symptomatology (pursuant to the parties' agreement and the Interim Order), and while its subsequent acceptance of claimant's post-concussive condition was therefore somewhat duplicative, we have taken these circumstances into account in evaluating the attorney fee issue on de novo review. In other words, we have not awarded more than one fee for the same services.

The denial is reinstated and upheld with respect to those conditions. That portion of the order that awarded a $3,000 attorney fee is modified. In lieu of the ALJ's fee award, claimant is awarded a $2,300 attorney fee for services at the hearing level, payable by the employer. The remainder of the order is affirmed. Claimant is awarded a $1,200 attorney fee for services on Board review, payable by the employer.

In the Matter of the Compensation
BEYENE B. EDO, Claimant
WCB Case No. 96-03207
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Admistrative Law Judge (ALJ) Thye's order that: (1) found that the SAIF Corporation's denial was premature; and (2) declined to award an attorney fee for services at hearing. On review, the issues are whether the denial was "premature" and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Denial

We adopt and affirm the ALJ's reasoning regarding SAIF's premature denial. See Vicki L. Davis, 49 Van Natta 603 (1997) (Where neither the claimant nor her physician made a "clear request" for a "formal written acceptance" of any degenerative conditions, no new medical condition claim was made pursuant to ORS 656.262(7)(a). Consequently, because a denial issued in the absence of a claim is a nullity, the carrier's denial had no legal effect). Accordingly, we agree with the ALJ's characterization of SAIF's denial as "premature,"[1] and we conclude that the ALJ properly set aside the denial on that basis.

We do not adopt the ALJ's reasoning in the second full paragraph on page 3 of the Opinion and Order regarding medical services claims.

Attorney fees

Relying on our decision in Ramona E. Hamilton, 48 Van Natta 2438 (1996), the ALJ declined to award an attorney fee pursuant to ORS 656.386(1) as claimant had not prevailed over a denied claim. On review, claimant argues that, even if an assessed fee is not available under ORS 656.386(1), an attorney fee may be awarded pursuant to ORS 656.382(1). We disagree.

ORS 656.382(1) provides that, when a carrier "unreasonably resists the payment of compensation," the carrier shall pay a reasonable attorney fee to claimant's attorney. Here, because claimant has not made a claim for the degenerative condition, there has been no unreasonable resistance to the payment of compensation. Furthermore, because the denial was set aside as premature, there has been no finding that a denied claim was compensable. See SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993). Accordingly, we find no basis for an attorney fee award under ORS 656.382(1).

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[1] On review, claimant argues that the ALJ incorrectly characterized the denial as "premature," rather than a "current condition" denial. We disagree. Nothing in the denial refers to claimant's current condition. (Ex. 34). Furthermore, at hearing, counsel for SAIF stated that SAIF was not denying claimant's current condition. (Tr. 21).

ORDER

The ALJ's order dated March 7, 1997 is affirmed.

August 22, 1997 Cite as 49 Van Natta 1329 (1997)

In the Matter of the Compensation of
PATRICIA J. KLING, Claimant
Own Motion No. 97-0349M
OWN MOTION ORDER
Emmons, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable left knee strain injury. Claimant's aggravation rights expired on December 1, 1986. 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.

In an April 24, 1997 hospital admittance report, Dr. Cronk, claimant's treating physician, reported that claimant would undergo arthroscopic debridement of her left knee. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of disability because she failed to provide documentation of employment. On July 24, 1997, we requested claimant's position regarding the work force issue. On August 7, 1997, claimant responded that she was self-employed and has operated "Better Way Electrolysis" for the past 15 years.

On this unrebutted record, we conclude that claimant has established that she was working until the time of her surgery in April 1997.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning April 24, 1997, the date she 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
LESLIE J. KASTERKO, Claimant
WCB Case No. 96-10991
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that declined to award scheduled permanent disability for claimant's right leg condition. We modify.

FINDINGS OF FACT

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

On November 22, 1995, claimant underwent an L5-S1 lumbar laminotomy for her disc herniation at L5-S1.

CONCLUSIONS OF LAW AND OPINION

On review, claimant argues that she is entitled to an award for loss of use or function of the right leg, due to the compensable low back injury. For the following reasons, we agree with claimant.

When asked to describe any muscle strength loss due to the compensable injury, the medical arbiter, Dr. Peterson, identified loss of strength in the right leg as "5-/5 weakness of the right hamstring, right quadriceps, and right extensor hallicus (sic) longus...felt to be due to the residuals of her surgery and...therefore related to the accepted condition." (Ex. 19-5).

Relying on Ronald L. Tipton, 48 Van Natta 2521 (1996), the ALJ found that, because the arbiter failed to identify atrophy due to the injury, or a nerve or musculotendenous unit affected by the injury, the arbiter's report was not sufficient to establish an award under the standards. However, we note that Tipton, was decided under a different set of disability standards. (WCD Admin. Orders 6-1992 and 93-056).[1] Moreover, for the following reasons, we do not find the current version of the rule discussed in Tipton to be applicable to this case.

Here, claimant was declared medically stationary on February 14, 1996 and the claim was closed by Determination Order dated July 3, 1996. Therefore, the standards set forth in WCD Admin. Order 96-051 apply to this claim.

On review, claimant argues that the applicable rule is OAR 436-035-0230(10), which provides, in part:

> "Valid loss of strength in the leg or foot, substantiated by clinical findings, shall be valued pursuant to section (9) of this rule as if the nerve supplying (innervating) the weakened muscle(s) was impaired."

The aforementioned rule does address loss of leg strength. Nevertheless, Dr. Peterson's report regarding leg impairment is based on the finding that the compensable low back condition and surgery (L5-S1 disc surgery) resulted in claimant's loss of leg strength. Consequently, we conclude that claimant's impairment is properly rated under OAR 436-035-0230(8), which provides that:

> "Injuries to unilateral spinal nerve roots with resultant loss of strength in the leg or foot shall be determined according to the specific nerve root supplying (innervating) the weakened muscle(s), as described in the following table and modified pursuant to OAR 436-035-0007(18).

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[1] Tipton is also distinguishable insofar as it involved upper extremity impairment. The present case involves loss of leg strength as a residual of a compensable low back condition and surgery.

In the alternative, SAIF argues that claimant was receiving social security disability benefits until December 1996 for a variety of medical conditions, and that the receipt of those benefits was for conditions other than his compensable right knee condition. In response to that allegation, claimant contends that it is irrelevant whether or not he received social security benefits prior to or at the time of disability, nor does he request that the Board consider his receipt of those benefits to determine whether he qualifies for temporary disability compensation.

In our prior order, we concluded that claimant had not established that his entitlement to social security benefits was due to the compensable injury. A claimant's eligibility for social security benefits indicates that he is disabled from work due to one or a number of medical conditions. However, the provision of social security benefits does not establish that a claimant is disabled from work because of a compensable injury. Therefore, even if claimant was receiving social security benefits at the time of disability, the receipt of those benefits would not necessarily be verification that he was in the work force unless he can establish that he was unable to work due to a compensable injury at the time of disability. See Kenneth C. Felton, 48 Van Natta at 725; Robert E. Carper, 48 Van Natta 1160 (1996). Here, claimant relies on the opinion of his treating physician, rather than his eligibility for social security benefits, to support his position that he was unable to work at that time.

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

Accordingly, on reconsideration, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning March 5, 1997, 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.

August 22, 1997 Cite as 49 Van Natta 1333 (1997)

In the Matter of the Compensation of
JAMES A. LINDEKUGEL, Claimant
WCB Case No. 96-07810
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that awarded 35 percent (52.5 degrees) scheduled permanent disability for each hand, whereas an Order on Reconsideration awarded 63 percent (94.5 degrees) scheduled permanent disability for each hand. The SAIF Corporation cross-requests review of the ALJ's order, contending that claimant did not raise the issue of impairment at the time of reconsideration. SAIF also contends that the Department and the ALJ should not have considered a report submitted by claimant's treating doctor which was generated after the time of claim closure. Alternatively, SAIF seeks a reduction in claimant's scheduled permanent disability award. On review, the issues are whether the issue of impairment was properly addressed, evidence, and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Impairment

On review, SAIF argues that the ALJ should not have addressed the issue of impairment, as claimant did not check the "yes" box on the reconsideration request form to indicate that impairment findings were being contested. We disagree.

The Notice of Closure awarded 3 percent scheduled permanent disability for claimant's vascular condition, based on the condition falling within a "Class 1" designation. On reconsideration, claimant submitted a report from his treating doctor which stated that claimant was more properly placed within a "Class 4" designation. Claimant also checked a box on the reconsideration form which indicated that he disagreed with the "rating of scheduled permanent partial disability." (Ex. 9-2).

Under the circumstances, we conclude that claimant properly raised the issue of rating of his scheduled permanent condition at the time of reconsideration. Consequently, because the issue was raised at the time of reconsideration, it was also proper for the ALJ to address it at the time of hearing. ORS 656.268(8).

Evidence/Extent

SAIF also argues that the Department and the ALJ erred by considering a "post-closure" report from claimant's treating doctor. At the time of closure, claimant's treating doctor, Dr. Newcomb, rated claimant as falling within Class 1 of OAR 436-035-0110(6), the rule which provides for an award for Raynaud's phenomenon. Despite her rating, Dr. Newcomb also noted that, although Class 1 was most appropriate, "none fits." (Ex. 5-1).

Following the June 11, 1996 Notice of Closure, Dr. Newcomb reported that she had seen claimant on July 9, 1996. Dr. Newcomb reported that she now believed that claimant "probably does better fit within class 4...." (Ex. 7).

Relying on Kristine M. Trump, 45 Van Natta 1268 (1993), SAIF contends that it is proper to exclude a report generated after claim closure where the report concerns a claimant's condition after the time of closure. However, we need not decide the issue of whether the post-closure report was properly considered by the Department and the ALJ, as we do not find that the report changes the outcome in this case.

Although claimant argues that Dr. Newcomb has now classified him as "Class 4" and SAIF argues that Dr. Newcomb classified him originally as "Class 1," we do not find the doctor's opinion regarding the proper class to be dispositive. Rather, we agree with the ALJ that the remainder of the doctor's opinion supports a finding that claimant's condition falls within Class 3, as claimant has intermittent pain with moderate upper extremity usage.[1] OAR 436-035-0110(6).

Accordingly, we affirm the ALJ's order and the ultimate award of 35 percent scheduled permanent disability for each hand.

Claimant's attorney is entitled to an attorney fee for services on review in defending against SAIF's request for a reduction of his award. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the issue of extent of scheduled permanent disability is $800, 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 February 18, 1997, as reconsidered by the March 4, 1997 order, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by the SAIF Corporation.

[1] As explained above, we find this conclusion to be consistent with the substance of Dr. Newcomb's opinions, whether the information is drawn from either the pre-closure or post-closure reports.

(a) SPINAL NERVE ROOT	LEG IMPAIRMENT
L-3	20%
L-4	34%
L-5	37%
S-1	20%

Dr. Peterson has identified claimant's weakened leg muscles as the right hamstring, right quadriceps, and right extensor hallucis longus. (Ex. 19-5). The insurer does not disagree with claimant's identification of the L-4, L-5, and S-1 spinal nerve roots as the nerve roots which supply or innervate the weakened muscles listed by the arbiter.[2] See OAR 436-035-0007(18)(b) (The spinal nerve root which supplies certain muscles may be identified by referencing current anatomy texts or the AMA Guides to the Evaluation of Permanent Impairment).

Finally, each of claimant's impairment values for the nerve roots must be modified by OAR 436-035-0007(18). Pursuant to that rule, the grade of strength reported by the arbiter (5-/5) is assigned a percentage (5 percent). The impairment value of the involved nerve is multiplied by that value. OAR 436-0035-0007(18). Consequently, claimant's impairment for the L-4 nerve root is derived by taking the total impairment value (34 percent) and multiplying it by 5 percent for a value of 1.7. Claimant's impairment for the L-5 nerve root is 37 percent, multiplied by 5 percent, for a value of 1.85 percent. Claimant's impairment for the S-1 nerve root is 20%, multiplied by 5%, for a value of 1.1. Finally, the values are combined for a total overall loss of strength of 5 percent. OAR 436-035-0007(20). Therefore, claimant is entitled to an award of 5 percent scheduled permanent disability for her right leg impairment under the "standards."

ORDER

The ALJ's order dated April 2, 1997 is modified. In addition to claimant's unscheduled permanent disability award, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg. Claimant's counsel is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order payable directly to claimant's attorney. However, the total "out-of-compensation" attorney fee granted by the ALJ's order and this order shall not exceed $3,800. The remainder of the ALJ's order is affirmed.

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[2] Rather, the insurer's argument that claimant has not identified a specific peripheral nerve or shown that the loss of strength was caused by a peripheral nerve injury, loss of muscle or disruption of the musculotendonous unit, is also based on its reliance on standards that are not applicable in this case.

In the Matter of the Compensation of
JEFFREY A. KYLE, Claimant
Own Motion No. 97-0119M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Douglas L. Minson, Claimant Attorney
SAIF Legal Department, Defense Attorney

On June 13, 1997, we withdrew our March 27, 1997 Own Motion Order, as reconsidered on May 2, 1997, in which we declined to reopen his 1979 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability. We took this action to consider claimant's request for reconsideration. With his request for reconsideration, claimant submitted additional information regarding the work force issue. On reconsideration, we issue the following order in place of our prior orders.

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 anterior cruciate ligament surgery on March 5, 1997. Thus, as in our prior order, we conclude that claimant's compensable injury worsened requiring surgery.

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

SAIF contends that claimant has not been in the work force since December 1993. Claimant contends that he qualifies for temporary disability compensation because he was willing to work, but unable to seek work at the time of disability because of his compensable injury. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was willing to work, but that a work search would have been futile because of the compensable injury during the relevant time period.

Claimant submitted a June 16, 1997 affidavit and a July 21, 1997 supplemental affidavit, in which he attested that "I remained ready, willing and able to enter the job market should anything within my limitations be presented to me and should my physician allow my return to the job market." We are persuaded by claimant's affidavits that he has satisfied the "willingness" portion of the third Dawkins criteria above.

However, claimant must also establish that he was unable to work because of the compensable injury at the time of disability. SAIF contends that the relevant time period during which claimant must establish his inability to work is the time from December 1993 until claimant's March 1997 surgery. We disagree. The relevant time period for which claimant must establish an inability to work because of his compensable injury is the time prior to his March 1997 surgery, when his condition worsened requiring that surgery.

In an April 2, 1997 letter, SAIF's claims examiner sought the opinion of Dr. Blake, claimant's treating physician, as to whether claimant was unable to work during the previous three and one-half years. In that letter, the claims examiner asked Dr. Blake:

> "Subsequent to the last claim closure for disability benefits in December of 1993, what is your medical opinion regarding the ability of [claimant] to seek employment? Would the [work] search have been futile based on his medical condition or was he capable of employment? Please explain."

In an April 8, 1997 reply, Dr. Blake replied that he "was not the treating physician until 10/28/96 so [I] cannot answer above questions." However, in a June 10, 1997 letter, Dr. Blake opined that:

> "Please be advised that [claimant] was unable to work from 10-28-96 until undetermined [time] due to knee injury and subsequent surgery."

Here, Dr. Blake correctly defined claimant's time of disability to include the time he worsened requiring surgery in late 1996 until the surgery actually occurred. Thus, we reject SAIF's argument that claimant must establish an inability to work in December 1993. See generally Wausau Ins. Companies v. Morris, 103 Or App 270, 273 (1990) (a finding that a claimant withdrew from the work force at one time does not irrevocably bar claimant from proving he reentered the work force); Dean L. Watkins, 48 Van Natta 60 (1996) (voluntary withdrawal from the labor force is not necessarily permanent). Rather, we conclude that claimant must establish that he was unable to work in late 1996 when his condition worsened precipitating Dr. Blake's surgery recommendation. See Weyerhaeuser v. Kepford, 100 Or App at 410 (the critical time for determining whether a claimant is in the work force is at the time of disability); Kenneth C. Felton, 48 Van Natta 725 (1996) (although the claimant failed to establish that he was in the work force at the time of a prior disability, he successfully established that he was in the work force at a later time of disability); Michael C. Batori, 49 Van Natta 535 (1997) (the claimant was not required to prove he was in the work force for two years prior to his worsening as the relevant time period to determine whether the claimant was in the work force was the current time of disability).

In the Matter of the Compensation of
EMILY Y. LOGSDON-MCBEE, Claimant
WCB Case No. 96-02759
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 that portion of Administrative Law Judge (ALJ) Crumme's order that upheld the self-insured employer's denial of claimant's current left shoulder/neck condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In 1988, claimant had neck symptoms and underwent surgery at C5-6. No claim was filed. In 1991, claimant began working for the employer. In December 1993, the employer accepted a claim for left shoulder strain. A Determination Order awarded 35 percent unscheduled permanent disability. An Order on Reconsideration reduced the award to 20 percent. The Order on Reconsideration was not appealed.

In January 1995, claimant sought treatment for her neck and shoulder. In March 1995, the employer issued a denial of the aggravation claim, which in part stated that "your current condition is a continuation of your October 22, 1993 injury." In May 1995, an ALJ approved a Disputed Claim Settlement (DCS) providing that

> "claimant's treatment and any worsening of her condition subsequent to her reconsideration order represents a waxing of her condition that was contemplated by her disability award in that order as specified in ORS 656.273(8) and the parties agree that was the intent of the [employer's] denial." (Ex. 27-2).

The DCS further stated that the employer's denial "shall remain in full force and effect and claimant's request for hearing thereon shall be dismissed with prejudice as to all issues raised or raisable between the parties with respect to this claim." (Id.)

In February 1996, the employer issued a denial of claimant's current condition.[1] The ALJ first determined that the May 1995 DCS did not preclude the employer from contesting claimant's current condition, reasoning that the neck and left shoulder conditions had changed subsequent to the DCS. Further finding that claimant's accepted left shoulder condition "combined" with a preexisting cervical condition, the ALJ concluded that claimant failed to prove that her compensable left shoulder injury was the major contributing cause of her disability and need for treatment and, thus, upheld the employer's denial pursuant to ORS 656.005(7)(a)(B).

Claimant first contends that the preexisting neck condition had "combined" with the left shoulder condition before claim closure and, hence, part of claimant's award was based on the neck condition. Relying on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), claimant argues that the neck condition "must be considered compensable" and cannot be denied. Alternatively, claimant asserts that, based on the DCS, the employer agreed it was responsible for claimant's condition as of May 1995 and, because the condition has not changed, the employer is precluded from now contesting it.

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[1] The employer also denied an aggravation claim. The ALJ upheld the denial. That issue is not contested on review.

In Messmer, the court held that the enactment of former ORS 656.262(10)[2] did not overrule its previous decision in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995). The latter case held that a carrier's failure to challenge a Determination Order that in part based its award of permanent disability on a noncompensable condition precluded it from contending later that that condition is not part of the compensable claim. 130 Or App at 258.

Here, the "Explanatory Notes" accompanying the Order on Reconsideration refers only to impairment of the shoulder. (Ex. 19). The contemporaneous medical evidence is consistent with the "Explanatory Notes" in that only shoulder impairment is rated without any indication that such impairment was affected by the neck condition. (Exs. 12, 13, 18). Thus, the Order on Reconsideration shows that the permanent disability was based only on the shoulder condition. Consequently, we find an absence of proof that the Order on Reconsideration awarded any compensation for the noncompensable neck condition and, thus, the employer is not precluded from denying the compensability of such condition. Messmer, 140 Or App at 554.[3]

We turn to claimant's argument that the employer's denial is precluded by the DCS. Subsequent to the ALJ's order, the court analyzed whether a DCS precluded the claimant from asserting a headache claim, which was denied after the claimant and the carrier entered into a DCS that upheld a denial for bilateral temporomandibular joint (TMJ) problems. Trevisan v. SAIF, 146 Or App 358 (1997). After examining the statutory and administrative requirements for a DCS, the court held that, as a matter of law, "the DCS did not settle [the] claimant's headache claim, because the headache claim was not denied at the time that the parties entered into the DCS." Id. at 361-62.

The court further disagreed with the carrier's argument that the "raised or raisable" language in the DCS precluded the headache claim because that condition had been diagnosed and treated before the parties entered into the DCS. Explaining that, by statute, a DCS could be "used only to settle denied claims," the court explained that the "raised or raisable" language referred only to conditions associated with TMJ. Id. at 362-63.

Based on Trevisan, we conclude that, as a matter of law, the scope of the DCS in this case concerned only the denied aggravation claim. The compensability of claimant's current condition was not denied at the time of the DCS; the employer did not issue the current condition denial until after the parties entered into the DCS. Consequently, we conclude that the DCS has no preclusive effect on the employer's current condition denial, whether or not claimant's condition is currently the same as it was at the time of the DCS. Trevisan, 146 Or App at 362.

Claimant does not challenge the ALJ's conclusion that, on the merits, claimant did not prove compensability. We agree with the ALJ that claimant did not carry her burden of proof under ORS 656.005(7)(a)(B) and adopt that portion of the order.

ORDER

The ALJ's order dated August 23, 1996 is affirmed.

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[2] The statute provided:

"Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

The legislature recently amended the last sentence to state: "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order, **or the failure to appeal or seek review of such an order or notice of closure,** shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." HB 2971, 69th Leg., Reg. Sess., § 1 (July 25, 1997) (addition in bold).

[3] In light of this conclusion, we need not determine the effect of the amendment to ORS 656.262(10).

In the Matter of the Compensation of
JOHN W. MEYER, Claimant
Own Motion No. 96-0053M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schwabe, et al, Defense Attorneys

Claimant requests review of the self-insured employer's May 28, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from January 24, 1996 through May 19, 1997. The employer declared claimant medically stationary as of May 19, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

FINDINGS OF FACT

Claimant sustained a compensable right knee injury with the employer on February 25, 1982. Claimant's aggravation rights on that claim expired on August 31, 1987.

On January 24, 1996, claimant underwent surgery to repair a lateral meniscal tear in his right knee. On January 26, 1996, we issued an Own Motion Order reopening claimant's claim for the payment of temporary disability compensation.

On February 9, 1996, Dr. Beach, claimant's treating physician, recommended that claimant undergo a high tibial osteotomy to his right knee. The employer disputed the necessity of the proposed surgery and requested Director review to determine its appropriateness. The Director's review was dismissed by Administrative Order of Dismissal dated March 31, 1997, as it was determined that Dr. Beach no longer recommended the surgery. On May 28, 1997, the employer closed claimant's claim.

The employer then submitted a new recommendation, in which it requested that the Board deny reopening claimant's February 25, 1982 injury claim on the grounds that claimant's current condition does not require surgery or hospitalization nor would surgery or hospitalization be reasonable and necessary for claimant's compensable injury.[1]

In a July 3, 1997 letter, we requested that the employer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. Claimant's response has been received.

On July 15, 1997, we advised the parties that we would take the Own Motion matters under consideration "within a reasonable time to allow claimant sufficient time to notify the parties whether he is currently represented." Claimant has not responded whether he has obtained counsel, therefore, we will proceed with our review of the employer's May 28, 1997 closure according to claimant's *pro se* request.

CONCLUSIONS OF LAW AND OPINION

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 28, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980). Even though medical opinion established that claimant required ongoing care for an indefinite period of time, the ongoing care does not necessarily establish that claimant was not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

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[1] In an order issued on today's date, we have addressed claimant's new request to have his claim reopened for the payment of temporary disability compensation. Because Dr. Beach has withdrawn his surgery recommendation, we are unable to find that claimant's compensable condition has worsened requiring surgery or hospitalization. See ORS 656.278(1)(a).

In an April 15, 1997 chart note, Dr. Beach reported that he was continuing to follow medical treatment of claimant's finger and hand stiffness and joint pain to determine whether that treatment might help claimant's knee swelling and pain as well. Dr. Beach noted that "[w]e will need to follow [claimant] along and I will see him back now in the near future." Claimant contends that Dr. Beach's April 15, 1997 statements prove that he was not medically stationary at claim closure.

In a May 19, 1997 response directed to the employer regarding claimant's medical condition at that time, Dr. Beach agreed that he would not expect "further material improvement" of claimant's compensable condition "from medical treatment or the passage of time." Furthermore, Dr. Beach did not express any disagreement with the employer's letter which noted that no further surgery or projected treatment plan was indicated. Dr. Beach's contemporary opinion that claimant was medically stationary is unrebutted. Therefore, we conclude that Dr. Beach's opinion that claimant was medically stationary at claim closure is more persuasive, and thus defeats, his suggestion that the treatment being offered claimant for his hands might be of some benefit as treatment for claimant's knee. Maarefi v. SAIF, 69 Or App at 527.

On this record, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the insurer's May 28, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
CRIS TOMKO YOUNG, Claimant
Own Motion No. 95-0396M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Bruce W. Brewer, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 30, 1996 Notice of Closure which closed her claim with an award of temporary disability compensation from September 30, 1994 through December 30, 1994. SAIF declared claimant medically stationary as of August 1, 1996. Claimant contends that: (1) SAIF has not paid or processed her otherwise compensable medical bills in this claim; and (2) she is entitled to additional substantive temporary disability benefits prior to her medically stationary date.

In an October 16, 1996 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. On October 29, 1996, SAIF submitted its response. In a July 18, 1997 letter, the Board notified claimant that it would grant a further extension of time until August 8, 1997 for claimant to submit any further information. No further response has been received from claimant. Therefore, we will proceed with our review.

Medical Payments

On June 27, 1997, SAIF submitted copies of medical bills and payment ledgers which it contends satisfies claimant's request. Because we have no Own Motion authority over such medical services disputes, we cannot address this issue. In any event, because claimant has not responded to SAIF's submission, it is conceivable that claimant's questions regarding the payment / processing of her medical bills have been answered.

Entitlement to Temporary Disability

We are authorized to consider claimant's appeal of SAIF's Notice of Closure. Therefore, we proceed with our review of claimant's request for additional temporary disability.

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). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

Claimant does not contend that her medically stationary date is incorrect or that she was not medically stationary when SAIF closed her claim. In any event, the record would not support such a contention. Rather, claimant contends that she is entitled to further substantive temporary disability benefits prior to becoming medically stationary. Claimant is substantively entitled to temporary disability benefits if a preponderance of evidence in the entire record shows that she was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

SAIF submitted an August 1, 1996 chart note from Dr. Fleming, claimant's treating physician, in which her physician opined that:

> "I have not seen [claimant] since December of 1994. She is doing well now. She occasionally gets some cramping in her right calf, not nearly as severe or as frequently as she used to. Her sensation has been normal. She has no radicular-type pain.
>
> "Her examination today shows that she has slight reflex asymmetry at her knees, with her right being 2 and her left being 1. Ankle reflexes are excellent. Her motor strength is normal and symmetric, and sensation to touch is symmetric as well.
>
> "She returned today mostly to get a final release. I would call her completely stable at this time."

Claimant has not submitted any evidence that she was not medically stationary in August 1996 or that she was disabled due to her compensable injury prior to being declared medically stationary. Dr. Fleming does not address claimant's condition between his December 1994 and August 1996 examinations. While Dr. Fleming does opine that claimant is medically stationary as of August 1, 1996, he does not indicate that she was disabled for any time prior to that date. Dr. Fleming's August 1, 1996 opinion is unrebutted. SAIF paid claimant temporary disability compensation though December 1994. Because claimant has not carried her burden of proving that she was disabled due to her compensable injury for any of the time between December 1994 and August 1996, we are persuaded that claimant has not established entitlement to further substantive temporary disability prior to being declared medically stationary. See Lebanon Plywood v. Seiber, 113 Or App at 651; Donna Anderson, 46 Van Natta 1160 (1994). Therefore, we conclude that SAIF's closure and its award of temporary disability were proper.

Accordingly, we affirm SAIF's August 30, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
WINFRIED H. SEIDEL, Claimant
WCB Case No. 96-09311
ORDER OF ABATEMENT
Bischoff & Strooband, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our July 24, 1997 order that affirmed the Administrative Law Judge's (ALJ's) order awarding claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm. Citing William L. Fischbach, 48 Van Natta 1233 (1996), SAIF argues that, because there are no symptoms, impairment or condition in the right arm, claimant is not entitled to a chronic condition award for the right arm.

In order to consider this matter, we withdraw our July 24, 1997 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 will proceed with our reconsideration

IT IS SO ORDERED.

In the Matter of the Compensation of
LEAH M. COLUMBUS, Claimant
WCB Case Nos. 97-00898 & 95-09411
ORDER OF ABATEMENT
Rasmussen, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorney

Claimant requests abatement and reconsideration of our July 25, 1997 Order on Review which reversed the Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's low back injury claim for internal disc disruption (IDD). Claimant contends that she has proven her injury claim and that the ALJ's order should be affirmed.

In order to allow us sufficient time to consider claimant's motion, the July 25, 1997 order is withdrawn. The insurer is granted an opportunity to file a response to the motion. To be considered, the insurer's response must be filed within 14 days after the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT E. RALPH, Claimant
WCB Case No. 96-01973
ORDER ON RECONSIDERATION
Cole, Cary & Wing, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our August 1, 1997 order that set aside the insurer's denial of claimant's claim for a low back injury and awarded a $4,000 attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services at hearing and on Board review. Specifically, claimant argues that $4,000 is an inadequate fee and seeks a fee of no less than $4,800.

The insurer has submitted a response to claimant's motion for reconsideration opposing claimant's request for a greater attorney fee award. Accordingly, having received the parties' positions, we proceed with our reconsideration.

In any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) The time devoted to the case; (b) The complexity of the issue(s) involved; (c) The value of the interest involved; (d) The skill of the attorneys; (e) The nature of the proceedings; (f) The benefit secured for the represented party; (g) The risk in a particular case that an attorney's efforts may go uncompensated; and (h) The assertion of frivolous issues or defenses. OAR 438-015-0010(4).

Here, the issue was compensability of claimant's low back condition with a focus on claimant's credibility. Six witnesses testified, including claimant. The hearing convened at 11:00 a.m. and concluded at 2:30 p.m. The record contains 46 exhibits, approximately 14 of which were generated by claimant. On Board review, claimant submitted a 10 page appellant brief and a 5 page reply brief.[1]

The compensability and credibility issues presented factual and medical questions of a complexity similar to those generally submitted for Board consideration. The value of the claim and the benefits secured are significant inasmuch as claimant's condition will likely require surgery. Both attorneys were skilled and presented well reasoned arguments. No frivolous issues or defenses were raised and there was a risk that claimant's counsel's efforts might go uncompensated.

Based upon our evaluation of the factors contained in OAR 438-015-0010(4), we continue to find that $4,000 constituted a reasonable and appropriate attorney fee for the hearing and Board levels for this compensability case.[2] In reaching this conclusion, we have particularly considered the time devoted to the compensability/credibility issues (as represented by the record), the complexity of the issues, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

Accordingly, our August 1, 1997 order is withdrawn. As supplemented herein, we republish our August 1, 1997 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant's counsel did not file a "Request At Board Review For Assessed Fees." See OAR 438-015-0029(1). In light of such circumstances, claimant's request shall not be considered in determining the amount of a reasonable assessed fee. OAR 438-015-0029(4). Nonetheless, because claimant seeks reconsideration of a Board order (a portion of which awarded an attorney fee), we do consider claimant's contentions to the extent that they address findings and conclusions reached by our prior order. See Anthony Foster, 45 Van Natta 1997 (1995).

[2] We note claimant's request that the "total assessed fee be apportioned specifically between services on review and services at hearing in order to reflect a specific fee for each level." Claimant cites no authority for such a request. To the contrary, pursuant to ORS 656.386(1), we are authorized to award "a reasonable attorney fee" where the claimant "prevails finally" following Board review. Inasmuch as we have complied with that statutory directive, we decline claimant's request to apportion our award between the hearings and review levels. Rather, consistent with the aforementioned statutory authority, we adhere to our longstanding practice of awarding an attorney fee for claimant's counsel's services performed at both the hearing and Board review levels.

In the Matter of the Compensation of
GEORGE L. ALLENBY, Claimant
WCB Case No. 96-05090
ORDER ON REVEIW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denials of claimant's L5 radiculopathy, right hand/wrist condition, and hemorrhoid conditions; and (2) awarded attorney fees for services related to claimant's myofascial/mechanical low back pain, hemorrhoids, and the scope of the insurer's acceptance of claimant's pain disorder. On review, the issues are compensability and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found claimant's L5 radiculopathy compensable because Dr. Grant's "reflective" opinion was the most consistent with claimant's "pre-injury" history without back problems and his "post-injury" finding of an L5 disc bulge compressing the nerve root. We agree and adopt the ALJ's opinion in this regard. See ORS 656.005(7)(a).

The ALJ found claimant's right hand/wrist condition compensable because the work injury caused a scar that "tethered" and shortened wrist tendons causing the "semi-fist," which required treatment. We agree, based on claimant's physical therapist's observation that claimant's minor flexor tendon tethering contributed to his decreased finger extension and thus, his "semi-fist." (Ex. 31-1, see Ex. 29). In addition, we note that Dr. Grant reported claimant's right hand and wrist "locking up" and prescribed ultrasound therapy and an active resistance exercise program for claimant's right hand. (Ex. 29-1, 29-3). Accordingly, we adopt the ALJ's opinion on this issue, as supplemented. See ORS 656.005(7)(a)(A).

The ALJ found claimant's hemorrhoid condition compensable as a consequence of constipation resulting from medication prescribed for the compensable injury. Based on the opinion of Dr. Bates, we agree. (Ex. 37). Accordingly, we adopt the ALJ's conclusion on this issue, as supplemented. See ORS 656.005(7)(a)(A).

Attorney Fees

Pain Disorder

Neither the insurer nor claimant object to the ALJ's correction of an apparent scrivener's error in the insurer's acceptance of claimant's claim for a psychological condition.[1] However, the insurer contests the ALJ's attorney fee award based on this modification. We reverse.

Claimant's counsel stated at the beginning of the hearing that he was not alleging that the claim for a pain disorder condition had been denied. (Tr. 7). We agree that the claim was not denied. Accordingly, because claimant has not prevailed on a denied psychological condition, no attorney fee may be awarded under ORS 656.386(1). Jerome M. Baldock, 48 Van Natta 355 (1996) (an attorney fee may not be awarded under ORS 656.386(1) where a "denied claim" has not been established).

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[1] The written acceptance referred to a "pain disorder with medical and physical features," whereas Dr. Villanueava had diagnosed "pain disorder with medical and psychological features." (See Exs. 28, 64, emphasis added).

Myofascial/Mechanical Low Back Pain

The insurer also challenges the ALJ's attorney fee award based on the insurer's withdrawal of its denial of claimant's claim for "myofascial/mechanical low back pain." Specifically, the insurer contends that the fee is inappropriate, because claimant has no such condition separable from the accepted low back strain. We agree. (See Ex. 63-2).[2]

Under these circumstances, the insurer was not required to separately process a claim for myofascial/mechanical low back pain. ORS 656.262(7)(a). Further, the insurer did not "deny" those conditions on the express basis that they were not compensable or otherwise did not give rise to entitlement to compensation. ORS 656.386(1). Therefore, claimant is not entitled to an attorney fee based on services associated with the insurer's acceptance of that claim. See Craig B. Johnson, 48 Van Natta 965 (1996).

Hemorrhoids

The ALJ awarded a $1,000 attorney fee for claimant's counsel's services associated with prevailing over the insurer's denial of claimant's claim for a consequential hemorrhoid condition. The insurer argues that the fee is excessive, because the claim's value to claimant is very slight.

In determining a reasonable attorney fee for claimant's counsel's services at the hearings level regarding the claim for a consequential hemorrhoid condition, we have considered the factors set forth in OAR 438-015-0010(4). After applying those factors to this case, we agree with the ALJ that a reasonable fee for claimant's attorney's services at hearing on this issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.[3]

Claimant's attorney is entitled to an assessed fee for services on review associated with the claims for L5 radiculopathy, and the right hand/wrist and hemorrhoid conditions. 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 $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved. Claimant is not entitled to an attorney fee for services on reveiw regarding the ALJ's attorney fee awards. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 28, 1997 is reversed in part and affirmed in part. Those portions of the order that awarded attorney fees associated with the myofascial/mechanical low back pain claim and modification of the acceptance of the psychiatric condition are reversed. The remainder of the order is affirmed. For services on review associated with the claims for L5 radiculopathy, and the right hand/wrist and hemorrhoid conditions, claimant is awarded a $1,200 attorney fee, payable by the insurer.

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[2] Dr. Grant explained: "My use of the mechanical/muscular/myofascial low back diagnoses are [sic] a more detailed description of [claimant's] low back problem that the 'lumbar strain' diagnosis [addresses]. They are not in addition to it, but further define and describe it." (Ex. 63-2). Dr. Grant's explanation in this regard is persuasive and uncontroverted.

[3] On de novo review, we evaluate the attorney fees assessed for claimant's counsel's services at the hearings level regarding the claims for L5 radiculopathy, and right hand/wrist conditions, by considering the factors set forth in OAR 438-015-0010(4) and applying them to this case. Having done that, we find that a reasonable fee for claimant's attorney's services at hearing on these issues is $2,000, as awarded by the ALJ. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the complexity of the issues, the value of the interests involved, and the risk that counsel may go uncompensated.

In the Matter of the Compensation of
RICKY P. BARNES, Claimant
WCB Case No. 96-10548
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's cervical condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to establish that he had any permanent disability due to his compensable cervical condition. Claimant contends that he is entitled to impairment for cervical range of motion losses and/or a chronic cervical condition. We agree with the ALJ's reasoning and conclusion that claimant failed to establish that he has permanent impairment due to loss of cervical range of motion. However, we find that claimant is entitled to a chronic condition award. Therefore, we modify the ALJ's order.

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).

First, we briefly summarize the pertinent facts. Claimant sustained a work injury on January 7, 1994, when he was involved in a motor vehicle accident. The claim was accepted for a cervical strain and post concussion headache conditions. The claim was closed by a Determination Order issued July 31, 1996, which awarded claimant no permanent disability. Claimant requested reconsideration.

Dr. Bell performed a medical arbiter's examination. (Ex. 52). The appellate reviewer did not rely on Dr. Bell's examination findings and issued an Order on Reconsideration on October 28, 1996 affirming the Determination Order in all respects. (Ex. 54). Claimant requested a hearing.

The ALJ found that claimant had failed to establish any permanent disability and affirmed the Order on Reconsideration. Claimant requested review.

On review, we adopt the ALJ's reasoning and conclusion with respect to claimant's failure to establish impairment based on loss of cervical range of motion. Finding that neither Dr. Bell's examination nor an independent medical examiners' examination in December 1995 provided reliable cervical range of motion measurements, the ALJ concluded that there was no persuasive medical evidence that would allow rating loss of cervical motion under the standards. We agree. However, after our review of the record, we conclude that claimant has established impairment based on a chronic condition.

Pursuant to OAR 436-035-0320(5), "[a] worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition." One "body area" is the cervical/upper thoracic spine area. Id. If a worker has less than 5 percent total unscheduled impairment in a body area, the worker is entitled to 5 percent chronic condition impairment in lieu of all other unscheduled impairment in that body area. OAR 436-035-0320(5)(b).

Because we have found that claimant has no other unscheduled impairment in the cervical spine area, it is appropriate to consider whether claimant is entitled to a chronic condition award.

Dr. Bell, the medical arbiter, examined claimant on September 20, 1996. Although Dr. Bell opined that "the degree" of claimant's restricted range of cervical motion "is partly on the basis of caution or guarding," she nonetheless opined that claimant does have a chronic and permanent impairment due to his cervical strain injury. (Ex. 52-4). In this regard, Dr. Bell reported that claimant is limited to sitting with his head in a forward flexed posture for no more than two hours. (Id.). Finally, although we agree with the ALJ that Dr. Bell's range of motion measurements are not sufficient to establish impairment, we nevertheless find they establish some range of motion restrictions indicative of a chronic condition. Simply because we have found that the medical arbiter's range of motion measurements are not ratable under the standards does not mean that claimant has failed to establish permanent repetitive use limitations. There is no other medical evidence that addresses repetitive use limitations. Therefore, we conclude that claimant is entitled to a 5 percent chronic condition award for her cervical spine.

Pursuant to ORS 656.386(2) and OAR 438-015-0055(1), claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the compensation created by this order, payable directly to claimant's attorney.

ORDER

The ALJ's order dated March 21, 1997 is modified. In lieu of the Order on Reconsideration and the ALJ's order, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for her cervical condition. Claimant's counsel is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, payable directly to claimant's attorney.

In the Matter of the Compensation of
REED HANKS, Claimant
WCB Case No. 96-04004
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the SAIF Corporation's denial of claimant's diabetes condition; and (2) declined to assess a penalty for allegedly unreasonable claim processing. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant is a quadriplegic as a result of a compensable injury and was declared permanently and totally disabled in 1963. In 1990, claimant was diagnosed with diabetes mellitus; this condition is controlled with insulin. In April 1996, SAIF denied the "treatment or disability related" to claimant's diabetic condition.

Applying ORS 656.005(7)(a)(B), the ALJ upheld SAIF's denial. In particular, the ALJ found the medical evidence insufficient to show that claimant's quadriplegia was the major contributing cause of his diabetes. Claimant challenges this conclusion, asserting that the opinion of his treating internist, Dr. Leverette, carried his burden of proof.

As the court explained in SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309 (1997), when a "case turns on the fact that there is a difference between the primary cause of claimant's condition and the primary cause of his need for treatment," then compensability is established under ORS

656.005(7)(a)(B) with proof that the major contributing cause of the need for treatment is the compensable injury. 149 Or App at 313. The court agreed with the Board's conclusion that the claimant's combined condition was compensable because the work injury, when weighed against the extent of the preexisting condition, was the major cause of his need for treatment. Id. at 315.

We find that the distinction between the primary cause of the combined condition and the primary cause of the need for treatment discussed by the Nehl court is applicable here. We agree with the ALJ that claimant's quadriplegia was not the primary cause of his diabetes, the combined condition. There is persuasive evidence, however, that quadriplegia was the primary cause of claimant's need for insulin treatment for the diabetes condition.

Claimant's treating internist, Dr. Leverette, testified at hearing that claimant's quadriplegia "worsened" claimant's diabetes to the point of necessitating insulin. (Tr. 46-47). Specifically, Dr. Leverette explained that conditions resulting from quadriplegia, including urinary tract infections, bed sores, and muscle atrophy, all contributed to increasing claimant's blood sugar level and the need for insulin. (Id. at 32-34). Dr. Leverette also stated that claimant's quadriplegia prevented him from the two major treatment options, exercise and diet, and narrowed claimant's treatment to insulin. (Id. at 35-36). Dr. Curosh, examining endocrinologist, and Dr. Ahmann, endocrinologist who reviewed the medical record on behalf of SAIF, agreed with Dr. Leverette to the extent that claimant's quadriplegia took away the treatment options of diet and exercise and that such methods normally preceded the introduction of insulin. (Exs. 28-11, 29-14). Dr. Curosh, in particular, stated that the unavailability of exercise necessitated the substitution of "other treatment methods like medication." (Ex. 29-26).

As the treating physician, we find Dr. Leverette's opinion most persuasive. See Weiland v. SAIF, 64 Or App 810 (1983). Consequently, we conclude that claimant, by showing that the primary cause of the need for insulin treatment is his quadriplegia, proved that his diabetes, the combined condition, is compensable. ORS 656.005(7)(a)(B); Nehl, 149 Or App at 315.

Penalties

Claimant contends that, because claimant's diabetes was diagnosed in 1990 but SAIF did not deny the condition until 1996 (and, in the interim, paid for medical services related to the diabetes), SAIF's denial was unreasonably late. We agree. ORS 656.262(11)(a). Consequently, SAIF is liable for 25 percent of the "amounts then due."

Claimant's attorney is entitled to an assessed fee for services at hearing and on review in prevailing over the denial of insulin treatment. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the 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 November 22, 1996 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded for processing according to law. That portion of the order declining to assess a penalty is reversed. SAIF is assessed a penalty equal to 25 percent of all amounts of compensation due and unpaid at the time of its denial, payable in equal shares to claimant and his attorney. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by SAIF.

Board Member Haynes dissenting.

I dissent. First, I am very troubled by the majority's application of Nehl. 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 Nehl, the court continued to adhere to its previous decision that "the Board correctly said that when [the] claimant has a combined condition, not caused in major part by the on-the-job injury, the condition is nevertheless compensable when the on-the-job- incident is primarily responsible for claimant's need for treatment." 149 Or App at 312. In rejecting the carrier's assertion that such a conclusion conflicted with its holding in Robinson v. SAIF, 147 Or App 157 (1997), the court stated:

> "In Robinson, we did not need to distinguish between the major cause of claimant's combined condition and the major cause of claimant's need for treatment, because they were the same. Here, we need to make that distinction, because this case turns on the fact that there is a difference between the primary cause of claimant's condition and the primary cause of his need for treatment." Id. at 313.

The court concluded that claimant's combined condition was compensable because he proved that the work injury was the major contributing cause of his need for treatment. Id. at 315.

As I read this case, ORS 656.005(7)(a)(B) can be satisfied with either proof that the compensable injury is the major or primary contributing cause of the combined condition or the need for treatment; if the latter test is satisfied then the "combined condition" is compensable. What is confusing about the modified Nehl decision is that it is not clear what the court considered to be the "combined condition." The ALJ's and Board orders were careful in distinguishing the entire combined condition from the "post surgical low back with loosened hardware" condition, which was characterized as "a very specific and limited part" of the entire combined condition. The first Nehl decision appeared to be in agreement with this distinction; the modified decision, however, makes no mention of it, referring only to the "combined condition," making it unclear what the court considered to be the scope of the "combined condition."

If the court's reference to "combined condition" was to the entire combined condition, then the court held that a different condition (post surgical low back with loosened hardware) from the entire low back "combined condition" can prove compensability of the entire combined condition if there is proof that the compensable injury is the major or primary cause of the need for treatment. I understand the majority as taking this approach because it sets aside the entire denial of claimant's diabetic condition. If that is the case, I cannot understand how the statute allows for the application of two definitions of "combined condition."

What I do find clear in Nehl, however, is that a distinction is not made between the causes of the combined condition and the need for treatment when such causes are the same. 149 Or App at 313. Here, as I read the medical evidence, there is no difference between the cause of the combined condition of diabetes and the need for insulin treatment because the primary cause of both is a preexisting condition. Consequently, I do not find Nehl applicable to this case. Rather, the proper burden of proof is for claimant to establish that his quadriplegia is the major contributing cause of his entire diabetic condition.

Finally, even if I could accept the application of Nehl, I disagree with the majority's evaluation of the medical evidence. The ALJ was right in deciding that Dr. Leverette did not provide the most persuasive opinion. First, his opinion was rebutted by physicians who, as endocrinologists, had more expertise to evaluate claimant's condition. Additionally, in deciding causation, this case involves expert analysis rather than external observation. For these reasons, Dr. Leverette's status as the treating physician does not entitle his opinion to deference. See Allie v. SAIF, 79 Or App 284, 287 (1986).

Dr. Leverette's opinion also lacked persuasive reasoning. There is no dispute that, because claimant is a quadriplegic, the treatment options of diet and exercise are not available to him. Dr. Leverette can depend only on speculation, however, in deciding that such fact necessarily leads to the conclusion that claimant's quadriplegia is the major contributing cause of his need for insulin. While testifying, Dr. Leverette agreed that "we don't know" how "bad" claimant's diabetes would be if he was not quadriplegic. (Tr. 47-48). Dr. Ahmann explained that diet and exercise would delay the need for

insulin for a period of time but that eventually the person would be required to use it. (Ex. 28-13). Dr. Ahmann also found that claimant, even if not quadriplegic, would have required insulin at some point, citing a study showing that 85 percent of people with claimant's type of diabetes eventually used insulin. (Id. at 16). In sum, Dr. Ahmann found it "impossible" to state the major contributing cause of claimant's diabetes because of the "many variables about the disease that we just don't understand." (Id. at 15).

Dr. Curosh similarly stated that "there's no way of knowing" whether, if claimant could exercise, he would not require insulin, also stating that, statistically, most patients eventually go on insulin but that the timing could not be predicted. (Ex. 29-12, -13). Like Dr. Ahmann, Dr. Curosh stated that diet and exercise could slow the progression of diabetes but such treatments did not prevent the eventual need for insulin. (Id. at 40). Dr. Curosh found that "just the length of time of his diabetes" was the major contributing cause of claimant's need for insulin. (Id. at 14).

In sum, whether or not Nehl is applied, claimant did not prove compensability. Consequently, I dissent.

In the Matter of the Compensation of
DOROTHY M. HARRIS, Claimant
WCB Case No. 96-06362
ORDER ON REVIEW
Dierking & Schuster, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that reduced her scheduled permanent disability award for a bilateral carpal tunnel syndrome (CTS) condition from 11 percent (16.5 degrees) for loss of use or function of the right forearm (wrist) and 3 percent (4.5 degrees) for loss of use or function of the left forearm (wrist), as awarded by an Order on Reconsideration, to 5 percent (7.5 degrees) for the right forearm (wrist) and 2 percent (3 degrees) for the left forearm (wrist). On review, the issue is extent of scheduled permanent disability.

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

On May 28, 1992, claimant injured her left wrist/thumb while working. The self-insured employer accepted the claim as a nondisabling left wrist/thumb sprain. Subsequently, a March 14, 1995 Opinion and Order upheld in part and set aside in part a January 24, 1994 denial, as amended on December 9, 1994. (Ex. 26). Those portions of the amended denial which denied an aggravation claim, a left trigger thumb condition, and a bilateral metacarpal joint arthritis condition were upheld. That portion of the amended denial which denied a new occupational disease claim for a bilateral CTS condition was set aside and the employer ordered to process the claim. The order became final as a matter of law.

The employer issued a formal notice of acceptance for a disabling bilateral CTS condition. (Ex. 32). Subsequently, claimant underwent surgery for this condition. On January 30, 1996, claimant was found medically stationary by Dr. Buehler, M.D., her attending physician. The claim was closed by a February 23, 1996 Notice of Closure, which awarded 9 percent scheduled permanent disability for the right forearm. Claimant appealed.

Claimant was examined by a panel of medical arbiters consisting of, Dr. Bell, neurologist, Dr. Nonweiler, M.D., and Dr. Martens, orthopedist, who diagnosed "polyneuropathy related to diabetes with superimposed CTS bilaterally." (Ex. 39-2). They opined that the impairment relating to claimant's median nerve entrapment was 40 percent due to claimant's work and 60 percent due to her diabetes and associated polyneuropathy. (Ex. 39-3).

On July 2, 1996, an Order on Reconsideration issued that rated claimant's impairment in full, without apportioning the impairment the medical arbiters' attributed to claimant's preexisting diabetes and associated polyneuropathy. (Ex. 41-6). The employer appealed.

At hearing, claimant argued that the applicable rule was former OAR 436-035-0007(3)(c),[1] WCD Admin. Order 96-051, which applies to combined condition claims and does not allow apportionment where a major contributing cause denial has not been issued under ORS 656.262(7)(b). The ALJ disagreed and determined that former OAR 436-035-0007(3)(c) did not apply to claimant's claim because claimant's occupational disease claim for bilateral CTS was not accepted, either voluntarily or by means of a litigation order, as a combined condition claim. Instead, the ALJ determined that the applicable rule was former OAR 436-035-0007(2)(a),[2] which provides for apportionment where a worker has a superimposed condition. Accordingly, the ALJ apportioned claimant's median nerve impairment and found claimant entitled to 40 percent of that impairment.

On review, claimant renews her argument that the bilateral CTS condition was accepted as a combined condition and, therefore, former OAR 436-035-0007(3)(c) applies to her claim to prohibit apportionment. We agree with the ALJ's analysis of this issue.

The March 14, 1995 Opinion and Order found the bilateral CTS condition compensable as an initial occupational disease claim under ORS 656.802(1)(c). (Ex. 26). The order noted that claimant had worked as a housekeeper for the employer since April 1988 and first began experiencing right hand/wrist symptoms in May 1989. Claimant sought treatment from her then-treating physician, Dr. McAninch, who diagnosed mild right CTS. Claimant's housekeeper work involved repetitive use of the hands and wrists and she engaged in no significant off-work activities. By 1993, she was diagnosed with bilateral CTS. Regarding causation, the order relied on the opinion of Dr. McAninch, who opined that claimant's work activities were the major contributing cause of the development and worsening of her bilateral CTS. The order contained no discussion regarding the contribution of the diabetes condition except to say that Dr. McAninch had considered it in his analysis. Based on this record, the order concluded that claimant had established a new compensable occupational disease claim for bilateral CTS. (Ex. 26-5-6).

Thus, this prior order found claimant's bilateral CTS compensable as an occupational disease claim. This compensability finding was not premised on a "combined condition" involving diabetes and/or polyneuropathy. Therefore, it follows that the order did not order the employer to accept a combined condition that included diabetes and/or polyneuropathy. Furthermore, the employer did not voluntarily accept a combined condition. Instead, the employer accepted a claim for disabling bilateral CTS. (Ex. 32-1). Accordingly, because this claim does not involve a combined condition, former OAR 436-035-0007(3)(c) does not apply to prohibit apportionment.

In addition, because a combined condition was not accepted, either voluntarily or by a litigation order, the employer was not required to issue a "major contributing cause" denial under ORS 656.262(7)(b) before it could argue that part of claimant's impairment is related to a noncompensable condition. See Robin W. Spivey, 48 Van Natta 2363 (1996) (Before ORS 656.262(7)(b) applies, a

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[1] Former OAR 436-035-0007(3)(c) provides, in part:

"(3) Where a worker has a preexisting condition, the following applies:

"* * * * *

"(c) Where a worker's compensable condition combines with a preexisting condition, pursuant to ORS 656.005(7), the current disability resulting from the total combined condition shall be rated in accordance with these rules as long as the compensable condition remains the major contributing cause of the combined condition, i.e., a major contributing cause denial has not been issued pursuant to ORS 656.262(7)(b). Apportionment of disability is not appropriate."

[2] Former OAR 436-035-0007(2)(a) provides, in part:

"(2) Where a worker has a superimposed condition, only disability due to the compensable condition shall be rated as long as the compensable condition is medically stationary and remains the major contributing cause of the superimposed condition. Then, apportionment is appropriate. Disability shall be determined as follows:

"(a) The physician shall describe the current total overall findings of impairment[.] The physician shall describe the percentage of those findings that are due to the compensable condition. Only the portion of those impairment findings that are due to the compensable condition shall receive a value."

condition must have been accepted under ORS 656.005(7) as a combined condition; because no combined condition was accepted, the carrier was not obligated to issue a preclosure denial under ORS 656.262(7)(b) before it could argue that a preexisting condition was the cause of some of the claimant's impairment and apportionment was allowed); compare Boyd K. Belden, 49 Van Natta 59 (1997) (where a carrier has accepted a combined condition and does not issue a preclosure denial under ORS 656.262(7)(b), 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).

Claimant also argues that former OAR 436-035-0007(3)(b) applies to her claim and prohibits apportionment. Former OAR 436-035-0007(3)(b) provides, in part, that "disability caused solely by a worker's preexisting condition shall be rated completely if work conditions or events were the major contributing cause of a pathological worsening of the preexisting physical condition." Claimant argues that the law of the case establishes that she had a preexisting bilateral CTS condition, which was worsened by her work activities. Therefore, claimant argues, apportionment is not appropriate under former OAR 436-035-0007(3)(b). We disagree.

According to the medical arbiters, claimant's median nerve disability is 60 percent due to her diabetes and associated polyneuropathy. Although claimant had preexisting diabetes, the prior order did not hold that the work activities combined with or worsened the preexisting diabetes condition. Therefore, former OAR 436-035-0007(3)(b) does not apply to prohibit apportionment.

The standard for determining whether impairment is related to a compensable injury is specifically set out by statute. ORS 656.214(2) provides that "the criteria for the rating of scheduled disability shall be the permanent loss of use or function of the injured member due to the industrial injury." ORS 656.214(2) (emphasis added); see former OAR 436-035-0007(1).[3] Thus, the question before us is what impairment is "due to" the compensable bilateral CTS condition as opposed to some noncompensable condition.

Furthermore, with the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(2)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. See former OAR 436-035-0007(12); Roseburg Forest Products v. Owen, 127 Or App 442 (1994).

Claimant's attending physician at claim closure was Dr. Buehler. (Ex. 30). In his closing examination, Dr. Buehler measured claimant's range of motion, indicated no sensory loss, and found grip strength 4/5 on the right secondary to deconditioning. (Ex. 36). Dr. Buehler did not address the cause of any impairment.

The medical arbiters' examination was more thorough and they addressed the cause of claimant's impairment. (Ex. 39). Therefore, we find the medical arbiters' opinion more persuasive.[4] They opined that 40 percent of the median nerve impairment was due to the compensable bilateral CTS condition and 60 percent was due to the diabetes and related polyneuropathy condition.

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[3] Former OAR 436-035-0007(1) provides, in part:

"Except for sections (3) and (4) of this rule, a worker is entitled to a value under these rules for those findings of impairment that are permanent and were caused by the compensable injury or disease including the compensable condition, a consequential condition and direct medical sequelea [sic]. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules."

[4] We note that claimant does not rely on Dr. Buehler's closing examination. Instead, she relies on the medical arbiters' findings and argues that, notwithstanding the medical arbiters' opinion to the contrary, those findings are all caused by the compensable CTS condition because the opinion of her former treating physician, Dr. McAninch, established compensability of that condition. We disagree with this reasoning. Dr. McAninch rendered no opinion regarding the cause of claimant's impairment. Furthermore, because Dr. McAninch was not claimant's attending physician at claim closure, his opinion would have no bearing on the issue. ORS 656.245(2)(b)(B).

Based on the medical arbiters' opinion, the ALJ determined that claimant was entitled to 40 percent of the median nerve impairment. Claimant argues that the ALJ erred[5] in relying on former OAR 436-035-0007(2) to reach this determination. Claimant asserts that, by its terms, former OAR 436-035-0007(2) does not apply to her claim. It is questionable that former OAR 436-035-0007(2) applies, because it requires that the compensable condition remain the "major contributing cause of the superimposed condition." Here, the compensable condition is the cause of only 40 percent of claimant's median nerve impairment. Therefore, no matter how the "superimposed condition" is defined, the compensable condition is not the major contributing cause of it. However, even if former OAR 436-035-0007(2) is inapplicable here, claimant is not entitled to impairment that is not due to her compensable condition under the provisions of ORS 656.214(2) and former OAR 436-035-0007(1).

ORDER

The ALJ's order dated February 24, 1997 is affirmed.

[5] Claimant also contends that the ALJ incorrectly characterized the medical arbiters' opinion regarding the superimposed condition, arguing that the "medical arbiters opined that the bilateral carpal tunnel condition was superimposed on the diabetes and polyneuropathy (Exhibit 39-2), not the other way around." (Claimant's Opening Brief, page 5). However, even if the ALJ misspoke, we do not find that it makes any difference. The relevant point is that the medical arbiters found that claimant's median nerve impairment was only 40 percent due to the compensable condition.

In the Matter of the Compensation of
WILLIAM E. KANEHL, Claimant
WCB Case No. 96-08734
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Alice Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our July 29, 1997 Order on Review that reduced claimant's unscheduled and scheduled permanent disability awards to zero. Relying on amended ORS 656.262(6)(c), claimant contends that the SAIF Corporation was required to issue an amended Notice of Acceptance at the time of claim closure which would have eliminated the need for us to determine that it was inappropriate to rate impairment related to his unaccepted degenerative condition.

The amended statute provides that when a carrier determines that the claim qualifies for closure, it shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The statute further states that any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. Finally, if a condition is found compensable after claim closure, the carrier shall reopen the claim for processing regarding that condition. See ORS 656.262(6)(c).

Assuming without deciding that the amended statute is retroactively applicable, such amendments do not alter our permanent disability determination which arises from the closure of claimant's accepted lumbar strain and contusion claim. In reaching this conclusion, we note that the amended statute expressly provides that any objection to an updated notice or the appeal of denied conditions shall not delay claim closure. Thus, it is apparent that a carrier's refusal to accept a particular condition at claim closure does not forestall claim closure procedures. Moreover, the amended statute further insures that "post-closure" compensable conditions will also be processed by the carrier.

In light of such circumstances, where, as here, a claimant is contending that an unaccepted condition should have been considered when evaluating the extent of the claimant's permanent disability, the claimant's remedy is to seek an amendment of the carrier's notice of acceptance. Should the carrier refuse such a request and the claimant prevails over such a denial, the carrier must reopen the claim for processing regarding that "post-closure" compensable condition. Nonetheless, such circumstances do not negate the previous closure of the claim and the evaluation of the accepted conditions which existed at that closure.

Accordingly, we withdraw our July 29, 1997 order. On reconsideration, as supplemented herein, we republish our July 29, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

In the Matter of the Compensation of
TERRY L. MASON, Claimant
WCB Case Nos. 96-07364 & 96-02372
ORDER ON RECONSIDERATION
Coughlin, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Agricomp Insurance Company (AIC) requests reconsideration of our July 29, 1997 Order on Review which affirmed the ALJ's order that set aside its denial of claimant's injury claim for a herniated disc at L4-5. AIC contends that we incorrectly applied a material contributing cause standard of proof when the appropriate standard should be major contributing cause under either ORS 656.005(7)(a)(B) or ORS 656.005(7)(a)(A). For the following reasons, we disagree.

AIC cites evidence from which it concludes that there was preexisting degenerative condition. (Ex. 48, 59-49). AIC also cites deposition testimony from Dr. Dahlin, claimant's attending physician, which it contends establishes that claimant's alleged September 25, 1995 injury "combined" with the preexisting degenerative condition, thus requiring application of the major contributing cause standard of ORS 656.005(7)(a)(B). (Ex. 59-18, 19). Upon further consideration of this testimony, we again conclude that there is insufficient evidence of a "combined condition." Even though under Sharon D. Dan, 49 Van Natta 1025 (1997) "magic words" are not essential to a finding of a "combined condition," we nevertheless agree with the ALJ that evidence of a "combined condition" is lacking in this case. Accordingly, we again find that ORS 656.005(7)(a)(B) does not apply in this case.

ORS 656.005(7)(a)(A) provides that "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." (emphasis added). As noted in our previous order, claimant is contending that the herniated disc is a direct, though belated, result of the alleged September 25, 1995 lifting incident. Thus, we continue to conclude that ORS 656.005(7)(a)(A) is not applicable. Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992). Moreover, AIC did not accept a compensable injury as a result of the September 25, 1995 incident. Inasmuch as a "compensable injury" is a prerequisite to the application of ORS 656.005(7)(a)(A), and because that element is lacking with respect to AIC, we again decline to apply the major causation standard of ORS 656.005(7)(a)(A).

Finally, AIC asserts that claimant failed to sustain his burden of proof under a material causation standard. We acknowledge Dr. Dahlin's testimony that there was insufficient evidence that the September 1995 incident was the major contributing cause of the L4-5 disc herniation, (Ex. 59-40). However, as explained above, major contributing cause is not the applicable standard. Because Dr. Dahlin never retracted his opinion that the September 25, 1996 incident was a causal factor in claimant's herniated disc, we once more conclude that claimant has satisfied his burden of proof under a material causation standard. (Ex. 58-2).

Accordingly, we withdraw our July 29, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our July 29, 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
BEVERLY A. TOMPKINS, Claimant
WCB Case No. 96-09724
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order which upheld the insurer's denial of claimant's occupational disease claim for a bilateral thumb condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

For four and one-half years, claimant was employed as a sandwich maker in the employer's restaurant and deli. Her primary duty of preparing sandwiches involved a wide variety of hand-intensive tasks, such as slicing meat with an electric slicer, lifting packages of meat and plastic containers of sandwich ingredients, retrieving gallon jars of pickles, mayonnaise and sauerkraut from a nearby deli case, and creating the sandwiches themselves with the assistance of another sandwich maker. Two employees would create up to 250 sandwiches per day during the busiest months of summer: June, July and August.

Claimant sought treatment from a family practitioner, Dr. Ponte, on July 2, 1996, for bilateral thumb pain. Dr. Ponte reported that claimant sliced deli meats and cheeses, lifted heavy trays, and wrapped sandwiches, "sometimes 200 or 300 in a 2-3 hour period of time." (Ex. 2). Dr. Ponte diagnosed bilateral Dequervain's tenosynovitis secondary to claimant's work.

On July 10, 1996, claimant filed a workers' compensation claim, alleging that her thumbs began hurting the first week of June 1996. (Ex. 6).

On July 23, 1996, Dr. Coe, an orthopedist, began treating claimant. He described claimant's duties as involving constant use of the hands for chopping and slicing as she made "three or four hundred" sandwiches in a day. (Ex. 10). Although claimant had been off work for several weeks, Dr. Coe reported that her dorsal thumb pain had continued. After reviewing x-rays, Dr. Coe diagnosed degenerative arthritis of the basal joints of both thumbs and chronic sprain of the ulnar collateral ligaments of her MP joints with possible mild arthritis of those joints. According to Dr. Coe, the combined injuries appeared to be work related. Id.

On September 12, 1996, examining physicians Drs. Melson and Smith evaluated claimant's thumb condition. (Ex. 16). Claimant related the onset of her condition to May 1996 when the employer enlarged their restaurant, greatly expanding her job as meat slicer and sandwich maker. The Melson/Smith panel did not provide a description of claimant's job duties, but they diagnosed degenerative arthritis of the bilateral carpometacarpal joints and wrist sprain. The panel concluded: "the injury was the major contributing cause of the pain that resulted in [claimant's] time loss." (Ex. 16-4). However, they also concluded that, since claimant's condition had improved, the preexisting condition was now the major contributing cause of claimant's need for treatment and time loss. (Ex.16-5).

The insurer denied the bilateral thumb claim on September 27, 1996. (Ex.18). Claimant requested a hearing.

In December 1996, claimant's attorney provided both Dr. Coe and Dr. Ponte with a detailed description of claimant's job duties. (Exs. 20, 20A). According to counsel's letters, claimant lifted plastic containers weighing 6 to 8 pounds from a shelf area underneath a counter to the top of the counter. After lifting the container filled with tuna, sausages, turkey and other cold cuts, claimant would make the sandwich and replace the container on the lower shelf. According to the job description, this would be done repetitiously throughout claimant's six to seven-hour day. Claimant would also be required to pick up gallon jars of mayonnaise and other dressings while "they" would make 150 to 250 sandwiches primarily between 11 a.m. and 2:30 p.m. Claimant was also described as slicing meat for up to four hours at a time, which would be difficult because she was required to lift meat onto the slicer and put pressure on the meat while going back and forth with the slicer.

Based on the history contained in counsel's letters, the physicians were asked to answer a list of questions in preparation for litigation of the compensability issue. Dr. Coe stated that the degenerative arthritis of the basal thumb joint undoubtedly preceded the onset of claimant's symptoms in June 1996, but that her working conditions involving continuous grasping over a period of years precipitated or accelerated the underlying pathologic process. According to Dr. Coe, continuous grasping and pinching applies repeated axial and shearing forces to the basal thumb joint leading to "pathologic worsening of degenerative arthritis." (Ex. 21-1). Dr. Coe concluded that work activity was the major contributing cause of claimant's current condition.

Dr. Ponte noted that claimant was asymptomatic prior to the onset of symptoms. (Ex. 22). According to Dr. Ponte, the weight of the deli trays and the frequency with which she lifted them clearly worsened her underlying arthritis.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial. In so doing, the ALJ found that the medical evidence did not establish a pathological worsening of claimant's preexisting degenerative arthritis. Alternatively, the ALJ reasoned that, even if there had been a pathological worsening, the medical evidence from Dr. Coe and Dr. Ponte did not prove that claimant's work activity was the major contributing cause of the worsening. Specifically, the ALJ noted claimant's initial history given to her physicians that she created 300 to 400 sandwiches by herself in a work day. Finding this history at variance with hearing testimony that claimant and a coworker made up to 250 sandwiches on a very busy day, the ALJ concluded that the doctors had a "serious misunderstanding" as to the intensity and speed with which claimant was required to work. Thus, the ALJ did not find the opinions of Drs. Coe and Ponte persuasive.

On review, claimant contends that the opinions of Drs. Coe and Ponte prove a pathological worsening of her arthritis condition occurred. Moreover, claimant asserts that those physicians' opinions also established that her hand-intensive work activities were the major contributing cause of the pathological worsening. For the following reasons, we find that claimant proved a compensable occupational disease claim.

Because this occupational disease claim is based on a worsening of claimant's preexisting degenerative arthritis, claimant must prove that her employment conditions were the major contributing cause of the combined condition and pathological worsening of her degenerative condition. ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 1010, on recon 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995).

The application of the "major contributing cause" standard in this case presents a complex medical question that must be resolved by expert medical opinion that is well-reasoned and based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986). We give greater weight to the opinion of the treating doctors, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we do not find persuasive reasons to do otherwise.

We first address the issue of whether claimant's physicians had an accurate understanding of claimant's job duties on which to base their opinions. At the hearing, considerable testimony was presented regarding the precise nature of the tasks claimant performed on the job. There was testimony from claimant, a coworker (Bankston) and a former general manager (Fuller) regarding the typical number of sandwiches prepared, the weight of objects lifted, the frequency with which those objects were lifted, and the amount of time devoted to slicing meat. As previously noted, the ALJ determined that there was an inconsistency between claimant's initial estimation of the number of sandwiches she prepared (300-400) and the hearing testimony that placed the number anywhere from 80 to 250 during the busy summer season and much less than that during other times of the year. (Trs. 25, 40, 68, 88). The ALJ also noted the hearing testimony established that claimant did not prepare the sandwiches by herself, but rather that they were prepared with the assistance of another sandwich maker. (Trs. 68, 88). Given what he considered to be a significant inconsistency between the history in Dr.Coe's and Dr. Ponte's chart notes and the hearing testimony, the ALJ found the medical opinions of those physicians to be unpersuasive with respect to proving medical causation.

The ALJ, however, did not address the history provided in claimant's counsel's letters to Drs. Coe and Ponte. That history merely stated "they would make and sell 150 to 250 sandwiches, primarily between the hours of 11:00 a.m. and 2:30 p.m." (Exs. 20, 20A-2, emphasis added). We find that this

history is generally consistent with testimony presented at hearing that up to 250 sandwiches could be prepared by claimant and an assistant during busy days in the summer between 11:00 a.m. and 2:30 p.m. (Trs. 87, 88).

We acknowledge the conflicting testimony regarding the amount of time claimant would spend slicing meat (compare Tr. 19 with Tr. 97), the weight of the plastic containers (compare Tr. 18 with Tr. 35), and the frequency with which claimant would lift those containers, as well as gallon jars of sandwich ingredients. (Compare Trs. 17, 72, 87 with Trs. 37, 92). However, there is no dispute that claimant was involved in hand-intensive preparation of many sandwiches during a typical busy summer day. Although the testimony of the witnesses differed somewhat as to details of claimant's tasks, no witness testified that claimant spent significant periods doing little or no work.

Based on our de novo review of the hearing testimony, we find that the history provided to Drs. Coe and Ponte in claimant's counsel's December 1996 letters is a sufficiently accurate description of claimant's job duties. Thus, we find that the ALJ improperly discounted the probative value of those physicians' opinions on the ground that they had an inadequate understanding of the nature of claimant's work. See Samuel J. Adams, 46 Van Natta 1914, 1915 (1994) (inconsistencies regarding details of the claimant's injury did not affect medical evidence relating back condition to work incident).

Having made this determination, we now proceed to the compensability issues. The ALJ concluded that the medical evidence did not prove a pathological worsening of claimant's bilateral thumb condition. We disagree.

Dr. Coe opined that the grasping and pinching activities claimant performed on the job applied repeated axial and shearing forces to the basal thumb joints leading to a "pathological worsening" of claimant's degenerative arthritis. (Ex. 21-1). Dr. Ponte opined that repetitive lifting of deli trays created significant stress on the thumb joints that significantly "accelerated' the degenerative process. (Ex. 22-2). Dr. Melson concluded that x-rays or repeat measurements of functions of the affected joints would be necessary to determine whether there was a worsening of the underlying degenerative process. (Ex. 23-5).

In summary, Dr. Coe's and Dr. Ponte's opinions support a finding of a pathological worsening. Dr. Melson's opinion does not because he believed there was inadequate information on which to make such a determination. We conclude that, based on the medical opinions of Drs. Coe and Ponte, a preponderance of the evidence does support a finding of a pathological worsening. We, therefore, conclude that such a worsening did occur.

The remaining question is whether claimant's work activity was the major contributing cause of the pathological worsening and of the "combined condition" consisting of claimant's current bilateral thumb condition, which allegedly resulted from the combination of the preexisting degenerative condition and claimant's hand-intensive job duties. Dan D. Cone, 47 Van Natta at 2221. The ALJ found that, even if there had been a pathological worsening, the medical evidence from Dr. Coe and Dr. Ponte did not establish that work activities were the major contributing cause of the worsening. Both Dr. Coe and Dr. Ponte clearly opined that claimant's hand intensive work activity was the major contributing cause of claimant's current combined condition and pathological worsening of the preexisting degenerative thumb condition. (Exs. 21-2, 22). Because those opinions are well-reasoned and based on an accurate history, we find them persuasive. Somers, 77 Or App at 263. Moreover, those opinions are supported by the lack of evidence of an off-the-job cause of claimant's bilateral thumb symptoms and the absence of prior thumb symptoms before claimant developed them in conjunction with her hand-intensive work in the late spring and early summer of 1996.[1]

Accordingly, we conclude that claimant sustained her burden of proving a compensable occupational disease. ORS 656.266. Because the ALJ reached the opposite conclusion, we reverse.

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[1] We also note that the Melson/Smith panel also opined that claimant's "injury" resulting from repetitive use of the thumb was the major contributing cause of claimant's disability. (Ex. 16-4).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,500, payable by insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 19, 1997 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by the insurer.

In the Matter of the Compensation of
CHERYL A. CALDWELL, Claimant
WCB Case No. 96-08744
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed claimant's request for hearing on the ground that the Hearings Division lacked jurisdiction. On review, the issue is whether claimant's hearing request was properly dismissed. We affirm.

FINDINGS OF FACT

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

Claimant was compensably injured on October 2, 1995. Her claim was closed by Notice of Closure (NOC) on March 21, 1996, and a corrected NOC issued May 3, 1996. The NOC did not award permanent disability benefits.

On May 16, 1996, claimant requested reconsideration and disagreed with the impairment findings used to rate disability. On June 12, 1996, the Department issued a Notice of Postponement of Reconsideration Proceeding which informed the parties that the Order on Reconsideration (OOR) was postponed for purposes of obtaining a medical arbiter exam. The Notice advised the parties that the OOR, which was originally due June 13, 1996, was scheduled to be issued August 12, 1996, following receipt of the arbiter's report. The Notice also advised that if an OOR was not mailed by August 12, 1996, the reconsideration request was deemed denied and the parties could proceed to hearing as if the NOC had been affirmed.

On July 13, 1996, the date of the scheduled arbiter exam, claimant failed to appear for her examination. On July 18, 1996, the Department issued an Order Suspending Disability Benefits, on the ground that claimant had not attended the scheduled arbiter exam and had not shown good cause for failing to attend the exam.

On August 24, 1996, claimant was examined by a medical arbiter panel.

On August 27, 1996, the Department issued a Statutory Affirming Order. The order provided that, in accordance with ORS 656.268(6)(d), claimant's request for reconsideration was deemed denied and any further proceedings would occur as though an Order on Reconsideration affirming the Notice of Closure had been issued. The order further provided that any party to the claim had the right to request a hearing with the Board for a period of 30 days from August 12, 1996.

Claimant's request for hearing was filed with the Board on September 26, 1996.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, under the facts of the case, claimant had essentially failed to proceed through the reconsideration process. Accordingly, pursuant to ORS 656.268(8), the ALJ held that, because claimant had not preserved or raised issues on reconsideration, a hearing could not be held. The ALJ acknowledged that subsection (8) of the statute however, was in apparent conflict with another section of the statute, ORS 656.268(6)(d), which provides a time frame for the issuance of an Order on Reconsideration.

The ALJ found that, even though the Department's order provided that claimant could proceed directly to the Board for a hearing if the OOR was not timely issued, the statute nevertheless provided that no hearing could be held on issues that were not previously before the Department on reconsideration. The ALJ cited to a Department order, Danna K. Warren, 1 WCSR 484 (1996), where the hearings officer found that the Department's apparent interpretation of ORS 656.268(6)(d), as evidenced by the appeal rights provided on its notices, would allow a worker to effectively circumvent the reconsideration process by delaying issuance of an OOR. Because he agreed with the reasoning expressed in Warren, the ALJ found that ORS 656.268(8) must be given effect and, as claimant had not proceeded through reconsideration, there was no subject matter jurisdiction over her request for hearing.

On review, claimant argues that the reconsideration process in this case was "deferred," pursuant to the Department's own rules. Additionally, claimant contends that, although ORS 656.268(8) provides that no hearing shall be held on issues not raised or preserved before the Department at reconsideration, the statute further provides that issues "arising out of the reconsideration order may be addressed and resolved at hearing." Claimant also contends that her request for hearing was timely.

We find that it is not necessary to determine whether the reasoning expressed by the Department in Warren is correct and whether ORS 656.268(8) prevents claimant from proceeding to hearing in this case. For the following reasons, we conclude that, even if we accepted claimant's argument that she was entitled to directly proceed to hearing and raise issues regarding her permanent disability, claimant did not timely request a hearing under ORS 656.268(6)(d) and (f).

Claimant acknowledges that she was twice informed that the time period for requesting a hearing (30 days) would run from August 12, 1996, the date on which the OOR was due to have issued. Claimant was informed of the August 12 date in both the Notice of Postponement (Ex. 9C) and the Statutory Affirming Order. (Ex. 13). Nevertheless, claimant contends that the August 12, 1996 date is not the appropriate date from which her 30 days to request a hearing should begin to run.

Claimant first argues that the Department had the authority to "defer" the reconsideration proceeding through its own rule, OAR 436-030-0165(5)(a). That rule provides that:

> "The reconsideration proceeding is deferred during the time a worker's disability benefits are suspended and the time during the suspension shall not be counted in the time allowed to complete the reconsideration."

ORS 656.268(6)(d) requires the Department to issue an Order on Reconsideration within 18 working days of a request for reconsideration, plus 60 calendar days in the event that an arbiter's examination has been requested. Consequently, if an OOR had not issued by August 12, 1996, application of the statute would result in the request for reconsideration being deemed denied and claimant would have 30 days within which to request a hearing.

Claimant contends, however, that because the Department suspended her disability benefits when she failed to attend the arbiter exam, the time needed to complete the reconsideration process should not be counted as an exception has been made pursuant to the Department's own rule. Therefore, claimant argues that the time from the July 18, 1996 Order Suspending Disability Benefits through the August 24, 1996 arbiter's exam which was attended by claimant, would not count against her time to appeal. Under such circumstances, claimant contends that the 30 day appeal period would begin on September 16, 1996, which is 18 working days, plus 60 calendar days, excluding the time which was not to be counted during the suspension. Under such a scenario, claimant argues, her request for hearing was timely.

Claimant further argues that, although the hearings officer in Warren found the aforementioned rule to be invalid, the Board is not required to rely on such a ruling. Claimant is correct that we are not bound by such a decision. Nevertheless, for the following reasons, we decline to give the rule any effect.

In Benzinger v. Oregon Department of Insurance and Finance, 107 Or App 449 (1991), the court held that the statutory time frame within which the Department is required to issue its orders on reconsideration is mandatory. Moreover, it is axiomatic that an agency may not amend, alter, enlarge or limit terms of legislative enactment by rule. See Miller v. Employment Division, 290 Or 285 (1980). Accordingly, because we find that the Department's rule attempts to lengthen a statutory time limit, we cannot give the rule the effect sought by claimant. Therefore, we do not rely on the Department's rule which would permit the statute to be ignored while days during a suspension period are not "counted" as part of the time allowed to complete reconsideration. Consequently, we do not find that claimant timely requested a hearing under her theory regarding the deferral/suspension.

Alternatively, claimant contends that her hearing request is timely filed if the 30 days began to run when the Department issued its "Statutory Order Affirming." Although it is not dispositive to this case, we do not find that the statute requires the Department to issue such an order. Rather, the statute provides only that, if an OOR is not issued within the statutory time limits, "reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue." ORS 656.268(6)(d). There is no statutory requirement, therefore, which directs the Department to issue an order such as the "Statutory Affirming Order."

In this case, the Department followed the statutory time frame and advised claimant on two occasions that the "due to issue" date was August 12, 1996. Claimant was never advised that the Statutory Affirming Order triggered the 30-day appeal period. Rather, the Order itself specified that the 30-day period began to run on August 12. (Ex. 13). Accordingly, claimant's hearing request which was filed more than 30 days after August 12, 1996 was untimely.

For the aforementioned reasons, we agree with the ALJ that the Hearings Division did not have jurisdiction over claimant's request for hearing. We therefore affirm the ALJ's dismissal of the hearing request.

ORDER

The ALJ's order dated February 7, 1997 is affirmed.

In the Matter of the Compensation of
BARBARA S. CASSANO, Claimant
WCB Case No. 96-09463
ORDER ON REVIEW
Cole Cary & Wing, Claimant Attorneys
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that increased claimant's scheduled permanent disability award for loss of use or function of the right forearm from 9 percent (13.5 degrees), as awarded by an Order on Reconsideration, to 25 percent (37.5 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation to the ninth finding of fact. Dr. Neumann, the medical arbiter, measured strength in both left and right wrist extension as "4/5" due to give way discomfort. (Ex. 23-3). The accepted condition is "right wrist tendonitis." (Ex. 9). The right wrist is the injured extremity and the left wrist is the contralateral body part. There is no history of injury or disease in the left wrist.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded scheduled impairment values due to claimant's right wrist injury of 5 percent for chronic condition impairment, 4 percent for loss of range of motion, and 18 percent for loss of strength. The ALJ combined these impairment values for a total scheduled permanent disability award of 25 percent. On review, the insurer disputes only the impairment value for loss of strength, contending that claimant has not established any loss of strength due to the compensable right wrist tendonitis. Claimant counters that the ALJ's award should be affirmed.

We adopt the ALJ's reasoning and conclusions regarding the evaluation of claimant's loss of strength in the injured right wrist with the exception of the evaluation of the loss of strength in the right wrist extension.

As the ALJ found, the standards found in WCD Admin. Order 96-051 (effective February 17, 1996) apply to claimant's claim, which was closed by Determination Order on June 17, 1996. OAR 436-035-0003(2). Former OAR 436-035-0007(22) provides that the "strength of an injured extremity, shoulder or hip shall be compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease."

Dr. Neumann, the medical arbiter, measured 4/5 wrist extension strength in both the left and right wrists due to give way from discomfort. (Ex. 23-3). He also indicated that claimant's loss of strength in the right wrist extension was due to the accepted injury. (Ex. 23-4). However, where, as here, the contralateral body part (the left wrist) has no history of injury or disease, the strength of the injured extremity (the right wrist) is compared to and valued proportionately to the contralateral body part (the left wrist). Former OAR 436-035-0007(22). Comparing the right wrist extension strength of 4/5 to the contralateral left wrist extension strength of 4/5 results in no impairment value for that loss.[1]

However, for the reasons explained by the ALJ, we agree that claimant has established 9 percent impairment for loss of strength in her right wrist flexion. This 9 percent value combined with the undisputed values for chronic condition impairment (5 percent) and loss of range of motion (4 percent), results in 17 percent scheduled permanent disability.

ORDER

The ALJ's order dated April 17, 1997 is modified. In lieu of the ALJ's award and in addition to the 9 percent (13.5 degrees) scheduled permanent disability awarded by the Order on Reconsideration, claimant is awarded 8 percent (12 degrees) scheduled permanent disability, for a total award to date of 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). Claimant's attorney fee shall be modified accordingly.

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[1] We note that Dr. Layne, the attending physician, measured extension strength at the wrists as 5+ bilaterally at claim closure. (Ex. 19). Therefore, the result would be the same if we used the wrist extension strength measurements taken by Dr. Layne.

In the Matter of the Compensation of
ELLEN G. JOHNSON, Claimant
WCB Case No. 96-04863
ORDER ON REVIEW
Brown, Roseta, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a respiratory disease condition (porphyria). In her appellate briefs, claimant refers to various articles and studies pertaining to herbicides and pesticides and has submitted a number of documents (an affidavit, a newspaper article, chart notes, medical reports, a hand-written statement and correspondence), some of which were not admitted as evidence at the hearing. We treat such submissions as a motion to remand to the ALJ for the introduction of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability. We deny the motion and affirm the ALJ's order.

FINDINGS OF FACT

Claimant has had a long-standing history of allergies, asthma, food reactions and intolerance of fumes, chemicals and odors. (Exs. 1, 2). Employed as a school bus driver, claimant filed a workers' compensation claim on April 25, 1996, alleging an adverse reaction to exposure to weed killer and to secondhand smoke present in the break room. (Ex. 3).

Noting claimant's history of exposure to tobacco smoke, Dr. Morgan, her attending physician, reported on April 26, 1996 that claimant had also been exposed to gasoline fumes when another employee cleaned a floor at work with gasoline. (Ex. 2-10). Dr. Morgan also reported claimant's belief that herbicide spraying in the vicinity of the bus garage might be a factor in her symptoms, which included severe headaches, irritability, impaired "cerebration," muscle spasms in the neck, chest and back, and a general feeling of being sick. Id. Recommending a one-month leave of absence, Dr. Morgan opined that claimant's history suggested acute illness due to workplace exposures. Id.

In response to the respiratory claim, the employer issued a denial on May 9, 1996. Claimant appealed the denial.

When next seen by Dr. Morgan on May 23, 1996, claimant reported that she was reacting more acutely to environmental exposures. (Ex. 2-12). Dr. Morgan stated that it was uncertain whether claimant's condition would improve sufficiently to allow her to work. Id.

On July 30, 1996, Dr. Morgan concluded that claimant's history "strongly incriminate[d] workplace exposures as the major precipitating cause of her worsened state of health." (Ex. 8). However, Dr. Morgan conceded that he did not have any definitive tests which could be used for "absolute verification." Id.

In September 1996, claimant consulted Dr. Morton, a physician board-certified in both general preventative medicine and occupational medicine. Based on claimant's history of exposure in April 1996 to an herbicide spray (Roundup), second-hand smoke and gasoline fumes, Dr. Morton diagnosed probable mixed-type chronic porphyria (an enzyme deficiency). (Ex. 9-3, 4).

In a follow-up report, Dr. Morton explained that claimant was tested by the Mayo Lab for porphyria because of her neuropsychiatric symptoms that interfered with her ability to work and to participate in off-the job activities. (Ex. 11). According to Dr. Morton, the Mayo-Lab testing showed elevated levels of uroporphyrin I and other dicarboxyl porphyrins, indicating dysfunction of porphyrin metabolism. In case of symptom exacerbation, Dr. Morton recommended repeat quantitative urine and stool porphyrin tests for further documentation. Concluding that claimant's susceptibility to porphyrogenic substances was permanent, Dr. Morton advised claimant to avoid porphyrogenic substances. Id.

On October 30, 1996, Dr. Morton opined that workplace exposures were the major contributing cause of a material worsening and aggravation of claimant's porphyria symptoms and susceptibility to further aggravation by other chemical exposures. (Ex. 11). Dr. Morton was subsequently deposed. (Ex. 12). Dr. Dordevich, an examining physician, also evaluated claimant's condition in January 1997.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial of claimant's occupational disease claim. The ALJ reasoned that claimant's exposure to secondhand smoke and gasoline could not be fairly viewed as exposures to which she was not ordinarily subjected other than during a period of regular employment. See ORS 656.802(1)(a). With regard to the alleged exposure to the herbicide Roundup, the ALJ concluded that there was no evidence that claimant was exposed to the chemical. Apart from these deficiencies in claimant's claim, the ALJ further concluded that claimant failed to prove medical causation.[1] In reaching this conclusion, the ALJ found the opinion of Dr. Dordevich, the examining physician, more persuasive than that of Drs. Morgan and Morton.[2]

As previously noted, claimant has submitted a number of documents not admitted into evidence, and referred to studies and articles that are also not part of the record before the ALJ. Claimant has also forwarded a "post-hearing" medical report from Dr. Morton dated May 27, 1997. Since our review is limited to the record developed before the ALJ, we treat claimant's submissions 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 submitted materials were unobtainable with due diligence at the January 15, 1997 hearing. In addition, we note that Dr. Morton's opinion is already present in the record through his medical reports and deposition. Furthermore, for the reasons discussed in this order, we are not persuaded that the proffered evidence would likely affect the outcome of the case. We conclude that the record was not improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ and, therefore, we decline to remand the case to the ALJ for additional proceedings.

On the merits, claimant contends that the ALJ incorrectly upheld the employer's denial because Dr. Morton's opinion is the most persuasive medical opinion in this record. For the following reasons, we find that the ALJ properly upheld the employer's denial.

An occupational disease is any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment. ORS 656.802(1)(a). ORS 656.802(2)(b) provides that if the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions

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[1] The ALJ also determined that claimant was not a reliable historian based on her demeanor. Although we generally defer to demeanor-based credibility findings, see International Paper Co. v. McElroy, 101 Or App 61 (1990), we need not address the credibility issue given our resolution of the medical causation issue.

[2] Claimant avers that she was unable to review exhibits before or during the hearing. She alleges that, had she been able to do so, she would have objected to certain exhibits, including those provided by Dr. Otto, a physician who allegedly did not treat claimant and whose reports were allegedly mistakenly introduced into the record. Claimant also alleges that she was unable to review Dr. Dordevich's medical report at the hearing. We note, however, that claimant's attorney did not object to the admission of any of the proposed exhibits. (Tr. 2). In addition, we have disregarded Dr. Otto's records. Regarding Dr. Dordevich's medical report, it was incumbent upon claimant to discuss the report with her counsel at the hearing. Because all submitted exhibits were admitted without objection by claimant's counsel, we find no basis to exclude any of the admitted exhibits.

were the major contributing cause of the combined condition and pathological worsening of the disease. See Dan D. Cone, 47 Van Natta 2220 (1995). Claimant has the burden of proving the occupational disease by a preponderance of the evidence. ORS 656.266.

In this case, we agree with the ALJ's finding that claimant failed to prove that she was not ordinarily exposed or subjected to tobacco smoke and gasoline fumes other than during a period of regular actual employment. Claimant testified that on April 21, 1996, a non-work day, she was exposed to cigarette smoke at a restaurant banquet room. (Tr. 33, 34). Claimant agreed that the exposure was bothersome. (Tr. 34). Moreover, claimant also testified that she has had trouble with secondhand smoke in public places. (Tr. 40).

With respect to gasoline fumes, claimant testified that she has had difficulty fueling her car at gasoline stations. (Tr. 39, 42). Claimant also testified that prior to April 1996, she had been periodically exposed to odors such as gasoline exhaust and that she had reacted to them occasionally. (Trs. 52, 53). In addition to claimant's testimony, the medical record establishes prior exposures to tobacco smoke and gasoline fumes. (Exs. 1-1, 2-7).

We also agree with the ALJ that there is no evidence that claimant was exposed to Roundup. A representative of the employer (Robertson) testified that the herbicide was sprayed around the perimeter of the area in which claimant worked during spring break, a time when no school bus drivers were present. (Tr. 59). Claimant presented no testimony or documentary evidence that establishes actual contact with an herbicide. Claimant refers to several articles/studies relating to the persistence of herbicides in the environment, the effect of herbicides on humans after application and the manner in which herbicides may be absorbed into the body. However, we are limited to the record developed by the ALJ. Judy Britton. Based on that record, we find insufficient evidence that claimant absorbed Roundup as a result of the employer's spraying. Moreover, even if we were to consider the articles and studies to which claimant refers, we would not consider them sufficient to establish a toxic exposure in this particular case, because the evidence is not sufficiently specific to claimant. Cf. Sherman v. Western Employer's Insurance, 87 Or App 602, 606 (1987) (to be persuasive, medical opinions must be specific to the claimant).

Alternatively, even if we assumed that claimant was not ordinarily exposed to cigarette smoke and gasoline fumes other than during her employment, and, further, that she was in fact exposed to an herbicide, we would conclude that she failed to prove that her employment exposure was the major contributing cause of her preexisting chronic porphyria or of its pathological worsening.

To prove a compensable occupational disease, claimant must prove that her work activities were the major contributing cause of the onset or pathological worsening of her porphyria condition. ORS 656.802(2) Due to the number of potential causes of claimant's condition, the causation question is medically complex and resolution of the issue requires expert medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Department, 247 Or 420, 424 (1967). Medical opinions that are well-reasoned and based on complete and accurate histories are given greater weight. Somers v. SAIF, 77 Or App 259 (1986). Additionally, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons not to rely on the medical opinion of claimant's attending physician, Dr. Morgan.

As previously noted, Dr. Morgan opined that claimant's history "strongly incriminated" workplace exposures as the "major precipitating cause" of claimant's "worsened state of health." (Ex. 8). However, Dr. Morgan supplied no reasoning to support his conclusion. Therefore, we do not find his opinion to be persuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Moreover, Dr. Morgan's opinion does not establish that claimant suffered a pathological, as opposed to a symptomatic, worsening of her preexisting chronic porphyria condition. For this additional reason, we are not persuaded by Dr. Morgan's opinion.

We recognize that Dr. Morton, a consulting physician, testified that claimant's employment exposures in April 1996 were the major contributing cause of the combined, worsened, progressive porphyria condition. (Ex. 12-29). However, Dr. Morton conceded that he was in a "distinct minority" with respect to his method of diagnosing porphyria. (Ex. 12-33). Moreover, of the three aspects of the

Mayo Lab testing (blood, urine and stool), Dr. Morton confirmed that claimant's urine test was normal, her blood test was "marginal," and her stool sample was abnormal for two of the porphyrin fractions. (Ex. 12-17, 18). However, the stool sample was considerably larger than normal. (Ex. 12-17). In addition, Dr. Morton testified that, while he was comfortable with relying on the stool sample obtained (Ex. 12-32), it would be "useful" to repeat the test. (Ex. 12-31). Under these circumstances in which no repeat testing was conducted, and in which another examining physician, Dr. Dordevich, concluded that the testing abnormalities were "very minor," (Ex. 13-10), we are not persuaded that Dr. Morton's opinion satisfies claimant's burden of proof.

In conclusion, based on our de novo review of the record, we find that claimant failed to sustain her burden of proving a compensable occupational disease claim for porphyria. Therefore, we agree with the ALJ's decision to uphold the employer's denial.[3]

ORDER

The ALJ's order dated February 14, 1997 is affirmed.

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[3] Claimant has submitted for our consideration a copy of an ALJ's order in which it was determined that the claimant's porphyria in that case was compensable. However, an ALJ's order in another case is not binding on the Board. Moreover, we decide this case based on the medical record developed in this case.

August 27, 1997 Cite as 49 Van Natta 1363 (1997)

In the Matter of the Compensation of
JEFFREY A. KIENZLE, Claimant
WCB Case No. 96-09614
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of his occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his work activities for the employer were the major contributing cause of his bilateral carpal tunnel syndrome (CTS). See ORS 656.802(2)(a). We agree.

A determination of the "major contributing cause" requires an evaluation of the relative contribution of each cause of an injury or disease to establish which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995).

Claimant's treating physician, Dr. Aversano, evaluated the relative contributions of different possible causes to claimant's condition and concluded that his hand intensive work activities as a machinist were the major cause of his bilateral CTS. (Exs. 15, 16). Dr. Aversano considered such factors as claimant's height, weight, thyroid condition and alcohol consumption in reaching his conclusion. (Ex. 15). Dr. Aversano explained that claimant's thyroid problem was under control. (Id.) Claimant testified that his thyroid problem had been under control since 1990. (Tr. 15). Dr. Aversano explained that claimant's weight and alcohol consumption were not factors because he was not overweight and did not drink. (Ex. 15).

Dr. Aversano's opinion is supported by Dr. Zimmerman. Dr. Zimmerman reported that claimant's CTS "comes on and worsens during working and gets better when not using his hands." (Ex. 12A-2). Dr. Zimmerman opined that claimant's work with his hands provided a significant major contribution to his CTS. (Id.) Dr. Zimmerman felt that claimant's hypothyroidism, alcohol and life style were probably not pertinent. (Id.)

The insurer relies on the opinion of Dr. Radecki to argue that the claim is not compensable. Dr. Radecki determined that claimant's CTS probably developed over a number of years, due to personal factors. (Ex. 8-5). Dr. Radecki explained that the personal factors, including claimant's age, body mass index, wrist ratio, history of hypothyroidism and alcoholism were the major contributing cause of his CTS. (Ex. 8-6). In a supplemental report, Dr. Radecki offered additional evidence in support of his conclusion that claimant's age, body mass index and wrist ratio were the major contributing cause of his median nerve slowing. (Ex. 13).

We are not persuaded by Dr. Radecki'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). According to Dr. Radecki, claimant was in the habit of consuming 60 drinks or more per week and he described claimant as a "recovering alcoholic." (Ex. 8-2, 8-4). Claimant testified that he does not have a drinking problem and was never an alcoholic. (Tr. 16). Moreover, Dr. Radecki overlooked the fact that claimant's thyroid condition was under control and had been under control since 1990. (Tr. 15).

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 are persuaded by Dr. Aversano's opinion, as supported by Dr. Zimmerman's opinion, that claimant's work activities were the major contributing cause of his bilateral CTS. Thus, claimant proved compensability of his occupational disease claim. ORS 656.802(2)(a).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 14, 1997 is reversed. The insurer's denial of claimant's bilateral carpal tunnel syndrome claim is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by the insurer.

In the Matter of the Compensation of
SHARRON D. LEMLEY, Claimant
WCB Case No. 95-00750
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorneys
Nancy J. Meserow, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the self-insured employer's denial of claimant's psychological condition; and (2) declined to assess a penalty for an allegedly unreasonable denial. Claimant also challenges: (1) the ALJ's admission of a report by examining psychiatrist Dr. Parvaresh; and (2) the ALJ's rejection of claimant's motion for a continuance to obtain rebuttal testimony. In its brief, the employer asserts that the ALJ abused his discretion in excluding some exhibits and limiting admission of another exhibit. On review, the issues are continuance, evidence, compensability, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm that portion of the ALJ's order regarding this issue with the following supplementation.

Claimant has accepted claims for a cervical disc condition and right shoulder condition. Claimant asserts that her psychological condition is a compensable consequence of her compensable injuries. ORS 656.005(7)(a)(A).[1] We agree with the ALJ that the opinions of claimant's treating psychologist, Dr. Kohen, and treating physician, Dr. Engstrom, do not satisfy claimant's burden of proof.

Although Dr. Kohen indicated that claimant's "present difficulties" were "a direct result of multiple on the job injuries in which she sustained physical damage," he also attributed her condition to "difficult work conditions," including "safety issues, increased physical demands, increased demands in terms of hours worked and decrease in time to recoup, inadequate number of personnel to do the various jobs, threats re: being fired as means of motivation." (Exs. 55A, 62A). Dr. Kohen further noted claimant's report "that she is not alone in finding the changes at [the employer] extremely stressful" and that "other employees have quit or had stress related difficulties secondary to the changes in the organization." (Ex. 55A). Therefore, Dr. Kohen relates claimant's psychological condition to a number of factors independent of her compensable cervical and shoulder conditions.

Dr. Engstrom similarly reported that claimant had a "stress reaction/depression" "primarily related to work" but also noted that claimant's cervical symptoms "were not the primary contributing problem." (Exs. 45, 56). Dr. Engstrom noted that claimant attributed her emotional state to long hours, new management, and conflicting work requirements. (Ex. 48).

Because we conclude that neither the opinion of Dr. Kohen nor that of Dr. Engstrom establishes that claimant's compensable injuries were the major contributing cause of her psychological condition, her claim fails. ORS 656.005(7)(a)(A). Like the ALJ, we reach our conclusion that claimant has failed to sustain her burden of proof without relying on the causation opinions of Drs. Bald and Klecan.

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[1] At commencement of the hearing, claimant's counsel objected to the admission of an exhibit on the basis that it might be relevant to a claim for a mental disorder under ORS 656.802, but that claimant was proceeding under a theory of a consequential condition. (Tr. 3). During closing arguments, claimant attempted to raise the issue of compensability as an occupational disease. The ALJ found that claimant's attempt to raise this claim was not timely. Claimant has not challenged that ruling on review.

Continuance and Evidence

The hearing in this case first convened on January 10, 1996. Included in the record received into evidence at that time were reports from Dr. Bald, orthopedic surgeon, and Dr. Klecan, psychiatrist. Each physician had examined claimant at the employer's request on April 4, 1995. Both physicians also testified at the hearing. (Tr. 125-218 (Day 2)), Tr. 2-32 (Day 3)). The remaining witnesses called by the employer consisted of persons who currently or formerly worked for the employer.

At the end of the employer's case, claimant's attorney moved to continue the hearing to obtain rebuttal testimony from Dr. Kohen and, perhaps, Dr. Engstrom. (Tr. 204 (Day 3)). Counsel earlier had informed the ALJ that he "will likely call a treating doctor in rebuttal." Claimant's attorney explained that he had not subpoenaed any rebuttal witnesses because he had assumed that the employer's defense would not be finished until 5:00 p.m. on the third scheduled day of hearing and he "didn't see that there'd be any reason to make people come here if they're not going to testify." (Id.) The ALJ continued the hearing only for claimant's rebuttal testimony, refusing to allow a continuance for the testimony of Drs. Kohen and Engstrom based on the lack of "extraordinary circumstances." (Id. at 206).

Claimant asserts that the ALJ abused his discretion in denying the motion and moves for remand to obtain the testimony. Claimant contends that the "time afforded was inadequate to allow the parties to present all their evidence and argument" and claimant "demonstrated due diligence in trying to have his [sic] rebuttal witness appear to testify at the conclusion of the defense case."

OAR 438-006-0091(3) provides that an ALJ "may continue a hearing * * * [u]pon a showing of due diligence if necessary to afford a reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal testimony." Because the rule gives discretion to the ALJ in deciding whether to continue a hearing for presentation of rebuttal testimony, we review the ALJ's ruling for abuse of discretion. E.g., Larry E. Fournier, 47 Van Natta 786, 787 (1995).

We have found no abuse of discretion in denying a continuance for rebuttal testimony when claimant could have obtained such evidence prior to hearing. For instance, in Fournier, the claimant moved for a continuance to obtain rebuttal testimony from his attending physician in response to deposition testimony from examining physicians. The Board acknowledged that the depositions occurred too close in time to the hearing for the claimant to rebut such evidence before the hearing. The Board further found, however, that the basic conclusions expressed in the depositions did not differ from earlier reports from the examining physicians that were submitted well in advance of the hearing, giving the claimant an opportunity to provide rebuttal evidence at that time. The Board concluded that claimant had not shown due diligence and the ALJ did not abuse her discretion in denying the motion for continuance. 47 Van Natta at 787. Similarly, in Robert L. Armstrong, 47 Van Natta 1399 (1995), the Board concluded that there was no abuse of discretion in denying a continuance to obtain rebuttal testimony in response to deposition evidence that was presented in earlier medical reports. Id. at 1400.

We find the holdings in Fournier and Armstrong applicable in this case. On review, claimant does not assert that any of the employer's experts testified at hearing to new or different opinions in comparison to their earlier reports. As explained above, the employer's defense experts, Drs. Bald and Klecan, provided reports well in advance of the January 1996 hearing. Their testimony was consistent with the opinions expressed in their reports.[2] Thus, we conclude that claimant had the opportunity before hearing to provide expert rebuttal evidence.[3] Because she did not exercise that opportunity, we further conclude that she failed to show due diligence sufficient to continue the hearing.

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[2] We distinguish this case from Diane H. Kuran, 49 Van Natta 715 (1997), where we found no abuse of discretion in an ALJ's decision to continue a hearing to allow the claimant to present her treating physician's response to testimony from a carrier's medical expert. In reaching our conclusion, we noted that the ALJ had found that it would not have been possible for the claimant to have known the substance of the opinion of the carrier's expert witness prior to the hearing. Here, in contrast, the employer's medical experts had provided medical reports well in advance of the hearing and their testimony was consistent with their prior opinions. Under such circumstances, we find no abuse of discretion in the ALJ's denial of claimant's continuance motion.

[3] In fact, Dr. Engstrom provided a report to claimant's attorney containing his disagreement with the reports from Drs. Bald and Klecan. (Ex. 61C).

In addition, claimant explains that the employer's defense evidence she seeks to rebut relates to her medical record prior to her compensable injury, including in particular her medication history and the existence or nonexistence of a preexisting disorder. (Cl's Reply Br at pp 4-5). However, our decision in this matter is based on the failure of claimant's own medical evidence to carry her burden of proof independent of the persuasiveness of the evidence on which the employer relies to disprove compensability. Consequently, we find no reasonable likelihood that rebuttal testimony from Drs. Kohen and Engstrom, which would be directed to refuting the contrary opinions of Drs. Bald and Klecan, would affect the outcome of this case. Consequently, remand would not be appropriate. Metro Machinery Rigging v. Talbert, 94 Or App 245, 249 (1988).

Finally, claimant objects to the ALJ's admission of Dr. Parvaresh's report, asserting that it is not admissible because she was not provided an opportunity to cross examine Dr. Parvaresh. The employer argues that the ALJ erred in refusing to admit Exhibits 1 through 11, 01 through 05, and 8A and 29A and admitting Exhibit 4-2 only for impeachment purposes. The ALJ did so because the documents pertained to claimant's prior medical treatment and the issue was whether claimant's compensable 1993 and 1994 injuries were the major contributing cause of her psychological condition.

Even assuming that the parties are correct, our conclusion would not change concerning the compensability issue. In finding that claimant did not carry her burden of proof, in no way do we rely on Dr. Parvaresh's report or make any finding of a preexisting condition. Thus, whether or not Dr. Parvaresh's report and the prior medical records are in the record, we would continue to conclude that claimant did not prove compensability.

ORDER

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

August 27, 1997 Cite as 49 Van Natta 1367 (1997)

In the Matter of the Compensation of
CHRIS W. POE, Claimant
WCB Case No. 96-11025
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that affirmed an Order on Reconsideration awarding 4 percent (5.4 degrees) scheduled permanent disability for loss of use or function of the right foot. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fourth paragraph of the findings of fact, we change the fifth sentence to read: "Claimant's bilateral ankle range of motion was 18 degrees dorsiflexion, 55 degrees plantar flexion, 30 degrees inversion and 15 degrees eversion. (Ex. 6-4)." We delete the sixth sentence in that paragraph.

Reduced Range of Motion

The ALJ found that claimant's symmetrical ankle motion, although less than the norms established by the standards, were usual for claimant and, therefore, not "due to" his compensable injury. The ALJ concluded that claimant failed to prove that he experienced injury-related permanent disability in the form of reduced ankle motion.

Claimant argues that he is entitled to a 4 percent award for reduced range of motion of his right ankle and a 5 percent award for reduced range of motion of his left ankle. He contends that it is not appropriate to use the contralateral joint for comparison because he has accepted injuries to both lower extremities.

Claimant's July 7, 1995 claim was accepted as a right and left leg crush injury. (Exs. 3, 4). Claimant's treating physician, Dr. Irvine, released claimant to regular work on April 16, 1996. (Ex. 5).

On May 10, 1996, Dr. Duff reported that claimant's bilateral ankle range of motion was 18 degrees dorsiflexion, 55 degrees plantar flexion, 30 degrees inversion and 15 degrees eversion. (Ex. 6-4). He reported that, with regard to claimant's left lower extremity, he had "absolutely no complaints and no impairment whatever." (Ex. 6-5). Dr. Duff reported that "[a]ll ranges of motion are normal." (Ex. 6-6). Dr. Irvine concurred with Dr. Duff's report. (Ex. 7).

On December 23, 1996, Dr. Geist, medical arbiter, reported that claimant's range of motion in both ankles was "symmetrical and full." (Ex. 11-4). The ankle range of motion findings were: "dorsiflexion 20 degrees right and 20 degrees left; plantar flexion 39 degrees right and 38 degrees left; inversion 20 degrees right and 20 degrees left; and eversion 10 degrees right and 10 degrees left." (Id.) Later in the report, Dr. Geist concluded that claimant's ankle ranges of motion were "normal and symmetrical." (Ex. 11-5).

Former OAR 436-035-0007(22) (WCD Admin. Order 96-051) provides, in part:

> "The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease."

Here, claimant has an accepted left leg crush injury. (Ex. 3). However, there is insufficient evidence to establish that claimant's left ankle joint was injured as a result of the compensable injury. See Bessie B. Mitts, 49 Van Natta 799 (1997). To the contrary, the medical record establishes that claimant's injury was at - or just below - his knees. (Exs. 6-2, 11-2). Thus, we are not persuaded that claimant's contralateral left ankle joint had a "history of injury or disease" for purposes of rating his ankle impairment under former OAR 436-035-0007(22). Under these circumstances, we conclude that comparison of the joints was appropriate. We agree with the ALJ's reasoning and conclusion that claimant's symmetrical ankle motion was usual for claimant and, therefore, not "due to" his compensable injury.

ORDER

The ALJ's order dated March 24, 1997 is affirmed.

In the Matter of the Compensation of
WILLIAM R. SHAPTON, Claimant
WCB Case Nos. 96-06273 & 96-04455
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the insurer's denial of claimant's aggravation claim for his sacroiliac strain and L4-5 and L5-S1 herniated discs[1]; and (2) declined to award penalties and attorney fees for an alleged discovery violation. On review, the issues are aggravation, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Between 1977 and 1986, claimant experienced several periods of low back pain, sciatica and bilateral leg numbness, worse on the right, for which he was treated conservatively. (Exs. A through G; 1-3).

In December 1994, claimant sought treatment for low back pain after getting out of bed. He was diagnosed with degenerative disc disease (DDD), acute facet syndrome and chronic right S1 radiculopathy. (Ex. 1).

On May 29, 1995, claimant, 6' 2" and 230 pounds, was sitting on a concrete form constructed of 2 x 12's and duplex nails. The form collapsed and claimant was thrown backward about 4 feet from a height of about 30 inches, landing on his back across a 2 x 12 board. He sustained a blunt trauma to his low back and was impaled by a duplex nail into the soft tissue about one half inch to the left of the spine and about one inch above the belt line. He sought treatment at an emergency room, where x-rays were taken. (Exs. 4, 5, 7, 8, 26). Claimant filed a claim, which the insurer accepted as a nondisabling "puncture wound to [the] back." (Ex. 11).

On July 3, 1995, claimant sought treatment for sharp low back and buttock pain on the left, which had become progressively symptomatic since the May 1995 injury. (Exs. 11a, 34-17, -18). Dr. Battalia, internist, diagnosed a sacroiliac strain, placed claimant on modified work and prescribed physical therapy. (Exs. 11a through 11f; 12; 13; 34-11, -12). Dr. Battalia released claimant to regular work on September 10, 1995. (Ex. 34-11). On December 13, 1995, Dr. Battalia declared claimant medically stationary with no permanent disability. (Ex. 34-11). Claimant continued to have sciatic pain with prolonged sitting.

On March 7, 1996, claimant slipped and fell on his right hip and knee after getting out of a swimming pool. After two days of work, during which claimant lifted 20 balled and burlapped shrubs weighing about 50 pounds, he experienced pain in the low back, left buttock, calf and heel, for which he sought chiropractic treatment. (Tr. 20, 21, 26). On March 14, 1996, he sought emergency room treatment after his symptoms worsened to where he was unable to stand on his left leg. (Exs. 15, 16). Claimant was diagnosed with herniated discs at L4-5 and L5-S1 that were displacing the L5 nerve root on the left and the S1 nerve root on the right. On March 18, 1996, claimant filed a claim for the herniated discs, specifying the date of injury as March 9, 1996 and contending that his herniated disks were related to his May 29, 1995 injury. (Ex. 21). On March 19, 1996, Dr. Mason, neurosurgeon, performed a diskectomy at L4-5 and a laminectomy at L4-5 and L5-S1. He found a herniated disk at L4-5 on the left and an osteophyte associated with spondylosis at L5-S1 on the right. (Exs. 23, 24).

On March 28, 1996, the insurer issued a denial, which provided in part:

> "Based on information available to date, we believe the work activities of 3-9-96 for our insured are not the major cause of your current back problems. Therefore, we are denying compensability of your claim." (Ex. 25).

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[1] Claimant concedes in his reply brief that the diagnosed L5-S1 disc herniation, which surgery revealed to be an osteophyte related to his degenerative condition, is not at issue here.

On May 8, 1996, claimant retained counsel, who requested a hearing and wrote to the insurer requesting copies of all relevant claims documents, including investigative materials. Claimant's counsel received some file information on May 30, 1996. (Ex. 31).

On July 3, 1996, claimant filed a second request for hearing, raising the issue of de facto denial of aggravation. On the same date, claimant again requested investigation materials, correspondence to doctors, a payment record, unpaid bills, claims processing notes, and claimant's statement. (Ex. 28a).

The insurer provided claimant's recorded statement on July 10, 1996. (Ex. 31).

On July 15, 1996, the insurer issued an "Amended Notice of Denial", which provided in part:

> "On March 28, 1996 we issued a notice of denial advising you of our position that your back condition was not related to your employment activities on March 9, 1996. This notice amends our earlier notice to include a denial of an aggravation of your May 29, 1995 injury. It is our position that your current back condition, need for treatment, and disability are not related to your May 29, 1995 injury or to your employment activities on March 9, 1996." (Ex. 29).

On August 5, 1996, claimant's counsel wrote to the insurer's counsel regarding discovery which had not yet been provided. (Ex. 31).

Claimant timely requested a hearing on the amended denial. At hearing, claimant's attorney clarified the issues, stating:

> "This is either an aggravation of the original injury of May 29, 1995 or a new injury which occurred on or about -- an occupational disease injury on or about March 8, 1996. There are Denials now for each of those, one July 15, '96 and the other March 28 '96, so the issue is compensability of claimant's back condition, which has been diagnosed as a back strain and discs at -- herniated discs at L4-5 and L5-S1." (Tr. 6).

The insurer's attorney stated:

> "This is a case involving an aggravation versus new injury, competing theories, alternative theories, with the principal issue being compensability as either a new injury or as an aggravation of a back strain and also of herniated discs at L4-5 and L5-S1. * * * [A]s I understand it, [claimant is] saying those are two different conditions, so hypothetically, the ALJ could find one of those, for instance the back strain * * * compensable while the herniated discs could not." (Tr. 7).

Claimant agreed that the strain and the disc were separate conditions. (Id.).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's preexisting degenerative disc disease combined with his May 29, 1995 work injury. The ALJ also found that claimant's current low back condition did not arise directly from the injury. Finally, the ALJ concluded that the May 1995 injury was not the major contributing cause of claimant's herniated discs. On review, claimant asserts that the ALJ erred in upholding the insurer's denial of his aggravation claim, contending that his low back strain and herniated disc at L4-5 arose directly from his May 1995 injury. We agree that claimant's back strain and herniated disc at L4-5 are compensable, based on the following reasoning.

ORS 656.273(1) provides, in pertinent part:

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

ORS 656.273(1) requires proof of two elements in order to establish a worsened condition: (1) "actual worsening"; and (2) a compensable condition. Both elements must be satisfied in order to establish "a worsened condition resulting from the original injury." Gloria T. Olson, 47 Van Natta 2348, 2350 (1995).

Since the compensability of a condition is established under ORS 656.005(7)(a), the statute requires that a condition which is not already compensable be established as compensable in order to prove "a worsened condition resulting from the original injury" under ORS 656.273. Id. We turn to a determination of claimant's compensable condition.

Claimant's accepted low back condition was diagnosed as a puncture wound. The conditions for which claimant claims compensation are a sacroiliac strain and an L4-5 disc herniation. These conditions are not accepted conditions. The sacroiliac strain was diagnosed by Dr. Battalia after claimant sought treatment in July 1995 for his left low back and buttocks symptoms. The L4-5 disc condition was diagnosed by Dr. Mason ten months after the May 1995 injury. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the low back strain and L4-5 disc are compensable conditions.

Claimant contends that his herniated disc arose directly from the original injury. However, because claimant has also been diagnosed with a degenerative condition in his low back that preexisted his 1995 injury (Exs. A, 1, 23, 33-19), we must ascertain whether claimant's injury combined with that degenerative condition. We conclude that it did.

Under ORS 656.005(7)(a)(B), a "combined condition" exists when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment. A "combined condition" is compensable only if, so long as and to the extent that the otherwise compensable injury remains the major contributing cause of the disability or need for treatment of the combined condition.

Claimant was diagnosed with degenerative arthritis at L4-5 and L5-S1, which included disc degeneration and disc space changes, and which preexisted the May 1995 injury. (Exs. 5, 6, 33-6, -7, -8, -10, -14, -15, -24). He was also diagnosed with herniated discs at L4-5 and L5-S1. During the low back surgery, however, Dr. Mason, claimant's treating neurosurgeon, ascertained that claimant had a herniated disc at L4-5 on the left and an osteophyte on the right at L5-S1, midline and right, which had the appearance of a herniated disc on the MRI. (Ex. 23). In discussing the relationship between these conditions, Dr. Mason stated that claimant's degenerative disk disease was a partial cause for claimant's need for surgery, explaining that the long-standing degenerative arthritic changes at L5-S1 produced canal narrowing and deformity of the lumbar nerve root on the right, and that the herniated disk at L4-5 caused the severe left leg pain for which he performed surgery. (Ex. 33-18, -19). Dr. Mason further explained that, while both spaces were looked at during surgery, it was clear that the L4-5 level was the major area of pathology. (Ex. 33-19). We interpret Dr. Mason's discussion to support the conclusion that claimant's preexisting degenerative condition combined with his herniated disc condition.

Accordingly, we conclude that ORS 656.005(7)(a)(B) is applicable. Therefore, claimant is required to prove that the May 1995 work injury was the major contributing cause of the need for treatment of the combined condition. Determination of major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. Deitz v. Ramuda, 130 Or App 397 (1994). Considering the passage of time and the number of potential causes of claimant's need for treatment, this issue presents a complex medical question requiring expert medical opinion. Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 122 Or App 281 (1993).

Based on his review of claimant's medical records, his surgical findings, and claimant's history, including the swimming pool incident, Dr. Mason opined that the major contributing cause of claimant's need for treatment of the combined condition was the May 1995 injury. (Exs. 30; 33-17, -18, -19, -20, -38, -39, -40). Dr. Mason explained that claimant's herniated disk was recent, occurring within a year of the surgery. Although Dr. Mason acknowledged that the incident precipitating claimant's need for surgery was his turning over in bed, Dr. Mason explained that disk herniations tend to occur in stages, with the body experiencing increasing symptoms until the body accommodates to the changes. Then, if the condition changes substantially, i.e., when the size and location of the disk produces nerve compression, a patient will develop sciatica or leg pain. Dr. Mason also opined that the diagnosis of claimant's condition following the May 1995 incident as a "sacroiliac strain" was a generic diagnosis--that claimant was having back and leg pain, and that a true diagnosis had not been made.

Dr. Battalia, internist, who treated claimant for pain on the left side of his low back and buttocks following the May 1995 incident, diagnosed claimant's condition at that time as a sacroiliac strain. Dr. Battalia testified that claimant's sacroiliac strain was directly related to the May 1995 injury, but because claimant showed no evidence of radiculopathy during his treatment, he was unable to say that the injury was the major contributing cause of the herniated disc condition. (Ex. 34-12). However, Dr. Battalia also admitted that the diagnosis of a sacroiliac strain might be changed to a diagnosis of a disc after subsequent studies. Moreover, in regard to causation, he deferred to Dr. Mason's greater expertise as a neurosurgeon. (Ex. 34-14).

Here, we rely on Dr. Mason's opinion, as it is well-reasoned and based on a complete history. See Allie v. SAIF, 79 Or App 284 (1986) (where a case involves expert analysis rather than expert external observation, the status of "treating physician" confers no special deference); Somers v. SAIF, 77 Or App 259, 263 (1986); Dietz v. Ramuda, 130 Or App 394 (1994) (the relative contribution of each cause, including the precipitating cause, must be evaluated to determine which is the major contributing cause). Consequently, we conclude that claimant's L4-5 herniated disc condition (which encompasses the "sacroiliac strain" diagnosis) is compensable.

As noted above, to establish an aggravation claim, claimant must also prove that his compensable condition has "actually worsened." ORS 656.273(1). Here, claimant initially sought treatment for left leg and buttock pain, which was initially diagnosed as a sacroiliac strain. Subsequently, however, Dr. Mason explained, his "strain" condition, which was actually a herniating disc, worsened, resulting in severe nerve compression on the left, which was demonstrated during surgery. Based on Dr. Mason's opinion, we conclude that claimant has established an "actual worsening" of his compensable low back condition.

Penalties - Discovery

The ALJ declined to award penalties and attorney fees for the insurer's alleged discovery violation.

The insurer denied claimant's claim on March 28, 1996. Claimant requested discovery on May 8, 1996. (Ex. 26a). Partial discovery was provided on May 30, 1996, more than 15 days after the request for discovery. See OAR 438-007-0015(2). Inasmuch as the insurer's denial preceded the alleged discovery violation, there was no compensation due at the time of the alleged discovery violation. Therefore, there were no "amounts then due" at the time of the allegedly unreasonable conduct on which to base a penalty under ORS 656.262(11)(a). See Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989) (penalty for discovery violation based on compensation due at the time of the violation); Betty V. West, 46 Van Natta 1469 (1994) (no penalty authorized under former ORS 656.262(10)(a) when claim was in denied status at the time of discovery violation).

However, based on our compensability decision regarding claimant's L4-5 herniated disc condition, we conclude there is authority to award an attorney fee for failure to comply with discovery requirements. See Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991); Boehr v. Mid- Willamette Valley Food, 109 Or App 292, 295 (1991) (failure to comply with discovery requirements may result in attorney fee award under ORS 656.382(1) provided underlying claim is compensable). Attorney fees under ORS 656.382(1) do not depend on "amounts then due"; such fees may be assessed, provided that there is unreasonable resistance to the payment of compensation. See Eastmoreland Hospital v. Reeves, 94 Or App at 702.

The insurer's failure to timely disclose the relevant claims documents was unexplained and, therefore, unreasonable.[2] Inasmuch as the records in the possession of the insurer were important to the compensability and aggravation issues, we also conclude that the insurer unreasonably resisted the

[2] The insurer contends that, because claimant abandoned his May 8, 1996 request for hearing on the March 28, 1996 denial, and appealed only the July 15, 1996 aggravation denial, he may not allege any discovery violation with regard to his earlier request for hearing. The insurer's argument lacks merit. Claimant requested a hearing on the March 28, 1996 new injury denial, which the insurer expressly amended to include a denial of the same condition as an aggravation of claimant's May 1995 injury. At hearing, the parties agreed to go forward on both new injury and aggravation theories.

payment of compensation after issuance of its March 28, 1996 denial, as amended July 15, 1996 (as a result of our order setting aside the denial), insofar as it pertained to claimant's claim for the L4-5 herniated disc condition. Accordingly, we assess an attorney fee under ORS 656.382(1).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for the insurer's discovery violation is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the same factors set forth above and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 13, 1997, is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the insurer's aggravation denial is reversed. The insurer's denial of claimant's aggravation claim is set aside and the claim is remanded to the insurer for processing according to law. That portion of the ALJ's order denying an attorney fee for a discovery violation is reversed, and claimant's counsel is awarded an attorney fee of $500, to be paid by the insurer. The remainder of the ALJ's order is affirmed. Claimant's counsel is awarded an attorney fee for services at hearing and on review of $3,500, to be paid by the insurer.

In the Matter of the Compensation of
MATTHEW E. CARSNER, Claimant
WCB Case No. 96-09744
ORDER ON REVIEW
Dennis W. Skarstad, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that awarded claimant an assessed attorney fee in the amount of $5,000. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

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

Following the hearing, claimant's counsel submitted a statement of services detailing 25 hours spent in representing claimant, for which the attorney requested a $5,000 attorney fee, based on an hourly rate of $200. SAIF's counsel responded that a reasonable attorney fee would be half that amount. (Administrative Record).

The ALJ awarded claimant an assessed attorney fee in the amount of $5,000. SAIF requested Board review of that portion of the ALJ's order that awarded the assessed attorney fee.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that both claimant's attorney's hourly rate and the time he spent on the case (25 hours) were reasonable. Taking into consideration claimant's attorney's statement of services, SAIF's objections to the requested attorney fee, and the factors set forth in OAR 438-015-0010(4), the ALJ concluded that $5,000 was a reasonable attorney fee. On review, SAIF contends that the attorney fee is excessive. We disagree.

Because claimant finally prevailed at hearing on a denied claim, he is entitled to a reasonable assessed fee for his attorney's services at hearing. ORS 656.386(1). In determining whether an attorney fee is reasonable, the following factors listed in OAR 438-015-0010(4) are considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

The Board must reveal its rationale for an attorney fee award, including how it weighs the above-cited factors, particularly when there is a discrepancy between the amount of the attorney fee sought and the Board's award. Schoch v. Leupold & Stevens, 325 Or 112, 118-19 (1997).

SAIF contends that a fee in the range of $2,500 to $3,750 is reasonable because the case was relatively uncomplicated, and because claimant prevailed on only one of two denied conditions. We disagree.

While it is true that SAIF denied two conditions (a lumbar strain and T11-12 disc bulge), claimant did not litigate the T11-12 disc bulge condition. (Ex. 16; Tr. 1-2). The only compensability issue the ALJ identified was compensability of claimant's lumbosacral strain claim. (Opinion and Order at 1; Tr. 1). There is no evidence that any of the time spent by claimant's counsel on this case was devoted to establishing compensability of the T11-12 disc bulge. (See Exs. 20-2, 21; claimant's attorney's statement of services). Therefore, we find no merit in SAIF's argument that claimant's attorney fee award should be reduced because he prevailed only on the lumbosacral strain claim.

SAIF also argues that the attorney fee should be reduced because the case was relatively uncomplicated. We construe SAIF's argument as pertaining specifically to the nature of the proceedings and complexity of the issues factors. We are not persuaded by SAIF's argument. We generally defer to the ALJ's assessment of a reasonable attorney fee, because the ALJ is in the best position to evaluate the attorney's effort at hearing, particularly in relation to the complexity of the issues and the nature of the proceedings. Here, the ALJ determined that a $5,000 fee was reasonable, taking into consideration the factors set forth in OAR 438-015-0100(4), including complexity of the issues and nature of the proceedings. We find no basis for disturbing the ALJ's assessment.

Finally, SAIF concedes, and we so find, that the benefit secured for claimant is great, and that claimant's counsel has substantial experience in workers' compensation matters. We also find that there was a risk that claimant's counsel might go uncompensated in this case.

SAIF does not specifically dispute the amount of time claimant's counsel spent on this case. Rather, SAIF contends that, if the fee is based on the time devoted to the case, the fee should be based on an hourly rate of $125 to $150, rather than $200. In light of claimant's counsel's substantial experience, and taking into consideration the risk that claimant's counsel may go uncompensated, we agree with the ALJ's determination that an hourly rate of $200 is reasonable in this case. Accordingly, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we agree with the ALJ's determination that a reasonable fee for claimant's attorney's services at hearing is $5,000, payable by SAIF.

Because the only issue on review was attorney fees, claimant's counsel is not entitled to an attorney fee for his services on review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 21, 1997 is affirmed.

August 28, 1997 Cite as 49 Van Natta 1375 (1997)

In the Matter of the Compensation of
DONALD CONVERSE, Claimant
WCB Case No. 96-07686
ORDER DENYING RECONSIDERATION
Neil Jackson & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our July 25, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of his injury claim for head, neck and wrist lacerations and contusions.

Claimant has also petitioned the Court of Appeals for judicial review of our Order on Review. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. Thus, jurisdiction of this matter rests with the court. ORS 656.295(8), ORS 656.298(1). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. See ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). This authority is rarely exercised. See Carole A. VanLanen, 45 Van Natta 178 (1993).

Here, claimant requests that we reconsider our decision in light of Redman Industries, Inc. v. Lang, 326 Or 32 (1997), which issued subsequent to our order. Specifically, claimant asks us to reconsider our adoption of the ALJ's finding that claimant was an active participant in the assault which resulted in his injury. Asserting that the fight with his co-worker was connected to his job assignment, claimant argues that this claim is not barred by the "aggressor defense" of ORS 656.005(7)(b)(A).

Because the question posed by claimant's request is one of legal interpretation and because this matter presently is before the court, the parties may present their respective positions before that forum concerning Lang and its effect on this case. See Eric E. Smith, 48 Van Natta 1125 (1996). Consequently, we find that judicial and administrative efficiency is best served by declining the request to withdraw our order for reconsideration. Carole A. VanLanen, 45 Van Natta at 178.

Accordingly, claimant's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986).

IT IS SO ORDERED.

In the Matter of the Compensation of
ATHER FRAZIER, Claimant
Own Motion No. 97-0076M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our May 14, 1997 Own Motion Order, as reconsidered on June 3, 1997, in which we declined to reopen his 1979 left knee injury claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability. Specifically, we concluded that, although claimant established he was willing to work, he failed to prove that he was unable to work due to the compensable injury during the relevant time. In response, the insurer filed a Motion to Compel, requesting that the Board require claimant to submit to a recorded statement or deposition in this matter. On reconsideration, we withdraw our prior orders and issue the following order in place of our prior orders.

FINDINGS OF FACT

On October 4, 1979, claimant sustained a compensable injury to his left knee. Claimant's aggravation rights expired on April 25, 1985.

In a December 20, 1996 report, Dr. Strudwick, claimant's treating physician, requested authorization to perform claimant's left total knee replacement. On January 16, 1997, the insurer submitted its recommendation that the Board deny claimant's request for temporary disability compensation, contending that claimant was not in the work force at the time of disability. On March 17, 1997, claimant underwent left knee surgery.

In an April 23, 1997 affidavit, claimant attested that he had not withdrawn from the labor force, and that the only reason he had not worked in the recent past was that it was medically impossible for him to do so.

On May 14, 1997, we issued an Own Motion Order, in which we concluded that, although claimant had established that he was willing to work at the time of disability, he had not provided persuasive evidence that he was unable to work or that a work search would have been futile during the relevant time.

Disputing that claimant had established that he was willing to work, the insurer requested reconsideration of our May 14, 1997 order. In a June 3, 1997 order, we concluded that our finding that claimant was willing to work was "non-determinative," particularly since we had concluded that claimant had not established that it was futile for him to work at the time of disability.

On June 4, 1997, claimant requested reconsideration of our May 14, 1997 order (as reconsidered on June 3, 1997), contending that Dr. Strudwick's May 23, 1997 opinion that claimant was unable to work between April 1996 and December 1996 proved that he was in the work force at that time.

On June 16, 1997, the insurer requested that the Board place claimant's request for reconsideration in "deferred status" pending its receipt of claimant's social security information, and moved the Board to compel claimant to submit to a recorded statement or deposition regarding the work force issue.

On June 24, 1997, the Board abated its prior orders and established a supplemental briefing schedule. The parties' respective supplemental briefs have been received, and we proceed with our review of the record.

CONCLUSIONS OF LAW AND OPINION

Motion to Compel

The insurer moves that the Board compel claimant to submit to a recorded statement or deposition, and to require that claimant obtain and produce documents that have qualified him for the receipt of social security disability benefits since 1986.

The insurer does not further address its motion in its supplemental brief. In any event, the Board would not have Own Motion authority to order claimant to submit to a deposition in this matter. Moreover, even if the Board had authority to require claimant to submit to a recorded statement or to produce documents regarding social security, we would not be so inclined, as the insurer had ample time prior to the reconsideration process to secure such information.[1] Finally, because claimant does not rely on the receipt of social security benefits to establish whether his compensable condition prevented him from seeking work at the time of disability, his eligibility for those benefits is unrelated to our inquiry here.

Therefore, the insurer's Motion to Compel is dismissed.

Entitlement to Temporary Disability Compensation

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

As noted in our prior orders, Dr. Strudwick recommended surgery on December 20, 1996. Thus, as in our prior order, we conclude that claimant's compensable injury worsened requiring surgery.

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

In our prior orders, we concluded that claimant had established that he was willing to work at the time of disability. See Weyerhaeuser v. Kepford, 100 Or App at 410; Dawkins v. Pacific Motor Trucking, 308 Or at 254; Debbie A. Kahn, 49 Van Natta 761 (1997); Janice Connell, 47 Van Natta 292 (1995).

However, claimant must also establish that he was medically unable to work at the time of disability because of his compensable left knee condition. Claimant does not dispute that he has not worked in many years, nor does he dispute that he is receiving social security benefits. However, as in our prior orders, we note that the record establishes that claimant's 1979 injury claim remained reopened for the payment of temporary disability compensation subsequent to a 1995 surgery until April 8, 1996. Therefore, by virtue of claimant's entitlement to temporary disability compensation for his compensable injury until April 8, 1996, we conclude that it would have been futile for claimant to seek work until that time. See Dawkins v. Pacific Motor Trucking, 308 Or at 258; Harry R. Bostwick, 49 Van Natta 490 (1997); Michael C. Johnstone, 48 Van Natta 761 (1996).

We have previously found that, although a claimant is willing to work, if the claimant is not working or seeking work, the claimant must establish that a work search would have been futile at the time of disability. See Dawkins v. Pacific Motor Trucking, 308 Or at 258; Mark C. Brunson, 49 Van Natta 1170 (1997); Debbie A. Kahn, 49 Van Natta at 761; Janice Connell, 47 Van Natta at 292. Here, Dr. Strudwick requested surgery authorization in December 1996. Claimant was unable to work because of the compensable injury until April 1996. Therefore, claimant must provide persuasive evidence that he was unable to work from April 1996 until his compensable injury worsened requiring surgery, in December 1996. See Weyerhaeuser v. Kepford, 100 Or App at 410.

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[1] As a general rule, we do not consider issues that are raised for the first time on reconsideration. See Vogel v. Liberty Northwest Ins. Corp, 132 Or App 7, 13 (1994); Marcia G. Williams, 49 Van Natta 313, on recon 49 Van Natta 612 (1997); Howard L. Browne, 49 Van Natta 864 (1997). In light of such circumstances, even if we had the authority to require claimant to submit to a deposition, we would not be inclined to consider the insurer's belated challenge to claimant's receipt of social security benefits.

Dr. Strudwick reports that he has been claimant's treating physician for almost two years. In a May 23, 1997 letter, Dr. Strudwick opined that "[d]uring the period of my evaluation from its very onset I feel that [claimant] was temporarily totally disabled and medically unable to work." Dr. Strudwick further opined that:

> "Prior to the [total knee replacement] surgery[, claimant] had particularly disabling arthritis in his knee which would have made it very difficult for him to work between the months of April [19]96 through December [19]96. The issues were primarily those of mobility of getting back and forth to a job site. I hope this clarifies any questions which may have arisen about [claimant's] disability status during that period."

Dr. Strudwick's opinion is unrebutted.

The insurer's argument is premised on the fact that claimant has not worked since 1985. However, the relevant time in our inquiry of whether claimant was in the work force is in December 1996. See Michael C. Batori, 49 Van Natta 535 (1997). Furthermore, the insurer contends that claimant has retired, and thus, has not been in the work force since 1985. Even though a claimant may have retired previously, he may reenter the work force at a later time. See Dean L. Watkins, 48 Van Natta 60 (1996); Kenneth C. Felton, 48 Van Natta 725 (1996). Finally, the insurer contends that claimant's entitlement to social security benefits proves he is retired. Entitlement to social security benefits is not necessarily determinative as to whether a claimant is in the work force. See Robert E. Carper, 48 Van Natta 1160 (1996); Kenneth C. Felton, 48 Van Natta at 725.

On this record, we find claimant's affidavit and Dr. Strudwick's unrebutted opinion persuasive, and conclude that claimant has established that he was willing to work, but unable to work because of his compensable injury at the time of disability.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BONNIE C. THOMAS, Claimant
WCB Case No. 96-06742
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

The self-insured employer requests reconsideration of our July 8, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order upholding its denial of a consequential left knee condition. In its motion, the employer requests reconsideration by the Board en banc[1] and contends that our reliance on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), is no longer viable after the recent enactment of HB 2971. The employer further argues that, on the merits, claimant did not prove the compensability of her claim.

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[1] 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. Trevor E. Shaw, 49 Van Natta 10 (1997). 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, we deny the employer's request.

In order to consider this matter, we withdrew our July 8, 1997 order on August 1, 1997. Claimant was granted an opportunity to respond. Having received claimant's response to the employer's motion, we proceed with our reconsideration.

In setting aside the employer's denial of claimant's consequential left knee condition, our prior order relied, in part, on the court's decision in Messmer. The employer asserts that HB 2971, which amended ORS 656.262(10), has overruled the Messmer decision. See HB 2971, 69th Leg., Reg. Sess, sec. 1. Because we continue to conclude that claimant's consequential left knee condition is compensable on the merits, we find it unnecessary to address the effect of HB 2971 on this case.

In our prior order, addressing the merits of the compensability issue, we stated:

> "To prove entitlement to compensation for her current left knee condition, claimant would be required to prove that her 1985 work injury is the major contributing cause of her consequential condition. ORS 656.005(7)(a)(A).
>
> "Drs. Vessely, Zimmerman, and Gripekoven opined that claimant's current tri-compartmental left knee degeneration results from natural progression of degenerative disease (rather than the 1985 injury), largely because there is no evidence that the 1985 injury affected more than one knee compartment and she did not have a meniscus tear in 1985. (Exs. 96, 99, 101).
>
> "Dr. Griffin, on the other hand, persuasively described the specific mechanism of injury which led indirectly to claimant's current condition: The 1985 injury caused direct damage to the cartilage and subsequent swelling and damage to the tendons surrounding the joint which led to disturbance of normal joint function, which, in turn, led to more damage. (Ex. 100). In other words, the work injury caused claimant's current widespread left knee problems indirectly. Dr. Griffin also ruled out causes other than the work injury, noting that claimant has no apparent genetic predisposition for degenerative disease. Considering Dr. Griffin's advantage as claimant's longtime treating physician and his well-reasoned opinion (based on an accurate history), we find his conclusions regarding causation persuasive. See Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, based on Dr. Griffin's opinion, we would conclude that claimant's current consequential left knee condition is compensable."

The employer argues on reconsideration that Dr. Griffin's opinion is unpersuasive because he fails to address four falls that involved the left knee, which claimant sustained subsequent to the December 12, 1985 compensable injury. We do not agree that Dr. Griffin's opinion is unpersuasive on this basis.

First, no physician attributes claimant's current left knee conditions to the falls occurring in 1987, 1989, February 1995 and November 1995. Drs. Griffin and Gripekoven specifically addressed the February 1995 fall. Dr. Gripekoven opined that the February 1995 fall was not the major contributing factor of the left knee condition and need for treatment. Similarly, when asked if he attributed claimant's current complaints to the February 1995 fall, Dr. Griffin indicated that the current complaints were not due to the February 1995 fall.

With regard to the November 1995 fall, Dr. Zimmerman thought the fall caused only a local contusion. There is no medical evidence that attributes claimant's current left knee condition to the 1987 or 1989 falls. Given that no medical evidence indicates that the 1987, 1989 and 1995 falls contributed to claimant's current left knee condition, we do not find Dr. Griffin's opinion unpersuasive on the basis that he failed to specifically address the falls.

The employer also argues that Dr. Griffin's opinion is less persuasive than the opinions offered by the orthopedists. Dr. Griffin is a specialist in internal medicine and rheumatology and has treated claimant's knee problems for many years. There is no indication that he is unqualified or less qualified than Drs. Gripekoven, Zimmerman or Vessely to address problems involving the knee joint. In addition, as stated in our prior order, Dr. Griffin is most familiar with claimant's left knee condition having treated claimant the longest of any physician offering an opinion.[2]

Finally, the employer seeks a reduction in the $6,000 attorney fee awarded by our prior order. In any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) The time devoted to the case; (b) The complexity of the issue(s) involved; (c) The value of the interest involved; (d) The skill of the attorneys; (e) The nature of the proceedings; (f) The benefit secured for the represented party; (g) The risk in a particular case that an attorney's efforts may go uncompensated; and (h) The assertion of frivolous issues or defenses. OAR 438-015-0010(4).

We acknowledge that claimant's counsel obtained few of the 100 exhibits admitted into evidence and that claimant's aggravation rights on the claim have expired such that only medical benefits are at issue. Nonetheless, we find that the value of the interest involved and the benefit secured are significant in that claimant's physicians have recommended total left knee replacement surgery. In addition, the case involved procedural and substantive questions, which are more complex than typical cases that come before the Board for review. Finally, based on the arguments posed regarding these complex questions, there was a decided risk that claimant's counsel might go uncompensated for his services. Under such circumstances, we continue to find that $6,000 constitutes a reasonable attorney fee for services at hearing and on review.

In addition, after considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services on reconsideration regarding the compensability issue is $400, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the employer's motion), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We further note that claimant is not entitled to a fee on reconsideration for services devoted to the attorney fee issue. Dotson v. Bohemia Inc., 80 Or App 233 (1986).

Accordingly, as supplemented and modified herein, we republish our July 8, 1997 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] We also note that Dr. Vessely's report was based on a record review and that Dr. Gripekoven saw claimant on only one occasion.

In the Matter of the Compensation of
ROSEMARY A. BARNES, Claimant
WCB Case No. 96-03212
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's current low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we modify and recap as follows.

Claimant has preexisting degenerative joint disease (facet arthropathy). On December 17, 1993 she sustained an injury to her neck and low back, which the insurer accepted as "cervical/lumbar strain."[1] (Exs. 1, 3, 4, 6). In April 1994, Dr. Corson diagnosed degenerative spondylolisthesis L-5 on S-1. (Exs. 7, 12). In May 1994, claimant experienced another twisting injury at work and developed increasing low back pain. (Ex. 13). On November 18, 1994, claimant sought emergency room treatment for pain down her right leg. (Ex. 11).

In April 1995, Dr. Grant, physiatrist, performed electrodiagnostic evaluation of claimant's persistent low back and right leg symptoms. The evaluation revealed no specific neurophysiologic abnormalities. Dr. Grant diagnosed claimant's condition as chronic myofascial low back and right lower extremity pain syndrome, with underlying degenerative disc and/or joint disease with mechanical and myofascial pain components. The degenerative conditions included spondylosis, Grade I spondylolisthesis and a herniated disk at L5-S1. (Exs. 15, 16, 17, 19).

On July 14, 1995, claimant was evaluated by Dr. Peterson, orthopedic surgeon. He recommended surgical decompression and fusion at L5-S1. (Ex. 23).

Claimant's claim was closed by a July 20, 1995 Notice of Closure, which awarded 14 percent permanent disability for the low back. (Ex. 24). The closure was not appealed.

Claimant filed an aggravation claim, requesting reopening for the recommended surgery. On February 9, 1996, the insurer denied claimant's aggravation claim,[2] and, after further inquiry, denied her current low back condition on the basis that her accepted condition was no longer the major contributing cause of her combined condition. (Ex. 32A).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded on the merits that claimant's current treatment for her disc condition was compensable and accordingly set aside the insurer's denial of claimant's current low back condition.[3] On review, the insurer contends that the preponderance of the medical evidence shows that claimant's current low back condition is not compensable. We disagree.

We begin with a brief summary of the relevant facts. Claimant has degenerative joint disease (DJD) that preexisted her December 1993 low back injury. Subsequent to the injury, she was diagnosed with degenerative spondylolisthesis at L5-S1, a herniated disc at L5-S1, spondylosis, and chronic myofascial low back and right leg pain syndrome. In July 1995, Dr. Peterson, orthopedic surgeon, recommended surgical decompression and fusion at L5-S1. The insurer denied claimant's current low back condition on the basis that her accepted injury was no longer the major contributing cause of her combined condition.

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[1] The cervical portion of the claim is not at issue in this case.

[2] The aggravation denial was upheld by the ALJ. That portion of the ALJ's decision is not in dispute here.

[3] Relying on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II), the ALJ alternatively concluded that the insurer was barred from denying compensability of claimant's spondylosis and spondylolisthesis because it failed to appeal the Notice of Closure's 14 percent unscheduled permanent disability award. Former ORS 656.262(10) provided that payment of permanent disability benefits pursuant to a closure notice, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein. The court in Messmer II held that this statutory language did not overrule the court's holding in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (Messmer I), that an employer's failure to appeal a Determination Order that awarded permanent disability based, in part, on the effects of surgery for noncompensable degenerative disease, precluded the employer from contending later that the condition was not part of the compensable claim. Messmer, 140 Or App at 556. The 1997 legislature recently amended ORS 656.262(10) to provide that "the failure to appeal or seek review of such an order or notice of closure" also shall not preclude a carrier from contesting the compensability of a condition rated therein. HB 2971, 69th Leg., Reg. Sess. (July 25, 1997). We need not determine the effect of this amendment in this case because we have determined that claimant's current condition is compensable on the merits.

A "combined condition" is compensable only if, so long as and to the extent that the otherwise compensable injury remains the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B).

In light of claimant's prior medical history, multiple diagnoses and the passage of time since her 1993 industrial injury, we find that the causation issue regarding claimant's current condition is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Moreover, when there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Grant, physiatrist, who became claimant's treating physician in April 1995, found no neurophysiologic abnormalities to correlate with her complaints of low back pain with radiation into the right hip/buttock, heel and foot. He diagnosed claimant with chronic myofascial/mechanical low back and right lower extremity pain syndrome, a herniated disc at L5-S1, spinal canal stenosis, and spondylolisthesis at L5-S1. (Exs. 15, 17, 22). During a December 26, 1996 deposition, Dr. Grant opined that the myofascial pain syndrome and the disk herniation were caused by the 1993 injury. He also indicated that the surgery proposed by Dr. Peterson would relate primarily to the herniated disk and secondarily the degenerative spondylolisthesis. (Ex. 39-7, -8).

Dr. Grant also evaluated the relative contribution of claimant's four diagnosed conditions to her current condition: (1) the chronic myofascial/mechanical low back and right leg pain syndrome was caused by the December 1993 injury and contributed 30 percent to claimant's clinical symptoms; (2) the L5-S1 herniated disk was caused by the December 1993 injury and contributed 30 percent to her symptoms; (3) the degenerative disc disease (DDD) was symptomatically worsened by the December 1993 injury and contributed 20 percent to her symptoms; and (4) claimant's degenerative spondylolisthesis at L5-S1 contributed about 20 percent to her symptoms. (Exs. 26; 27; 32; 39-7, -11, -12).

Dr. Young, radiologist, evaluated imaging studies of claimant's low back dating from March 17, 1986 to April 20, 1995 and reviewed claimant's medical records up to July 20, 1995. Based on his interpretation of the studies, he found that claimant suffered from gradually progressive degenerative joint disease (DJD) at L5-S1; her spondylolisthesis at L5 on S1did not arise immediately after her injury, but arose before June 9, 1994; and her L5-S1 disk showed progressive degeneration.

Based on the absence of physical findings of radiculopathy during this period, Dr. Young opined that claimant's L5-S1 disc bulge was not a new entity resulting from claimant's injury. He also opined that claimant's preexisting degenerative joint and disc disease combined with her lumbar strain to cause her need for treatment, but the major cause of the combined condition and need for treatment was the preexisting degenerative disease. He further opined that claimant's lumbar strain had resolved and she now suffers from a chronic mechanical low back condition.[4] (Exs. 30, 36).

Dr. Peterson, claimant's neurosurgeon, agreed with Dr. Young that claimant had preexisting degenerative conditions at L5-S1. However, he differed with Dr. Young's interpretation of the April 20, 1995 MRI as showing only a disc bulge, finding that the MRI revealed a herniated disc at L5-S1, which was confirmed by other physicians, and mild L5 nerve root compression. (Ex. 34-1). Dr. Peterson opined that claimant's December 1993 fall caused a disc injury, as demonstrated by the MRI. He explained that such an injury may cause the loss of structural and functional integrity of the disc such that spondylolisthesis may result, as demonstrated in Dr. Young's sequential review of the radiographic studies. (Ex. 34-2).

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[4] Dr. Grant initially concurred with Dr. Young's opinion, but, during his deposition, retracted his concurrence. (Ex. 33; Tr. 39-4, -5, -6). The insurer asserts that Dr. Grant's retraction is questionable. We disagree. Dr. Grant explained that he overlooked Dr. Young's opinion on causation. Acknowledging Dr. Young's expertise at reading radiologic studies, Dr. Grant stated that he would not have concurred with Dr. Young's opinion on causation because Dr. Young had neither examined nor treated claimant, or taken a history from her. We find Dr. Grant's explanation of his retraction persuasive.

In formulating his opinion that the major contributing cause of claimant's current condition was her December 1993 injury, Dr. Peterson reasoned that the gradual progression of degenerative disc disease would be revealed by a gradual onset of symptoms. Instead, he noted, the onset of claimant's symptoms began shortly after the specific 1993 injurious event. Accordingly, based on the radiographic evidence and claimant's clinical history, Dr. Peterson concluded that the cause of claimant's current symptoms and need for treatment was not the gradual progression of degenerative disc disease, but the injury itself. (Ex. 34-2).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Here, we are not persuaded to do otherwise. Somers v. SAIF, 77 Or App at 259. Dr. Peterson explained his disagreement with Dr. Young, who did not examine claimant. Moreover, Dr. Peterson's well-reasoned opinion is supported by that of Dr. Grant. Consequently, we conclude that claimant's December 1993 industrial injury remains the major contributing cause of her need for treatment of her current combined condition.[5]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, 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 December 20, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by the insurer.

[5] We note that the medical evidence does not establish the independent compensability of claimant's spondylosis or spondylolisthesis under ORS 656.005(7)(a)(B). See Richard P. Beckel, 46 Van Natta 2364, on recon 46 Van Natta 2461 (1994).

August 29, 1997 Cite as 49 Van Natta 1383 (1997)

In the Matter of the Compensation of
BARBARA R. FLOYD, Claimant
WCB Case Nos. 96-06033, 96-04985 & 96-04984
ORDER OF ABATEMENT
Daniel M. Spencer, Claimant Attorney
Reinisch, et al, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

The self-insured employer, (Jeld-Wen), requests reconsideration of our August 1, 1997 order, which among other decisions, affirmed an Administrative Law Judge's (ALJ's) penalty assessment and awarded attorney fees. Contending that its claim processing conduct was proper, Jeld-Wen asks that we reconsider our decision to affirm the ALJ's penalty assessment. Alternatively, Jeld-Wen seeks clarification regarding the time period on which the penalty is based and the manner in which the penalty is to be divided between claimant and her counsel. Finally, Jeld-Wen challenges the basis for our $1,000 attorney fee award, as well as requests clarification regarding the total attorney fee granted by the ALJ's order and our decision.

In order to further consider Jeld-Wen's contentions, we withdraw our August 1, 1997 order. The other parties are granted an opportunity to respond. To be considered, claimant's and Crawford & Company's responses must be received within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROY D. HODGKIN, Claimant
WCB Case Nos. 96-07532 & 96-04123
ORDER ON RECONSIDERATION
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

On August 12, 1997, we set aside a denial of claimant's occupational disease claim for lead poisoning and toxic encephalopathy issued by the SAIF Corporation (on behalf of Roko Associates, Inc.) and upheld a denial of the same conditions issued by SAIF (on behalf of Roy's Preferred Painting). We also affirmed an Administrative Law Judge's (ALJ's) $500 attorney fee award under ORS 656.382(1) payable by SAIF / Roy's for an unreasonable / untimely denial. Contending that it issued its denial some 20 days after receiving a medical report from an examining physician, SAIF asserts that its conduct was not unreasonable.

SAIF / Roy's does not challenge the ALJ's and our finding that claimant's claim was filed on September 26, 1995 and that its denial issued on March 5, 1996. Instead, asserting that claimant was unable to attend an insurer-arranged medical examination between October 9, 1995 and January 19, 1996, SAIF / Roy's contends that its March 5, 1996 denial was not unreasonably untimely because it issued within 20 days of its February 14, 1996 receipt of the examining physician's February 10, 1996 report.

In support of its position, SAIF / Roy's cites to our finding that its denial issued "over six weeks after claimant attended Dr. Burton's January 19, 1996 examination in a wheelchair," noting that it did not receive the examining physician's report until some three weeks after the examination. SAIF / Roy's misunderstands the primary theme of our previous finding, which was not based on when SAIF / Roy's received Dr. Burton's report. In fact, our prior finding made no reference to the examining physician's report or SAIF / Roy's receipt of such a report. Rather, our finding was primarily directed to the fact that claimant attended the examination "in a wheelchair," which was precisely the reason SAIF / Roy's gave for the delay in responding to the claim (that claimant was unable to attend such examinations because he was confined to a wheelchair).

In conclusion, we acknowledge that SAIF / Roy's received the examining physician's report some 26 days after the examination and issued its denial approximately 20 days thereafter. Nonetheless, such circumstances do not alter our ultimate conclusion that SAIF / Roy's March 5, 1996 denial (issued over 5 months after the filing of the claim) was unreasonable. Consequently, we continue to hold that SAIF / Roy's conduct in responding to claimant's claim constitutes an unreasonable resistance to the payment of compensation, which warrants the imposition of an attorney fee award under ORS 656.382(1).

Accordingly, we withdraw our August 12, 1997 order. On reconsideration, as supplemented herein, we republish our August 12, 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
TERESA McPHERSON, Claimant
WCB Case No. 95-10760
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Reinisch, et al, Defense Attorneys

On August 18, 1997, we abated our July 23, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the insurer's denial of claimant's current neck condition; and (2) upheld the insurer's denial of claimant's aggravation claim for the same condition. We took this action to consider claimant's motion for reconsideration.

In moving for reconsideration, claimant asserts that we erroneously found that Dr. Jones had an inaccurate history. Specifically, claimant contends that, in light of Dr. Jones' chart note that claimant had "no tx since" the claim was closed, his statement that claimant has "obviously needed markedly increased conservative care" since the August 7, 1992 injury, referred to claimant's "need" for care and not that she "received" care.

We need not resolve the distinction raised by claimant because, as stated in our order, Dr. Jones failed to analyze the relative contributions of claimant's kyphosis, degenerative changes in her neck, and the stress that was affecting her condition. We therefore continue to find that his conclusory opinion is insufficient to establish medical causation. Dietz v. Ramuda, 130 Or App 387 (1994); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 23, 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
MANUEL VILLA-GALLEGOS, Claimant
WCB Case No. 96-10478
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order which affirmed an Order on Reconsideration that did not award any unscheduled permanent disability for claimant's low back injury. On review, the issue is unscheduled permanent disability.

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

The ALJ determined that claimant was not entitled to an award of unscheduled permanent disability due to his compensable January 16, 1996 low back injury, reasoning that the medical evidence did not establish that claimant's Oregon injury caused permanent impairment over and above that due to injuries he had sustained in California. On review, claimant contends that he should be awarded unscheduled permanent disability based on findings of reduced range of motion made by the medical arbiter, Dr. Gripekoven. We disagree.

As claimant correctly observes, Dr. Gripekoven noted that claimant had reductions in lumbar extension and lateral bending. (Ex. 20-5). However, Dr. Gripekoven reported that claimant displayed exaggerated pain behavior during attempts at range of motion and that he had a positive Waddell's sign to both compression and rotation. (Ex. 20-2). Dr. Gripekoven also stated that his measurements did not meet the criteria for straight leg raising validity. (Ex. 20-2). Dr. Gripekoven concluded that his range of motion findings were invalid under AMA guidelines. (Ex. 20-5).

Based on Dr. Gripekoven's medical arbiter's report, we conclude that claimant has not proven impairment based on reduced range of motion, even if we assumed that Dr. Gripekoven's findings were due to the compensable Oregon injury. See Harvey Clark, 47 Van Natta 136, 137 (1995) (where the medical arbiter found the claimant's range of motion findings invalid, the claimant failed to prove impairment); Cf Justeen L. Parker, 49 Van Natta 334 (1997) (arbiter's range of motion (ROM) measurements rated as impairment when arbiter 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). Accordingly, we conclude that the ALJ properly affirmed the Order on Reconsideration.

ORDER

The ALJ's order dated March 11, 1997 is affirmed.

In the Matter of the Compensation of
GEORGIA A. CASSLE, Claimant
WCB Case No. C702015
CORRECTED ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Jon C. Correll, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

On August 11, 1997, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The body of the CDA provides for a total consideration for the CDA of $25,000. Included within the $25,000 is a lump sum payment to claimant of $16,633.68, less an attorney fee, and an overpayment in the amount of $8,366.32.

We have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. See Ronald Smith, 47 Van Natta 38 (1995); Timothy W. Moore, 44 Van Natta 2060 (1992). Furthermore, a carrier's contractual forbearance of its right to pursue an offset cannot serve as consideration for a claimant's release of rights to workers' compensation benefits. Id. Consequently, the carrier's release of the $8,366.32 overpayment in this case cannot be included as consideration for the CDA.[1] Nevertheless, such a provision does not automatically result in the disapproval of the proposed disposition.

In Roy D. Welty, 47 Van Natta 1544 (1995), we considered a CDA which provided, as consideration for the disposition, the release of the carrier's claims to an overpayment, as well as a lump sum payment. After noting that a carrier's contractual relinquishment of the right to pursue an overpayment could not serve as consideration for a CDA, we interpreted the CDA's total consideration as consisting of the lump sum payment, excluding the overpayment.

Similarly, in Steven T. Kunz, 48 Van Natta 2279 (1996), we considered a CDA which provided for the payment of a lump sum of $20,000, and indicated that "part of the consideration" included the carrier's agreement to waive an overpayment. Relying on Welty and Margie L. Brame, 48 Van Natta 204 (1996), we construed the consideration underlying the CDA as being limited to the $20,000 lump sum and approved the proposed CDA.

Here, as we did in Welty, Brame and Kunz, we interpret the consideration underlying the CDA to include only the $16,633.68 lump sum, and not to include the carrier's waiver of the overpayment. Based on such an interpretation, we do not consider the consideration for the release of claimant's "non-medical service" benefits to be unreasonable as a matter of law. See ORS 656.236(1)(a)(A).

Accordingly, as interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. Therefore, the parties' CDA is approved.

IT IS SO ORDERED.

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[1] Although the overpayment cannot be consideration for the CDA, the agreement nonetheless memorializes the parties' agreement that the carrier will not seek recovery of the overpayment from claimant.

In the Matter of the Compensation of
ROGER R. POWERS, Claimant
WCB Case No. 96-01765
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Yturri, Rose, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Davis's order that increased claimant's scheduled permanent disability award for loss of use or function of the left knee from 44 percent (66 degrees), as awarded by an Order on Reconsideration, to 47 percent (70.5 degrees). Claimant cross-requests review of those portions of the order that: (1) awarded a penalty based on the amount of permanent disability benefits due in monthly increments through the date of hearing; and (2) declined to award a carrier-paid attorney fee. On review, the issues are extent of scheduled permanent disability, and penalties and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

On January 22, 1994, claimant sustained a compensable injury to his left knee and groin. An October 27, 1995 Determination Order awarded 44 percent scheduled permanent disability for the left knee. On November 16, 1995, claimant filed a timely request for reconsideration of the Determination Order under ORS 656.268(5)(b), contending that, inter alia, he was entitled to increased permanent disability for his compensable injury. The employer did not request reconsideration of the Determination Order. A January 12, 1996 Order on Reconsideration affirmed the Determination Order's permanent disability award. Claimant timely requested a hearing. The employer did not request a hearing. At hearing, the employer sought reduction of the permanent partial disability award to zero on the ground that the condition rated in the Determination Order was not compensable.

CONCLUSIONS OF LAW AND OPINION

Reduction of the Scheduled Permanent Disability Award

The ALJ awarded claimant an additional 3 percent scheduled permanent disability, for a total of 47 percent, and declined to consider the employer's request to reduce claimant's scheduled permanent disability award to zero because the employer failed to raise the issue on reconsideration. ORS 656.268(8); Duncan v. Liberty Northwest Ins. Corp., 133 Or App 605 (1995). The employer argues that it accepted a disabling left knee and groin strain, but the Determination Order's permanent disability award was based on a preexisting degenerative condition which was not part of its accepted claim. The employer asserts, therefore, that it is entitled to challenge the Determination Order's award at hearing.[1] We disagree.[2]

As we discussed in Robin W. Spivey, 48 Van Natta 2363 (1996), permanent partial disability awards are granted based only on "accepted" conditions. Here, the employer accepted a strain to the left knee and groin (Ex. 12).[3] In this case, the employer contends that the Determination Order's

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[1] The employer cites to Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996) in its argument on review. Messmer is not applicable here, as the Determination Order has not become final.

[2] We acknowledge the employer's submission of a supplemental brief arguing that the amendment to ORS 656.262(10) by House Bill 2971, which it asserts legislatively overrules the Messmer holding, is applicable here. However, there is no need to address the matter further, because our reasoning and conclusion is not based on the Messmer holding, as is noted in footnote 1.

[3] There is no evidence that the employer voluntarily accepted a combined or consequential condition, nor did claimant request the employer to accept the preexisting degenerative condition in his left knee, or a combination of the knee strain and degenerative condition. Thus, ORS 656.262(7)(b) does not apply here to preclude the employer from litigating whether the non-accepted condition is compensable. See Robin W. Spivey, 48 Van Natta at 2363, n 5, 6.

permanent partial disability award is based on impairment values for an unaccepted preexisting degenerative condition. Consequently, had the employer properly raised its challenge to the Determination Order's permanent partial disability award at reconsideration, the ALJ could have addressed the issue at hearing. However, the employer did not request reconsideration of the Determination Order's permanent disability award. Since the employer failed to raise the issue during the reconsideration proceeding, it is barred from seeking reduction of claimant's permanent disability benefits below the Determination Order's award.[4] See ORS 656.268(8); 656.283(7).

Although the insurer is barred from challenging the permanent disability benefits awarded by Determination Order, there is no statutory prohibition which would prevent it from challenging the ALJ's additional 3 percent scheduled award.

Permanent partial disability is based on the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214. Here, the uncontradicted medical evidence shows that claimant suffered from severe degenerative joint disease in his left knee that preexisted his compensable 1994 left knee injury. (Exs. 11, 18, 23-2, 24, 31, 33-1, 34, 57-2, 70). Based on claimant's history, Dr. Kopp, claimant's attending physician, opined that the majority of claimant's present knee problems were due to his preexisting degenerative joint disease, which was related in part to a compensable knee injury at the employer that took place 20 years earlier. (Ex. 18). Dr. Kopp declined to allocate proportion because he thought the matter irrelevant, since the same employer was responsible for both injuries. (Ex. 29).

Subsequently, however, the records from claimant's 1970 injury revealed that there was no treatable injury to claimant's knee at that time. Therefore, Dr. Kopp's assumption about the earlier injury was based on an incorrect history and is therefore unpersuasive. Somers v. SAIF, 77 Or App 259 (1986) (we do not give great weight to medical opinions which are not both well-reasoned and based on complete information).

Consequently, the record does not establish that claimant's permanent disability is due to the 1994 industrial injury. Nonetheless, as previously noted, the employer is only authorized to contest the ALJ's 3 percent increased award. Accordingly, we reverse the ALJ's award of an additional 3 percent permanent disability.

Penalties

The ALJ concluded that the employer's failure to pay the permanent partial disability award was unreasonable and awarded a 25 percent penalty on the amount of the permanent partial disability award due in monthly increments through the date of hearing. Claimant contends that the penalty should be based on the entire amount of the Determination Order. We agree.

We previously addressed this issue in George Violett, 42 Van Natta 2647 (1990), in which we held that a penalty should be based on the entire amount awarded by the Determination Order, regardless of how, in fact, payment of the award was ultimately made.

In Violett, the Board had awarded the claimant a penalty for the self-insured employer's failure to process the claim to closure in a timely manner. The employer argued that the "amounts then due" upon which to base the penalty should be determined upon the "installments" required to be paid under ORS 656.230, at the time of hearing. The Board cited Harold A. Lester, 37 Van Natta 745 (1985), in which it had held that the delay period was the "then" referred to in the phrase "amounts then due" and concluded that the "amounts then due" was the permanent partial disability award granted by the Determination Order issued at the time of hearing.

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[4] In Duncan v. Liberty Northwest Ins. Co., 133 Or App at 611, the court explained that a party may seek review of the order on reconsideration, but when a party objects at a hearing to a part of the reconsideration order that merely affirms the determination order, the party's true objections are to the determination order and ORS 656.268(5) forecloses the objection if no request for reconsideration was made. Thus, the determination order becomes the instrument that defines the maximum or minimum awards when a party fails to raise its objections through a request for reconsideration. Here, as in Duncan, the Determination Order's award serves as a floor, and the employer could not seek reduction of the temporary or permanent disability benefits below that level at hearing because it did not request reconsideration on that issue.

In Violett, the Board considered the language of the determination order to be controlling, noting that ORS 656.230, 656.216 and former OAR 436-06-060 concerned the method of payment of permanent disability awards. The claimant's entitlement to permanent disability, including when the disability award became due, was not affected by the above cited statutes and administrative rule. Therefore, the fact that claimant's disability award was being paid in installments was not relevant to the collateral issue of penalties. Accordingly, the Board decided that the permanent disability awarded by the Determination Order constituted the "amounts then due" upon which to base the penalty. Violett, 42 Van Natta at 2647, 2648.[5]

We therefore look first to the Determination Order itself, which was unpaid at the time of hearing. Claimant was awarded 44 percent for 66 degrees scheduled permanent disability. The Determination Order stated, "The insurer is now ordered to pay you $21,873.06." Thus, by the employer's failure to timely pay the amounts ordered, the clear and unambiguous language of the Determination Order demands payment of the entire sum "now." This amount is certain and is not prospective or speculative, and thus, came due upon issuance of the Determination Order.

Here, as in Violett, the "amounts then due" is the permanent partial disability award granted by the Determination Order. The insurer was required to pay claimant's permanent disability benefits within 30 days of the date of the Determination Order. Former OAR 436-60-150(6); Sisters of Providence v. East, 122 Or App 366, 369 (1993) (employer was required to pay the claimant's permanent disability benefits within 30 days of the date of the determination order). Thus, the delay occurred when the insurer failed to pay the permanent partial disability award upon the 31st day after the Determination Order issued. Consequently, as in Violett, the entire amount came due on that date, regardless of how, in fact, payment of the award may be ultimately made. Therefore, the penalty should be based on the entire amount awarded by the Determination Order.

Attorney Fees

The ALJ found that the employer requested reduction of claimant's permanent partial disability award, which was not reduced. Nevertheless, the ALJ declined to award attorney fees for lack of jurisdiction[6], "because the employer's issue is a nullity." On review, claimant contends that he is entitled to attorney fees at hearing under ORS 656.382(2) for successfully defending against the employer's assertion at hearing that claimant's permanent partial disability, as awarded by the Determination Order, should be reduced. We agree.

On review, the employer argues that there is no basis for attorney fees because claimant, not the employer, requested the hearing. Under ORS 656.382(2), if the carrier files a request for hearing and the ALJ finds that the compensation awarded to a claimant should not be disallowed or reduced, the carrier is required to pay to claimant a reasonable attorney fee. An attorney fee is warranted under ORS 656.382(2) whenever a claimant's compensation award is challenged at hearing, regardless of whether that challenge arises in the carrier's formal cross-request or informally at hearing, and the claimant successfully defends against it. Kordon v. Mercer Industries, 308 Or 290 (1989); Christopher E. Lindon, 47 Van Natta 1104 (1995) (ORS 656.382(2) applicable when a claimant's compensation award is challenged without a formal cross-request for review).

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[5] In Violett, the Board reasoned that, should only the installments due and owing at the time of hearing under ORS 656.230 and 656.216 be used to calculate the penalty, any installment payments made subsequent to the hearing would be equally late. In other words, once the delay has occurred, which is the "then" with regard to amounts then due, it does not matter whether the permanent disability award is treated as a whole or is treated as individual installments, it is all late and penalties may be assessed accordingly. The Board further noted that, theoretically speaking, if paid in such an incremental fashion, claimant would be entitled to request a hearing to seek a penalty on each and every late installment then "coming due," a redundant and time-consuming procedure that the Board declined to endorse. Violett, 42 Van Natta at 2648.

[6] As to the ALJ's conclusion that he was unable to award an attorney fee because he did not have jurisdiction over the employer's "issue" of the reduction of claimant's permanent disability award, the court held in Duncan v. Liberty Northwest Ins. Co., 133 Or App at 610-611, that ORS 656.268(5) does not relate to jurisdiction to conduct a hearing, but to preservation of issues that may be raised at the hearing. See also Diane's Foods v. Stephens, 133 Or App 707 (1995) (applying Duncan to extent issue). Consequently, the ALJ was not deprived of jurisdiction to consider the employer's request for reduction of claimant's permanent disability award. Rather, the employer was barred from raising the issue of reduction of claimant's permanent disability award at hearing by its failure to raise the issue for the first time before the proper forum.

Accordingly, even if the employer did not formally cross-request a hearing, the employer's argument at hearing that claimant was not entitled to the Determination Order's 44 percent permanent disability award is sufficient to satisfy the requirements of ORS 656.382(2). Consequently, because claimant successfully defended against the employer's request for reduction or disallowance of claimant's scheduled permanent disability award, claimant is entitled to an employer-paid attorney fee under ORS 656.382(2) for services at hearing and on review.[7]

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 successfully defending against the employer's request for reduction of his permanent disability award is $3,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the reduction issue (as represented by the hearings record and claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might be uncompensated. We note that no attorney fee is awarded for those portions of claimant's brief devoted to seeking an attorney fee award, and to defending the ALJ's 3 percent increase in scheduled permanent disability. See Dotson v. Bohemia Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated July 8, 1996, as reconsidered September 4, 1996, is reversed in part, modified in part, and affirmed in part. That portion of the order that increased claimant's scheduled permanent disability award for loss of use and function of the left knee by 3 percent and assessed an out-of-compensation attorney fee is reversed. The Determination Order and Order on Reconsideration award of 44 percent (66 degrees) is affirmed. That portion of the order that awarded a 25 percent penalty on the amount of the permanent partial disability award due in monthly increments through the date of hearing is modified to award the penalty on the entire amount of permanent partial disability awarded by the Determination Order. For services at hearing and on Board review regarding the employer's attempts to reduce claimant's scheduled permanent disability as awarded by Determination Order, claimant's attorney is awarded a fee of $3,500, to be paid by the employer. The remainder of the order is affirmed.

[7] Claimant also asserts that he is entitled to an assessed fee under ORS 656.386(1) for successfully defending against the employer's challenge to compensability at hearing. We need not resolve that question because, even if ORS 656.386(1) was also applicable, we would find that our attorney fee award represents a reasonable award for claimant's counsel's services at hearing regardless of the statutory bases.

In the Matter of the Compensation of
SHARON K. FALSETTO, Claimant
WCB Case No. TP-97003
ORDER OF ABATEMENT
Gaylord & Eyerman, Attorneys
Sather, Byerly, et al, Defense Attorneys

On July 31, 1997, we issued a Third Party Distribution Order that determined that the insurer had not established its entitlement to the remaining balance of proceeds from claimant's third party settlement. Based on a long-standing principle expressed in cases such as David L. Whitlow, 41 Van Natta 1517 (1989), and Cynthia G. Lavelle, 41 Van Natta 1399 (1989), we held that it was not "reasonably certain" that the insurer would incur future expenses for fusion surgery arising from claimant's compensable injury. Asserting that it should not be required to establish that its future expenses are "certain," the insurer contends that it is entitled to recover its lien for future medical expenses because it has proven that the surgery is "reasonably to be expected."

In order to further consider the insurer's contentions, we withdraw our July 31, 1997 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 will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN A. SZABO, Claimant
WCB Case No. 95-13484
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's right leg/foot injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated February 28, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

Board Member Haynes dissenting.

On October 9, 1995, while working, claimant experienced the onset of right foot and ankle symptoms. Claimant had experienced similar symptoms on previous occasions. The issue in this case is whether claimant proved the compensability of his need for treatment or disability under ORS 656.005(7)(a)(B). I disagree with the majority that the medical evidence was sufficient to carry claimant's burden of proof.

The record contains two opinions concerning causation. Examining physicians Dr. Hohf, internist, and Dr. Braun, general surgeon, suspected the presence of "an underlying inflammatory arthritis," such as gout or rheumatoid arthritis. (Ex. 4C-3). The panel also found that the major contributing cause was a preexisting condition based on the "several prior episodes going back to the 1980's, with similar symptoms, but not provoked by any specific trauma." (Id. at 4).

Claimant's treating podiatrist, Dr. Leas, indicated that he concurred with the examining panel's report. (Ex. 4D).

Dr. Leas then provided a report saying that claimant had a "pre-existing condition that has been pathologically worsened due to industrial exposure." (Ex. 5-1). The report then outlined the course of claimant's treatment following the October 1995 incident and noted claimant's "several prior documented episodes going back to 1986 of lower extremity work related problems with inflammatory symptoms." (Id. at 1-2). The report ended with the statement that "even though a current diagnosis has not been reached as to the exact type of inflammatory process that is causing [claimant's] problem, his findings for the above named claim are consistent with exacerbation of a pre-existing condition due to work-related conditions." (Id. at 2).

Finally, Dr. Leas indicated that claimant's "pre-existing condition combined with the industrial exposure" and "the major contributor to [claimant's] treatment" was the "industrial exposure." (Ex. 6).

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). Here, I find no basis for deferring to Dr. Leas. First, his report stating that claimant's work "pathologically worsened" or "exacerbated" the preexisting condition contains no reasoning or explanation. At best, it contains bare conclusions and recites claimant's medical history. Furthermore, Dr. Leas' concurrence with the examining panel's report is not

consistent with an opinion that a work injury is the major contributing cause of a combined condition.[1] Finally, there is the rebutting opinion from the examining panel attributing claimant's need for treatment to a preexisting condition.

Consequently, lacking persuasive medical evidence of causation, I would conclude that claimant failed to prove compensability. Thus, I dissent.

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[1] Relying on Terry R. Myers, 48 Van Natta 1039 (1996), the ALJ found that the concurrence did not constitute an unexplained change of opinion because it was in the form of a "check-the-box" report and preceded more thorough and well-reasoned reports. Myers is distinguishable from this case because, as explained above, Dr. Leas' subsequent reports are not thorough and well-reasoned and, thus, by themselves are not sufficient to establish compensability.

In the Matter of the Compensation of
HILLARD J. FORTSON, Claimant
WCB Case No. 96-01843
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order which upheld the SAIF Corporation's denial of claimant's injury claim for bilateral arm fractures. On review, the issue is whether claimant's injury arose out of and in the course and scope of 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

Claimant is a production/maintenance lead worker at the employer's mid-valley paper production plant. His principal duties involve keeping equipment operating properly in the recovery boiler area. He sometimes performed "extra work" as well.

On February 1, 1996, claimant was assigned to keep outdoor diesel heaters running on a 6:30 p.m. to 4:00 or 6:00 a.m. shift. Heater duty required two approximately two-hour rounds to the various heater locations. Between rounds, a worker on this job could usually be found in the break and control room areas.[1]

The employer had a policy of allowing employees to remove surplus materials, if the worker obtained a pass to do so. The employer's written policy provided: "Items such as wood rejects, 49'er belts, scrap lumber will be free, subject to availability." (Ex. 1; See Ex. 10-4; Tr. 35-36, 43).

The day before his injury, claimant noticed a large wooden crate lying in the yard area. He contacted the employer's production manager and requested a pass to remove the box. The production manager approved the pass and left it with claimant's shift supervisor.

Claimant arrived at work at about 6:30 p.m. on February 1, 1996. He worked for about 30 minutes, then appropriately anticipated an idle hour waiting for the diesel truck to be refueled. He set out to locate the crate he had seen the previous day.

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[1] Because this was an "extra work" assignment, claimant was not expected to involve himself in other work projects.

The crate was not in the yard. Suspecting that the crate had been discarded, claimant climbed a ladder to look for it in a large dumpster. His feet slipped and he fell about 6 feet to the pavement, breaking both arms.

SAIF denied claimant's claim, contending that the injury did not occur in the course and scope of employment.

The ALJ upheld the denial, reasoning that claimant was on an errand of his own at the time of injury, performing an activity which deviated from his work such that the injury fell outside the course and scope of the employment. We disagree.

"An injury is compensable if it 'aris[es] out of and in the course of employment.'" ORS 656.005(7)(a). The 'arising out of [employment]' prong concerns the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). The 'in the course of employment' prong concerns the time, place, and circumstances of the injury. Id. The two prongs constitute a unitary work-connection test, 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 (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 (1994)." SAIF v. Burke, 145 Or App 427, 430 (1996).

In this case, claimant was on paid time when he was injured. The injury occurred on the employer's premises. Because claimant had no work responsibility (other than to be available in the event of heater malfunction) at the of the injury, he did not "depart" from work duty to investigate the contents of the dumpster. Instead, because the dumpster was within sight of the heater area, claimant was available to perform his work duties while he looked for the crate (at least until he fell and broke both arms).

In addition, we find that claimant and the employer generally contemplated that employees would look for salvage materials while working, so long as such activity did not interfere with work. (Tr. 37-38, 49). We also find that the employer knew claimant was doing that on February 1, 1996, because claimant informed his supervisor that he was going to look for the crate before he climbed the dumpster ladder. (Tr. 17, 19). We further note the employer's course of conduct in allowing employees to identify discarded materials on paid time. Finally, because employer-discarded materials would reasonably be expected to reach a trash receptacle before leaving the premises, we conclude that the employer effectively acquiesced in, if not outwardly condoned, claimant's investigation of the dumpster for the purpose of locating the previously identified discarded crate.[2] (See Tr. 35-36, 49). Under these circumstances, we do not find that claimant was on a purely personal mission when he was injured. See Chris T. Singlestad, 46 Van Natta 894 (1994), aff'd mem 132 Or App 626 (1995).

A closer question is whether the crate-locating activity was an ordinary risk of, and incidental to, claimant's employment. There is no contention that claimant's work ever involved the dumpster. (See Tr. 24-26). However, there is no doubt that the employer retained authority over claimant during his idle time on the night in question. Moreover, again considering the employer's policy and course of conduct regarding employee locating of salvage materials and the fact a worker would reasonably expect to find discarded materials in a dumpster, we do not find that climbing the dumpster ladder was an activity that severed the work connection. See Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, rev den 300 Or 249 (1985) (Where the claimant's coffee break activity was contemplated by both employer and worker and acquiesced in by the employer, it was not a departure from the employment relationship).

The record does not reveal precisely why claimant slipped from the ladder.[3] (See Ex. 10-15). There is no evidence that the injury resulted from a risk personal to claimant or from an employer-

[2] Such acquiescence was consistent with the employer's liberal policy of allowing employees to take discarded materials, free of cost, for their own use. (See Ex. 1, Tr. 43).

[3] There is no evidence that the injury resulted from a risk personal to claimant or from an employer-created hazard.

created hazard. However, we surmise that any hazard involved would have been under the employer's control, because the injury occurred on the employer's premises (without evidence of intervening natural or catastrophic forces).

Finally, we note that SAIF is correct that there is no showing that claimant's crate-locating activity benefited the employer. Nonetheless, considering the time, place and circumstances of the injury, as well as the risks of claimant's employment and the employer's permissive policy regarding discarded materials (including allowing employees to locate such materials while working), we conclude that claimant has established that his injury arose out of and in the course and scope of employment under the totality of circumstances.

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 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 October 25, 1996 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant is awarded a $4,000 attorney fee, payable by SAIF.

Board Member Haynes dissenting.

I disagree with the majority that claimant's injury was in the course and scope of his employment. Claimant's job was in production/maintenance. At the time he was injured, claimant's specific job was to maintain diesel heaters by keeping them running and fueled. There is no contention that this job also included the duty of climbing a ladder to inspect a dumpster for a crate that claimant planned to take for his own personal use. Rather, the majority's conclusion essentially rests on the fact that the employer had a policy allowing employees to obtain and remove scrap lumber.

In determining whether an injury is within the course and scope of employment, we are to decide whether the totality of the events that gave rise to claimant's injury was causally related to his employment. E.g., SAIF v. Marin, 139 Or App 518, 522, rev den 323 Or 535 (1996). Part of that inquiry includes categorizing the nature of the risk of harm that resulted in the injury. Id. at 523. Here, because the dumpster was not part of claimant's job duties, it should be categorized as a "neutral risk" because it is neither distinctly employment nor distinctly personal in character. Consequently, claimant's injury is compensable only if his work conditions caused him to be in a position to be injured. Id. at 524-25.

Here, as stated above, claimant's job of running and refueling the heaters was completely separate from checking a dumpster for scrap lumber. Consequently, such activity broke the causal connection between claimant's normal conditions of employment and his injury. In deciding to the contrary, the majority "consider[s] the employer's policy and course of conduct regarding employee locating of salvage materials and the fact that a worker would reasonably expect to find discarded materials in a dumpster[.]" I believe such reasoning shows that, rather than truly assessing the risk of harm from claimant's work conditions, the majority applies a negligence standard by determining whether it was foreseeable that claimant could be injured while taking advantage of the employer's scrap lumber policy.

Finally, I expect that, with this decision, the employer no longer will allow employees to collect and remove scrap lumber.

In the Matter of the Compensation of
WILLIAM J. KELLEY, Claimant
WCB Case No. 96-05889
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the SAIF Corporation's denial of his right index finger injury claim; and (2) declined to assess penalties and attorney fees for SAIF's 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 changes. We replace the second paragraph of the findings of fact with the following:

> "Hooker Creek Ranch contains approximately 400 acres and is owned by Matt and Lesley Day. Lesley Day operates an animal sanctuary, which was formerly called 'Day's Exotic Animal Retreat.' The animal sanctuary was located on part of 100 acres of the ranch owned by Lesley Day. At the time of the hearing, the retreat had been renamed and was owned by 'Chimps, Inc.' The animal sanctuary includes a chimp 'house,' a chimp 'cage,' and a snow leopard cage. (Tr. I-155-157)."

On page 3, we replace the second paragraph with the following:

> "On October 12, 1995, Janine Koehler, claimant's supervisor, asked claimant if he would apply DMSO to a horse the next day. Claimant agreed and on October 13, 1995, he set out to complete that job. He needed rubber gloves for it; Koehler had told him that she thought the gloves were in the chimp house. Claimant went to look for them there."

In the third paragraph on page 3, we replace the first two sentences with the following sentence: "On the way to the chimp house, claimant stepped off the path to the house and went toward Topo's cage."

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant, a ranch worker, was injured when part of his right index finger was bitten off by Topo, a chimpanzee. He had worked at the ranch since 1994, performing a variety of tasks. In September 1995, Ms. Day, one of the ranch owners, arranged for the delivery of Topo. Ms. Day invited some people, including some ranch employees, to serve as volunteers before Topo arrived. Among others, claimant and his wife volunteered. Before Topo arrived, the volunteers were given general information about chimpanzees and were told of the importance of "acknowledging" the chimp's area before entering because of his territoriality. Topo arrived on October 6, 1995 and claimant was injured on October 13, 1995.

The ALJ concluded that, among other things, claimant's injury occurred in a place other than where claimant was normally employed. The ALJ found that the injury occurred in a separate enclave set aside for the animal retreat owned exclusively by Ms. Day. The ALJ concluded that "grooming" Topo had nothing to do with claimant's ranch activities and there was no causal nexus between chimp grooming and performing ranch work.

ORS 656.005(7)(a) provides that a " 'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" There are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arise out of employment" tests the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). Both elements must be evaluated; neither is dispositive. Id.

Claimant contends that his injury occurred in the course and scope of his employment. For the following reasons, we agree.

We first examine the time, place and circumstances of the injury. Claimant's injury occurred during his normal working hours. Moreover, his injury occurred in the place where claimant was normally employed. Ms. Day testified that, at the time of the injury, she owned the acreage upon which the chimp cage and chimp house were located, as well as the 100 acres upon which the working ranch was located. (Tr. I-156). She testified that it was only after claimant's injury that the chimp house and chimp cage became a separate legal entity, known as Chimps, Inc. (Tr. I-155). We are not persuaded that claimant's injury occurred in a "separate enclave."

We must consider "all the circumstances" to determine if claimant has shown a sufficient work-connection. Norpac, 318 Or at 369. Here, we conclude that the circumstances of claimant's injury were in the course of his employment. Claimant testified that his supervisor, Ms. Koehler, called him on October 12, 1995 and requested that he put some DMSO on a horse. The next day, when claimant went to perform the task, he realized there were no gloves in the barn and he walked up to the chimpanzee's area where he recalled the gloves had been taken at the time of Topo's arrival. (Tr. I-13-14).

In order to obtain the gloves, claimant had to enter Topo's area. Claimant testified that it was his understanding that, when entering Topo's area, it was necessary to greet Topo. (Tr. I-13, -14, -27, -49, -51, -66). One acceptable way to greet Topo was to groom him by touching him. (Tr. I-27, -51, -66, -191, -192). At the time of the injury, claimant was engaged in grooming Topo. Claimant testified that he intended to greet Topo, obtain the rubber gloves and complete his work task. (Tr. I-31).

Before the injury, claimant had groomed Topo on two other occasions and had no problems interacting with Topo. (Tr. I-27). On one occasion, claimant's wife and Ms. Day were present. (Id.) Claimant's wife had also been involved with grooming Topo before the injury occurred. Claimant's wife had previously groomed Topo and interacted with him in the same manner as claimant did on the day he was injured. (Tr. II-11). Ms. Day was present at that time.

The ALJ found that "greeting" Topo was accepted and perhaps required, but "grooming" was not required and was discouraged by Ms. Day. We disagree with the ALJ's conclusion.

In Andrews v. Tektronix, Inc., 323 Or 154, 166 (1996), the Court rejected the view that an employee's violation of an employment rule rendered his or her claim per se noncompensable. The Court commented that the Board's focus on "misconduct" carries with it a connotation of fault, which has no place in our workers' compensation scheme. Id. at 159. Rather, the initial inquiry is whether the claimant was engaged in an activity that was within the boundaries of his or her ultimate work. Id. at 166. That determination is made by evaluating all the factors that are pertinent to the question of work-connectedness and weighing those factors in light of the policy underlying the Workers' Compensation Act. Id.

Here, we conclude that, at the time of the injury, claimant was engaged in an activity that was within the boundaries of his ultimate work.

As we discussed earlier, claimant testified that, when entering Topo's area, it was necessary to "greet" or acknowledge Topo. In order to obtain the gloves to put DMSO on the horse, claimant had to enter Topo's area. Claimant chose to greet Topo by grooming him.

One of claimant's supervisors, Ms. Koehler, testified that they were supposed to acknowledge Topo when going by his area:

> "I was told that if I should pass [Topo] or get within talking distance and didn't acknowledge him that that upset him. And so I took it upon myself then if I didn't have time to stop and chat with him for a minute or two, I always waved and said hello just because I was told that it upset him to see me walk by his cage and not acknowledge him." (Ex. 14-14).

Claimant's wife also testified that, because chimpanzees were territorial, they were supposed to acknowledge Topo and make their presence known before going into his area. (Tr. II-10). She testified that Topo's "area" was an area where Topo could see you. (Tr. II-21-22).

We are not persuaded that, at the time of the injury, greeting Topo by "grooming" or touching him was forbidden. Ms. Day was asked whether she had told claimant before the injury how he was supposed to greet Topo. She replied:

> "I don't think we -- I don't recall it at all. I don't -- we didn't know how to greet Topo. This was a learning situation for everybody involved. And there's no one way to greet a chimpanzee except as know -- you know, to be submissive." (Tr. I-136).

On the other hand, Ms. Day testified that she never told claimant that he needed to have physical contact with Topo. (Tr. I-137).

At the time of claimant's injury, the rules surrounding the interaction and care of Topo were not established. Ms. Day was asked about the rules regarding Topo:

> "Q. * * * Were the rules firmly in place in terms of where people were supposed to be, and what their expectations were --
>
> "A. Absolutely not.
>
> "Q. Regarding Topo?
>
> "A. Absolutely not." (Tr. I-165-166).

Ms. Jarrett, a ranch employee and "Topo" volunteer, testified that, before the injury, claimant was looking for rubber gloves and had come close to the chimp cage and she had warned him to keep his distance. (Tr. I-88-92, -100-106). Claimant testified, however, that he never had to look for gloves in the chimp house before October 13, 1995. (Tr. I-180-183). In light of claimant's testimony, we are not persuaded by Jarrett's testimony that claimant previously went to the chimp area to look for rubber gloves.

We conclude that the circumstances of claimant's injury were in the course of his employment. We also conclude that, at the time of the injury, claimant was engaged in an activity that was within the boundaries of his ultimate work.

Furthermore, we conclude that claimant's injury "arose" out his employment. In analyzing the "arising out of employment" prong of the work-connection test, we must determine whether the conditions of claimant's employment put him in a position to be injured. Henderson v. S. D. Deacon Corp., 127 Or App 333, 338-39 (1994). Considering all the circumstances, we conclude that they did.

Claimant testified that, in order to complete his October 13, 1995 job assignment of putting DMSO on a horse, he had to enter Topo's area. Topo's chimp house and chimp cage were located in the middle of the ranch. At the time of the injury, claimant was not forbidden from going on any part of the ranch. (Tr. I-37). As we discussed earlier, claimant believed that he had to greet Topo in order to obtain the gloves. Claimant understood that grooming Topo was an appropriate method of greeting him. Claimant was injured while he was grooming Topo.

We conclude that the conditions of claimant's employment put him in a position to be injured and, therefore his injury "arose" out his employment.

Finally, we reject the ALJ's conclusion that claimant could have "greeted" Topo from several feet outside the fence that enclosed the chimp cage, rather than placing his fingers inside the chimp cage. We agree with claimant that any "fault" on his part is not relevant to the analysis. See Andrews, 323 Or at 159-160 ("fault" is irrelevant in determining a worker's entitlement to compensation).

In sum, we find that claimant's right finger injury arose out of and occurred in the course of his employment.

Penalties

Claimant argues that he is entitled to a penalty for SAIF's unreasonable denial. Claimant asserts that SAIF attempted to avoid responsibility for his injury by arguing that the place of his injury was not a part of the ranch and that claimant was acting as a volunteer at the time of the injury. Instead, claimant asserts that, at the time of the injury, he was engaged in activities necessary for him to complete his work as a ranch hand.

SAIF's denial was issued on June 19, 1996, asserting that claimant was not in the course and scope of his employment at the time of the alleged injury. (Ex. 11).

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, we conclude that SAIF had a legitimate doubt concerning its liability for the claim. There is a legitimate legal question concerning whether claimant's injury arose out of and within the course and scope of his employment. Although we have concluded that the injury did arise in the course and scope of claimant's employment, we believe that there was a legitimate legal basis upon which SAIF could question its liability for the claim. Therefore, we conclude that claimant is not entitled to a penalty.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $6,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee for services at hearing and on review concerning the penalty issue.

ORDER

The ALJ's order dated December 17, 1996 is reversed in part and affirmed in part. The SAIF Corporation's denial of claimant's right index finger claim is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $6,000, payable by SAIF.

In the Matter of the Compensation of
GAYE E. WHITEHEAD, Claimant
WCB Case No. 9604317
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's denials of claimant's aggravation claim for a left knee condition and her new injury claim for the same condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction and supplementation. We replace the fourth sentence of the fifth paragraph of the findings of fact with the following: After the July 24, 1995 work incident, on August 16, 1995, claimant returned to Dr. James, treating orthopedist, for treatment of her left knee. At that time, Dr. James diagnosed "[a]cute synovitis, left knee, superimposed on [claimant's] old degenerative arthritis and an aggravation of the old arthritis." (Ex. 21-1).

On January 8, 1997, Dr. McKillop, orthopedist, performed a record review on behalf of SAIF. (Ex. 30).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the July 24, 1995 work incident combined with claimant's preexisting left knee condition to cause disability or need for treatment. Thus, the ALJ found ORS 656.005(7)(a)(B)[1] applicable to claimant's claim. We adopt the ALJ's reasoning and conclusions that claimant's left knee condition is a "combined condition" within the meaning of ORS 656.005(7)(a)(B). However, we disagree with the ALJ's conclusion that claimant failed to meet her burden of proof under that statute and thereby failed to establish either a compensable new injury or aggravation claim. Based on the following reasoning, we find that claimant has established a compensable new injury claim under ORS 656.005(7)(a)(B).

Claimant first injured her left knee in high school in the late 1960's. She underwent surgery (lateral meniscectomy) on the left knee in 1968 and had a good result. The 1968 meniscectomy was performed as an open (rather than arthroscopic) procedure and the entire meniscus was removed. X-rays in 1984 showed advanced degenerative osteoarthritis in the left knee for her age of 30.

In 1993, claimant compensably injured each knee in separate incidents while working for the employer. Her right knee problems were worse than the left knee, and she ultimately had surgery on the right knee. SAIF accepted the 1993 injury claim for bilateral knee strains. Subsequent to the right knee surgery, claimant developed worsening left knee symptoms and was able to work only four hours per day. The 1993 claim was ultimately closed with an award of 5 percent and 16 percent scheduled permanent disability for the left and right knees, respectively. (Ex. 18).

Subsequent to claim closure, on July 24, 1995, claimant was working when she stood up from a stool and her left knee popped. She had immediate pain and swelling and was unable to work for a short time before resuming her work schedule of four hours per day. She sought treatment from Dr. James, treating orthopedist, who diagnosed "[a]cute synovitis, left knee, superimposed on [claimant's] old degenerative arthritis and an aggravation of the old arthritis." (Ex. 21-1). SAIF denied the left knee condition both as an aggravation claim and a new injury claim. (Exs. 24, 26). The ALJ upheld SAIF's denials.

After the ALJ issued his order, the court decided SAIF v. Nehl, 148 Or App 101 (1997), recon 104 Or App 309 (1997), which clarified what a worker must prove under ORS 656.005(7)(a)(B) in order to establish a compensable combined condition claim. In Nehl, as a result of a noncompensable low back injury, the claimant underwent multiple surgeries, including a surgical fusion from L3 to the sacrum with the installation of Steffe plates, which were secured to the spine with screws. Several years later, the claimant experienced a change in his back pain while working. Subsequently, the claimant was found to have loss of bone around the screws in the L3 vertebrae and underwent another surgery on his low back. He filed a claim for a low back injury, which the carrier denied.

After a hearing, the ALJ set aside the carrier's denial, finding that the claimant's otherwise compensable injury was the major contributing cause of the need for treatment of his combined low back condition under ORS 656.005(7)(a)(B). The Board affirmed and adopted the ALJ's order. The Nehl court, in turn, affirmed the Board.

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[1] ORS 656.005(7)(a)(B) provides:

"(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; 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:

"* * * * *

"(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."

In rendering its decision, the court rejected the carrier's argument that the claimant must show that his entire combined condition, not just his specific need for treatment, was caused in major part by his work injury. On reconsideration, the court continued to reject that argument. However, the court agreed that the concluding sentence in its initial decision misstated the test contemplated by ORS 656.005(7)(a)(B) and replaced that sentence with the following: "We conclude that, regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment, the combined condition is compensable." Nehl, 149 Or App at 315.

The court also rejected the carrier's argument that its current holding was inconsistent with its holding in Robinson v. SAIF, 147 Or App 157 (1997), in which the court emphasized the "combined condition" language in ORS 656.005(7)(a)(B). The court noted that the two cases were distinguishable. In this regard, the court explained that, in Robinson, it emphasized the "combined condition" language to point out that, under the statute, the claimant must do more than establish that a work injury precipitates a claimant's need for treatment to establish the compensability of his combined condition. The court also noted that, in Robinson, there was no need to distinguish between the major cause of the claimant's combined condition and the major cause of claimant's need for treatment, because they were the same. However, the court needed to make that distinction in Nehl, because Nehl turned on the fact that there was a difference between the primary cause of the claimant's condition and the primary cause of his need for treatment.

In addition, the court rejected the carrier's argument that the appropriate weighing process in ORS 656.005(7)(a)(B) required putting all of the contributions of the claimant's prior surgeries on one side of the scales and the loosening of the screws in the prosthesis caused by the work incident on the other side of the scales. The court found that such an interpretation would read the language "need for treatment" out of the statute. Finally, the court concluded that ORS 656.005(7)(a)(B) "expressly refers to the compensability of the combined condition and says that the combined condition itself is compensable when the on-the-job injury is the major cause of claimant's disability or need for treatment." Nehl, 149 Or App at 315 (emphasis in original). The court found that the Board correctly applied ORS 656.005(7)(a)(B) in determining that the claimant's work injury, when weighed against the extent of his preexisting condition was the major contributing cause of his need for treatment; therefore, the combined condition was compensable.

Based on the following, we find that the reasoning in Nehl applies to the present case to determine compensability of the combined condition. Because there are various factors contributing to claimant's left knee condition, this case presents a complex medical question requiring expert medical opinion for its resolution. Uris v. Workers Compensation Dept., 247 Or (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). The record contains medical opinions regarding causation from three physicians: Dr. James, Dr. Dinneen,[2] orthopedist, who examined claimant on behalf of SAIF, and Dr. McKillop, orthopedist, who performed a record review on behalf of SAIF.

On October 20, 1995, Dr. Dinneen examined claimant and indicated that claimant had a "[s]prain, left knee, with probable tearing of scar tissue and/or loose body impingement." (Ex. 22-3). He also stated that claimant's "current diagnosis is status post degenerative arthritis, left knee, with

Dr. James agreed with Dr. Dinneen's findings and conclusions. (Ex. 22, 25, 27). It appears that Dr. James also initially agreed with SAIF's statement that "the major contributing cause of [claimant's] worsened left knee condition in July, 1995 was the pre-existing degenerative changes in the left knee that antedated this May 7, 1993 injury." (Ex. 22). However, Dr. James later clarified that he did not agree with that statement, which he found at odds with the conclusions in Dr. Dinneen's report. (Exs. 25, 27). Instead, he agreed with Dr. Dinneen's opinion that the major contributing cause of claimant's overall condition was the preexistent problems with her left knee, but the worsening, for which Dr. James treated claimant after the July 24, 1995 work incident was caused in major part by that incident. (Ex. 27).

Subsequently, Dr. Dinneen was deposed. (Ex. 28). He maintained his opinion that the left knee scar tissue and loose body were preexistent conditions due to claimant's prior surgery. He explained that the cartilage (meniscus) between the bones in claimant's left knee had been removed during the prior surgery and that her body attempted to heal itself by forming scar tissue to mimic the cartilage. However, because scar tissue generally is not as elastic or strong as normal cartilage, it was susceptible to tearing. (Ex. 28-8-10). He concluded that the July 1995 incident caused the scar tissue to tear and may have also dislodged a loose body that was already present in the knee. (Ex. 28-11-12). He opined that the major cause of "the initial treatment and all for up to some weeks or even a few months" was the July 1995 incident. (Ex. 28-13). He stated that the left knee condition was worsened by the July 1995 incident, which involved tearing of scar tissue, some fluid build-up for awhile, and formation of a little more scar tissue. (Ex. 28-14). However, he thought that this worsening would return to its baseline status within a couple of months. (Ex. 28-13-14).

Dr. Dinneen opined that, by the time of the 1993 work injury, claimant had a serious preexisting condition in her left knee, which predisposed her to tears in the scar tissue that resulted from the prior meniscectomy. (Ex. 28-17). Responding to questions regarding the composition of claimant's current combined condition, Dr. Dinneen ultimately concluded that 92 to 93 percent of the left knee condition preexisted the 1993 work injury, with the 1993 injury contributing 2 to 3 percent and the 1995 injury contributing 3 to 4 percent. (Ex. 28-18-21). Based on this analysis, Dr. Dinneen stated that the major contributing cause of claimant's need for treatment was "by far, the pre-1993 condition." (Ex. 28-20). However, he opined that claimant would not have needed medical treatment in July 1995 if she had not strained her knee in the July 1995 incident, but that she eventually may be a candidate for a total knee replacement due to the preexisting condition. (Ex. 28-27).

Dr. McKillop performed a record review at SAIF's request. It is apparent that Dr. McKillop had an inaccurate understanding that claimant underwent surgery to her left knee due to the 1993 compensable injury, because this surgery was actually performed on the right knee. (Exs. 30-6, -7). He opined that the major contributing cause of the need for treatment following the July 24, 1995 incident was the preexisting degenerative disease which had been caused by injuries and surgeries in 1968 and which preexisted the 1993 injury. (Ex. 30-7). He stated the July 1995 incident was probably the cause for some short-term need for treatment and short-term disability at that time; however, it was not the major cause of her ongoing disability. Id. He opined that the major contributing cause of the overall combined condition of the left knee continued to be the degenerative disease caused by the 1968 trauma. (Ex. 30-8).

656.005(7)(a)(B). Here, as in Nehl, the medical evidence establishes that the primary cause of claimant's combined condition is different from the primary cause of her need for treatment. Under such circumstances, "the extent of claimant's preexisting condition is weighed against the extent of his on-the-job injury in determining which of the two is the primary cause of his need for treatment of the combined condition. The extent of claimant's preexisting condition is not weighed against the extent of his on-the-job injury to determine which of the two is the primary cause of his combined condition." Nehl, 149 Or App at 312 (emphasis in original).

SAIF argues that, in his deposition, Dr. Dinneen quantified the contributions of claimant's preexisting degenerative conditions and the 1993 and 1995 work incidents to claimant's need for treatment after the 1995 incident, and concluded that the preexisting conditions were "by far" the major contributing cause of her need for treatment after the 1995 incident. (Ex. 28-18, -20). SAIF argues that this analysis satisfies the comparative analysis required by Dietz v. Ramuda, 130 Or App 397 (1994), review dismissed 321 Or 416 (1995) (determining major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). SAIF argues that Dr. Dinneen's earlier opinion attributing the major contributing cause of the need for treatment to the 1995 incident was rendered before Dr. Dinneen performed the comparative analysis mandated by Dietz. We disagree with the underlying premise of SAIF's argument.

Dr. Dinneen's quantification of the contributions of claimant's preexisting degenerative conditions and the 1993 and 1995 work incidents related to the composition of claimant's entire current combined condition in her left knee, this quantification did not relate to claimant's need for treatment after the 1995 incident. (Ex. 28-18-21). Thus, it follows that the basis of Dr. Dinneen's subsequent opinion regarding the major contributing cause of claimant's need for treatment was incorrect. Therefore, we find Dr. Dinneen's earlier opinion that the July 1995 incident was the major cause of the need for treatment of the combined condition more persuasive. Accordingly, we find that claimant's combined condition is compensable as a new injury claim.

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

ORDER

The ALJ's order dated February 14, 1997 is reversed in part. The SAIF Corporation's new injury claim denial dated April 8, 1996 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 a fee of $4,000, payable by SAIF.

In the Matter of the Compensation of
KATHLEEN A. BEBER, Claimant
WCB Case No. 97-00122
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that affirmed an Order on Reconsideration that awarded 5 percent (9.6 degrees) permanent disability for claimant's loss of use or function of her right arm (elbow). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's argument.

Claimant contends that she is entitled to an additional 1 percent permanent disability because the range of motion of her right elbow should be compared to the range of motion values set forth in the Director's disability standards, rather than to the contralateral joint. Claimant asserts that she has a history of injury or disease in the left elbow and, therefore, the right elbow must not be compared to the contralateral joint. See former OAR 436-035-0007(22). Specifically, claimant contends that she has established a history of injury or disease in the left elbow by giving the medical arbiters a history that she injured her left elbow in a motor vehicle accident in April 1996. (See Ex. 7-2). Based on medical evidence which does not support claimant's contention, we disagree.

We have previously held that there must be "evidence of injury or disease to the contralateral joint sufficient to preclude a comparison of that joint to the injured body part, before the contralateral joint comparison rating method is bypassed." Serafin C. Lopez, 49 Van Natta 874, 874 (1997), citing William L. Fishbach, 48 Van Natta 1233 (1996); Bessie B. Mitts, 49 Van Natta 799 (1997); Kenneth A. Mutzel, 48 Van Natta 2122 (1996).

Here, claimant's contention that she injured her left elbow in a manner sufficient to prevent usage of the "comparison rating method" is not supported by the rest of the record. Although there is evidence that claimant injured her left upper extremity in the April 1996 motor vehicle accident, the medical evidence does not support a finding that this injury was sufficient to preclude a comparison. (See Exs. 4A, 6B). In fact, the medical evidence establishes that claimant had full range of motion in the left elbow following the April 1996 accident. (Exs. 5, 7-3). In light of such circumstances, we agree with the ALJ's conclusion that the "comparison rating method" of OAR 436-035-0007(22) is applicable.

ORDER

The ALJ's order dated April 25, 1997 is affirmed.

Member Bock specially concurring.

Although I concur with the decision that the extent of claimant's permanent disability should be determined based on the "comparison rating method" of OAR 436-035-0007(22), I write separately to clarify my opinion.

Based on William L. Fishbach, 48 Van Natta 1233 (1996) and its progeny, I feel compelled to follow case precedent which effectively reads the word "medical" as a modifier for "history of injury or disease" as used in the rule. Nonetheless, I would note that such an interpretation of the rule causes us to essentially discard this injured worker's statements regarding her history of a left elbow injury absent medical evidence that such injury or disease damages the joint so as to preclude comparison.

In the Matter of the Compensation of
LARRY D. PEELER, Claimant
WCB Case No. 96-10630
ORDER ON REVIEW
Whitehead & Klosterman, 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) Michael V. Johnson's order that: (1) found claimant's claim for a left shoulder injury was timely filed; and (2) set aside its denial of the left shoulder injury claim. On review, the issues are timeliness of claim filing and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and the parties' stipulation, but we make the following modifications and correction to the ALJ's findings of fact.

In lieu of the first sentence of the seventh paragraph of the ALJ's findings of fact, we make the following finding: "Although claimant was not scheduled to work until Monday, December 4, 1995, on or about Sunday, December 3, 1995, claimant went to work to talk to his new 'boss,' store manager Marie Trucco. (Tr. 55-56)."

The quotation in the last sentence of the tenth paragraph of the ALJ's findings of fact is corrected as follows: "Larry's injury of 11/27/95 does not appear to be a workmen's comp. related problem at this time."

After the twelfth paragraph of the ALJ's findings of fact, we add the following: "In August 1996, Ms. Trucco became aware that claimant considered his November 1995 left shoulder injury to be a worker's compensation claim. (Ex. 26B; Tr. 63-64)."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant timely filed his claim for the left shoulder injury, and that the injury occurred in the course and scope of his employment. The insurer disagrees with both findings. We affirm the ALJ's order, with the following supplementation to address the insurer's arguments.

Timeliness of Claim Filing

The insurer contends that claimant is not credible and that, therefore, the ALJ erred in finding that claimant had filed an 801 form on December 4, 1995. The insurer contends that since there is no credible evidence that claimant filed a claim within 90 days after his injury, claimant failed to establish that he filed a timely claim. We disagree.

Although not making any explicit credibility findings, the ALJ nevertheless accepted claimant's testimony in making findings of fact regarding claimant filling out and mailing the 801 form on December 4, 1995. Thus, the ALJ implicitly found claimant's testimony credible.

We defer to the ALJ's credibility determination to the extent it is based on the ALJ's observation of a witness' demeanor at hearing. However, the ALJ is in no better position than we are to evaluate credibility based on the substance of a witness' testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). After our review of the record, we find no material inconsistencies in claimant's testimony, or between the documentary record and claimant's testimony, such that we feel compelled to reverse the ALJ's implicit credibility determination. Nor do we find that claimant's practical joke on a co-worker, which involved claimant directing another co-worker to forge their supervisor's signature, undermines claimant's credibility regarding the filing of his claim. Therefore, we accept the ALJ's determination that claimant's testimony was credible. Accordingly, we agree with the ALJ that claimant filed his claim within 90 days after the injury.

In the alternative, we agree with the ALJ that claimant provided notice of his claim within one year after the injury. ORS 656.265(4) provides, in material part, that failure to give notice as provided by ORS 656.265 "bars a claim under this chapter unless the notice is given within one year after the date of the accident and . . .[t]he employer had knowledge of the injury or death[.]" Here, claimant's supervisor, Ms. Trucco, knew of claimant's injury shortly after it occurred. She knew that the injury constituted a worker's compensation claim in August 1996, less than one year after the injury occurred. Finally, the insurer had knowledge of the claim at least by November 6, 1996, when it issued a denial. Thus, even if claimant did not give notice of his claim within 90 days after the injury, he nevertheless gave notice within one year after the injury, so that his claim would be timely under ORS 656.265(4).

Compensability

The ALJ found that claimant's injury occurred in the course and scope of his employment. Therefore, pursuant to the parties' stipulation that the November 1995 injury is the major cause of claimant's left shoulder condition, the ALJ concluded that claimant's left shoulder claim is compensable. The insurer disputes that claimant's injury occurred in the course and scope of his employment. We agree with the ALJ's reasoning and conclusion.

Claimant, a loss control manager employed by a multi-state retail store, injured his left shoulder when he slipped and fell inside a moving van as he was unloading his belongings at his new home. Claimant had been transferred from the employer's store in Union Gap, Washington to Salem, Oregon. Although claimant requested the transfer to Salem, the employer transferred claimant because it needed a loss control manager at the Salem store. Consistent with the employer's relocation policy, claimant was paid his regular salary during the course of his move from Washington to Oregon, and he was also reimbursed for his moving expenses.

We agree with the ALJ's analysis under Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994) and the factors set forth in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 574, rev den 300 Or 249 (1985), as well as his conclusion that claimant's injury occurred in the course of his employment and arose out of his employment. Specifically, we agree that claimant's injury occurred in the course of his employment because both parties benefited from claimant's transfer, employee relocation was contemplated by both parties, claimant was paid during his relocation, and the employer at least acquiesced in claimant moving his belongings in order to relocate to Salem, Oregon. That claimant was not on the employer's premises when he was injured we consider to be of minor significance in this particular case, because claimant's transfer from Washington to Oregon could not physically take place on the employer's premises.

We also agree with the ALJ that claimant's injury arose out of his employment because moving his personal belongings was precisely the activity that the employer expected claimant to be doing at that time, and for which the employer compensated claimant. We further find that claimant's fall in the moving van was a usual risk associated with his transfer and relocation from one store location to another. Accordingly, we affirm the ALJ's conclusion that claimant's injury occurred in the course and scope of his employment and is, therefore, compensable.

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

ORDER

The ALJ's order dated April 18, 1997 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,000 for his services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
ILLA J. JACKSON, Claimant
WCB Case No. 96-10374
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of claimant's right foot condition claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Hallux valgus refers to the angulation of the great toe toward the other toes and away from the midline of the body. (Ex. B-1). A bunion is an abnormal prominence of the inner aspect of the first metatarsal head, accompanied by bursal formation and resulting in a valgus displacement of the great toe. (Ex. B-2).

Claimant had mild hallux valgus conditions and bunions present bilaterally at the time of her June 30, 1995 work injury. (Ex. 17 at 4-5, 7-8). These conditions were asymptomatic prior to claimant's work injury. (Tr. 13).

In August 1995, claimant began treating with Dr. Campbell, podiatrist, for the injury to her right foot. (Ex. 7). In April 1996, Dr. Campbell referred claimant to Dr. Zirschky, orthopedist, and Dr. Zirschky became claimant's attending physician. (Exs. 13-2, 14). In September 1996, Dr. Zirschky recommended surgery for claimant's right hallux valgus and bunion conditions. (Ex. 15-2).

Dr. Thompson, orthopedist, examined claimant at SAIF's request in September 1996. (Ex. 16).

Approximately one year after the work injury, claimant began noticing visible changes to her right foot, including inflammation of the right great toe. At about the same time, claimant also noticed more pain in her right great toe. (Tr. 12-13).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's condition was not compensable, finding the opinion supporting claimant's position to be legally insufficient to carry claimant's burden. We agree with the ALJ that claimant's condition is not compensable, but we do so based on the following reasoning.

The medical evidence establishes that claimant's right hallux valgus and bunion conditions preexisted the June 30, 1995 work injury to her right foot. (Exs. 17 at 7-8; 21-1). Dr. Zirschky also believes that claimant's preexisting conditions combined with the work injury trauma to her right foot, causing the preexisting conditions to become symptomatic and require treatment. (Ex. 21 at pp. 2-3). Therefore, claimant must establish the compensability of her right hallux valgus and bunion conditions under ORS 656.005(7)(a)(B).[1]

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[1] ORS 656.005 provides, in part:

"(7)(a) A 'compensable injury' is an accidental injury * * * rising out of and in the course of employment requiring medical services or resulting in disability or death; * * *

"* * * * *

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

Pursuant to ORS 656.005(7)(a)(B), claimant must establish that her work injury was the major contributing cause of her disability or need for treatment of the combined condition (symptomatic right hallux valgus and bunion). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta 764 (1997). Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993).

Only Dr. Zirschky opines that claimant's work injury was the major contributing cause of her need for treatment for the right hallux valgus and bunion conditions. Dr. Zirschky's opinion is based on claimant's history that her hallux valgus and bunion conditions worsened following the work injury. However, according to claimant's testimony, her hallux valgus and bunion conditions worsened about one year after the work injury. Dr. Zirschky's opinion gives no indication that he was aware that the worsening occurred one year after the traumatic injury to claimant's right foot, nor does he account for the delay. Because Dr. Zirschky's opinion is either based on incomplete information, or fails to fully account for claimant's history, we do not find his opinion persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986).

On the other hand, Drs. Thompson and Campbell believe that claimant's preexisting conditions and symptomotology are unrelated to the work injury. (Exs. 17-8; 20). They recognize that claimant's hallux valgus and bunion conditions became symptomatic a considerable time after the work injury. Because of the delay in the onset of symptoms, Dr. Thompson believed that claimant's symptomatic right hallux valgus and bunion conditions were not related to the work injury. Dr. Campbell agreed with Dr. Thompson's analysis and noted that claimant is at an age when hallux valgus and bunion formation can become symptomatic.

Because both Dr. Thompson and Dr. Campbell accounted for the delay in onset of claimant's hallux valgus and bunion symptoms, their opinions are more persuasive than Dr. Zirschky's conclusory opinion. Therefore, because neither Dr. Thompson nor Dr. Campbell believe that claimant's symptomatic hallux valgus and bunion conditions were related to the work injury, claimant has failed to establish that her work injury was the major contributing cause of her disability or need for treatment for those conditions. Accordingly, the ALJ's order is affirmed.

ORDER

The ALJ's order dated March 14, 1997 is affirmed.

In the Matter of the Compensation of
CHARLES D. GREENOUGH, Claimant
WCB Case No. 96-10574
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our August 13, 1997 order that reduced his scheduled permanent disability award for loss of use or function of the left arm to 2 percent (3 degrees). Claimant contends that we misinterpreted the arbiter panel's conclusion that his two point discrimination in the left hand was "less than 7 mm." (Ex. 24-3).

In order to consider this matter, we withdraw our August 13, 1997 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVE L. PIERSALL, Claimant
WCB Case No. 96-05500
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's denial of claimant's aggravation claim for a C5-6 herniated disc condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact,[1] which we briefly summarize as follows.

Claimant worked as a chip truck driver for the employer. The insurer accepted claimant's claim for left shoulder and cervical strains sustained in December 1992 in Oregon. In May 1993, claimant was declared medically stationary and the claim was closed by Notice of Closure without any award of permanent disability benefits. In the Fall of 1993, claimant sustained a scalp laceration after an assault. In October 1993, the cab and trailer of claimant's double-trailer truck fell over on the passenger side; claimant sustained a right scalp laceration, bilateral scapular pain, and right shoulder pain. Claimant denied neck pain or radicular symptoms, although he was subsequently diagnosed with tenderness in the neck.

In March 1994, claimant began driving flat-bed trucks for a New Mexico employer. On December 16, 1994, claimant experienced the sudden onset of right shoulder and neck pain and an acute muscle spasm in his neck after tarping a load. He sought emergency room treatment and was released to regular work on December 22, 1994.

In March 1995, claimant sought medical treatment, complaining of persistent, episodically worse left neck and shoulder pain. He was diagnosed with cervical myofascitis; x-rays revealed minimal disc degeneration at C5-6. In April 1995, claimant filed an injury claim against the New Mexico employer.

In January 1996, an MRI revealed a posterior herniated disc at C5-6, for which Dr. Bert recommended surgery. Claimant filed an aggravation claim which the insurer denied.[2]

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant failed to establish that his compensable 1992 neck injury was and remained the major contributing cause of his herniated disc condition. ORS 656.005(7)(a)(B). Citing Albany General Hospital v. Gasperino, 113 Or App 411 (1992), claimant first contends that the ALJ erred in applying the major contributing cause standard of proof, asserting that his disc herniation arose directly from the 1992 injury. We disagree, reasoning as follows.

ORS 656.273(1) provides, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." Thus, in order to

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[1] On June 4, 1997, we requested the insurer's counsel to forward pages 11, 12, 20, 21, 26 and 27 of Exhibit 31, which were received in evidence but missing from the record, to claimant's counsel for review and authentication within 21 days from the date of the letter. On June 12, 1997, we received the requested evidence from the insurer's counsel, which was copied to claimant's counsel. We have received no response from claimant's counsel and, therefore, assume claimant has no objection to their inclusion in the record.

[2] The insurer initially denied responsibility for the aggravation claim on the basis that a subsequent injury at the New Mexico employer was the cause of the C5-6 herniated disc. (Ex. 24). At hearing, the parties agreed that compensability of claimant's current disc condition was also at issue. (Tr. 4).

establish a compensable aggravation, claimant must prove two elements: (1) a compensable condition; and (2) an "actual worsening." ORS 656.273(1); Paul D. Rutter, 48 Van Natta 119 (1996); Gloria T. Olson, 47 Van Natta 2348, 2350 (1995). If the worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

Here, the insurer accepted a left shoulder and neck strain as a result of claimant's 1992 injury. Claimant's current condition has been diagnosed as a herniated disc at C5-6. Since claimant's herniated disc is not an accepted condition, in order to establish a worsened condition resulting from the original injury, he must first establish that the herniated disc is a compensable condition.

We first determine which provisions of ORS 656.005(7)(a) are applicable. Hewlett-Packard Co. v. Renalds, 132 Or App 288, 292 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Michelle K. Dibrito, 47 Van Natta 970 (1995) (it is our obligation as fact finder to apply the appropriate legal standards to determine compensability of a worker's claim).

On December 19, 1992, claimant injured his left shoulder and neck at the employer. On June 14, 1993, the insurer issued a Notice of Closure that awarded no permanent disability benefits.

In the Fall of 1993, claimant sustained a noncompensable scalp laceration after an assault. On October 26, 1993, claimant sustained a scalp laceration on the right and bilateral scapular pain, right shoulder pain, and tenderness in the neck after a truck rollover at the employer.

Claimant quit his job with the employer and went to work as a long-distance truck driver with a New Mexico employer. On December 16, 1994, he experienced the sudden onset of right shoulder and neck pain and neck spasm after tarping a load. He sought emergency room treatment and was released to regular work on December 22, 1994.

In March 1995, claimant sought medical treatment, complaining of persistent, episodically worse left side neck and shoulder pain. He was diagnosed with cervical myofascitis; x-rays revealed minimal disc degeneration at C5-6. In January 1996, an MRI revealed a posterior herniated disc at C5-6, for which Dr. Bert recommended surgery.

As noted above, x-rays revealed minimal disc degeneration at C5-6 in 1995. Drs. Watson and Arbeene, who first examined claimant for the insurer in March 1996, agreed that claimant had degenerative disc disease (DDD) at C5-6 with suggestive nerve root compression on the left. They opined that, by history, the DDD could have been present for the three and a half years since claimant's first symptoms were reported. The doctors also noted that there was no indication that a C5-6 herniated disc was caused by the December 1992 injury, as there was no medical evidence of neurological impairment at that time. (Ex. 23).

Dr. Klatt, who treated claimant for the 1992 neck and shoulder strain, also noted nothing in the contemporary record to establish radiculopathy or signs of a disc herniation resulting from the 1992 injury. Klatt was unable to state with reasonable medical probability that claimant's disc condition was caused or worsened by the 1992 injury. (Exs. 28; 30-15, -23, 24).

Dr. Bert, claimant's current attending physician, opined that claimant's herniated disc was caused by the 1992 incident. He based his opinion solely on the fact that, because claimant had no symptoms prior to 1992, the 1992 injury was the precipitating cause of claimant's herniated disc. (Ex. 31-20, -21). However, he also admitted that there was no contemporary medical evidence to support his opinion. (Ex. 31-23). Moreover, he stated that the 1992 injury, the 1993 assault and rollover incidents could each cause the herniated disc, and "suspected" that they each contributed to the herniated disc. (Ex. 31-20, -21).

Considering the passage of time and claimant's subsequent injuries, determination of the cause of claimant's condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In 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).

First, we agree with the ALJ that there is no persuasive medical evidence that claimant's degenerative condition preexisted and combined with his 1992 neck injury. ORS 656.005(7)(a)(B). The only doctor who opined that claimant's herniated disc arose directly from the 1992 injury is Dr. Bert. However, we do not find his opinion persuasive, as it is unsupported by the contemporary medical record. Consequently, claimant must establish that his compensable injury was the major contributing cause of the consequential herniated disc condition. ORS 656.005(7)(a)(A). This, claimant has failed to do.

As discussed by the ALJ, Dr. Bert identified three potential causes for claimant's herniated disc: the original 1992 injury; the 1993 off-the-job assault; and the 1993 roll-over injury. Moreover, Dr. Bert also agreed that the 1994 incident could have been sufficient to have herniated claimant's disc. Because claimant's herniated disc condition is subject to the major contributing cause standard, the persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined. See Dietz v. Ramuda, 130 Or App 397 (1994), rev den 321 Or 416 (1995). Moreover, the fact that a work injury precipitated a claimant's condition does not necessarily mean that the injury was the major contributing cause of the condition. Id.; see also Robinson v. SAIF, 147 Or App 157 (1997). Consequently, because Dr. Bert failed to evaluate the relative contribution of the aforementioned causes, claimant has failed to establish that his herniated disc condition is a compensable consequence of his 1992 injury.[3]

ORDER

The ALJ's order dated February 10, 1997 is affirmed.

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[3] Claimant also contends that the ALJ erred in requiring "certainty" of Dr. Bert in order to establish "major contributing cause." Although "certainty" is not required to establish "major contributing cause," Hutchson v. Weyerhaeuser, 288 Or 51, 55 (1979), Dr. Bert was unable to state with reasonable probability that the 1992 injury was the major contributing cause of claimant's disc condition. (Ex. 29). Moreover, Dr. Bert also reasoned that, based on claimant's lack of symptoms prior to 1992, the 1992 injury was the precipitating cause of claimant's herniated disc and need for surgery. (Ex. 31-20, -21). However, absent contemporary medical evidence to support that opinion, we understand Dr. Bert to be saying, at most, that the 1992 injury may have precipitated the onset of claimant's herniated disc. Given the presence of the other contributing factors, claimant has established no more than a possibility that the 1992 injury was the major contributing cause of his disc herniation. That is insufficient to meet his burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

In the Matter of the Compensation of
RICHARD J. ROCHA, Claimant
WCB Case No. 96-10131
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant[1] requests review of Administrative Law Judge (ALJ) Mills' order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

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[1] Although represented at the time of the hearing request and the withdrawal of that request, it is unclear whether claimant continues to be represented. In this regard, by letter dated March 18, 1997, claimant stated that he did not know if his attorney "will represent [him], it may not be worth his while[.]" We note that by letter dated April 24, 1997, Board staff notified the parties of the briefing schedule in this matter, indicated that it was unclear whether claimant continued to be represented, and sent a copy of that letter to claimant's attorney. No response was received from claimant's attorney. Moreover, we have no record that claimant's attorney withdrew his representation or that claimant terminated his attorney. Therefore, it remains unclear whether claimant continues to be represented.

FINDINGS OF FACT

On September 18, 1995, claimant signed a retainer agreement employing his attorney of record to represent him in connection with his workers' compensation claim. A provision of that retainer agreement stated that "I authorize my attorneys to sign my name and in all other respects to act for me in relation to my claim."

On November 7, 1996, claimant, through his attorney, requested a hearing regarding an Order on Reconsideration and raised the issue of an alleged math error in the calculation of loss of range of motion of the left knee. A hearing was scheduled for February 5, 1997.

By letter dated January 31, 1997, claimant's attorney withdrew the hearing request. On February 19, 1997, the ALJ dismissed claimant's hearing request.

By letter dated March 18, 1997, postmarked March 19, 1997, and received by the Board on March 21, 1997, claimant stated that his correspondence was "in regards to a hearing that was canceled [sic] by [his] attorney back in February." Claimant noted dissatisfaction with his attorney's action and stated that he did not know if his attorney would continue to represent him. He stated that his knee condition was worsening and that he was denied treatment from his doctor because of an unpaid medical bill. He requested that the Board reschedule another hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's hearing request. We treat claimant's March 18, 1997 letter as a request for review of that Order of Dismissal. In doing so, we emphasize that the sole issue before us is whether claimant's hearing request should have been dismissed.[2] Based on the following reasoning, we find the ALJ's dismissal order was appropriate.

By letter dated January 31, 1997, claimant's attorney withdrew the hearing request. In addition, the retainer agreement between claimant and his attorney authorized claimant's attorney to act on claimant's behalf. Finally, although it is not clear whether claimant continues to be represented, he does not allege that he was not represented by his attorney at the time in question. To the contrary, claimant acknowledges that his attorney requested that claimant's hearing request be withdrawn. (See claimant's letter dated March 18, 1997).

We find that the record establishes that claimant, through his attorney, withdrew his request for hearing. Although claimant is dissatisfied with his attorney's action, he does not dispute his attorney's authority to act on his behalf, nor does he dispute the fact that the ALJ dismissed his request for hearing on this claim in response to his former attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the dismissal order. William A. Martin, 46 Van Natta 1704 (1994); Mike D. Sullivan, 45 Van Natta 900 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

The ALJ's order dated February 19, 1997 is affirmed.

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[2] We note that the request for hearing was limited to the issue of an alleged math error in an Order on Reconsideration regarding the calculation of loss of range of motion of the left knee. In his March 18, 1997 letter, claimant also alleged that his knee condition was worsening and that he was denied treatment from his doctor because of an unpaid medical bill. However, the issue currently before us relates solely to the propriety of the ALJ's February 19, 1997 dismissal order of claimants hearing request contesting the Order on Reconsideration to the extent claimant's March 18, 1997 letter raises potential issues of aggression and medical issues, such issues are not subject to review at this time.

In the Matter of the Compensation of
DALE F. CECIL, Claimant
WCB Case No. 96-03412
ORDER ON REVIEW
Max Rae, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) declined to award an attorney fee under ORS 656.386(1) after finding that claimant established a compensable aggravation for a bilateral wrist condition; (2) declined to award procedural temporary disability benefits; and (3) declined to assess a penalty for allegedly unreasonable claims processing and discovery violations. The self-insured employer cross-requests review of those portions of the ALJ's order that: (1) held that claimant had perfected an aggravation claim; (2) found that claimant had established a compensable aggravation claim; and (3) awarded an "out-of-compensation" attorney fee. On review, the issues are claims processing, aggravation, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Aggravation

The ALJ found that claimant had perfected an aggravation claim and, on the merits, concluded that claimant had established an aggravation of his compensable bilateral wrist condition. We reverse.[1]

We need not decide whether claimant perfected an aggravation claim, because on the merits, claimant has not established that his compensable right wrist condition has "actually worsened," as required by ORS 656.273(1). We reach this conclusion based on the following reasoning.

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 that it is not 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.

Here, the record contains no medical evidence suggesting that claimant's right wrist condition pathologically worsened. Moreover, there is no direct medical evidence which established that the compensable condition has worsened. In this regard, the fact that Dr. Carter performed right wrist surgery on April 18, 1995 and subsequently retroactively authorized time loss benefits from that date are not direct medical evidence sufficient to establish an "actual worsening of claimant's compensable condition."[2] (Exs. 11, 25). SAIF v. Walker, 145 Or App at 305. Under these circumstances, claimant has not proven that his compensable bilateral wrist condition has "actually worsened" to support a reopening of his claim under ORS 656.273(1). Consequently, we reverse that portion of the ALJ's order which set aside the employer's "de facto" denial of claimant's aggravation claim.

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[1] In a related proceeding before the Workers' Compensation Division of the Department of Consumers and Business Services, claimant sought reclassification of his claim from nondisabling to disabling. (Ex. 24). The Department found that claimant's reclassification request was made more than one year after the date of injury so that the Department lacked jurisdiction to consider the request. See ORS 656.277. The Department's order cited to our decision in Donald R. Dodgin, 45 Van Natta 1642 (1993), for the proposition that claimant could "petition the Board to consider his request for reclassification of his claim." (Exs. 26 and 27). However, both at hearing and on review, claimant proceeds solely on the basis that he is entitled to "reopening" of his claim under ORS 656.273. We according limit our discussion to this issue.

[2] ORS 656.273(1)(a) and (b) provide that a worsened condition is not established by either an absence from work or inpatient hospitalization or a combination of those two events.

Because we have reversed the ALJ's order regarding the aggravation issue, claimant is likewise not entitled to the "out-of-compensation" attorney fee awarded by the ALJ.

Attorney Fee under ORS 656.386(1)

As a result of our conclusion that claimant has not established an aggravation, it follows that claimant has not prevailed over a "denied" claim. Consequently, for this reason, we affirm the ALJ's conclusion that claimant's counsel is not entitled to an assessed attorney fee pursuant to ORS 656.386(1).

Temporary Disability Benefits

We adopt and affirm the conclusions and reasoning set forth in the ALJ's order.

Penalties

We adopt and affirm the conclusions and reasoning set forth in the ALJ's order. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated September 26, 1996 is reversed in part and affirmed in part. That portion of the ALJ's order which found a compensable aggravation claim is reversed. The portion of the ALJ's order that awarded claimant's counsel an "out-of-compensation" attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
SHAWN R. STONE, Claimant
WCB Case No. 96-02481
ORDER ON RECONSIDERATION
Cole, Cary & Wing, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

On August 13, 1997, we withdrew our July 25, 1997 order that had affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's consequential condition/reflex sympathetic dystrophy claim. We took this action to retain jurisdiction to consider the parties' forthcoming settlement. Having received that agreement, we proceed with our reconsideration.

The parties have submitted a proposed "Disputed Claim Settlement Pursuant to ORS 656.289(4)," which is designed to resolve all issues raised or raisable between them in this case, as well as those issues pending in WCB Case No. 96-06052, another case that is pending Board review. Those portions of the settlement which pertain to issues pending in WCB Case No. 96-06052 have received ALJ approval.

Pursuant to the settlement, claimant agrees that the "denial is affirmed and the claims shall remain denied." The agreement further provides that claimant's hearing request "shall be dismissed with prejudice as to all issues raised or raisable at any time relating to the denied conditions."

We have approved those portions of the parties' settlement which pertain to issues pending in this case, thereby fully and finally resolving this dispute. Accordingly, in lieu of our prior orders, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
TWILA P. COLEMAN, Claimant
WCB Case No. 95-13301
ORDER ON RECONSIDERATION
Dennis O'Malley, Claimant Attorney
Scheminske, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our August 13, 1997 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that awarded claimant's counsel an assessed attorney fee of $4,500 for services at hearing in prevailing over the employer's denial of claimant's claim for a bilateral foot condition. The employer asserts that our order did not mention the attorney fee issue.

Contrary to the employer's assertion, our order did address the attorney fee issue by noting the employer's appeal of the ALJ's $4,500 assessed fee award. Although our order did not specifically address the employer's arguments that the fee award was excessive, it did "adopt and affirm the order of the ALJ." Thus, we adopted as our own the ALJ's conclusion that, "[a]fter considering the factors outlined in OAR 438-15-010(4)," claimant's counsel is entitled to an attorney fee of $4,500, payable by the employer. See O & O, p. 7. Implicit in that conclusion was our finding that $4,500 was a reasonable attorney fee for counsel's services, based on our consideration of the factors set forth in OAR 438-015-0010(4).

OAR 438-015-0010(4) provides that the following factors must be considered in determining a reasonable attorney fee: (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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

We review each of the factors. The compensability (of bilateral plantar fascitis) issue in this case was of average complexity. The value of the foot injury claim is significant, with present and potential future benefits. The benefits secured in prevailing on the claim, which include aggravation rights for future worsenings, are particularly valuable to claimant because her lifelong occupation as an emergency room nurse requires that she work on her feet. There was a significant risk that counsel's services might go uncompensated because the expert medical evidence was divided, with Dr. Gambee opining that the foot condition was due to preexisting conditions. Finally, counsel devoted considerable time to preparation for the hearing in this matter. The hearing was postponed once due to a medical emergency involving counsel's daughter; it was reconvened and continued for a deposition and recorded closing arguments. Although the employer did not cause the postponement, claimant's counsel's time in preparing again for the reset hearing, as well as the subsequent deposition and closing arguments, may be considered in determining a reasonable fee under OAR 438-015-0010(4)(a). See Marilyn M. Keener, 49 Van Natta 110 (1997).

Based on our consideration of the aforementioned factors, we find that the ALJ's attorney fee award of $4,500 was reasonable for counsel's services at hearing. Accordingly, our August 13, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 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
EDWARD B. DeROCHE, JR., Claimant
WCB Case Nos. 96-07875 & 96-06782
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) upheld the SAIF Corporation's denials (on behalf of Advanced Retail Products) of claimant's "new injury" claim for his lumbar and dorsal strain conditions; and (2) declined to assess a penalty for allegedly unreasonable denials. On review, the issues are compensability and penalties and attorney fees.

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

On review, claimant argues that the ALJ erred by not relying on the opinion of Dr. French, his treating physician. Specifically, claimant disagrees with the ALJ's conclusion that Dr. French did not have a complete history of claimant's prior back injuries. When informed of claimant's prior back injuries, Dr. French stated that his opinion regarding causation would not change unless claimant had experienced incapacitating pain or had sought treatment for the injuries. (Ex. 76-17).

The record shows that in 1988, claimant treated with a chiropractor for "severe low back pain for months, following a 1977 accident." Claimant was referred for treatment in 1988 because of "progressive pain" which worsened with inactivity or with prolonged standing and caused claimant to sleep poorly for months. Claimant was diagnosed with "chronic neck and back pain" and was provided with an exercise program and medication. (Ex. 12-3).

Under the circumstances, we are not persuaded by Dr. French's opinion, as it was premised on claimant not seeking treatment for prior back injuries. Additionally, we agree with the ALJ that it is unclear whether Dr. French had a complete and accurate history of claimant's prior injuries and back problems. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

Finally, Dr. French acknowledged that claimant had a preexisting degenerative condition which combined with the lumbar and thoracic strains. Dr. French also believed that claimant's obesity contributed to his condition. (Ex. 76). In light of these factors, we are not persuaded by Dr. French's conclusory opinion that the work strain is the major cause of claimant's need for treatment. (Ex. 70). See Dietz v. Ramuda, 130 Or App 397 (1994) rev dismissed 321 Or 416 (1995) (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).

Accordingly, for this additional reason, we agree with the ALJ that Dr. French's opinion is not persuasive, and claimant has failed to establish compensability.

ORDER

The ALJ's order dated March 31, 1997 is affirmed.

In the Matter of the Compensation of
LAURA D. GIRARD, Claimant
WCB Case No. 96-03090
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the insurer's denial of claimant's new medical condition claim for a cervical disc herniation; (2) upheld the insurer's aggravation denial for the same condition; and (3) found that claimant had abandoned her claims for interim compensation, penalties and attorney fees. On review, the issues are compensability, aggravation, interim compensation, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding the interim compensation, penalties and attorney fees issues.

On review, claimant argues that she did not abandon her claims for interim compensation and penalties and attorney fees arising out of the insurer's allegedly unreasonable claims processing. We need not resolve whether these issues were abandoned at hearing because even if they were preserved for review, claimant has not established any entitlement to such compensation and penalties.

At the beginning of the hearing, claimant's counsel asserted that claimant was entitled to interim compensation from February 26, 1996, the date that the insurer received a copy of claimant's aggravation claim signed by Dr. Cordes.[1] (Tr. 11). On review, claimant again asserts that the insurer was obligated to pay interim compensation from February 26, 1996 to March 21, 1996, the date she was released to regular work.

Under the aggravation statute, a 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 that satisfies the requirements of ORS 656.273(3). See Russell D. Parker, 49 Van Natta 83 (1997). ORS 656.273(3) requires that the claim for aggravation be in writing in a form and format prescribed by the Director and signed by the worker or the worker's representative. The statute further requires that the aggravation claim "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."

Here, the aggravation claim received on February 26, 1996 did not satisfy the requirements of ORS 656.273(3) because it was not accompanied by any medical report and Dr. Cordes specifically indicated that she "did not authorize time loss." Although the record also contains an aggravation claim signed by Dr. Goodwin, in which he checked "yes" to indicate that time loss was authorized, there is no evidence that this form was accompanied by a medical report satisfying the requirements of ORS 656.273(3). Even assuming that the insurer received this second claim form on or around February 26, 1996 and that Dr. Goodwin could be construed as claimant's attending physician at the time,[2] the date or dates of authorized time loss are not clear. Dr. Goodwin did not indicate when he signed the form and he listed only a single date in the time loss authorization box, December 26, 1995, the date of

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[1] In its May 13, 1996 denial of claimant's aggravation claim, the insurer acknowledged that it "first received a copy of the aggravation claim from Dr. Cordes on 2-26-96" but asserted that it had not received any medical evidence of a worsening of claimant's accepted cervical strain.

[2] An "attending physician" is the physician who is primarily responsible for the treatment of the worker's compensable injury. ORS 656.005(12)(b). Whether a physician qualifies as an attending physician is a question of fact. See Debbie I. Jensen, 48 Van Natta 1235 (1996). Here, claimant was treating with Dr. Cordes who referred her to Dr. Goodwin for a surgical consultation on December 26, 1995. Dr. Goodwin performed surgery on January 11, 1996 and treated claimant post-operatively through March 21, 1996.

claimant's first visit.[3] Because the record does not reflect when this form was signed by Dr. Goodwin or whether it was accompanied by medical evidence of a worsened condition attributable to the compensable injury, claimant has not established that the insurer was obligated to pay interim compensation between February 26 and March 21, 1996.

In view of the fact that claimant has not established an entitlement to interim compensation or the compensability of her C6-7 disc herniation, we need not consider her arguments concerning penalties and attorney fees.

ORDER

The ALJ's order dated March 10, 1997 is affirmed.

[3] Pursuant to ORS 656.262(4)(f), an attending physician's time loss authorization is effective to retroactively authorize temporary disability only 14 days prior to its issuance. Therefore, to the extent Dr. Goodwin intended to retroactively authorize time loss beginning December 26, 1995, he was statutorily prohibited from doing so.

In the Matter of the Compensation of
YVONNE PARAZOO, Claimant
WCB Case No. 96-09797
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our August 12, 1997 Order on Review that modified the Administrative Law Judge's (ALJ's) order awarding claimant 30 percent (40.5 degrees) scheduled permanent disability for loss of use or function of the left foot. The insurer has submitted a response to claimant's motion.

In her motion, claimant first asserts that, by adopting the ALJ's findings of fact, our order also adopted the ALJ's "ultimate" finding of fact that "claimant can walk or stand two hours or less cumulatively in an eight hour period of time." Claimant further contends that, consequently, this portion of the order is inconsistent with our order's conclusion finding more reliable the medical arbiter's opinion that claimant was not precluded from walking or standing for two hours or less during an 8-hour period.

Our order expressly adopted only the ALJ's "findings of fact." Because the ALJ's finding that claimant was limited to walking or standing for two hours during an 8-hour period was, as the ALJ termed it, an "ultimate finding of fact," our order did not adopt that portion of the ALJ's order. Consequently, we find no merit to claimant's argument.

Claimant also disputes our evaluation of the medical evidence, again contending that the treating physician provided the most reliable opinion. Our order sufficiently explained why we rejected this argument and we find it unnecessary to provide further discussion.

Accordingly, we withdraw our August 12, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our August 12, 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
VICKI D. POLLOCK, Claimant
WCB Case No. 94-10269
ORDER ON REMAND (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pollock v. Tri-Met, Inc., 144 Or App 431 (1996). The court has reversed our prior order, Vicki D. Pollock, 48 Van Natta 463 (1996), which affirmed the Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's aggravation claim for right shoulder bursitis. The court has remanded for reconsideration. On remand, the parties have submitted supplemental briefs. We now proceed with our reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. Claimant, a bus driver, filed three claims for injuries to her back, shoulders and arms between July 1993 and February 1994. The employer denied each claim, and claimant requested a hearing on each denial. Prior to the scheduled date of hearing (June 14, 1994), the parties entered into an oral agreement to settle the claims. Under the terms of the agreement, the employer agreed to rescind its denials and accept claimant's conditions under one nondisabling injury claim.

Meanwhile, in June 1994, claimant began working split shifts due to increased customer demand. During the afternoon shift, she drove route #78, a particularly busy route. There were more turns required on the route, and she was unable to get adequate rest breaks or sleep. After the shift change, claimant developed worsening pain in the neck, right upper back and right shoulder area. On June 29, 1994, prior to the execution of the parties' written settlement agreement, claimant returned to her attending physician, Dr. Parshley. The doctor diagnosed "[r]eexacerbation of her previous musculoskeletal injury secondary to change of her job status and job description," and released her from work for one week. (Ex. 26AA-1). Claimant's condition improved while off work and she continued to follow up with Dr. Parshley in July 1994.

The parties executed a Stipulation and Order in July 1994 which was approved by an ALJ on July 26, 1994. The terms of the written agreement were consistent with the parties' oral agreement. The written agreement stated in part that "claimant agrees that all her requests for hearing, and all issues that have been or could be raised at this time are hereby deemed settled by this settlement agreement." (Ex. 26A-2).

On August 1, 1994, claimant returned to Dr. Parshley with worsening right shoulder pain. She was prescribed anti-inflammatories. On August 19, 1994, the employer denied the aggravation claim. Claimant requested a hearing which is the subject of this review.

At hearing, the employer contended that claimant's aggravation claim was barred by the terms of the prior Stipulation and Order. The ALJ agreed, reasoning that, because the "reexacerbation" of claimant's right shoulder condition was diagnosed and claimant was released from work prior to the July 26, 1994 approval of the stipulation, the aggravation claim could have been raised and negotiated before the stipulation's approval.

We affirmed. Vicki D. Pollock, 48 Van Natta at 463. Citing Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994) and a prior Board case, we stated that, although there was no evidence that the employer received notice of claimant's aggravation claim prior to approval of the stipulation, claimant was aware of a potential dispute concerning her aggravation claim prior to the stipulation. Therefore, we concluded that the aggravation claim was an issue that "could have been raised" by claimant before approval of the stipulation.

The court disagreed with our analysis. Reasoning that settlement agreements are contracts and therefore implicate general principles of contract law, the court stated that, when such an agreement is ambiguous, the interpretation of the agreement is a question of law to be decided by a court based on an examination of the terms of the agreement as a whole. The court further stated that the construction of such an agreement should render, if possible, all of its provisions harmonious and carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. Noting that we did not undertake to ascertain the intent of the parties at the time of their settlement, the court instructed us on remand to construe the parties' settlement in such a way as to carry into effect their purpose and intent at the time of the agreement.

On remand, the threshold issue is whether, by entering the stipulation, the parties intended to resolve claimant's aggravation claim for an allegedly worsened right shoulder condition that required treatment and resulted in disability beginning June 29, 1994. To resolve this issue, we must ascertain the parties' intent by applying standard rules of contract construction. See Taylor v. Cabax Saw Mill, 142 Or App 121, 124 (1996); Trevitts v. Hoffman-Marmolejo, 138 Or App 455, 459 (1996). Generally, that application consists of two steps, beginning with a determination whether, as a matter of law, the terms of the agreement are ambiguous and, if so, proceeding to a determination of the "objectively reasonable construction of the terms" in the light of the parties' intentions and other extrinsic evidence. Taylor, 142 Or App at 125; Williams v. Wise, 139 Or App 276, 281 (1996).

The stipulation states in part:

> "IT IS HEREBY STIPULATED AND AGREED that the parties, now wishing to resolve all issues relating to all of claimant's request for hearings (August 13, 1993; September 7, 1993; & March 15, 1994) agree to the following.
>
> [The terms provide that the employer shall rescind its denials dated July 27, 1993, August 27, 1993 and March 10, 1994 and process the claims under one nondisabling injury claim and, in addition, that the employer shall pay claimant the sum of $2,500 "in settlement and compromise of her claim" and her attorney a carrier-paid fee of $1,500 "for his efforts in obtaining recision [sic] of the denials."]
>
> "IT IS FURTHER STIPULATED AND AGREED that, in consideration for the above, claimant agrees that all her requests for hearing, and all issues that have been or could be raised at this time are hereby deemed settled by this settlement agreement." (Ex. 26A-2).

The first quoted paragraph states that it was the parties' intention to resolve all issues relating to claimant's hearing requests dated August 13, 1993, September 7, 1993 and March 15, 1994. The issues relating to claimant's hearing requests are set forth in the first page of the agreement, which explains that claimant filed the hearing requests to contest the employer's denials of her initial claims for injuries to the neck, shoulders and arms, and an aggravation claim arising from those injuries. Those denials are dated July 27, 1993, August 27, 1993 and March 10, 1994 and, thus, predate claimant's alleged worsening in June 1994. Because the issues addressed by the first quoted paragraph concern denials that predated claimant's June 1994 aggravation claim, this portion of the agreement does not evidence an intention by the parties to settle any issues relating to the June 1994 aggravation claim.

There is, however, some ambiguity in the language of the last paragraph of the agreement. In the last paragraph, the parties agreed that, in consideration for the employer's acceptance of claimant's injury claim and its payment of monies to claimant and her attorney, "claimant agrees that all her requests for hearing, and all issues that have been or could be raised at this time are hereby deemed settled by this settlement agreement." (Ex. 26A-2, emphasis supplied). According to the employer, the last paragraph states the parties' intention to settle all issues that were raised or could have been raised prior to the date of the agreement, including the June 1994 aggravation claim, not just the issues relating to claimant's hearing requests. We disagree for the following reason.

The agreement does not specify what "raised or raisable" issues are deemed settled under the agreement. While the employer asserts that the parties intended to settle all issues that could have been raised prior to the date of the agreement, including issues not related to claimant's hearing requests, the agreement itself does not state that intention. The "raised or raisable issues" language, when read harmoniously with the provisions addressing claimant's hearing requests, could reasonably be

interpreted as stating an intention to settle all "raised or raisable" issues relating to claimant's hearing requests, i.e., issues arising from the denials that predated the June 1994 aggravation claim. Because the agreement does not clarify whether the parties intended to settle only "raised or raisable" issues relating to the hearing requests or whether they intended to settle all "raised or raisable" issues that arose prior to the date of the agreement, we find that the language of the agreement is ambiguous.

Therefore, we look to extrinsic evidence of the parties' intentions to determine the "objectively reasonable construction" of the terms of the agreement. See Taylor, 142 Or App at 125; Williams, 139 Or App at 281. There is extrinsic evidence that the parties entered into an oral agreement to settle before the scheduled date of hearing (June 14, 1994). Under the terms of the oral agreement, the employer agreed to rescind its denials and accept claimant's conditions under one nondisabling injury claim. Those terms were eventually recorded in the written agreement that the parties executed in July 1994. Because the parties reached their oral settlement agreement before June 29, 1994, the date claimant sought treatment and was released from work for an allegedly worsened shoulder condition, we conclude that the existence of the June 1994 aggravation claim was unknown to either claimant or the employer at the time they entered their oral agreement.

In addition, there is no evidence that the employer received notice of the aggravation claim prior to the ALJ's approval of the stipulation on July 26, 1994. Exhibit 26AA-1 is a copy of Dr. Parshley's June 29, 1994 chart note, which reports claimant's increased shoulder complaints and releases her from work; it does not bear any date stamp to indicate when the employer received it, nor is there any evidence of when it was received by the employer.

Because the June 1994 aggravation claim was not in existence at the time the parties orally agreed to settle, and we do not find that the employer received notice of an aggravation claim prior to the ALJ's approval of the written agreement, we conclude that the June 1994 aggravation claim was not among the "raised or raisable issues" that were contemplated by the parties' settlement agreement. Accordingly, we conclude that the June 1994 aggravation claim was not barred by the terms of the agreement.[1]

The employer argues that it is immaterial when it received notice of the aggravation claim. It argues that because claimant was aware of the aggravation claim prior to approval of the written agreement and therefore knew of a "potential dispute" concerning the claim, it was a "raisable" issue that was settled under the terms of the written agreement. The employer's proposed analysis, which we applied on review in this matter, was expressly rejected by the court. The court has instructed us, instead, to "construe the parties' settlement in such a way as to carry into effect their express purpose and intent at the time of the agreement." (Emphasis supplied.) By focusing our attention to "their" (i.e., the parties') intent, the court is presumably reiterating the general principle of contract law that an agreement, such as the stipulation in question, is a "negotiated, signed, meeting of the minds, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party." Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993). Here, because the June 1994 aggravation claim was not in existence at the time the parties orally agreed to settle, and the employer apparently did not receive notice of the June 1994 aggravation claim prior to approval of the written settlement, we conclude there could not have been a "meeting of the minds" to resolve that issue pursuant to the agreement.

Having determined that claimant's aggravation claim was not precluded by the parties' stipulation, we turn to the merits of the claim. To begin, we reject the employer's contention that claimant intentionally caused the alleged worsening of her shoulder condition by electing to work split shifts and is therefore barred from receiving compensation pursuant to ORS 656.156(1). Claimant testified that she elected to work the split shifts in June 1994 because of its convenience for her and her family. She explained that the split shifts allowed her and her husband, who also worked for the employer, to drive to work together in one car. (Tr. 10-11). After claimant completed her first split shift, she would use the car to get something to eat, and then she would return for her second shift.

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[1] Claimant submitted new evidence on remand that was not previously submitted at hearing. She also requested that this matter be remanded to the ALJ for the purpose of taking testimony regarding the parties' intentions in entering the stipulation. Because we have concluded that claimant's aggravation claim is not barred by the terms of the stipulation, we do not need to address claimant's remand request, nor do we need to consider the additional evidence submitted on remand.

(Id.) When her husband completed his shift in the afternoon, he would drive home to be with their children until claimant completed her shift. (Id.) Based on claimant's unrebutted testimony, we do not find that claimant deliberately intended to cause any alleged worsening of her shoulder condition.

Turning to an application of ORS 656.273, we note that the hearing in this matter was held prior to the June 7, 1995 effective date of the 1995 amendments to ORS 656.273, the aggravation statute. Or Laws 1995, ch 332, § 31. Those amendments apply retroactively to this case. See Volk v. America West Airlines, 135 Or App 565 (1995).

Before the amendments to ORS 656.273, a worker could establish an aggravation claim by showing worsened symptoms without showing a worsening of the underlying compensable condition. See Perry v. SAIF, 307 Or 654 (1989); Gwynn v. SAIF, 304 Or 345, 353 (1987). Amended ORS 656.273(1) now requires that the worker prove, by medical evidence supported by objective findings, an "actual worsening" of the compensable condition since the last award or arrangement of compensation. "Actual worsening" requires direct medical evidence of a pathological worsening of the compensable condition. SAIF v. Walker, 145 Or App 294, 305 (1996). If an aggravation claim is based on increased symptoms, a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. Id.

The present record includes some medical evidence addressing claimant's complaints and whether such symptoms and / or claimant's current condition represents a worsening (pathological or otherwise) of her compensable right shoulder muscle strain. Notwithstanding such evidence, where, as here, the "actual worsening" standard of amended ORS 656.273(1) has become retroactively applicable concerning a case that we are reviewing on remand from the court, we generally find a compelling reason to remand the case to the Hearings Division for further development of the record. See Stanley Meyers, 48 Van Natta 1776 (1996).

Consistent with the general principle enunciated in Meyers and because we consider the present record insufficiently developed to resolve the question of whether claimant's compensable right shoulder muscle strain condition has "actually worsened" under the amended ORS 656.273(1) and Walker standard, we find a compelling reason to remand this matter to the Hearings Division for further evidence taking. See ORS 656.295(5); Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Stanley Meyers, 48 Van Natta at 1778.

Accordingly, the ALJ's order dated May 18, 1995 is vacated and this matter is remanded to the Presiding ALJ for assignment to an ALJ for further proceedings to be conducted in any manner that will achieve substantial justice. Thereafter, the assigned ALJ shall issue a final, appealable order regarding the aggravation claim.

IT IS SO ORDERED.

In the Matter of the Compensation of
LANCE D. FARLEIGH, Claimant
WCB Case Nos. 96-06376, 96-03531, 95-10308 & 96-02976
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Lundeen, et al, Defense Attorneys
Steven T. Maher, Defense Attorney
Jerome P. Larkin (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer, Barrett Business Services (Barrett), requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for a bilateral hearing loss condition; (2) upheld denials of responsibility for the same condition from the SAIF Corporation, on behalf of Central Oregon Utility Contractors (COUC/SAIF); Liberty Northwest Insurance Corporation (Liberty) on behalf of Central Oregon Utility Contractors (COUC/Liberty); and Liberty on behalf of Henkels & McCoy, Inc. (Henkels/Liberty). On review, the issue is responsibility.

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

During claimant's employment at COUC, Liberty provided workers' compensation coverage from October 1, 1987 to October 1, 1991. SAIF's coverage began October 1, 1991 and continued through the time claimant left COUC's employ at the end of December 1994. (Exs. 40, 41, 43, Tr. 73-74). Claimant was employed by Barrett, a temporary employment agency, from April 10, 1995 to June 23, 1995, during which time he was assigned to work for Mr. Dixon, a contractor. (Tr. 17, 63). Claimant's work for Dixon was mostly full time, although there was some part time work. (Tr. 31, 63).

On review, Barrett argues that the ALJ erred in applying the last injurious exposure rule to assign it responsibility because the record establishes actual causation against claimant's employment with COUC. We disagree.

The last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. Bracke v. Baza'r, 293 Or 239, 248-49 (1982). In addition, application of the last injurious exposure rule is the same in cases involving successive insurers as in those involving successive employers. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). 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).

Because of claimant's multiple work exposures, the causation issue presents a complex medical question requiring competent medical evidence. Uris v. Compensation Department, 247 Or 420 (1967). There are only two medical opinions that address the causation issue: those of Dr. Friess, treating otolaryngologist, and Dr. Ediger, examining audiologist. Both Drs. Friess and Ediger examined claimant only once.

For the reasons explained by the ALJ, we find that the record does not establish actual causation with regard to any specific work exposure. In addition, although Dr. Ediger found that the major contributing cause of claimant's hearing loss was excessive noise exposure, he was unable to identify, in terms of reasonable medical probability, the specific work exposure that was the major contributing cause of claimant's hearing loss. (Exs. 25). In this regard, Dr. Ediger noted that important information helpful in determining the major contributing cause of claimant's hearing loss was not available, such as hearing test information at the time claimant began working for COUC and noise level studies at COUC. (Ex. 25-5). Dr. Ediger stated that "[a]vailable information does not rule out the possibility that noise exposure during his work for Central Oregon Utility caused his hearing to worsen, and in fact was the major contributing cause of present hearing loss." (Ex. 25-6 (emphasis added)). However, because

claimant had received hearing tests only in recent months, Dr. Ediger stated that "it is not possible to determine when [claimant's] hearing loss occurred, except that it apparently did not occur during the past month when he has been working for Henkels and McCoy [Henkels/Liberty]." Id. Finally, Dr. Ediger stated that "available information suggest[s] that [claimant] experienced greater noise exposure at Central Oregon Utility than he did from other noise exposure sources[,]" noting that he worked there longer and did not wear hearing protection during the first two years of operating heavy equipment. Id.

Given the various qualifying terms/reasoning Dr. Ediger used in rendering his opinion, we find that his opinion established only the possibility that claimant's work at COUC was the major contributing cause of claimant's hearing loss. However, medical possibility is insufficient. See Gormley v. SAIF, 52 Or App 1055 (1981) (physician's opinion framed in terms of possibility, rather than probability, found unpersuasive). Moreover, as the ALJ found, Dr. Ediger did not distinguish between the exposure at COUC/Liberty and COUC/SAIF.

Furthermore, to the extent that Dr. Friess stated that the major contributing cause of claimant's hearing loss was the noise exposure at COUC prior to the time claimant started wearing hearing protection on a "regular basis" in 1990/1991, we agree with the ALJ that this opinion is unpersuasive because it is based on an inaccurate history. (Ex. 42, Tr. 35, 37, 39, 40, 53, 54). Therefore, on this record, we find that actual causation of claimant's hearing loss is not established.

Since actual causation has not been established, we find that the ALJ properly resorted to the last injurious exposure rule to determine responsibility. When, as here, a claimant is not actually disabled from work, the "triggering event" for initial assignment of responsibility is the date when claimant first seeks medical treatment for the condition. Bracke v. Baza'r, 293 Or at 248; Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994); Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

The ALJ found that claimant first sought medical treatment on May 30, 1995, when he was examined by Dr. Friess. Citing Donald J. Boies, 48 Van Natta 1259 (1996), and Norman L. Selthon, 45 Van Natta 2358 (1993), the ALJ found that a hearing test claimant received in a shopping center mall in 1994 did not constitute medical treatment for the purposes of assigning liability. We agree.

On review, Barrett argues that Boies and Selthon are distinguishable in that those cases held that audiometric tests obtained pursuant to OSHA requirements do not constitute medical treatment for purposes of determining onset of disability. Barrett argues that, here, the hearing test was not mandated by OSHA, rather, claimant sought the 1994 hearing test to get treatment for his hearing loss. Barrett further argues that, but for the fact that claimant could not afford a hearing aid at that time, he would have purchased one. Barrett argues that this establishes claimant first sought medical treatment in 1994 when COUC/SAIF was on the risk. We disagree.

Claimant testified that he had his hearing tested in 1994 at a store in a shopping center mall. (Tr. 49, 64-68). After the testing, claimant received a report and was told he needed a hearing aid. Id. However, the store has since gone out of business and claimant was unable to find the report in his records. Id. We do not find that this type of self-help represents medical treatment. In this regard, there is no indication regarding the qualifications of the tester. Compare Charles R. Morgan, 48 Van Natta 841 (1996) (Board found that the claimant had sought medical treatment from a physician regarding his compensable hearing loss and the date of that treatment established the "onset of disability," even assuming there was a problem with the audiogram performed by an audiologist in the physician's office). Without more, there is no evidence that claimant sought medical treatment for his hearing loss when he underwent testing in 1994 at a shopping center mall. To hold otherwise, would result in finding that almost any self-help measure constitutes seeking medical treatment.

Accordingly, we agree with the ALJ that claimant first sought medical treatment on May 30, 1995, when he was examined by Dr. Friess. At that time, Barrett was on the risk; therefore, Barrett is initially assigned responsibility under the last injurious exposure rule.

On review, Barrett argues that responsibility shifts to COUC/SAIF. We disagree. Barrett 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 hearing loss, or that it was impossible for conditions while Barrett was on the risk to have caused that condition. See Roseburg Forest Products v. Long, 325 Or 305 (1997); FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App at 374. For the reasons discussed above, the evidence does not establish that employment at COUC/SAIF (or COUC/Liberty) was the sole cause of claimant's hearing loss. Furthermore, because both Drs. Ediger and Friess stated that employment conditions at Barrett could have caused a hearing loss, Barrett has not established that it was impossible for conditions while Barrett was on the risk to have caused claimant's hearing loss. (Exs. 29, 42).

Barrett argues that Dr. Ediger changed his opinion when he agreed that, if claimant wore hearing protection when around saws, then the Barrett exposure did not contribute to claimant's hearing loss. (Ex. 45). However, Barrett overlooks the fact that the standard it must prove under the last injurious exposure rule is not whether its work exposure actually caused the condition, but whether it was impossible for its work exposure to cause the condition. Donald J. Boies, 48 Van Natta at 1261. Here, the evidence does not meet that standard. Therefore, we agree with the ALJ that responsibility remains with Barrett.

ORDER

The ALJ's order dated January 23, 1997 is affirmed.

In the Matter of the Compensation of
REED HANKS, Claimant
WCB Case No. 96-04004
ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our August 26, 1997 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that: (1) upheld the SAIF Corporation's denial of claimant's diabetes condition; and (2) declined to assess a penalty for allegedly unreasonable claims processing. Additionally, the order awarded an assessed fee to claimant's attorney of $3,000 for services at hearing and on review.

In moving for reconsideration, claimant contends that his counsel submitted a statement of services requesting an attorney fee of $8,000. Claimant further asserts that SAIF submitted an objection to the request, arguing that a fee of $3,500 was reasonable.

After again examining the file, we find an absence in the record of either claimant's counsel's submission or SAIF's objections. In order to further consider this matter, we withdraw our August 26, 1997 order and ask that the parties submit these materials, along with their respective arguments concerning the amount of the assessed attorney fee. Those written positions and submissions should be presented in accordance with the following supplemental briefing schedule.

Claimant's opening supplemental brief must be filed within 14 days of the date of this order. SAIF's supplemental respondent's brief must be filed within 14 days from the date of mailing of claimant's opening supplemental brief. Claimant's supplemental reply must be filed within 14 days from the date of mailing of SAIF's supplemental respondent's brief. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDMUND D. MOORE, Claimant
WCB Case Nos. 96-03437, 96-02024, 95-12030, 95-09425,
95-06334, 95-05533, 95-05532, 95-05531, 95-05530 & 95-03174
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's March 14, 1995 injury claim for an acute thoraco-cervical strain/sprain; (2) set aside its denial of claimant's June 16, 1995 injury claim for a lumbosacral and thoracic strain/sprain; (3) set aside its denial of claimant's December 26, 1995 injury claim for a head contusion; (4) set aside its denial of claimant's January 27, 1996 injury claim for a lumbosacral strain; (5) assessed penalties for the employer's allegedly unreasonable denials of the December 26, 1995 and January 27, 1996 claims; (6) directed the employer to pay temporary disability benefits from June 7, 1994 to August 15, 1994, and from August 27, 1994 to September 25, 1994; and (7) assessed penalties for the employer's allegedly unreasonable failure to pay temporary disability benefits from June 7, 1994 to August 15, 1994 and from August 27, 1994 to September 25, 1994. Claimant cross-requests review of that portion of the ALJ's order that upheld the employer's denial of his March 12, 1995 injury claim for prescription sunglasses. On review, the issues are compensability, temporary disability and penalties.

We adopt and affirm the ALJ's order, except for that portion of the order concerning claimant's temporary disability benefits from June 7, 1994 to August 15, 1994, and from August 27, 1994 to September 25, 1994. We replace that portion of the ALJ's order with the following:

Temporary Disability - WCB No. 95-05530

A June 28, 1995 Notice of Closure awarded claimant temporary total disability from December 23, 1993 to December 26, 1993; temporary partial disability from December 27, 1993 to September 25, 1994; and temporary total disability from September 26, 1994 to November 23, 1994. (Ex. 85). Claimant requested reconsideration, objecting to the impairment findings and the unscheduled permanent disability. (Ex. 85A). The October 2, 1995 Order on Reconsideration increased claimant's unscheduled permanent disability and affirmed the other portions of the Notice of Closure. (Ex. 85B). Neither party appealed the Order on Reconsideration.

At hearing, claimant asserted that this was an enforcement proceeding of the Notice of Closure. (Tr. 27, 28). Claimant argues that the employer did not pay temporary disability from June 7, 1994 to August 15, 1994, and from August 27, 1994 to September 25, 1994.

The ALJ found that Dr. Sedgewick had authorized time loss from May 18, 1994 to August 15, 1994, and the medical evidence showed that claimant was totally disabled by a shoulder injury during that time period. The ALJ concluded that claimant was entitled to temporary disability compensation from June 7, 1994 to August 15, 1994 and assessed a penalty for the employer's unreasonable failure to pay compensation. The ALJ also concluded that claimant was entitled to temporary disability compensation from August 27, 1994 to September 25, 1994 and assessed a penalty for the employer's unreasonable refusal to pay compensation.

The employer argues, among other things, that the period of time loss was covered in the June 28, 1995 Notice of Closure as temporary partial disability. The employer contends that claimant did not challenge this designation as part of the reconsideration process and, therefore, is precluded from raising the issue at this time. (Exs. 85, 85A, 85B).

Claimant agrees that the Notice of Closure is now final. He contends that the employer cannot contest the time loss award because it did not previously contest it by issuing an amended Notice of Closure or pursuing the issue on reconsideration. Claimant asserts that the ALJ is merely enforcing the Notice of Closure.

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); Jack M. Tucker, 49 Van Natta 287 (1997).

Here, the June 28, 1995 Notice of Closure included an award of temporary partial disability from December 27, 1993 to September 25, 1994. (Ex. 85). Although claimant requested reconsideration of the Notice of Closure, he did not object to the temporary total or temporary partial disability dates. Rather, he objected only to the impairment findings and the unscheduled permanent disability. (Ex. 85A). The October 2, 1995 Order on Reconsideration increased claimant's unscheduled permanent disability award and affirmed the other portions of the Notice of Closure. (Ex. 85B). Neither party appealed the Order on Reconsideration and the temporary disability dates in the Notice of Closure became final by operation of law. Consequently, the Notice of Closure has become, in effect, a "final judgment" that disposed of the temporary disability issue. See, e.g., Jack M. Tucker, 49 Van Natta at 289. As such, both the employer and claimant are barred from further litigating issues regarding the temporary disability benefits awarded in the June 28, 1995 Notice of Closure.[1]

Moreover, ORS 656.283(7) provides, in part: "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself." ORS 656.268(8) also provides that: "No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." Here, the issue of claimant's entitlement to temporary disability benefits was not raised on reconsideration and the issue did not "arise out of" the reconsideration order.

Nevertheless, claimant may seek enforcement of the June 28, 1995 Notice of Closure. See Jeld-Wen, Inc. v. Bartz, 142 Or App 433, 436 (1996) (the claimant was allowed to seek enforcement of the Board order requiring the carrier to pay temporary disability benefits, even though the Board order was a final order). We conclude that the employer should pay temporary partial disability benefits from June 7, 1994 to August 15, 1994, and from August 27, 1994 to September 25, 1994, as awarded by the Notice of Closure. (Ex. 85).

Claimant contends that the ALJ properly assessed a penalty for the employer's allegedly unreasonable failure to pay temporary disability benefits. 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).

The June 28, 1995 Notice of Closure was prepared by the employer. As we discussed earlier, the Notice of Closure has become final. The employer's contention that claimant is not entitled to such compensation does not persuade us that the employer had a legitimate doubt regarding its duty to comply with the Notice of Closure. See Mary J. McKenzie, 48 Van Natta 473 (1996); Imre Kamasz, 47 Van Natta 332, 334 (1995). Under these circumstances, we affirm the ALJ's assessment of a penalty for the employer's failure to pay temporary partial disability benefits from June 7, 1994 to August 15, 1994, and from August 27, 1994 to September 25, 1994.

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for services on review concerning the compensability of the March 14, 1995, June 16, 1995, December 26, 1995 and January 27, 1996 injury claims. ORS 656.382(2). Claimant's attorney has submitted an affidavit, requesting an assessed fee of $2,750. He asserts that his actions in preparing claimant's brief included the review of 135 exhibits and the 305 page transcript.

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[1] Under these circumstances, we do not address the employer's argument that it should not have to pay temporary disability compensation because Dr. Sedgewick's chart notes do not establish that claimant was unable to work and the employer's contention that Dr. Sedgewick may not authorize time loss retroactively.

The employer contends that claimant's attorney fee request is excessive and the fee should be no more than $1,000. Although the employer argues on review that the issues are not complex, in its closing argument at hearing, the employer stated: "[T]he employer would note the complexity associated with this matter because it involves so many industrial injury claims within a short period of time." (Employer's Closing Argument at 1). The employer asserts that the value of the claims in question are relatively small and there is nothing extraordinary about the number of exhibits in this case.

We consider the amount of claimant's counsel's attorney fee by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the 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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. Based upon our application of the aforementioned factors and considering the parties' arguments, we find that a reasonable fee for claimant's attorney's services on review is $2,000, payable by the self-insured employer.[2] Claimant is not entitled to an attorney fee for services on review concerning the unsuccessful cross-request regarding the March 12, 1995 injury, the unsuccessful defense of the ALJ's temporary total disability award, or the penalty and attorney fee issues. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated January 16, 1997 is modified in part and affirmed in part. In lieu of the ALJ's award of temporary total disability from June 7 to August 15, 1994 and from August 27 to September 25, 1994, claimant is awarded temporary partial disability for those same periods. The ALJ's "out-of-compensation" attorney fee is modified accordingly. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,000, payable by the self-insured employer.

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[2] Although claimant's attorney has submitted an affidavit in support of an attorney fee, his attorney did not file a request describing in detail how the relevant factors applied to this case. See OAR 438-015-0029(2)(b) (the attorney fee request shall be considered by the Board if the "request describes in detail the manner in which the factors set forth in OAR 438-015-0010(4) specifically apply to the case"). Consequently, although we have considered claimant's specific request (but found it less than probative), we have primarily relied on the factors in OAR 438-015-0010(4), as supported by the record, in determining an appropriate attorney fee. In particular, we have considered the time devoted to the case (as represented by the record), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

In the Matter of the Compensation of
BENJAMIN G. SANTOS, Claimant
WCB Case No. 96-01407
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Neal's order that directed it to recalculate claimant's unscheduled permanent disability award at the higher rate in accordance with amended ORS 656.214(6). In his respondent's brief, claimant contends that he is entitled to a penalty for SAIF's allegedly unreasonable resistance to the payment of compensation. On review, the issues are rate of unscheduled permanent disability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact, we change the third sentence to read: "Claimant's overpaid time loss compensation was deducted from his permanent partial disability award and claimant was paid the balance of the $5,760 due, or $1,216.95." In the second paragraph, we change the seventh sentence to read: "On September 27, 1994, the Workers' Compensation Board affirmed Referee Lipton's Opinion and Order. Benjamin G. Santos, 46 Van Natta 1912 (1994)."

CONCLUSIONS OF LAW AND OPINION

We briefly review the procedural history of the claim. Claimant sustained a compensable lumbar strain on January 7, 1991. The claim was closed by a January 6, 1993 Determination Order that found claimant medically stationary as of December 5, 1991, and awarded claimant 18 percent unscheduled permanent partial disability (PPD). (Ex. 5). Claimant's overpaid time loss compensation was deducted from his PPD award and claimant was paid the balance of the $5,760 due, or $1,216.95. (Exs. 5A, 5B). Claimant contested the deduction of time loss. On April 28, 1993, Referee Davis found that claimant was entitled to temporary disability compensation for the period December 6, 1991 through October 14, 1992. (Ex. 6). The April 28, 1993 Opinion and Order was later abated. (Ex. 7). On reconsideration, Referee Davis eliminated the award of time loss from December 6, 1991 through October 14, 1992. (Ex. 11).

Claimant also appealed the PPD award. A September 22, 1993 Order on Reconsideration reduced claimant's unscheduled PPD to 17 percent (54.4 degrees) and awarded time loss through December 5, 1991. (Ex. 9). Based on the Order on Reconsideration, SAIF calculated an overpayment of $320. (Ex. 10A).

Claimant appealed the September 22, 1993 Order on Reconsideration. On January 13, 1994, Referee Lipton affirmed the Order on Reconsideration and approved an offset for the $320 overpayment from future awards of permanent disability compensation. (Ex. 13). On September 27, 1994, the Board affirmed Referee Lipton's Opinion and Order. Benjamin G. Santos, 46 Van Natta 1912 (1994). Claimant appealed to the Court of Appeals. On January 24, 1996, the Court of Appeals affirmed as to the rating of impairment, but remanded to the Board for reconsideration of the temporary disability award. Santos v. Caryall Transport, 138 Or App 701 (1996). On July 10, 1996, the Board issued its order on remand, which addressed the temporary disability issue. Benjamin G. Santos, 48 Van Natta 1516 (1996). Claimant has appealed that order.

On February 5, 1996, claimant requested a hearing concerning the rate of unscheduled PPD. The ALJ concluded that claimant's award of unscheduled PPD awards should be paid at the higher rate set forth in the 1995 amendments to ORS 656.214(6).

Before the 1995 amendments, ORS 656.214(5) provided that, for unscheduled permanent disability awards, "the value of each degree of disability is $100." Amended ORS 656.214(6) now provides, in part:

"For injuries for which the disability is determined pursuant to subsection (5) of this section, the worker shall receive an amount equal to:

"(a) When the number of degrees stated against the disability is equal to or less than 96, $117.47 times the number of degrees."

The issue in this case is whether claimant's 17 percent (54.4 degrees) unscheduled PPD award granted by the September 22, 1993 Order on Reconsideration should be paid at the rate of $100 per degree or $117.47 per degree.

SAIF argues that, because claimant's unscheduled PPD award has become final, he is precluded from challenging the rate per degree that was used to calculate that award.

In Arlene J. Koitzsch, 49 Van Natta 847 (1997), we held that a scheduled PPD award for a 1988 injury, which did not become final before the 1995 Act went into effect on June 7, 1995, was payable at the increased rate of $347.51 under amended ORS 656.214(2). While appeals of the claimant's 1990 closure notice were pending, the carrier paid her PPD award at the $145 rate. After litigation on the PPD award became final (after June 7, 1995), the claimant requested a hearing, asserting entitlement to payment of the award at the increased rate of $347.51.

Relying on Randy L. Dare, 48 Van Natta 1230 (1996), we reiterated that amended ORS 656.214(2) was retroactively applicable to scheduled disability awards for injuries occurring before January 1, 1992. Citing Volk v. America West Airlines, 135 Or App 565 (1995), we stated that the 1995 statutory amendments were intended to apply retroactively unless there was a specific exception to such application. Referring to subsection 66(5)(a), we noted that one of the specific exceptions was that the 1995 statutory amendments do not apply to any matter for which an order or decision has become final on or before the effective date of the Act, i.e., June 7, 1995.

In Koitzsch, we acknowledged that the carrier was required to pay the PPD award pending the various levels of appeal, citing ORS 656.313 and Eliecer Vega, 46 Van Natta 2173 (1994). Notwithstanding these payments, we concluded that the claimant was not precluded from asserting that the final award should be paid at the $347.51 rate because the Board's eventual Order on Remand had not become final until after June 7, 1995.

Because the claimant's 1988 injury claim was in existence on June 7, 1995, we held that the 1995 statutory amendments to ORS 656.214(2) applied retroactively to her claim unless the scheduled PPD rate issue was a matter for which an order or decision had become final on or before June 7, 1995. Finding that the Order on Remand did not become final until after June 7, 1995, we concluded that the exception in subsection 66(5)(a) to retroactive application of the Act did not apply and, thus, payment of the scheduled disability award was to be made at the $347.51 rate under amended ORS 656.214(2). We recognized that, on June 7, 1995, the carrier's appeal of a prior Board order was limited to an attorney fee issue and not the claimant's PPD award. Nevertheless, relying on ORS 656.295(8), and Volk, we reasoned that the prior order was not final because it had been appealed (albeit limited to an attorney fee issue).

Here, claimant's unscheduled PPD award did not become final before the 1995 Act went into effect on June 7, 1995. Rather, on June 7, 1995, the Board's September 27, 1994 order in Benjamin G. Santos, 46 Van Natta 1912 (1994), had been appealed by claimant and was pending before the Court of Appeals. On January 24, 1996, the court specifically affirmed as to the rating of impairment, although it remanded to the Board for reconsideration of the temporary disability award. Compare Koitzsch, 49 Van Natta at 847 (the court did not affirm any portion of the Board's order; rather, it reversed and remanded to the Board for reconsideration).

Because claimant's unscheduled PPD award did not become final before the 1995 Act went into effect, subsection 66(5)(a) is not an applicable exception to retroactive application of the $117.47 rate under amended ORS 656.214(6) to claimant's award. However, due to the retroactive application of the 1995 amendments, we agree with SAIF that claimant is precluded from raising the issue of the rate of unscheduled PPD because he failed to raise the issue of the rate per degree during the reconsideration process.

Amended ORS 656.283(7) provides, in part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

In Ferral C. Crowder, 48 Van Natta 2322 (1996), we held that, because the claimant had not challenged the rate of his unscheduled PPD award granted by a Determination Order during the reconsideration proceeding, he was precluded from raising the issue at hearing. In awarding the claimant unscheduled PPD, an August 1994 Determination Order specified a dollar amount that was equivalent with a rate of $100 per degree. Following the claimant's reconsideration request, a May 1995 Order on Reconsideration affirmed the unscheduled PPD award and granted scheduled PPD. At hearing, the claimant contended that his permanent disability awards were payable at the higher rates set forth in amended ORS 656.214.

We rejected the claimant's contention, insofar as it pertained to the unscheduled PPD award. Because it was apparent that the claimant's unscheduled PPD award had been calculated at a certain rate, we reasoned that it was incumbent on the claimant to have raised his objection during the reconsideration proceeding. In reaching our conclusion, we relied on amended ORS 656.283(7) and William T. Masters, 48 Van Natta 1788 n.1 (1996) (where the rate of temporary total disability issue arose from claim closure, because the issue was not raised during reconsideration it could not be raised at hearing).

We acknowledged that the increased PPD rate under the 1995 statutory amendments took effect after the reconsideration order issued. Nonetheless, we disagreed with the claimant's assertion that the PPD rate issue could not have been raised on reconsideration. In addition, we reasoned that the fact that a change in the law took effect after the reconsideration order did not remove the statutory prohibition under the 1995 Act against raising claim closure issues at hearing that were not first raised on reconsideration.

Finally, we concluded that the claimant was entitled to raise at hearing the scheduled PPD rate issue. Noting that the scheduled PPD award had arisen from the reconsideration order itself, we determined that such circumstances established the one exception to the prohibition under ORS 656.283(7).

Here, as in Crowder, we conclude that claimant is barred from challenging the unscheduled PPD award because the rate issue was not previously raised at the Department's reconsideration proceeding. The January 6, 1993 Determination Order awarded claimant 18 percent (57.6 degrees) unscheduled permanent disability, and stated: "THE INSURER IS NOW ORDERED TO PAY YOU $5,760.00." (Ex. 5). Thus, the Determination Order awarded claimant a set dollar amount ($5,760) for his unscheduled PPD award. Based on that set sum award, it is apparent from the order that claimant's unscheduled PPD award was calculated at the rate of $100 per degree, (i.e., $5,760 divided by 57.6 degrees equals $100 per degree). Because claimant's Determination Order award of PPD was calculated at a certain rate, we conclude that the PPD rate issue arose from the Determination Order. Therefore, it was incumbent upon claimant to raise an objection to the PPD rate at the reconsideration proceeding. Because he did not do so, amended ORS 656.283(7) now bars him from raising at hearing the rate of unscheduled PPD awarded by the Determination Order. See Crowder, 48 Van Natta at 2323. Furthermore, there is no evidence to indicate that the rate of unscheduled PPD arose out of the reconsideration order itself.

Claimant argues that he could not have specifically raised the issue of rate of unscheduled PPD unless he, or his attorney, was blessed with clairvoyance. He asserts that there was only one possible rate that could have been applied to his claim at that time. As we noted in Crowder, the fact that a change in the law took effect after the reconsideration order does not remove the statutory prohibition against raising claim closure issues at hearing that were not first raised on reconsideration. 48 Van Natta at 2323. Although we understand claimant's frustration concerning his ability to raise the "rate" issue on reconsideration, it is not within our purview to ignore a clear legislative mandate, despite an arguably harsh result. See Southwood Homeowners v. City Council of Philomath, 106 Or App 21, 24

(1991). By making the 1995 Act fully retroactive under the provisions of section 66, the legislature has mandated that the amendments, including the increased PPD rates under amended ORS 656.214 and the procedural limitations under amended ORS 656.283(7), apply retroactively to all pending cases unless a specific exception to such application is set forth in the Act. As we stated above, we can find no specific exception to retroactive application of the Act to this case.

Alternatively, claimant contends that the ALJ properly concluded that he did all that he could do under the circumstances to raise the issue. The ALJ found that claimant sufficiently raised the "rate" issue by checking "other" on his request for reconsideration of the January 6, 1993 Determination Order. (Ex. 8).

In the request for reconsideration form, claimant checked "yes" by box number 8, which said "Other (Does not include any issue under 1 through 7). If you checked 'yes,' specify any other objection you have to the DO/NOC. State your reasons and list any supporting documents." (Ex. 8). There is no explanation in the record of what claimant objected to by checking "Other." In light of claimant's assertion that the rate of unscheduled PPD was not an issue in 1993, we are not persuaded that checking "other" on his request for reconsideration of the January 6, 1993 Determination Order was adequate to raise the rate issue. Moreover, the Order on Reconsideration did not refer to any issue involving the rate of unscheduled PPD. (Ex. 9).

Penalties

In his respondent's brief, claimant contends that he entitled to a penalty for SAIF's allegedly unreasonable resistance to the payment of compensation. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated November 26, 1996, as reconsidered February 5, 1997, is reversed. The ALJ's attorney fee award is also reversed.

Board Chair Hall dissenting.

I agree with that portion of the majority's analysis which applies the rationale expressed in Arlene J. Koitzsch, 49 Van Natta 847 (1997), to find that subsection 66(5)(a) of SB 369 is not an applicable exception to the retroactive application of amended ORS 656.214(6) because claimant's unscheduled permanent disability award did not become final before the June 7, 1995 effective date of the 1995 Act. However, because I disagree with the majority's determination that claimant's failure to raise the "rate of permanent disability" issue during the reconsideration proceeding precludes him from contesting the "rate" issue at hearing, I must respectfully dissent.

As expressed in my dissenting opinion in Ferral C. Crowder, 48 Van Natta 2322 (1996), I do not agree that the rate of a claimant's permanent disability is an issue subject to the reconsideration process. This case illustrates my point. During the reconsideration proceeding, there was no basis for claimant to contest the rate of his permanent disability award. However, by the time of the hearing, following the retroactively applicable amendment to ORS 656.214(6), the "rate" issue became ripe for resolution. Under such circumstances, the fact that claimant did not "raise" the rate of his permanent disability award as an issue during reconsideration is eminently understandable and should not preclude him from asserting the issue at hearing.

In the Matter of the Compensation of
LANNY K. SIGFRIDSON, Claimant
WCB Case No. 96-10051
ORDER ON REVIEW

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that affirmed an Order on Reconsideration that awarded 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). On review, the issues are extent of scheduled permanent disability and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed an Order on Reconsideration awarding claimant 15 percent (22.5 degrees) scheduled disability for loss of use or function of his right wrist. On review, the insurer contends that the ALJ erred in assigning it the burden of proof on the extent of permanent disability issue, and that claimant failed to prove entitlement to a chronic condition award for the right wrist. The insurer also contends that the ALJ awarded an excessive attorney fee. We agree with the ALJ's reasoning and conclusion regarding the extent of permanent disability issue, but we modify with the ALJ's attorney fee award. Regarding the extent of permanent disability issue, we write to address the insurer's arguments on review.

Scheduled Disability

Claimant has an accepted right carpal tunnel syndrome condition. Because the claim was closed on May 24, 1996, claimant became medically stationary after June 7, 1995, and the permanent disability rating had not become final by August 19, 1996, the extent of disability is determined pursuant to the Director's disability standards found in WCD Administrative Order 96-051, effective February 17, 1996, as modified by WCD Administrative Order 96-068 (temporary), effective August 19, 1996. OAR 436-035-0003(1), (2); see also Order of Adoption of Temporary Rules, WCD Administrative Order 96-068.

First, we address the insurer's burden of proof argument. Because the insurer contested the Order on Reconsideration, the ALJ assigned it the burden of proof, pursuant to our decision in Roberto Rodriguez, 46 Van Natta 1722, on recon 46 Van Natta 2230, on recon 46 Van Natta 2530 (1994). On review, the insurer continues to disagree with our decision in Roberto Rodriguez. We have previously declined to revisit this case, and we have relied on it as precedent, as did the ALJ. See Maria Jolley, 48 Van Natta 2316 (1996); Michael W. Weber, 48 Van Natta 2269 (1996). We continue to take that approach in this case. Accordingly, we continue to conclude that, where a carrier is seeking reduction of an award of permanent disability, the burden of proof is on the carrier. Therefore, because the insurer in this case sought to reduce claimant's permanent disability award, the ALJ did not err in assigning the burden of proof to the insurer.[1]

The insurer next contends that the permanent disability award should be reduced because claimant is not entitled to 5 percent impairment for a chronic right wrist condition. We disagree.

ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." The determination of impairment is further explained in OAR 436-035-0007(13), which provides in material part, that "[o]n reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence."

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[1] We further note that we would reach the same decision regarding the extent of claimant's permanent disability regardless of which party had the burden of proof.

Here we find that the medical arbiter, Dr. Wilson, performed a more complete examination for the purpose of determining extent of permanent disability than Dr. Hayes, claimant's treating physician. Although Dr. Hayes also examined claimant on April 30, 1996, Dr. Wilson's measurements and tests are more complete and precise. For example, Dr. Wilson tested and recorded precise measurements for dorsiflexion, palmar flexion, radial deviation, ulnar deviation, pronation, and supination in both hands, while Dr. Hayes tested only dorsiflexion and palmar flexion and gave a precise measurement only for dorsiflexion. (Compare Ex. 22 with Ex. 27-1). In addition, Dr. Wilson tested and reported precise measurements for grip strength, while Dr. Hayes reported only an approximate value for grip strength. (Compare Ex. 22 with Ex. 27-3). Furthermore, Dr. Wilson examined claimant closer in time to the issuance of the Order on Reconsideration, the point at which we and the ALJ must evaluate claimant's disability. ORS 656.283(7); 656.295(5). Therefore, Dr. Hayes' report is less persuasive than Dr. Wilson's medical arbiter report. Accordingly, because a preponderance of the evidence does not establish a different level of impairment, we rely on Dr. Wilson's report to establish the extent of claimant's disability. (Ex. 27).

Based on Dr. Wilson's report and OAR 436-035-0080(1), (3), (5), (7), (9), claimant has the following range of motion losses in the right wrist:

dorsiflexion	30 degrees	= 5.0%
palmar flexion	55 degrees	= 2.5%
radial deviation	15 degrees	= 1.0%
ulnar deviation	20 degrees	= 2.0%

The impairment values are added for a total impairment of 10.5 percent, which is rounded up to 11 percent. OAR 436-035-0007(14), (21). The insurer does not contest this value.

Pursuant to OAR 436-035-0010(5) and Dr. Wilson's report, we also find that claimant is entitled to 5 percent scheduled chronic condition impairment due to a chronic and permanent medical condition (right wrist CTS and post-surgery status), which significantly limits repetitive use of the right forearm (wrist). (Ex. 27-4). Considering that Dr. Hayes offered no opinion regarding any limitations on claimant's ability to repetitively use his right wrist, we find no basis for not relying on Dr. Wilson's opinion regarding chronic condition impairment. See Snyder v. Barrett Business Services, Inc., 147 Or App 619, 624-25 (1997) (where the treating physician offered no opinion to weigh against the medical arbiter's opinion, it is inappropriate to rely on the treating physician's lack of opinion to prove no permanent disability).

Combining claimant's impairment values for lost range of motion (11 percent) with chronic condition impairment (5 percent) results in a total impairment of 15 percent. OAR 436-035-0007(17). Accordingly, we affirm the ALJ's order.

Attorney Fees

The ALJ awarded claimant a $3,000 attorney fee for his attorney's efforts in successfully defending the compensation awarded to claimant by the Order on Reconsideration. On review, the insurer contends that the attorney fee awarded by the ALJ is excessive. We modify the ALJ's award.

Under ORS 656.382(2), claimant is entitled to a reasonable attorney fee, to be paid by the insurer, if the ALJ finds that the compensation awarded to claimant should not be disallowed or reduced. In determining whether an attorney fee is reasonable, the following factors listed in OAR 438-015-0010(4) are considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

Applying the first factor, we cannot determine how much time claimant's attorney devoted to defending the permanent disability award, as there is no statement of services. However, we find that the time devoted to the issue was relatively minimal, because no hearing was held, closing arguments were conducted by telephone, and claimant's attorney submitted only one document for the record. For the same reasons, we conclude that the proceedings were not unduly complex or time-consuming.

The key issue - extent of scheduled permanent disability - was not particularly complex, considering that the entire record contained only 17 exhibits and only two medical reports needed to be considered to rate the extent of disability. However, the parties also raised an issue concerning the burden of proof, which added to the complexity of the issues.

The value of the interest involved is $7,898.63. Both attorneys are skilled litigators with substantial experience in workers' compensation law. No frivolous issues or defenses were raised. There was a risk that claimant's attorney may go uncompensated.

After considering these factors, we find that $2,000 is a reasonable fee for claimant's attorney's services in defending the Order on Reconsideration award. In reaching this conclusion, we particularly rely on our findings that the proceedings were relatively limited and the issues were not particularly complex. We also consider the value of the interest involved and the benefit secured for claimant. We also consider that there is a risk that claimant's attorney's efforts may go uncompensated. See Schoch v. Leupold & Stevens, 325 Or 112 (1997).

Claimant's attorney is also entitled to an assessed fee for services on review concerning the extent of permanent disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. We further note that approximately one fourth of claimant's brief was devoted to defending the attorney fee award, for which claimant is not entitled to an attorney fee on review. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 18, 1997 is modified. In lieu of the $3,000 attorney fee awarded by the ALJ, claimant is awarded a $2,000 attorney fee for his attorney's services at hearing, payable by the insurer. In addition, claimant is awarded a $1,000 attorney fee for his attorney's services on review, to be paid by the insurer.

In the Matter of the Compensation of
CAMMY A. BOSCHEE, Claimant
WCB Case No. 96-10379
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Thomas A. Andersen, Defense Attorney

Claimant requests reconsideration of our August 18, 1997 Order on Review that adopted and affirmed the Administrative Law Judge's (ALJ) order upholding the insurer's denial of claimant's low back injury claim. In support of her motion, claimant contends that the ALJ's and our orders "failed to address many of the important issues in this case."

Claimant worked at the employer's thrift store. On August 23, 1996, claimant and her supervisor, Laura Jensen, physically struggled, resulting in injuries to claimant. The ALJ found that claimant was an "active participant" under ORS 656.005(7)(b)(A)[1] and, thus, her claim was not compensable. In reaching this decision, the ALJ found that neither claimant nor Ms. Jensen were "entirely credible" and made factual findings based on those "that appear to be most logical when all the circumstances of this altercation are considered." We agreed with the ALJ's reasoning and conclusion and adopted and affirmed the order.

Claimant contends that the ALJ's order failed to consider the inconsistencies between Ms. Jensen's testimony at hearing and her report to a police officer who interviewed claimant and Ms. Jensen concerning the incident, as well as determine the credibility of a defense witness, Brenda Butcher. Claimant also objects to the ALJ's findings of the event, contending that the ALJ simply assumed facts. According to claimant, we should rely on her testimony that Ms. Jensen initially grabbed claimant and caused her to fall down. Finally, claimant asserts that the ALJ's order failed to discuss her assertion that, because the insurer conceded legal and medical causation, it had the burden of proving that claimant was an active participant.

Although, as previously noted, the ALJ found neither claimant nor Ms. Jensen to be "entirely credible," the ALJ essentially accepted Ms. Jensen's testimony concerning the incident. Specifically, the ALJ found that there was tension between claimant and Ms. Jensen before the altercation and, on the day of the incident, claimant arrived late to work and treated Ms. Jensen in an insubordinate manner. The ALJ further found that, after claimant ignored Ms. Jensen's request to turn on a light and Ms. Jensen herself did so, Ms. Jensen pointed her finger at claimant and began "lecturing" her. As the ALJ found, claimant brushed away the finger and the two began physically struggling and claimant fell over a box onto her back with Ms. Jensen on top of her.

We continue to agree with the ALJ's order. The only substantive difference between the police officer's report and Ms. Jensen's testimony is that the report states that Ms. Jensen told the officer that claimant grabbed her arm and Ms. Jensen testified that claimant did not grab her but struck her on the arm after she pointed her finger at claimant. (Tr. 131-32, 145-46). Because Ms. Jensen's testimony was actually more favorable to claimant, we find her testimony more reliable. Moreover, we do not find the differences between the report (which was drafted by a third party) and Ms. Jensen's testimony sufficient to completely discount Ms. Jensen's testimony as not credible.

With regard to the credibility of Ms. Butcher, because we do not rely on her testimony in reaching our conclusion, we need not decide whether or not her testimony was reliable. Similarly, because we would reach the same result whether or not the burden of proof was on the insurer to prove that claimant was an active participant, we need not decide that issue.

Accordingly, we withdraw our August 18, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our August 18, 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] The statute provides "compensable injury" does not include: "Injury 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."

In the Matter of the Compensation of
SANDRA L. DeHART, Claimant
WCB Case No. 94-14935
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Bock and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the self-insured employer's partial denial of claimant's claim for a C6-7 condition; (2) upheld the employer's denial of claimant's aggravation claim for her current C5-6 condition; (3) declined to consider the issue of premature closure on the ground that the issue had not been raised at the time of reconsideration; and (4) declined to remand to the Director for promulgation of a rule. On review, the issues are compensability, aggravation, premature closure, and remand to the Director. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, except Finding 30 and the last sentence of Finding 27.

CONCLUSIONS OF LAW AND OPINION

Compensability/C6-7

The ALJ found that claimant's C6-7 condition was not compensable because claimant failed to prove that work-related factors were the major contributing cause of her C6-7 condition. Claimant contends that the C6-7 condition is compensable. We agree.

Claimant, who worked for the employer as a medical transcriptionist, has a compensable neck condition at C5-6, which the employer accepted after litigation in 1992 as a "cervical disc protrusion C5-6." (Ex. 96). Dr. Bert, claimant's treating physician, performed a discectomy and two fusion surgeries at that level. (Exs. 70, 90). In 1995, claimant sought treatment for increasing neck discomfort, which Dr. Bert determined was caused by a C6-7 condition. Claimant contends that the major contributing cause of her current C6-7 condition is her compensable C5-6 condition combined with work activities. Thus, we understand claimant's argument to be that her current C6-7 condition is a consequential condition flowing from her compensable C5-6 neck condition.

In order to establish the compensability of her C6-7 condition as a consequence of her compensable C5-6 condition, claimant must prove that her compensable injury was the major contributing cause of her consequential condition. ORS 656.005(7)(a)(A). Where reasonable and necessary treatment for a compensable condition is the major contributing cause of a new condition, the compensable injury is deemed to be the major contributing cause of the consequential condition within the meaning of ORS 656.005(7)(a)(A). Barrett Business Services v. Hames, 130 Or App 190, rev den, 320 Or 492 (1994).

Alternatively, to the extent that claimant contends that her current C6-7 condition is an occupational disease, it is claimant's burden to establish that work conditions were the major contributing cause of the disease. ORS 656.802(2)(a).

A finding of "major" causation requires that the compensable injury and/or work conditions contribute more to the claimed condition than all other causes, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); see also Kepford v. Weyerhaeuser Co., 77 Or App 363, rev den 300 Or 722 (1986) (consider compensable injuries, along with employment conditions, to determine major contributing cause). In other words, it is claimant's burden to establish that work-related factors were the major contributing cause of her current C6-7 condition.

There are conflicting medical opinions on this issue. Dr. Bert opined that work conditions and the fusion surgeries for her compensable C5-6 condition are the major contributing cause of her C6-7 condition. (Exs. 143, 157). Dr. Bert explained that the deterioration at the C6-7 level was a direct result

of the surgery at the adjacent (C5-6) level, which caused transfer of motion to the C6-7 level. (Exs. 143-2, 149, 154). Dr. Bert further explained that deterioration in a disc above a fusion can appear within one year after the fusion. (Ex. 157). Dr. Bert recognized that claimant had a preexisting degenerative condition at the C6-7 level; nevertheless, he believed that claimant's fusion surgeries for her compensable C5-6 condition, together with work activities, were the major contributing cause of the current C6-7 condition, which requires treatment. (Exs. 144-1, 149, 157).

Drs. Dickerman, Duff and Snodgrass, who examined claimant at the employer's request, and Dr. Tesar, who reviewed records for the employer, disagreed with Dr. Bert. They believe that claimant's current neck condition is due primarily to the natural progression of her preexisting degenerative condition. (Exs. 104-16, 139-9, 145-4, 155-2).

When medical opinions differ, we generally give greater weight to the treating physician's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to the treating physician's opinion. After our review of the record, we find no material inconsistencies in Dr. Bert's opinions. Furthermore, we find that Dr. Bert, as claimant's long-time treating physician, was aware of claimant's relevant medical history. (See e.g., Ex. 13). In addition, as claimant's treating physician and surgeon for her compensable C5-6 condition, Dr. Bert was in a superior position to render an opinion concerning the cause of her C6-7 condition. Accordingly, we rely on Dr. Bert's opinion and conclude that work-related factors were the major contributing cause of claimant's C6-7 condition. Therefore, we find the C6-7 condition to be compensable as an occupational disease claim. See ORS 656.802(2)(a).

Aggravation

We adopt the ALJ's Conclusions of Law on the issue of aggravation of claimant's C5-6 condition, except the seventh paragraph under the ALJ's section "II. Aggravation." Instead, we find that, because claimant has established the compensability of her C6-7 condition as an occupational disease claim, it is unnecessary to determine whether the C6-7 condition constituted an aggravation of the compensable C5-6 condition.

Premature closure

The ALJ declined to consider the issue of premature closure, on the ground that claimant had not raised the issue at the time of reconsideration. Additionally, with respect to the premature closure issue, the ALJ did not admit or consider evidence not submitted at the time of reconsideration. On review, claimant argues that such a ruling results in a denial of due process. However, as noted by the ALJ, we have previously addressed the aforementioned issue and have concluded that the retroactive application of amended ORS 656.283(7) does not violate workers' due process rights. Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996); Dean J. Evans, 48 Van Natta 1092 (1996).

Extent of unscheduled permanent disability

Claimant requests remand to the Director for promulgation of a rule. Claimant argues that her loss of earning capacity has not been accurately reflected in the Department's rules regarding "residual functional capacity."

Claimant has not cited any authority to support her remand request. Although the ALJ referred to ORS 656.726(3)(f)(C), that rule provides for a temporary rule to accommodate the worker's impairment. Here, claimant does not seek a rule dealing with her particular impairment; rather, she disputes the adaptability rule adopted by the Director. Accordingly, we are not persuaded that the aforementioned statute would provide a basis for a remand in this case.

Additionally, even if the statute did provide the authority, the Director specifically found that claimant's disability was addressed by the current rules, and there was no need to promulgate a temporary rule. (Ex. 128-5). Consequently, we do not find that claimant has proven that her disability is not addressed in the standards. See Terry J. Hockett, 48 Van Natta 1297 (1996). Therefore, we agree that the ALJ properly declined to remand this matter to the Director to adopt a temporary rule.

Finally, we have held that, under ORS 656.726(3)(f), the Director is charged with the duty to "[p]rovide standards for the evaluation of disabilities." The Board and ALJ's, on the other hand, are charged with the duty to apply the standards adopted by the Director pursuant to ORS 656.726. ORS 656.283(7), 656.295(5). We have no statutory authority to invalidate a Director's rule regarding the evaluation of permanent disability and are bound by statute to apply the standards adopted by the Director. Gregory D. Schultz, 47 Van Natta 2265, 2266 (1995). Accordingly, to the extent that claimant's argument could be construed as a challenge to the Director's rule, we also decline to invalidate the Director's rule regarding adaptability.

Attorney fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding compensability of the C6-7 condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated January 13, 1997 is affirmed in part and reversed in part. The employer's June 3, 1996 partial denial of claimant's C6-7 condition is set aside and the claim is remanded to the employer for processing in accordance with law. The remainder of the ALJ's order is affirmed. Claimant is awarded an attorney fee for her counsel's efforts at hearing and on review related to compensability of the C6-7 condition, in the amount of $4,000, to be paid by the self-insured employer.

September 11, 1997 Cite as 49 Van Natta 1439 (1997)

In the Matter of the Compensation of
CARLA J. FOSTER, Claimant
WCB Case Nos. 96-10627 & 96-09723
ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation, on behalf of employer Shear Precision, Inc., requests abatement and reconsideration of that portion of our August 13, 1997 Order on Review that set aside its responsibility denial of claimant's bilateral carpal tunnel condition. Specifically, SAIF alleges that claimant received treatment for her compensable condition before she began her employment at Shear Precision, and therefore we erred in finding SAIF responsible under the last injurious exposure rule. We disagree.

As set forth in our prior order, claimant has worked as a hairdresser for approximately 16 years. In 1993, she began working for Great Clips dba Smooth Sailing, a hair salon that serviced men, women and children on a walk-in basis. Her work activity included combing, cutting, blow drying, shampooing, setting and styling hair. She was terminated from Smooth Sailing in the spring of 1996, and soon began working for Shear Precision, Inc., another Great Clips franchise. At Shear Precision, claimant performed her customary haircutting and hairstyling activities, but also worked as a manager.

On October 13, 1995, while still employed with Smooth Sailing, claimant sought chiropractic treatment complaining of migraine headaches, and neck and upper back pain, which she related to automobile accidents that she had been involved in years before. Chiropractor Stellflug diagnosed cervical strain with attendant myofascial fibrosis and treated with a series of vertebral alignments over a few weeks. Dr. Stellflug also noted that claimant had some right hand numbness and tingling, but did not treat this problem. (Exs. 20-1, 21-1).

During the fall of 1995, claimant's hand symptoms continued, and she began to drop things at work. After beginning her employment at Shear Precision, her symptoms worsened, prompting her supervisor to suggest that she seek medical attention. On June 16, 1996, claimant's hand pain became

intolerable, and she was unable to finish her shift. She went to the emergency room and was diagnosed with "repetitive movement injury/carpal tunnel syndrome." She was given pain medication and advised to use warmth and stretches to limber up her hands and arms in the morning and to use elastic wrist supports while working. (Ex. 22).

Over the next several months, claimant sought follow-up treatment with Dr. Tongue. On January 15, 1997, he performed right carpal tunnel release surgery, which resulted in a decrease in claimant's right-sided symptoms.

As noted above, SAIF (Shear Precision) argues on reconsideration that claimant's "date of disability" for purposes of assigning initial responsibility for her bilateral carpal tunnel claim should be October 13, 1995, when she saw chiropractor Stellflug rather than June 16, 1996, when she sought emergency treatment. For the reasons set forth below, we adhere to our determination that claimant first began to receive treatment related to her compensable condition in June 1996 and that SAIF is therefore responsible under 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 at two or more places of employment, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

It is undisputed that claimant sought treatment for "bilateral hand pain" on June 16, 1996. Contrary to SAIF's argument, the record does not establish that she sought treatment for that particular condition at any time prior to that date. Although chiropractor Stellflug noted in October 1995 that claimant complained of some right hand numbness and tingling, there is no evidence that he treated the problem at that time or that he related it to repetitive use or carpal tunnel syndrome. Rather, Dr. Stellflug's records and chart notes indicate that claimant sought the chiropractic treatment because of her head, neck and back pain.[1] Dr. Stellflug performed a series of spinal adjustments, but did not treat claimant's right hand or wrist.[2]

Further, even if claimant experienced bilateral pain for months prior to her June 1996 treatment and believed that her symptoms stemmed from carpal tunnel syndrome, those facts are not determinative. As noted above, where, as here, the claimant receives treatment for the compensable condition before experiencing time loss due to that condition,[3] it is the date of that first treatment that is dispositive for the purpose of assigning initial responsibility for the claim. See Timm, 125 Or App at 401.

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[1] Indeed, claimant testified at hearing that she saw Dr. Stellflug for her back pain and did not receive any treatment on her wrists at that time. (Tr. 48-49).

[2] We distinguish this situation from the facts in Becky M. Stiles, 48 Van Natta 439 (1996), cited by SAIF. In that case, the claimant consulted her treating doctor in January 1994 for bilateral wrist problems, primarily on the left. She returned for treatment in February and March 1994, and her treating doctor suspected tendinitis. The claimant then returned for treatment in December 1994 after experiencing a flare up of bilateral wrist pain. She was diagnosed with CTS at that time, which was later confirmed by electrodiagnostic studies. We held that the "dispositive date" for purposes of assigning initial responsibility was the January 1994 consultation, because that was date the treating doctor first examined the claimant to evaluate her wrist symptoms (even though her condition was not correctly diagnosed until December 1994).

[3] Although claimant testified that in the fall of 1995 she started to drop things at work, she did not believe her symptoms affected her work at Smooth Sailing. (Tr. 49). She further testified that she was able to perform her duties until the pain became severe and she left work to obtain emergency treatment on June 16, 1996. (Tr. 30-35).

Accordingly, our August 13, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 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
RONALD L. KATZBERG, Claimant
Own Motion No. 97-0373M
OWN MOTION ORDER
Fireman's Fund Insurance, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable left knee and low back injury. Claimant's aggravation rights expired on July 1, 1981. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

In a July 14, 1997 chart note, Dr. Mahoney, claimant's treating physician, recommended that claimant undergo arthroscopic debridement of his left knee. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

On August 21, 1997, claimant forwarded to the Board medical reports from 1994 to the present, as well as an undated letter from the Social Security Administration which stated that claimant was entitled to disability benefits beginning in March 1994. Claimant contends that he was disabled because of his compensable injury and that a work search would have been futile at the time of disability. On August 22, 1997, we forwarded to the insurer a copy of the letter and documents submitted by claimant.

On August 25, 1997, the insurer responded that it recommended that temporary disability compensation be denied "based on the fact that the items [claimant] submitted indicate that he is receiving Social Security benefits and has been found eligible for those benefits since September 30, 1993." The insurer further contended that "[i]t is also clear that [claimant] has other medical condition(s) that are also probably keeping him from working."

A claimant's eligibility for social security benefits indicates that he is disabled from work due to one or a number of medical conditions. However, the provision of social security benefits does not automatically establish that a claimant is disabled from work because of compensable injury. Therefore, a claimant's entitlement to social security benefits is not determinative evidence regarding whether he is disabled due to a compensable injury, unless the claimant can establish the entitlement to disability benefits is due to the compensable condition. See Kenneth C. Felton, 48 Van Natta 725 (1996); Robert E. Carper, 48 Van Natta 1160 (1996).

Here, claimant has provided medical documentation to support his contention that he is receiving social security disability because of several disabling conditions. Claimant was not working at the time of disability. Therefore, claimant must establish that he was not working or seeking work at the time of current disability because, although willing to work, his compensable condition made a work search futile. See Dawkins v. Pacific Motor Trucking, 308 Or at 254.

Claimant's accepted conditions in this claim are his left knee and his low back. On his 1994 application for social security benefits, claimant listed his disabling conditions as: mitral valve replacement surgery (heart); need a knee joint replacement; and degenerative (disc disease) in spine. In response to an inquiry as to how his disabling conditions kept him from working, claimant indicated on his application that:

> "I cannot stand or sit for any length of time. I cannot bend, stood or lift. My left knee swells and causes great discomfort. I have upper back, neck and shoulder pain due to heart surgery and arthritis. From my waist to my neck the arthritis limits activity and causes pain, non-stop."

In a January 14, 1994 chart note, Dr. Carroll, claimant's then-treating physician, noted that "[claimant] has had what Dr. Karmy reports as two heart attacks since the aortic valve was replaced." Upon the physician's retirement, Dr. Carroll referred claimant to Dr. Mahoney "for further evaluation and treatment of [claimant's] ongoing left knee difficulties." In a July 14, 1997 chart note, Dr. Mahoney noted that:

> "[Claimant] is in good health except that he had a valve replaced in 1989 from damage from rheumatic fever. He has been on chronic Coumadin therapy since that time. He also has 'arthritis' in his back."

Here, although it is apparent that claimant is disabled from his left knee condition,[1] it is also apparent that he is disabled by neck, shoulder, upper back, and heart conditions. There is no evidence in the record which would establish that these conditions are compensable portions of claimant's 1974 injury claim. Thus, although we agree that claimant's compensable injury has contributed to his inability to work,[2] we are not persuaded that claimant was unable to work due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or at 254; Bill L. Martin, 48 Van Natta at 448.

Accordingly, claimant's request for temporary disability compensation is denied. See id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[1] Although claimant notes that his degenerative condition in his spine (his "arthritis") is painful and contributes to his inability to work, he focused his remarks on his upper back, neck and shoulder, as well as "arthritis" from his neck to his waist. Thus, we are not persuaded that claimant was unable to work because of his accepted low back condition.

[2] The language of Dawkins specifically states that a claimant is in the work force when, although willing to work, the claimant was "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." (Emphasis added). In other words, the test in this case would be whether, if claimant's left knee and low back conditions symptoms did not exist, claimant would have been able to work in spite of his neck, upper back, shoulder and heart conditions. Because claimant has other disabling conditions, and provides no evidence to support his contention that he was unable to work because of his compensable injury, we are not persuaded that any lost wages would have resulted because of the compensable, rather than the noncompensable, condition(s). Bill L. Martin, 48 Van Natta 448 (1996).

In the Matter of the Compensation of
PATRICK E. KELLY, Claimant
Own Motion No. 96-0308M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's June 17, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from May 3, 1996 though June 3, 1997. SAIF declared claimant medically stationary as of June 3, 1997. 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 June 17, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

In an October 14, 1996 medical report, Dr. Baldwin, claimant's treating physician, opined that claimant was not a candidate for a total knee arthroplasty, nor was he a candidate for fusion of his knee. Dr. Baldwin noted that he could not recommend any other surgical procedures which would relieve claimant's pain, but recommended that claimant be examined by Dr. Beals at the Oregon Health Sciences University Center. Dr. Baldwin also reported that he would not accept claimant's care as his knee surgeon.

In a February 3, 1997 letter, Dr. Marshall, consulting orthopedic surgeon, also recommended that, although Dr. Beals was not a participating physician with SAIF's managed care organization (MCO), "[Dr. Beals] would be the appropriate person to give a final recommendation regarding [claimant's] condition."

Claimant was examined by Dr. Beals on March 3, 1997. No chart notes or test results from that examination are in the record. In a March 28, 1997 letter, Dr. Marshall opined that "[i]t is clear, however, from the consultation [with Dr. Beals], that [claimant's] condition is not stationary." Dr. Marshall noted that, if claimant could change his lifestyle, he would contact Dr. Beals and arrange for possible surgery.

In an April 25, 1997 letter, Dr. Beals opined that he did not favor a knee replacement at that time. Dr. Beals further opined that claimant "should be managed expectantly and symptomatically." Dr. Beals asserted that, because claimant's last job involved climbing telephone and cable poles, it would be of benefit for claimant to change his vocational status to a job where he would have much less stress on his knee as claimant might not, at such a "young" age, treat a total knee replacement carefully. Finally, Dr. Beals noted that "[i]f [claimant] changes his lifestyle and his knee continues to bother him, he could in the future be considered for a total knee replacement, but I do not anticipate that would be in the near future."

Claimant moved to Washington and, apparently, was not able to obtain a primary care physician. Claimant was examined on June 5, 1997 by Dr. Mayhall in an independent medical evaluation (IME). Dr. Mayhall noted that claimant had not been examined by a physician since he was examined by Dr. Beals in March 1997. Noting that claimant could mow his lawn and that he worked on his computer at home, Dr. Mayhall opined that claimant could do light to sedentary jobs and was medically stationary. Dr. Mayhall recommended non-steroidal anti-inflammatories, analgesics, vigorous exercise and returning to work. Finally, Dr. Mayhall also agreed that claimant was not a candidate for a total knee replacement at that time.

Here, the physicians who examined claimant prior to and at claim closure recommended that claimant change his lifestyle before considering further surgery. Claimant's treating physician, Dr. Baldwin, noted that he could see no other surgical procedures which would alleviate claimant's knee problem, and would not agree to be his knee surgeon. Furthermore, although Dr. Marshall was the only physician to opine that claimant's condition was not medically stationary, he recommended that Dr. Beals provide the final recommendation regarding claimant's condition. Dr. Beals recommended a change in lifestyle, and did not anticipate that claimant would be a candidate for surgery in the near future. The record does not indicate that any further treatment, other than analgesics and exercise, was recommended to improve claimant's knee condition. Thus, based on this record, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's June 17, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICKEY A. STEVENS, Claimant
WCB Case No. 96-00962
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that dismissed claimant's hearing request on the SAIF Corporation's denial of his back and right elbow injury claim as untimely filed. Claimant also moves for remand for a hearing on the merits. On review, the issue is dismissal, and, if the dismissal was not proper, remand and compensability. We reverse the ALJ's dismissal order, deny remand and uphold SAIF's denial.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and summarize in pertinent part as follows.

Claimant worked for the noncomplying employer driving a flatbed truck, hauling construction debris. Claimant had two helpers to load the truck. (Tr. 20).

The employer terminated all of its employees on May 1, 1995. On May 2, 1995, the employer issued a final check to claimant. On the same day, the employer assisted the DEQ in serving an illegal dumping citation on claimant.

On May 3, 1995, claimant sought medical care for a right elbow and lumbar spine complaint. Claimant informed the medical personnel that he slipped and fell on the wet truckbed at work at about 1:30 pm on April 28, 1995, and identified two witnesses to his accident. Claimant also identified two prior back injuries that took place in about 1981 and 1991. Claimant was diagnosed with a back contusion and right elbow contusion.

On May 8, 1995, claimant's then-attorney, filed a claim with the Workers' Compensation Division and alleged that the employer was noncomplying. On July 7, 1995, the Division issued an order finding the employer noncomplying and forwarded the claim to SAIF for processing. On August 4, 1995, SAIF's claims adjuster spoke to claimant regarding time loss checks. On August 7, 1995, claimant's former attorney withdrew as her counsel.

On August 7, August 22 and September 6, 1995, claimant and SAIF's claims adjuster spoke on the phone regarding claimant's desire to settle the claim. From September 17 to September 21, 1995, claimant was out of state.

On September 20, 1995, SAIF's claims adjuster advised claimant by phone that she would be issuing a denial and that the denial had a 60-day period in which to appeal. SAIF's claims adjuster signed a September 20, 1995 letter denying claimant's injury claim. The letter was addressed to claimant. The record does not establish when the letter was mailed.

On September 27, 1995, claimant was incarcerated in Oregon City. On October 4, 1995, claimant's sister-in-law called SAIF to inform it of claimant's incarceration. On October 15, 1995, claimant wrote to SAIF inquiring as to the status of his anticipated settlement. SAIF did not respond. On October 25, 1995, claimant's sister-in-law called SAIF and asked whether SAIF was going to settle the claim. SAIF's claims representative said, "No." She also said it was up to claimant whether he wanted an attorney. On November 25, 1995, another of claimant's sisters-in-law informed claimant that a denial would be issued and that claimant should hire an attorney. On December 6, 1995, claimant wrote to another attorney requesting representation. That attorney refused claimant's request. In mid-December 1995, claimant contacted his current attorney, and on December 27, 1995, SAIF faxed a copy of the denial to that attorney. On January 24, 1996, claimant's current attorney filed a Request for Hearing on the denial.

CONCLUSIONS OF LAW AND OPINION

Dismissal

At hearing, SAIF raised the defense of an untimely request for hearing. The ALJ found that SAIF properly mailed the denial dated September 20, 1995, to claimant's address as specified by his former attorney, and concluded that claimant failed to establish "good cause" for not filing his request for hearing within 60 days after the denial issued. Reasoning that the Hearings Division did not have jurisdiction over claimant's request for hearing, the ALJ dismissed claimant's hearing request.

On review, claimant argues that the ALJ erred in failing to establish when claimant had either actual or constructive notice of the denial, and that claimant had good cause for failing to file the request for hearing within 60 days of its issuance. We conclude that claimant's request for hearing was filed timely, based on the following rationale.

A request for hearing must be filed no later than the 60th day after mailing the denial to claimant, or, if filed after 60 days but no later than 180 days after mailing, claimant must establish good cause for failure to file within the 60-day period. ORS 656.319(1)(a), (b). Thus, the running of the filing time is triggered by the mailing date, not the date of receipt. E.g., Giusti Wine Co. v. Adams, 94 Or App 175 (1988) (1988) (applying former ORS 656.319, the court determined that the running of the statutory filing time to request a hearing on a denial was triggered by the date of mailing of the denial, not the date of receipt). Compare Wright v. Bekins Moving & Storage Co., 97 Or App 45 (1989) (failure of a claimant to receive notice of denial of claim by employer was not extenuating circumstances excusing claimant's failure to timely seek review of denial).

It is well-established that, in order to determine when the 60 days were tolled, there must be some showing of when the letter was mailed. Madewell v. Salvation Army, 49 Or App 713, 715-16 (1980). In Madewell, the court stated: "While there is a presumption that a writing is truly dated, and that a letter directed and mailed was received in the regular course of the mail, there is no presumption that a letter is mailed on the day it is dated or on the day it was written." 49 Or App at 716 (citations omitted). See also SAIF v. Tull, 113 Or Ap 449, 451 (1992) (same).

SAIF's letter denying claimant's claim for compensation was dated September 20, 1995. However, SAIF offered neither documentary[1] nor testimonial evidence of the date on which the letter was actually mailed.[2] Because SAIF has not provided any evidence to establish the date of mailing, upon which the statutory filing time is predicated, (nor does the record establish when claimant received

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[1] OAR 438-005-0065 states: "Notice of denial or other notice from which statutory time runs against a claimant shall be in writing and shall be delivered by registered or certified mail with return receipt requested. Notice by personal service meeting the requirements for service of a summons may be substituted for mailed notice." There is no mailing certificate in the file to prove the date the letter was actually mailed.

[2] The parties stipulated that claimant's attorney received a faxed copy of the denial letter on December 27, 1995. He filed a request for hearing on January 24, 1996, within 60 days of receiving the faxed copy.

actual notice of the denial), we are not persuaded that the filing of claimant's Hearing Request was untimely under ORS 656.319(1)(a). Accordingly, we find that claimant filed the claim timely, and proceed to the merits.[3]

Remand

Claimant moves to remand to the ALJ for a hearing on the merits if we set aside the dismissal. We may remand to the ALJ if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986).

Here, the merits of the compensability issue were before the ALJ and documentary and testimonial evidence were taken. Claimant offers no basis for his request for remand and, after de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Consequently, we deny remand and proceed with our de novo review of the record.

Compensability

Claimant alleges that he injured his back and right elbow on April 28, 1995, while working as a truck driver for the noncomplying employer. SAIF contends that claimant failed to prove that his injury occurred as alleged, because claimant is not credible, and he failed to produce witnesses to corroborate his version of the injury.

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of his disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); see Mark N. Weidle, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656.266.

Claimant was employed to drive a truck between various construction sites and a local dump, hauling construction debris and other rubbish. Claimant alleges that, at 1:30 pm on April 28, 1995, he slipped and fell from the back of a wet flat-bed dump truck, twisting his back, hitting his right elbow, and landing hard on his buttocks. Claimant reported that two co-workers, Quantrall Bright and Ricky Gatorf, witnessed his injury. (Ex. 14). Claimant also reported that Richard Reed, a co-worker, and Jackie Reed, who was on site, witnessed the incident. (Tr. 44, 45). On April 29, 1995, claimant dumped debris at a recycling center. (Ex. 20). On May 2, 1995, the employer issued a check to claimant in payment for labor from April 24 to May 1, 1995. (Exs. 17A, 19). On May 3, 1995, claimant sought treatment for his low back and elbow at an emergency room. (Exs. 2, 7).

Claimant was the only witness on his behalf concerning the April 28, 1995 claimed back and elbow incident. Claimant did not produce his fellow workers, Quantrall Bright and Ricky Gatorf, who, he claimed, witnessed his injury, nor did claimant place in the record any reason why these witnesses were not called.

In Roberts v. SAIF, 18 Or App 590, 593 (1974), the court held that the claimant failed to prove that he sustained a compensable injury in the course of his employment when he failed to produce his fellow worker whom he claimed witnessed his injury, or place any reason in the record why the co-worker was not called.

In this case, both Mr. Borst and Mr. Larson, co-owners of the business, testified that claimant had not reported hurting his back or elbow to either of them prior to his seeking medical treatment. (Tr. 22, 26, 64, 66). Mr. Larson also testified that he did not see any evidence of physical disability or limping on May 1, 1995, the day claimant picked up his check. (Tr. 66).

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[3] Because we decide there is no evidence the filing was late, we do not reach the issue of whether claimant had good cause for a late filing.

Here, as in Roberts, claimant identified witnesses who could corroborate his testimony regarding the circumstances of his injury, but did not produce them or explain why they were not called at hearing. Thus, we construe the failure to call them against claimant. See e.g., Gloria A. Vaneekhoven, 47 Van Natta 670 (1995); Kirk Meyers, 42 Van Natta 2757 (1990) (where the claimant did not produce a witness at hearing who could allegedly verify that he was injured at this job, he failed to sustain his burden of proving that his injury occurred in the course and scope of employment). Claimant has failed, therefore, to prove that he sustained a work-related injury.

ORDER

The ALJ's order dated January 24, 1997, is reversed. Claimant's request for hearing is reinstated. The SAIF Corporation's denial of claimant's injury claim is upheld.

September 11, 1997 Cite as 49 Van Natta 1447 (1997)

In the Matter of the Compensation of
ROBERT S. WIGGET, Claimant
WCB Case No. 96-08995
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Claimant requested reconsideration of that portion of our August 13, 1997 Order on Review in which we awarded a $3,500 attorney fee for claimant's counsel's services at hearing and on review for prevailing over the insurer's denial of claimant's current condition. Specifically, claimant contends that our reduction of the ALJ's $5,000 attorney fee award for services at hearing regarding compensability and aggravation issues was not reasonable, as claimant's counsel devoted no more than two to two and one/half hours of the total time expended on the case, as documented in his statement of services, to the aggravation issue. The insurer opposes any increase in the fee for services at hearing because the value of the interest involved was substantially reduced. We modify our prior award.

In determining a reasonable attorney fee for claimant's counsel's services at hearing, the ALJ considered the factors set forth in OAR 438-015-0010(4) and applied them to this case. The ALJ awarded an assessed attorney fee of $5,000 for services at hearing for prevailing on two issues: compensability and aggravation. Because claimant did not prevail on the aggravation issue on review, we reduced the attorney fee for claimant's counsel's services at hearing, after applying the same factors.

We acknowledge that the insurer did not raise the aggravation issue until hearing and that claimant's counsel submitted an affidavit attesting to 31 hours and 5 minutes that was actually required to litigate the case up to that point.

However, the time devoted to the case is but one of the factors applied in determining an appropriate attorney fee. See Danny G. Luehrs, 45 Van Natta 889, 890 (1993). The other factors include the complexity of the issue involved, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefit secured for the represented party, the risk in a particular case that an attorney's efforts may go uncompensated, and the assertion of frivolous issues or defenses.

Our review of the record reveals the following. The issues in dispute were the compensability of claimant's current low back condition (degenerative disc disease) and aggravation of his accepted claim, which included his degenerative disc disease. Approximately 64 exhibits were received into evidence, 11 generated by claimant's counsel. The hearing lasted one hour, resulting in a 19-page transcript.

We find that the complexity of the compensability issue revolved solely around the propriety of the insurer's denial of a condition that had been found compensable by prior litigation orders; this was not a medically complex issue. Moreover, the claim's value and the benefit secured for claimant were considerably reduced on review, consisting of medical services for potential arthrodesis surgery only (in

contrast to the aggravation issue, which would have provided temporary disability, medical services, and, potentially, permanent disability).[1] The hearing was brief and involved an examination of one witness, claimant, to verify the medical reports regarding the worsening of his condition. Finally, when compared with other cases presented for our review, there was a moderate risk that claimant's counsel's efforts might go uncompensated in regard to the compensability issue.

After considering these factors, we acknowledge the time claimant's counsel devoted to the compensability issue in securing a successful result. However, our reconsideration of this record does not establish that the complexity of the issue differs appreciably from those in most cases litigated before this forum. Moreover, the value of the benefit resulting from this claim differs substantially from the value of the claim when claimant prevailed at hearing on the aggravation issue. On the other hand, claimant is entitled to a fee for both services at hearing and on review regarding this compensability issue. Under such circumstances, after having reconsidered the relevant factors in this case, we conclude that $4,200 is a reasonable attorney fee for claimant's counsel's services at hearing and on review regarding the compensability issue. Consequently, in lieu of all prior attorney fee awards, claimant's counsel is awarded $4,200, to be paid by the insurer.

Accordingly, our August 13, 1997 order is withdrawn. On reconsideration, as modified herein, we adhere to and republish our August 13, 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] We note that the ALJ acknowledged that the value of the aggravation issue was substantially greater than medical services for the potential arthrodesis surgery. (O&O at 7).

In the Matter of the Compensation
STUART C. YEKEL, Claimant
WCB Case Nos. 96-05168, 95-13821 & 95-13820
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Lundeen, et al, Defense Attorneys
Stoel Rives, Defense Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation/Yekel's Repair requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of compensability and responsibility of claimant's "new injury" claim for a left knee condition; (2) upheld SAIF/Wrench Ranch's responsibility denial of claimant's current left knee condition; (3) upheld Liberty Northwest's responsibility denial of claimant's current left knee condition; and (4) assessed a penalty against SAIF/Yekel's Repair for an allegedly unreasonable denial. SAIF/Wrench Ranch requests review of that portion of the order that awarded an assessed attorney fee payable by SAIF/Wrench Ranch. On review, the issues are compensability, responsibility, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

In 1982, claimant worked for Wrench Ranch. In June 1982, claimant filed a claim for a left knee injury. (Ex. 3). In July 1982, SAIF accepted the claim. (Ex. 5). Claimant underwent surgery on his left knee for a torn medial meniscus. (Ex. 8). In March 1983, claimant had surgery on both knees. (Ex. 13). In July 1984, a Determination Order awarded temporary disability and permanent disability. (Ex. 22).

In August 1986, claimant began working for Snow Mountain Pine Company. In October 1986, claimant sought treatment for his left knee after an off-work slip-and-fall. (Ex. 26). The next month, claimant underwent surgery for his left knee. (Ex. 26A).

In December 1987, claimant filed a claim for a "chipped bone" in his left knee, which was accepted by Liberty Northwest Insurance Corporation. (Ex. 27A). In January 1988, claimant had surgery on his left knee. (Ex. 27D). In October 1988, a Determination Order awarded temporary disability only. (Ex. 27M).

In February 1995, claimant saw Dr. Johnson, complaining of worsening pain in both knees and "catching" in the left knee. (Ex. 30-1). Claimant again saw Dr. Johnson in early May 1995 for bilateral knee symptoms. (Ex. 33).

Effective May 23, 1995, SAIF contracted to provide workers' compensation and employers' liability insurance for claimant's self-owned automobile repair business, Yekel's Repair. (Ex. 33AA).

On September 11, 1995, claimant traveled from his home in Burns to Portland. Claimant retrieved a vehicle that had been towed and picked up Sean Cook. While preparing the vehicle for towing back to Burns, claimant sustained an injury to his left knee. On September 13, 1995, claimant sought treatment from Dr. Johnson, telling him that he had twisted and bumped his left knee against a trailer and, since the incident, felt "something catching" in his knee. (Ex. 34-1). Dr. Johnson diagnosed a loose body. (Id.) Claimant filed a claim. (Ex. 36). In November 1995, Dr. Johnson surgically removed the loose body. (Ex. 45).

SAIF, on behalf of Wrench Ranch, denied compensability and responsibility of the claim. (Ex. 47, 52A). SAIF, on behalf of Yekel's Repair, also denied compensability and responsibility. (Ex. 48, 52). Finally, Liberty, on behalf of Snow Mountain Pine Company, denied compensability and responsibility. (Ex. 55A).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was injured in the course and scope of his employment on September 11, 1995; there was sufficient corroborating evidence to support the claim under ORS 656.128; and claimant carried his burden of proving compensability. Finding that the September 1995 injury was the major contributing cause of claimant's need for treatment and disability, the ALJ further assigned responsibility for the claim to SAIF/Yekel's Repair. Moreover, the ALJ assessed attorney fees against each carrier for claimant's attorney's efforts in prevailing against each denial of compensability. Finally, the ALJ assessed a penalty against SAIF/Yekel's Repair on the basis that its denial of compensability was unreasonable.

SAIF/Yekel's Repair challenges all of the ALJ's conclusions. SAIF/Wrench Ranch challenges only that portion of the order finding it liable for an assessed attorney fee.

Compensability

The record contains several opinions concerning claimant's left knee condition. Dr. Fuller, orthopedic surgeon, examined claimant at SAIF/Yekel's Repair request. Dr. Fuller found that x-rays of claimant's knee beginning in 1983 showed "progressive tricompartmental arthritis" and that the loose body was preexisting based on a 1993 x-ray. (Ex. 54-7). Dr. Fuller thought that claimant had sustained a knee strain from the September 11, 1995 event and the injury had "combined with the pre-existing degenerative arthritis in his knee, the pre-existing loose body and the pre-existing effusion to precipitate further knee discomfort." (Id. at 8). According to Dr. Fuller, the September 1995 injury was not the major contributing cause of the loose body formation or claimant's subsequent need for surgery. (Id. at 9).

Claimant was then examined by Dr. McKillop, orthopedic surgeon, and Dr. Rich, neurologist, on behalf of Liberty/Snow Mountain Pine Company. The panel found that claimant's "many injuries" and "many [surgical] procedures" made it difficult to assess causation with "complete accuracy." (Ex. 55-8). The panel thought it was "more logical to go back to the most severe injuries in order to determine the original causes of later development of loose bodies" and, because "the most severe and significant injury was the one occurring in June 1982, when he probably ruptured his anterior cruciate ligament and tore the medial meniscus," the loose body most likely related to the 1982 injury. (Id. at 8-9). Consequently, the panel found that "the major contributing cause of [claimant's] continuing knee problems would be the original June 1982 injury[.]" (Id. at 10).

Dr. Johnson thought that, because claimant's clinical presentation worsened after the September 1995 event and the subsequent x-ray showed the presence of a loose body, that event caused the loose body and, thus, the September 1995 injury was the major contributing cause of claimant's need for treatment. (Exs. 51, 55B). Dr. Johnson then agreed with a letter drafted by SAIF/Yekel's Repair attorney stating that he was "unsure" whether the loose body removed in November 1995 was the same one detected by the 1993 x-ray or if the September 1995 injury caused a new loose body. (Ex. 56-1). The report further stated that, even if the loose body preexisted the September 1995 injury, such event caused the loose body to migrate, thus precipitating claimant's need for treatment. (Id. at 2). Dr. Johnson himself added that the September 1995 injury "was the major cause for [the] loose body to become a symptomatic issue." (Id.)

Dr. Fuller then concurred with a report from SAIF/Wrench Ranch's counsel stating that the 1987 injury with Snow Mountain Pine Company "caused a significant worsening of the underlying pathology of [claimant's] left knee condition" and was as significant an event as the 1982 injury at Wrench Ranch. (Ex. 58-2). Dr. Fuller also provided a report to SAIF/Yekel's Repair attorney reiterating his opinion that the loose body was present before the September 1995 injury and that the waxing and waning of symptoms experienced by claimant since 1993 was "typical for a loose body as it makes a nuisance of itself in various compartments of the knee joint." (Ex. 59).

We first disagree with the ALJ that the September 1995 injury was the major contributing cause of claimant's left knee condition. First, the medical evidence shows that claimant's need for treatment was because he had a loose body in his left knee. Dr. Fuller persuasively explained that the loose body preexisted the September 1995 incident. By finding that the 1982 injury caused the loose body, the McKillop/Rich panel also found that the loose body was preexisting. Although Dr. Johnson first indicated that the September 1995 injury caused the loose body, following Dr. Fuller's report, he indicated that he was "unsure" whether the loose body was preexisting or was directly caused by the event. Based on this evidence, we find that Dr. Johnson's opinion concerning this issue does not rise to the level of medical probability.

Dr. Fuller, however, indicated only that the September 1995 injury was not the major contributing cause, without stating what did cause the loose body to form. The McKillop/Rich panel explained their conclusion for why the 1982 injury caused the loose body. Because their opinion is well-reasoned, based on an accurate history, and essentially unrebutted, we find it persuasive. See Somers v. SAIF 77 Or App 259 (1986). Because the panel stated that the 1982 injury was both the original and major contributing cause of the later development of the loose body, we understand their report as establishing the loose body as a consequential condition of the 1982 injury. See ORS 656.005(7)(a)(A). Consequently, we conclude that claimant proved compensability. Id.[1]

Responsibility

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. 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."

Here, because the loose body is a compensable consequential condition of the 1982 injury and SAIF/Wrench Ranch is the responsible carrier for the 1982 injury, SAIF/Wrench Ranch also is responsible for the loose body. SAIF/Wrench Ranch may shift responsibility if claimant has sustained a "new compensable injury." That is, SAIF/Wrench Ranch must prove that the 1987 injury with Liberty or the September 1995 injury was the major contributing cause of claimant's need for treatment and disability. E.g., Rito N. Nunez, 48 Van Natta 786 (1996).

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[1] Because we have found that claimant proved compensability as a consequential condition of the 1982 injury, but there was insufficient medical evidence that the 1995 injury was the major contributing cause, we need not address whether the September 1995 injury occurred in the course, and arose in the scope, of claimant's employment or if there was sufficient corroborating evidence under ORS 656.128.

For the reasons discussed in determining compensability, we find the medical evidence inadequate to prove that the September 1995 injury was the major contributing cause of claimant's need for treatment of the loose body. With regard to contribution from the 1987 injury, the only evidence is from Dr. Fuller's concurrence that the injury significantly worsened the underlying pathology of claimant's knee condition. There is no explanation, however, whether "pathology" refers to the loose body or the degenerative arthritis. Consequently, we are unable to decide, on this record, whether the 1987 injury was the major contributing cause of claimant's need for treatment of the loose body. Thus, we find an absence of evidence supporting a "new compensable injury" and SAIF/Wrench Ranch remains responsible for the loose body.

Penalties

The ALJ assessed a penalty against SAIF/Yekel's Repair for an unreasonable denial of compensability, finding that there was no medical or legal justification for denying compensability. SAIF/Yekel's Repair argues that no penalty is warranted.

Penalties are assessed if the carrier "unreasonably delays or unreasonably refuses to pay compensation[.]" ORS 656.262(11)(a). Whether a denial is unreasonable depends on whether the carrier has a legitimate doubt regarding its liability, based on the evidence available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988).

SAIF/Yekel's Repair first denial issued on December 7, 1995 and stated that SAIF/Yekel's Repair denied compensability because there was insufficient evidence of corroboration of the injury and the injury was not in the course and scope of employment. (Ex. 48). On February 22, 1996, SAIF/Yekel's Repair issued an amended denial that cited the same grounds for denying compensability. (Ex. 52).

At the time SAIF/Yekel's Repair issued its denials, the only medical evidence was from Dr. Johnson, who attributed the loose body to the September 1995 injury. (Ex. 51). Consequently, we agree with the ALJ that, when SAIF/Yekel's Repair issued the denials, there was no legitimate doubt concerning its liability based on medical causation.

Information concerning the injury itself showed that, while a customer unhooked a car dolly, claimant was hit in the back of his knee. (Exs. 34-3, 35, 36, 39). Sean Cook also was listed as a witness to the incident. (Exs. 35, 39). Because such evidence shows that claimant was injured in the course and scope of his employment and there was a corroborating witness to the incident, we further conclude that SAIF/Yekel's Repair lacked a legitimate doubt concerning its liability based on legal causation.[2]

Thus, we agree with the ALJ that SAIF/Yekel's Repair's denial of compensability was unreasonable and it should be assessed a penalty. See SAIF v. Whitney, 130 Or App 429 (1994); SAIF v. Moyer, 63 Or App 498, rev den 295 Or 541 (1983). Therefore, claimant was properly awarded a penalty, payable by SAIF/Yekel's Repair, based upon 25 percent of the amounts due at the time of hearing from the responsible carrier, SAIF/Wrench Ranch (as a result of this order). E.g., Donald S. Sheridan, 47 Van Natta 1565, 1566 (1995).

Attorney Fees

The ALJ assessed an attorney fee against each carrier for claimant's attorney's services in prevailing over each compensability denial. SAIF/Wrench Ranch asserts that, because another carrier was found responsible for the claim, it should not be assessed an attorney fee under ORS 656.386(1). We find SAIF/Wrench Ranch's argument has been rendered moot inasmuch as our order finds it responsible for the left knee claim. But see Gene R. Harrison, 48 Van Natta 2383 (1996) (responsible carrier, who denied compensability and responsibility, solely responsible for the claimant's attorney fee award, rather than other carriers who also denied compensability); Rita R. Lovelace, 47 Van Natta 107 (1995) (same).

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[2] At hearing, there was evidence that claimant may have been on a personal mission when he was injured. There also was evidence that Sean Cook was not a credible witness. Whether or not such proof would have provided a legitimate doubt is not relevant since the record was limited to the evidence cited above at the time SAIF/Yekel's Repair issued its denials.

Because compensability was an issue before the ALJ, it remained an issue on Board review; therefore, claimant is entitled to an insurer-paid attorney fee payable by the insurer that requested review. ORS 656.382(2); Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990); Charles R. Morgan, 48 Van Natta 841, on recon 48 Van Natta 960 (1996). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's attorney's services on review regarding the denial issue is $1,000, payable by SAIF/Yekel's Repair. In reaching this conclusion, we have particularly considered the time devoted to the denial issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services devoted on review to the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 13, 1996 is reversed in part and affirmed in part. Those portions of the order that set aside SAIF/Yekel's Repair responsibility disclaimer and set aside SAIF/Wrench Ranch's responsibility disclaimer are reversed. SAIF/Yekel's Ranch responsibility disclaimer is reinstated and upheld and SAIF/Wrench Ranch's responsibility disclaimer is set aside and the claim is remanded to SAIF/Wrench Ranch for processing according to law. The ALJ's assessed fee award of $3,000 is payable by SAIF/Wrench Ranch, rather than SAIF/Yekel's Repair. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF/Yekel's Repair.

In the Matter of the Compensation of
JOSEPH E. BRIDWELL, Claimant
WCB Case No. 96-07849
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On August 7, 1997, we abated our July 14, 1997 order that awarded claimant interim compensation and assessed a penalty for the self-insured employer's unreasonable failure to pay interim compensation. We took this action to consider the employer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

The employer seeks reconsideration of our assessment of a penalty for its unreasonable failure to pay interim compensation. Specifically, the employer contends that Dr. Rabie's time loss authorization is not effective because he was not claimant's attending physician. The employer also contends that even if its duty to pay interim compensation may have been triggered on either August 13 or August 17, 1996, it had no obligation to pay interim compensation because claimant had been fired on August 12, 1996. We are not persuaded by the employer's arguments.

So far as the record discloses, the employer raised the issue of whether Dr. Rabie was claimant's attending physician for the first time on reconsideration. As a general rule, we do not consider issues that are raised for the first time on review or reconsideration. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991); Joyce B. Mauceri, 48 Van Natta 1631 (1996) (issue not considered when raised for first time on reconsideration); see also Fister v. South Hills Health Care, 149 Or App 214, 218 (1997) (citing Gunther H. Jacobi, 41 Van Natta 1031 (1989)). Therefore, we are not inclined to address the employer's contention that Dr. Rabie was not claimant's attending physician.

Moreover, even if we were to address the attending physician issue, we would still find that Dr. Rabie was claimant's attending physician. An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b); David A. Matthews, 47 Van Natta 257 (1995). Whether a physician qualifies as an "attending physician" is a question of fact. See Debbie I. Jensen, 48 Van Natta 1235, 1236 (1996); Sharon A. Gambrel, 46 Van Natta 1881, 1884 n.2 (1994); Paula J. Gilman, 44 Van Natta 2539 (1992).

Here, although claimant first treated with Dr. Collins in The Dalles, Oregon, it is clear from the record that Dr. Collins would not continue as claimant's attending physician. Claimant saw Dr. Collins in the emergency room immediately following his work injury, when Dr. Collins advised claimant to follow-up with his own physician in Portland, Oregon. (Exs. 2, 4). Claimant did follow-up with his physician in Portland, Dr. Rabie of Kaiser Permanente, three days after his injury. (Ex. 7). Dr. Rabie performed a thorough examination, ordered x-rays, and prescribed treatment. (Id.). He also completed the "First Medical Report" form (Form 827), which the employer received on August 13, 1996. (Ex. 9).

Thus, the record establishes that Dr. Rabie was primarily responsible for treating claimant's compensable injury, beginning with the first treatment on August 8, 1996. Indeed, the employer's claims examiner also apparently assumed that Dr. Rabie was claimant's attending physician, since the claims examiner acknowledged the receipt of claimant's modified work restrictions from Dr. Rabie on August 8, 1996, but did not question his authority to impose work restrictions. (See Ex. 14).

The employer also contends that, because its obligation to pay interim compensation did not arise until after claimant was terminated, it had no obligation to pay interim compensation. Therefore, the employer contends, we erred in assessing a penalty.[1] We disagree.

As we explained in our original order, the caselaw is clear that a claimant is entitled to interim compensation if he or she has "left work" (i.e., was either absent from work or sustained diminished earning power) due to the compensable injury, regardless whether the claimant was also terminated for reasons unrelated to the compensable injury. RSG Forest Products v. Jensen, 127 Or App 247 (1994) (worker is entitled to interim compensation if he or she suffered loss of earnings as a result of the compensable injury, even if worker leaves job for reasons unrelated to compensable injury); Nix v. SAIF, 80 Or App 656 (1986) (claimant entitled to interim compensation for period during which claimant was unable to work due to his compensable injury, even though claimant had been terminated on the day of the injury); see also Lisa R. Angstadt, 47 Van Natta 981 (1995) (where claimant suffered diminished earning capacity after being terminated, she became entitled to interim compensation as of the date her diminished earning capacity began); Jerilyn Hendrickson, 46 Van Natta 1888 (1994) (where claimant suffered loss of earning capacity due to compensable injury, fact that she was fired for reasons unrelated to compensable injury did not preclude receipt of interim compensation). Thus, the caselaw is clear that a worker can be entitled to interim compensation even if the duty to pay interim compensation arises after the worker has been terminated for reasons unrelated to the compensable injury.

Where the law is clear regarding a carrier's obligation to pay interim compensation, the failure to do so is unreasonable and warrants assessment of a penalty. Stephen M. Snyder, 47 Van Natta 1956, 1959 (1995); Lisa R. Angstadt, 47 Van Natta at 983. Thus, we adhere to our prior decision that assessed a penalty against the employer for its unreasonable failure to pay interim compensation.[2]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 14, 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] The employer cites SAIF v. Christensen, 130 Or App 346, 351 (1994), in support of its argument that interim compensation was not payable after August 12, 1996 because claimant had been terminated on that date. That case, however, concerns the issue of when the obligation to pay temporary disability arises in the context of an aggravation claim. In Christensen, the court analyzed the differences between the obligation to begin paying temporary disability on an initial claim, ORS 656.262(4), and the duty to begin paying compensation on an aggravation claim, ORS 656.273(6), and concluded that, under ORS 656.273(6), the carrier was not obligated to seek medical verification of a claimant's inability to work when an aggravation claim has been filed. Since the present case concerns the duty to pay compensation on an initial claim, Christensen is inapposite.

[2] In doing so, we note that we did not charge the employer with the obligation to pay interim compensation until 14 days after September 24, 1996 (October 8, 1996). The employer concedes that the triggering date for paying interim compensation was September 24, 1996, if not earlier. (See Employer's Petition for Reconsideration at 2). Yet, the employer had paid no interim compensation as of the November 18, 1996 hearing. Therefore, we continue to find that the employer's failure to pay interim compensation warrants assessment of a penalty.

In the Matter of the Compensation of
WILLIAM CLARK, Claimant
WCB Case No. 95-05927
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order which set aside its denial of claimant's groin injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and briefly summarize as follows.

Claimant, age 49, worked as a flight attendant for the employer and a predecessor airline since 1978. Ms. Baughman worked as a flight attendant for the employer since 1987. On December 29, 1994, claimant and Ms. Baughman boarded the employer's airplane at Seoul, Korea, to prepare for a flight to Portland, Oregon. Ms. Baughman preceded claimant on board and placed her carry-on bag in a compartment above the coat closet located between the business and first class sections. (Tr. 30, 103, 113, 154, 155, 158). Soon after boarding, claimant told Ms. Baughman that she could not stow her bag at that location because she was working aft in the coach section. (Tr. 184). Claimant attempted to take Ms. Baughman's bag down. (Id.) She told him to leave it where it was and went to her work area. (Tr. 159, 184, 185). About two minutes later, claimant reported a groin injury to Ms. Meade, flight attendant coordinator, and requested immediate medical attention. (Tr. 138, 202). Claimant left the plane, was examined by an airport medical person, given a prescription, and returned to a hotel in Seoul. Two days later claimant flew back to Portland, where he sought emergency room treatment for groin pain.

The insurer denied the claim on the basis that it had not occurred in the course and scope of employment.

CONCLUSIONS OF LAW AND OPINION

The ALJ found the parties to be equally credible in both demeanor and substance regarding the circumstances of claimant's injury. The ALJ reasoned that, no matter how the injury occurred, claimant injured his groin while he was on the employer's airplane and required medical services. Thus, the ALJ concluded, claimant's injury was compensable. On review, the insurer contends that claimant failed to prove that he was injured in the manner he alleged. We agree.

In order to establish a compensable injury, claimant must prove that he sustained an injury arising out of and in the course of his employment, requiring medical services or resulting in disability. ORS 656.005(7)(a). It is claimant's burden to prove compensability of his claim by a preponderance of the evidence. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51, 55 (1979).

Here, claimant specifically contends that his groin was injured during an altercation with a co-worker. Thus, we begin by establishing whether claimant was injured in the manner he alleges.

Although we defer to the ALJ's demeanor-based credibility findings, we are equally qualified to make our 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). Furthermore, even if a claimant lacks credibility with regard to certain matters,[1] 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).

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[1] Claimant, who initially stated that he had never been disciplined by the employer, admitted that he had been suspended by the employer subsequent to the December 29, 1995, date of injury over an incident that took place in Taipei, Taiwan. The employer admitted that it withdrew its objection to claimant's application for unemployment benefits as a result of the suspension. We conclude that there is nothing in the circumstances of claimant's suspension that has any material bearing on claimant's credibility regarding the circumstances of his alleged work injury.

On December 29, 1994, claimant and Ms. Baughman, flight attendants, were part of the cabin crew preparing for a flight from Seoul, Korea, to Portland, Oregon. Claimant was one of the last to board the plane. Ms. Meade, the flight attendant coordinator for the first class section, was loading videos near the coat closet between the business and first class sections. She casually observed claimant storing his bags in the closet and Ms. Baughman, whose back was turned, walking through business class toward the coach section. (Tr. 105-107). Ms. Meade returned to her task. About two minutes later, claimant reported to her that he was in pain and that Ms. Baughman had "kneed" him in the groin. (Tr. 109).

Claimant and Ms. Baughman provided different versions of the event that took place between them on the plane. Claimant testified that he had begun to stow his bags in the coat closet between the first and business class sections of the plane when Ms. Baughman insisted that he place her bags in a storage area above the closet. He refused, telling her that he intended to put his bags there. He further testified that she argued with him and then placed her bags there herself. When he reached to get her bag to take it to the back of plane where she was assigned to work, their argument grew heated and Ms. Baughman then "kneed" him in the groin when he refused to be bossed around. (Tr. 38-41, 67; Exs. 13b-6 through -9, 26). Claimant stated that he then sat on the arm of a seat for a short time and then reported the incident to Ms. Meade. (Tr. 42).

Ms. Baughman testified that she boarded the plane before claimant and placed her bag in the compartment above the closet herself. (Tr. 155, 181-184). She stated that claimant started to remove her bag. She told him not to remove it, that she put it there because there was no room elsewhere, and then half-danced, half-walked aft to her duty station in the main cabin galley. (Tr. 181).

At the time of the alleged altercation, the nearest entrance to the plane (2-R) was closed, the caterers had left, and some flight attendants were in the galley setting up. (Tr. 102, 134, 168). Ms. Meade, one of the flight attendant coordinators, was loading videos, facing aft into the shared galley. (See Ex. 29). She took a step to the left into the aisle to store some videos in a compartment next to the coat closet. She saw claimant to the right of the closet and Ms. Baughman in the aisle a few steps in front of her, "skipping" toward the back of the plane. (Tr. 108, 136, 137, 138). Within about two minutes, claimant approached Ms. Meade, who by then was standing between the shared galley and the first class galley, and reported his version of the incident. (Tr. 99, 108, 109, 110, 139, 140). Ms. Meade immediately went to the coach section to talk to Ms. Baughman, who appeared to Ms. Meade to be genuinely shocked upon hearing claimant's allegations. (Ex. 112).

Although claimant asserted that there was a heated altercation and a physical attack, Ms. Meade did not overhear any interchange between the parties, although she was only a few steps away and the plane was relatively quiet. (Tr. 132, 133, 135). Moreover, she did not note claimant in any distress when she stepped into the passageway to store the videos. When she observed Ms. Baughman skipping down the aisle, going toward the coach section in the rear, she observed claimant simply standing at the closet. Although the alleged incident itself was unwitnessed, Ms. Meade's testimony tends to corroborate Ms. Baughman's version of events, rather than claimant's version.

Under such circumstances, we hold that claimant has failed to establish that he was injured in the manner he alleges during the course and scope of his employment. Consequently, we conclude that his claim is not compensable. E.g., Andrews v. Tektronix, Inc., 323 Or 154, 162 (1996) (ultimate test of compensability is whether, considering all the circumstances, the temporal, spatial, circumstantial, and causal connections between the claimant's injury and employment were sufficient to justify compensation).

ORDER

The ALJ's order dated December 2, 1996 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
MARYLIN L. HUNT, Claimant
WCB Case No. 96-04323
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that assessed a penalty for its alleged failure to timely provide discovery. On review, the issue is penalties.[1] We reverse.

FINDINGS OF FACT

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

On April 2, 1996, claimant requested that the insurer disclose all investigative material, including any taped statement of claimant and transcription thereof. The insurer disclosed its investigative material, with the exception of a recorded statement of claimant, which it withheld allegedly for impeachment purposes.

At hearing, the insurer attempted to use the recorded statement to impeach claimant's testimony. Claimant testified that she did not recall the responses given in the statement.[2] The insurer did not offer the recorded statement as evidence, but did disclose it to claimant prior to the close of hearing.

CONCLUSIONS OF LAW AND OPINION

After reviewing the withheld evidence, the ALJ determined that the transcribed statement was not relevant *only* for purposes of impeachment and therefore should have been disclosed to claimant prior to the hearing pursuant to OAR 438-007-0015.[3] The ALJ further found that the insurer was untimely in providing discovery of the transcribed statement and that such untimeliness was unreasonable. Therefore, the ALJ imposed a penalty for unreasonable delay pursuant to OAR 438-007-0015(5) and ORS 656.262(11).

On review, the insurer contends the penalty is unwarranted because it complied with the provisions of ORS 656.283(7) and OAR 438-007-0017(2) in withholding the statement for purposes of impeachment. Specifically, the insurer asserts that its withholding of the transcribed statement was not unreasonable even if the statement was not relevant and material only for impeachment purposes. We agree.

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[1] The parties agree that the compensability of claimant's low back injury is no longer in issue.

[2] On her 801 form, claimant had checked the "No" box regarding whether her "body part had been injured before." In her recorded statement, claimant reported that she had suffered a work-related back injury (which was "never like" her current back injury) about 10 years ago that had resolved with therapy and treatment.

In addition, claimant had advised the insurer's claim examiner in the recorded statement that she had not told her employer of her injury when she was terminated (two days after the alleged injury) and she did not know why she had not told her employer, except that she had arthritis and thought her discomfort was coming from that condition. At hearing, claimant testified that she had never told people that, after the work injury and before she had filed a claim, she thought her arthritis was acting up. She later testified that she did not remember making such a statement and did not know why she would have told that to anyone.

[3] OAR 438-007-0015(1) requires the disclosure of all documents pertaining to the claim. Similarly, OAR 438-007-0015(5) sets forth the Board's policy of "full and complete disclosure of all facts and opinion pertaining to the claim being litigated before the Hearings Division."

ORS 656.283(7) provides, in pertinent part, "[n]either the board nor an Administrative Law Judge may prevent a party from withholding impeachment evidence until the opposing party's case in chief has been presented, at which time impeachment evidence may be used."[4] Also applicable here is OAR 438-007-0017(2)(b) (effective January 1, 1996), which requires disclosure of all audio tapes, video tapes, transcriptions, summaries and notes of recorded or unrecorded statements given by a claimant "unless withheld as impeachment evidence." Neither of these provisions require that the withheld evidence be relevant "only" or "solely" for impeachment purposes.[5]

We acknowledge that in both Kenneth D. Legore, 48 Van Natta at 1577, and Sandra E. Post, 48 Van Natta 1741 (1996), where we applied the reasoning expressed in SAIF v. Cruz, 120 Or App 65 (1993), and remanded the discovery disputes back to the ALJ to view the withheld evidence, we directed the ALJ to determine whether the evidence was relevant and material "only for impeachment purposes," thereby suggesting that evidence which is relevant for impeachment as well as other purposes could not be withheld under ORS 656.283(7). In this regard, the ALJ correctly interpreted our holding in these cases. However, in Cruz, the applicable discovery rules specifically limited the withholding of evidence to that which was relevant "only" or "solely" for purposes of impeachment. Therefore, Cruz is distinguishable. Although we applied the same analysis in Post and Legore (in which the current Board rules were applicable), we now reconsider that approach. In other words, contrary to our indication in Post and Legore, we now find that under ORS 656.283(7) and OAR 438-007-0017, a party may withhold evidence it reasonably believes to be relevant and material for purposes of impeachment, i.e., evidence that tends to destroy a witness' or claimant's credibility in the estimation of the ALJ, even if that evidence may have some other relevance to the claim being litigated.[6]

Here, in her recorded statement, claimant acknowledged that she had suffered a prior work-related injury (albeit one that was "never like" her later back injury), which had resolved with therapy and treatment. In contrast to this statement, claimant's 801 form indicated that claimant had not sustained any prior injury to her back. Under these circumstances, the insurer could reasonably believe that portions of the transcribed statement tended to impair or destroy claimant's credibility and therefore elect to withhold the statement as impeachment evidence under ORS 656.283(7).

The ALJ reviewed the document and determined that, in addition to having impeachment value, the statement was also relevant to the claim for other (unspecified) purposes. However, in view of the fact that there is currently no requirement that the withheld evidence be relevant and material *only* or *solely* for impeachment purposes, the insurer's withholding of the written statement until the close of claimant's cross-examination was not unreasonable. Because we do not find the insurer's conduct unreasonable, we reverse the ALJ's penalty award. See Oswald F. Kuznik, 45 Van Natta 1194 (1993) (citing Brown v. Argonaut Insurance Co., 93 Or App 588 (1988)) (in the discovery context, the standard for determining unreasonable delay or refusal is whether the carrier had any legitimate doubt regarding its obligation to disclose the document to the claimant).

ORDER

The ALJ's order dated August 28, 1996, as reconsidered September 30, 1996 is affirmed in part and reversed in part. That part of the order that assessed a 25 percent penalty pursuant to ORS 656.262(11) is reversed. The remainder of the order is affirmed.

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[4] The term "impeachment evidence" is not defined in ORS Chapter 656 or in the workers' compensation administrative rules, but we have identified it as evidence that tends to impair or destroy the credibility of a witness in the estimation of the trier of fact. See Kenneth D. Legore, 48 Van Natta 1577 (1996) and Tim L. Besheone, 48 Van Natta 2337 (1996) (citing State v. Johanesen, 319 Or 128, 130 n. 4 (1994)).

[5] Prior to 1996, the Board rules permitted a party to withhold and offer at hearing documents that it "reasonably believed relevant and material *only* for purposes of impeachment of a witness." See former OAR 438-07-017(4) (emphasis added). The rules similarly allowed the withholding of a videotape or surveillance film "solely for impeachment purposes." Former OAR 438-07-017(3). However, both of these provisions were omitted when the rules were amended to conform to the 1995 amendments to ORS 656.283(7).

[6] This is not to say we completely disavow our determination in Sandra E. Post and Kenneth D. Legore. In other words, we continue to hold that when there is a dispute concerning the withholding of impeachment evidence, the ALJ shall review the evidence in camera to determine whether it constitutes impeachment evidence. If the ALJ determines the party acted unreasonably in withholding the evidence, i.e., if the evidence is found to have no relevancy toward claimant's or a witness' credibility, then the evidence is subject to disclosure under OAR 438-007-0015 and a penalty may be appropriate.

Board Member Moller specially concurring.

For the reasons that follow, I agree with the majority that the insurer's decision to withhold the claimant's transcribed statement was not unreasonable so that no penalty should be assessed.

In the discovery context, the standard for determining unreasonable delay or refusal is whether the carrier had any legitimate doubt regarding its obligation to disclose the document to claimant. See Oswald F. Kuznik, 45 Van Natta 1194 (1993) (citing Brown v. Argonaut Insurance Company, 93 Or App 588 (1988)). If the carrier had a legitimate doubt about its obligation to disclose the document, its failure to do so in a timely fashion is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time it elects to withhold the document. See Brown v. Argonaut Insurance Company, 93 Or App 588.

In early April 1996, the point in time that the insurer had to decide whether to disclose the recorded statement to claimant or to withhold it as impeachment evidence, we had not yet issued our opinion in Kenneth D. Legore, 48 Van Natta at 1577. Thus, the only guidance the insurer had in making its determination was the language of ORS 656.283(7) and OAR 438-007-0017(2)(b), neither of which specifically require that the withheld evidence be relevant and material *only* for purposes of impeachment. Furthermore, in her recorded statement, claimant acknowledged that she had suffered a prior work-related back injury (albeit that was "never like" her current back injury), which had resolved with therapy and treatment. In contrast to this statement, claimant's 801 form indicated that she had not sustained a prior injury to the injured body part.

Under these circumstances, I am not persuaded that the insurer's decision to withhold the transcribed statement until the close of claimant's cross-examination was unreasonable. Inasmuch as portions of the transcribed statement were designed to impair or destroy claimant's credibility before the ALJ, the insurer had a legitimate doubt regarding its responsibility for disclosing the document. Moreover, when the insurer made these decisions, no precedent existed concerning a party's disclosure obligations under the current version of OAR 438-007-0017.

The dissent argues that the authority to withhold impeachment evidence is limited to those selective portions of a document that impeach other evidence. In other words, the remaining "non-impeachment" portions of the document, less the redacted "impeachment" portion, must be disclosed to the other party. The dissent goes on to conclude that the insurer's failure to do so in this case warrants the imposition of a penalty. I disagree.

At the time this insurer was making its disclosure decision, no precedent existed that would have instructed the insurer to disclose the "non-impeachment" portions of the transcribed statement; i.e., there is no precedent for requiring a party to disclose a withheld document with the "impeachment" portions redacted. Nor am I aware of any common practice before this agency whereby such a "redaction" procedure is undertaken. To the contrary, our administrative rule can reasonably be read to address "transcriptions * * * of recorded or unrecorded statements given by a claimant to an insurer" as a single document that is subject as a whole to either being disclosed or withheld. See OAR 438-007-0017. While a "redaction" procedure such as that proposed by the dissent might well be appropriate for the Board to adopt as a component of its administrative rules dealing with disclosure of documents and impeachment evidence, in the absence of any such rule, I concur with the conclusion that the insurer's conduct was not unreasonable.

Board Chair Hall and Member Biehl dissenting.

The majority concludes that because the insurer could reasonably believe that *portions* of the transcribed statement tended to impair or destroy claimant's credibility, it should not be subject to a penalty for withholding the entire statement until the close of claimant's cross-examination at hearing. We respectfully dissent, for the reasons outlined below.

First, although the current statute and administrative rules no longer require that withheld evidence be relevant "only" or "solely" for impeachment purposes, the fact remains that only impeachment evidence may be withheld. All other non-privileged evidence pertaining to the claim is

discoverable prior to the hearing.[1] See OAR 438-007-0015; OAR 438-007-0017; see also Kenneth D. Legore, 49 Van Natta 1035 (1997) (Chair Hall, concurring). That being so, we continue to believe that if the same piece of evidence contains both impeaching and non-impeaching material, then only that portion of the document which is truly impeachment evidence can be withheld. See Dion T. Brown, 49 Van Natta 448 (1997) (Chair Hall, concurring) (assuming that a portion of the claimant's transcribed statement qualified as impeachment evidence, ORS 656.283(7) permits the employer to withhold only those portions; the non-impeachment portions should be timely disclosed).

In this case, because the insurer withheld the entire statement and not just those portions that it believed tended to impeach claimant, we cannot agree that its conduct was reasonable. At a minimum, the insurer should have redacted those parts of the transcribed statement that it intended to use as impeachment evidence at hearing and released the remainder of the statement to claimant.

Second, we are not persuaded that the subject portions of the withheld statement actually constitute "impeachment evidence."[2] In its brief, the insurer argues that claimant's statement that she did not know why she did not report her injury at the time it happened or her comment that she initially thought her arthritis was acting up is the type of evidence that might destroy claimant's credibility at the hearing. See Liberty's Brief at pp. 7, 11. Yet, at the time the insurer was obligated to disclose its investigative material, there was no other evidence in existence that was contrary to, or inconsistent with, claimant's statements in this regard. Indeed, claimant readily admitted her uncertainties in her statement. At best, as the insurer acknowledges, the insurer withheld the transcribed statement because:

> "Claimant stated that she didn't tell her employer prior to, or upon, her termination that she had injured her back. She further stated that she didn't know why she didn't tell her employer about the injury, she assumed that the discomfort was coming from her arthritis. This information would have been useful for impeachment purposes *should* Claimant have testified that she told her employer about her injury prior to her termination or if she testified that she never thought her injury was related to her arthritis. However, there is no way to know, at the time [the insurer] withheld the evidence, how Claimant would testify. Assuming claimant originally thought her pain was related to her arthritis, she *might* have been motivated to testify that she thought her condition was a direct result of the alleged injury."[3] (App. Br. at 11; emphasis added.)

Such speculation is an inadequate basis to withhold claimant's statement.[4]

In short, we believe that at the time the insurer elected to withhold claimant's transcribed statement, it had no reasonable basis to believe that any part of it constituted impeachment evidence under ORS 656.283(7). Furthermore, even if a portion of the statement was impeaching, the non-impeaching portions should have been disclosed. We therefore disagree with the majority's decision to reverse the penalty award.

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[1] We agree with the majority's statement that the applicable statute and administrative rules have changed. We also agree that the amended statute and rules should have been applied in Sandra E. Post. Nothing in this dissent contravenes ORS 656.283(7)'s restriction regarding "impeachment evidence." We do not agree, however, that the amended law changes the outcome in this case or that the amended law allows an employer or insurer to withhold nonimpeachment evidence. We submit that such is the inescapable effect of the majority's analysis and holding in this case. Indeed, the majority concludes that it was not unreasonable for the insurer to withhold the entire transcribed statement even though only "portions" of the statement are even arguably deemed to have impeachment value.

[2] As explained in Chair Hall's concurring opinion in Kenneth D. Legore, 49 Van Natta at 1040, we believe that evidence that may have some potential impeachment value at some future date is not "impeachment evidence" that may be withheld under the statute and rules. Impeachment evidence is evidence that tends to impeach some other evidence already in existence.

[3] In footnote 2, the majority notes that claimant checked the "no" box on her Form 801 when asked whether she had injured that body part before and then, in her statement, disclosed that she had suffered a previous work-related back injury. However, the insurer does not cite these statements as a reason why it withheld the transcribed statement.

[4] Moreover, even if claimant later denied that she initially related her discomfort to her arthritis, such an inconsistency would have no impeachment value because claimant's lay assessment concerning the cause of her pain or its pathology is not persuasive evidence in complex medical cases. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985) (where the claim involves a complex medical question, claimant's lay testimony is of only limited persuasive value).

In the Matter of the Compensation of
CINDY L. KEEN, Claimant
WCB Case No. 96-02120
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

On August 7, 1997, we abated our July 11, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding the insurer's denial of claimant's aggravation/current condition claim for a low back condition. We took this action to consider claimant's motion for reconsideration, which asserts that our compensability analysis is inconsistent with the approach set forth in SAIF v. Nehl, 148 Or App 101, on recon, 149 Or App 309 (1997). Having received the insurer's response, we proceed with our reconsideration.

As a preliminary matter, we note that the ALJ's order misquoted one portion of Dr. Scheinberg's testimony. The ALJ found that Dr. Scheinberg's opinion pertained to claimant's need for treatment in July 1993. On the contrary, at page 41 of the deposition transcript, Dr. Scheinberg was addressing claimant's need for medical services in November 1995. (See Ex. 59-41).

Claimant compensably injured her low back on July 26, 1993, while lifting countertops at work. The insurer accepted a low back strain. A MRI showed that claimant also had preexisting, underlying degenerative disc disease of the lumbar spine. Although the claim was initially closed in June 1994 without an award of permanent disability, it was reopened in 1995. A May 1995 Determination Order awarded claimant 6 percent unscheduled permanent disability due to her work injury.

On November 27, 1995, claimant returned to her attending physician complaining of progressive back pain that suddenly worsened while she was at home the previous Saturday. She filed an aggravation claim, alleging that her then- current symptoms were related to her accepted 1993 low back injury. In February 1996, the insurer denied that claimant's condition was related to her accepted injury and asserted that there had been no worsening of her compensable condition.

The ALJ upheld the insurer's current condition/aggravation denial, finding that claimant failed to prove that her accepted strain was the major contributing cause of her current (combined) low back condition. We affirmed.

On reconsideration, claimant asserts that, under SAIF v. Nehl, we must separately analyze whether her accepted low back strain was the major cause of her current disability *or* the major cause of her need for treatment on or after November 27, 1995. For the reasons set forth below, we continue to find that claimant's combined condition is not compensable under ORS 656.005(7)(a)(B).

In Nehl, the court construed ORS 656.005(7)(a)(B) and held that when the claimant has a combined condition, not caused in major part by an on-the-job injury, the condition is nevertheless compensable if an on-the-job incident is primarily responsible for (i.e. is the major contributing cause of) the claimant's need for treatment. The Nehl decision turned on the fact that there was a difference between the primary cause of the claimant's combined condition and the primary cause of his need for treatment.[1] See 149 Or App at 313. Indeed, the Nehl court specifically distinguished its holding from that in Robinson v. SAIF, 147 Or App 157 (1997), where there was no difference between the major contributing cause of the claimant's combined condition and the major contributing cause of his need for treatment of that condition.

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[1] In Nehl, prior to a February 1995 work incident, the claimant had a history of low back symptoms related to recurring disc herniations. He had undergone a lumbar surgical fusion with the installation Steffe plates, which were secured to the spine with screws. Then, on February 8, 1995, the claimant experienced a change in his back pain when he stood up from a squatting position at work. The medical evidence established that this work incident caused a loosening of the claimant's fusion instrumentation, which was the primary cause of his need for further surgical treatment. Consequently, on those facts, the court was able to make a distinction between the primary cause of the claimant's overall combined low back condition and the primary cause of his need for treatment, i.e., the February 8, 1995 work injury.

In this case, like Robinson and unlike Nehl, we do not need to distinguish between the primary cause of claimant's combined condition and the primary cause of claimant's current need for treatment because they are the same. The record does not establish the existence of any specific work event in November 1995 that was the major cause of claimant's need for treatment at that time. On the contrary, a preponderance of the evidence establishes that the major cause of claimant's disability and the major cause of her need for treatment on and after November 27, 1995 is her noncompensable, underlying degenerative condition.

After examining claimant in February 1996, Drs. Zivin and Scheinberg opined that claimant's preexisting degenerative condition was the major cause of her current complaints. (Ex. 50-7). Claimant's attending physician, Dr. Malloy, concurred with these findings. (Ex. 57). In his deposition, Dr. Scheinberg expressly reported that claimant's degenerative disc disease contributed more to her need for treatment in November 1995 than her accepted 1993 low back strain. (Ex. 59, pp. 39-48). Similarly, Dr. Malloy testified that he could not relate claimant's condition and need for treatment in November 1995 to her accepted 1993 injury. (Ex. 60-24)

Consequently, on this record, we conclude that claimant has failed to show that her July 27, 1993 injury is compensably related to her current disability or need for treatment. We therefore adhere to our prior order which upheld the insurer's denial.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 11, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

September 12, 1997 Cite as 49 Van Natta 1461 (1997)

In the Matter of the Compensation of
SUSAN KOLAR, Claimant
WCB Case No. C702142
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
S. David Eves, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On August 20, 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 her compensable injury. We approve the proposed disposition.

As originally submitted, the CDA provided on page 3, lines 13-25 and page 4, lines 6-7, that claimant's further rights to workers' compensation benefits, except for medical services, were released. However, on page 3, lines 3-7, the agreement provided that "[i]t is anticipated by the parties that claimant will use the proceeds of this Claims Disposition Agreement to purchase a voice activated computer to assist her in her present work duties at [the employer]."

The Board has previously disapproved CDAs which provide that proceeds will be used to fund improvements to items such as a claimant's van and house which are necessitated by the claimant's compensable injuries. See Thomas D. Olive, 45 Van Natta 523 (1993). In doing so, the Board has reasoned that such provisions constitute an impermissible limitation on a claimant's right to medical services under ORS 656.245. See Maria J. Orejal, 43 Van Natta 1731 (1991) (CDA provided that any future claim for home care services or modification of the claimant's motor vehicle or dwelling would not be compensable); Marilyn London, 43 Van Natta 1689 (1991) (CDA provided that the claimant would pay medical bills from the CDA proceeds).

On August 28, 1997, we wrote the parties seeking the parties' position regarding the effect, if any, of the abovementioned cases on the CDA. In response, the parties' counsels submitted a new version of page 3, which no longer refers to claimant's "anticipated use" of the CDA proceeds. The parties, through their respective counsel, ask that we replace the original version of page 3 with this current version. Consistent with the parties' request, we have substituted the new page 3 into the CDA.

Thus, the CDA, as revised, does not contain a provision which attempts to expressly limit claimant's rights to medical services arising from the compensable injury. Accordingly, we do not find the agreement, as modified by the addendum, to be unreasonable as a matter of law. Consequently, the amended CDA, including the proposed attorney fee, is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LAUREL A. NELSON, Claimant
WCB Case No. 96-04100
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant works as a secretary; her duties include typing, using the ten-key machine, faxing documents, answering the telephone, and photocopying. In December 1995, claimant sought treatment for pain and numbness in both hands. Her family physician, Dr. Stevens, diagnosed carpal tunnel syndrome and referred claimant to orthopedic surgeon Dr. Van Allen.

Dr. Van Allen took a history from claimant that, except for two 10-minute breaks and a half-hour lunch, claimant typed and ten-keyed while working. (Ex. 13-1). Dr. Van Allen also diagnosed carpal tunnel syndrome. (Id. at 2).

At the insurer's request, claimant was examined by neurologist Dr. Rosenbaum, who reported that claimant "spends 85% of her typing at the word processor." (Ex. 30-1). Dr. Rosenbaum diagnosed mild carpal tunnel syndrome. (Id. at 4). Although noting that obesity could be a contributing factor to the condition, Dr. Rosenbaum found that, based on claimant's work history, employment conditions were the major contributing cause of the carpal tunnel syndrome. (Id.)

After the insurer's attorney informed Dr. Rosenbaum that claimant spent only 30 percent of her work time at the keyboard and varied such activity with other duties, Dr. Rosenbaum indicated that the carpal tunnel syndrome was more likely idiopathic than work-induced. (Ex. 40). Dr. Rosenbaum stated that an "accurate work history is the basis of the distinction between idiopathic and work-induced carpal tunnel syndrome" and this was "particularly true" for claimant because her age, weight and gender put her at risk to develop the condition. (Id.)

Dr. Wilson, neurologist, performed a record review at the insurer's request. According to Dr. Wilson, data entry and ten-key operations were not the sort of heavy repetitious gripping or wrist movement that caused carpal tunnel syndrome. (Ex. 44-2). Dr. Wilson further opined that, if claimant performed data entry and ten-key operations for less than half of her work day, it was even less likely

that her secretarial duties were a factor in causing her condition. (Id.) In a subsequent deposition, Dr. Wilson reiterated his opinion and also stated that he found it medically improbable that claimant had carpal tunnel syndrome. (Ex. 50-12, 50-15).

Dr. Nolan, hand surgeon, also performed a record review at the insurer's request. Because claimant's nerve conduction studies were normal and the findings supporting the diagnosis of carpal tunnel syndrome were subjective, Dr. Nolan found "no good evidence" that claimant suffered from the condition. (Ex. 45-2). Dr. Nolan also reported that, even if claimant had the condition, because there was an absence of "significantly repetitive use of the hands in a significant stress activity involving production line work, impact tools, vibratory tools, etc.," he found that claimant's weight was a more likely cause than her work. (Id.)

Finally, Dr. Van Allen indicated that he understood that claimant "spen[t] most her time at work typing and operating a 10 key" and that, assuming the accuracy of such a history, claimant's work activities were the major cause of claimant's carpal tunnel syndrome. (Ex. 55-2). The report further stated that claimant's "work activities probably caused her CTS in that she rapidly and repetitively flexed her fingers and wrists at work, which overuse the flexor tendons." (Id.)

The ALJ upheld the insurer's compensability denial. We find that claimant has carried her burden of proof.

At hearing, both parties presented evidence concerning the portion of claimant's work spent performing work on the keyboard and ten-key during the fall of 1995, before claimant sought treatment. Claimant estimated that she spent approximately 80 to 85 percent of her day during that time period carrying out such duties. (Tr. 18). While the dissent makes much of the estimates provided by claimant about time spent on various activities, the dissent fails to note claimant's uncontroverted statements that she performed some of these tasks simultaneously; i.e., answering phones while typing. (Ex 20 pg.10).[1] Other witnesses, however, including Robert Rada, claimant's supervisor, and David Bochsler, the warranty administrator, estimated that claimant spent between 35 to 40 percent of her time typing and operating the ten-key. (Id. at 122, 137).[2]

We first note that the ALJ made no credibility findings. Based on our review of the record, we find claimant credible. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). We also find claimant in the best position to evaluate her work activities. Although both Mr. Rada and Mr. Bochsler testified that they could observe claimant while she performed her job, there is no question that both men also had their own work to accomplish. Consequently, as their testimony shows, their estimations of claimant's keyboard and ten-key work were just that--an estimation and impression. Consequently, relying on claimant's testimony, we conclude that she proved that she spent 85 percent of her work day prior to the development of her symptoms using the keyboard and ten-key.

As discussed above, Dr. Rosenbaum supported a causal relationship when he based his opinion on a history that claimant spent 85 percent of her work time using the word processor. Because we have found this to be accurate, we find Dr. Rosenbaum's opinion persuasive. The rebutting opinions from Drs. Wilson and Nolan were not based on examinations of claimant and on the incorrect assumption that claimant did not have carpal tunnel syndrome. For these reasons, we conclude that the persuasive medical evidence establishes that claimant's employment conditions were the major contributing cause of her carpal tunnel syndrome. Thus, claimant proved compensability. ORS 656.802(2).

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[1] Thus, if claimant was using the phone while keyboarding, she would be spending, at most, less than 2 hours per day on non-repetitive work such as faxing and copying.

[2] Claimant presented two witnesses who could not testify to the portion of claimant's work day she performed typing and ten-key during the fall of 1995. The insurer also presented two witnesses, the payroll clerk and service manager, both of whom provided estimates of claimant's keyboard activities without specifying that such testimony related to the period of time before claimant sought treatment. Because there is evidence that claimant's typing duties lessened after she sought treatment, and the medical evidence is based on claimant's pretreatment work activity, we have found that the above witnesses provided little or no evidence resolving the causation issue.

Penalties

The employer had notice of the claim in December 1995, but did not issue its denial until April 1996. The insurer provides no explanation for the untimeliness of its denial. Consequently, claimant is entitled to a 25 percent penalty of the "amounts then due" as of the date of hearing as a result of this order. ORS 656.262(11)(a). This fee penalty shall be equally shared by claimant and her counsel.

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

ORDER

The ALJ's order dated November 19, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant also is entitled to a 25 percent penalty based on "amounts then due" as a result of this order as of the date of hearing. This penalty shall be equally shared by claimant and her attorney. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,000, to be paid by the insurer.

Board Member Haynes dissenting.

I agree with the majority that this case comes down to deciding the reliability of claimant's testimony that she spent 85 percent of her work day on the keyboard and ten-key since such a decision also determines which of Dr. Rosenbaum's opinions is most persuasive. If Dr. Rosenbaum's first opinion based on the 85 percent figure is not persuasive, then claimant does not carry her burden of proof; the only other opinion supporting causation is from Dr. Van Allen who, as the ALJ found, based his opinion on the understanding that claimant flexed her wrists while using the keyboard when, as claimant demonstrated at hearing, claimant flexed only her fingers while performing such work (I note that neither the majority nor claimant relied on this opinion). I differ from the majority, however, in concluding that claimant proved her claim concerning her work duties.

First, claimant has shown a tendency to exaggerate. When claimant initially saw Dr. Van Allen in December 1995, she filled out a report stating: "Secretary for three large departments and a manager. Full eight hours of typing (90 wpm) and 10-key (12,000 sph). Also much writing." (Ex. 12). Dr. Van Allen's chart note states that claimant "gets about two 10 minute breaks a day with a 1/2 hour lunch. She says the remainder of the time she is typing 90 words a minute and ten-keying." (Ex. 13-1). As previously stated, at hearing, claimant was estimating that 85 percent of her work day was spent typing and ten-keying. Consequently, even claimant contradicted her initial reports that she spent her entire 8-hour work day performing only data entry on the keyboard and ten-key.

Claimant also gave a skewed picture of her job in another matter. Claimant told physicians and the insurer's investigator, as well as testified at hearing, that her employer did nothing to accommodate her after her doctor restricted her from typing. After some of her coworkers testified that there was a reduction in claimant's typing duties in response to her physician's restriction, however, claimant conceded that her employer had attempted to shift some typing work to another employee. (Tr. 172-73).[1]

This evidence shows that claimant was willing to misrepresent her job duties to support her claim and is enough for me to look at her testimony with a critical eye. The discrepancy, however, between claimant's estimation of her typing duties and the estimation provided by her coworkers is more than enough to put claimant's testimony in serious doubt. As noted by the majority, there was testimony that claimant spent only 35 to 40 percent of her work time on the keyboard and ten-key. The majority is wrong in so casually discounting such evidence as based on "estimation and impression."

[1] Claimant continued to insist that such action did not reduce her typing because she had to correct the employee's typing mistakes.

Both Mr. Rada and Mr. Bochsler described the work place as open without partitions and their desks as closely proximated to claimant's work area, enabling them to easily view claimant while she was working. (Tr. 119, 135). Mr. Rada was claimant's direct supervisor, making him particularly knowledgeable concerning claimant's job duties. Thus, both witnesses had strong bases for their testimony, making them reliable witnesses.

Finally, claimant's own testimony rebuts her 85 percent estimation. On rebuttal, claimant testified to the following estimates of particular job duties: she answered 10 to 50 phones calls per day and each call lasted between one and three minutes (Tr. 171); she faxed documents five to 20 times per day and each fax took about five minutes (id.); and she copied documents between 1 and five times daily, each session lasting about 10 minutes (id. at 172). Using these figures, claimant spent 10 to 150 minutes per day on phone calls, 25 to 100 minutes per day faxing, and 10 to 50 minutes per day copying. Thus, based on claimant's estimation, she could be spending up to 5 hours a day on phone calls, faxing and copying.[2] This certainly does not fit into her estimation that she was on the keyboard and ten-key 85 percent of her work day since this would leave only 1.2 hours out of an 8 hour day to perform nondata entry work.

In sum, claimant's testimony that she keyboarded and ten-keyed 85 percent of her work day is simply not reliable. Because claimant did not prove this part of her claim, there also is no support for Dr. Rosenbaum's opinion relying on such a history, rendering this opinion unpersuasive. Because the majority holds to the contrary, I dissent.

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[2] I disagree with the majority that all time spent on telephone calls should be counted with claimant's typing. Although claimant told the insurer's investigator that she answered the telephone while typing (Ex. 20-10), at hearing, claimant characterized her time on the telephone as a "non-typing activity." (Tr. 66). Claimant also stated that she paged people and wrote messages when on the phone (Tr. 170), which shows that claimant could not be typing the entire time she was answering telephones.

In the Matter of the Compensation of
JAMES A. LINDEKUGEL, Claimant
WCB Case No. 96-07810
ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
James Booth (Saif), Defense Attorney

On August 22, 1997, we affirmed an Administrative Law Judge's (ALJ's) order that awarded 35 percent (52.5 degrees) scheduled permanent disability for each hand, whereas an Order on Reconsideration awarded 63 percent (94.5 degrees) scheduled permanent disability for each hand. Announcing that the parties have settled this issue in conjunction with a Claim Disposition Agreement (CDA), the SAIF Corporation seeks abatement of our order to await receipt of their agreement.

Based on SAIF's unrebutted representation, we withdraw our August 22, 1997 order. On receipt of the parties' CDA, we will consider the agreement. In the event that the CDA receives our approval, we will proceed with our reconsideration and dismiss the parties' requests for Board review. In the meantime, the parties are asked to keep us apprised of further developments involving this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROXANNE E. ROSENBLATT, Claimant
WCB Case No. 96-05648
ORDER ON REVIEW
Lonergan & Lonergan, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for bilateral forearm strain and right lateral epicondylitis conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exceptions and supplementation. We do not adopt the last sentence of the 15th paragraph of the findings of fact or the last paragraph of the findings of fact.

Dr. Ushman, treating physician, disagreed with the opinion of Dr. Button, examining physician, that claimant's complaints were psychosomatic. (Exs. 35, 37). However, Dr. Ushman also stated: "I cannot say with any certainty what the cause of [claimant's] upper extremity pain is, nor say that her employment was 'most probably' the cause." (Ex. 37). Dr. Ushman did not explain his later change of opinion that claimant's work activities were the major contributing cause of her bilateral forearm strain and right elbow lateral epicondylitis. (Ex. 39).

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Ushman's opinion, the ALJ concluded that claimant established compensability of her occupational disease claim for bilateral forearm strain and right lateral epicondylitis conditions. We disagree.

Claimant has the burden of proving that employment conditions were the major contributing cause of the occupational disease. ORS 656.802(2)(a). She cannot meet this burden merely by disproving other possible explanations of how the disease occurred. ORS 656.266.

The medical evidence regarding causation is divided between the opinion of Dr. Button, M.D., who examined claimant on behalf of the insurer, and the opinions of Dr. Ushman, claimant's treating doctor. Dr. Button opined that claimant had no identifiable pathology, her complaints were psychosomatic, and work activities did not represent the major contributing cause of her subjective presentation. (Ex. 35). Although Dr. Ushman disagreed with Dr. Button that claimant's complaints were psychosomatic, his opinions regarding the cause of her upper extremity complaints varied. (Exs. 13, 19-2, 36-2, 37, 38, 39).

Given the multiple possible causes of claimant's upper extremity condition, we find the issue of the compensability of this 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). Based on the following reasoning, we find there are persuasive reasons not to defer to the opinion of Dr. Ushman.

Prior to leaving work on March 9, 1996, claimant worked part-time, about six hours per day, five days per week. (Tr. 14-16, 25-26, Ex. 6). Claimant returned to part-time work in June 1996. Dr. Ushman first treated claimant on March 11, 1996. (Ex. 8). He initially opined that claimant suffered from overuse of the upper extremities, primarily caused by her employment, which involved a lot of computer and data entry work. (Ex. 13). Due to the illness and death of her grandmother, claimant had to travel to Sweden in April 1996. She returned from Sweden on April 12, 1996.

On May 9, 1996, claimant returned to Dr. Ushman and reported severe bilateral upper extremity pain. (Ex. 19). At that time, Dr. Ushman noted "significant psychological overlay" and stated that he was "at a loss to explain the severity of [claimant's] symptoms given the lack of any objective findings." (Ex. 19-3). He ordered tests to rule out rheumatoid disease or lupus and noted that claimant may be suffering from fibromyalgia. He opined that claimant's problems were "only possibly related to her work because the diagnosis is in doubt." Id. He referred claimant to Dr. Jacobs for a physiatry consultation.

On May 21, 1996, Dr. Jacobs examined claimant. (Ex. 20). He did not think claimant had any underlying significant inflammatory musculoskeletal condition. (Ex. 20-2). He stated that claimant's response to treatment would help establish a diagnosis of soft tissue overuse syndrome or fibromyalgia. If claimant responded well, it was safe to assume the condition represented a soft tissue overuse syndrome and not fibromyalgia. (Ex. 20-3).

On May 23, 1996, Dr. Ushman examined claimant and noted that, despite being off work since March 9, 1996, claimant reported her symptoms were worsening. (Ex. 23-1). Dr. Ushman continued to treat claimant and noted that an ergonomic assessment of claimant's work station showed it was fairly well set up. (Exs. 27, 29, 31, 32, 33). On July 8, 1996, Dr. Ushman referred claimant back to Dr. Jacobs for a follow-up exam. On August 6, 1996, Dr. Jacobs reexamined claimant and opined that her symptoms represented a "soft tissue overuse syndrome or wrist strain." (Ex. 34-2).

On August 19, 1996, Dr. Ushman examined claimant, stating that he had been "treating claimant for overuse of the upper extremities, which [he feels] is the result of her computer use." (Ex. 36-2). He noted that he had reviewed Dr. Jacobs' report and was waiting for the report from claimant's independent medical examination.

On September 3, 1996, Dr. Ushman reviewed Dr. Button's report and disagreed with Button's opinion that claimant's complaints are psychosomatic. (Ex. 37). However, Dr. Ushman also stated that he could not say with any certainty what the cause of claimant's upper extremity pain is, "nor say that her employment was 'most probably' the cause." Id.

In an October 4, 1996 chart note, Dr. Ushman repeated that he disagreed that claimant's problems were psychosomatic, although it was really difficult for him to come up with an exact cause for her symptoms. (Ex. 38-2). He stated that claimant's condition was "probably work-related," noting that "[t]here really is not any other explanation that I can come up with for her symptoms, although it sounds to me as if she has primarily worked part-time and at a work station that was not set up too badly in an ergonomic sense." (Ex. 38-3). Finally, Dr. Ushman stated that claimant's work activities were the major contributing cause of her bilateral forearm strain and right elbow lateral epicondylitis. (Ex. 39).

Claimant argues that the fact that claimant's physicians explored other areas and eliminated them was simply sound medical practice. We agree that an accurate or definitive diagnosis is not required to establish compensability. See Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992). However, claimant must establish that employment conditions were the major contributing cause of the occupational disease, whatever its diagnosis. ORS 656.802(2)(a). Dr. Ushman's opinion does not meet claimant's burden of proof.

As the above summary indicates, Dr. Ushman's causation opinion vacillated even after Dr. Jacobs settled on a diagnosis of "soft tissue overuse syndrome or wrist strain." (Exs. 34-2, 36-2, 37, 38, 39). In this regard, after stating that he could not say that claimant's employment was "most probably" the cause of claimant's upper extremity condition, Dr. Ushman stated that it was "probably work-related." (Exs. 37, 38). However, at the same time, he questioned this relationship by noting that claimant worked part-time at a work station that was "not bad" ergonomically. (Ex. 38-3). Subsequently, without explanation, he stated that the work activities were the major contributing cause of claimant's condition. (Ex. 39). Accordingly, because Dr. Ushman changed his opinion without explanation, we do not find his opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987). Furthermore, because no other medical opinion supports a finding that the work activities were the major contributing cause of claimant's condition, we find that claimant has failed to establish a compensable occupational disease claim.

ORDER

The ALJ's order dated March 28, 1997 is reversed. The insurer's May 23, 1996 denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
VICKIE L. WING, Claimant
WCB Case No. 96-10007
ORDER ON REVIEW
Cole Cary & Wing, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that awarded claimant 33 percent (44.55 degrees) scheduled permanent disability award for loss of use or function of the left foot, whereas an Order on Reconsideration had not awarded claimant additional permanent disability beyond the 17 percent (22.95 degrees) granted by a prior, final Determination Order. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found, relying on the medical arbiter's examination and report, that claimant was entitled to a 16 percent (21.60 degrees) increase in her scheduled permanent disability award for loss of function or use of the left foot. We agree with the ALJ's reliance on the medical arbiter's report, but we conclude that claimant is entitled to an increase of 4 percent - rather then 16 percent - in her scheduled permanent disability award. Therefore, we modify the ALJ's order.

Scheduled Disability

On May 10, 1994, claimant sustained an injury to her left foot, which the insurer ultimately accepted as a crush injury to the left forefoot with a fracture at the distal ends of the proximal phalanx, and Morton's neuroma, left third interspace. The claim was initially closed on December 14, 1994, by a Determination Order that awarded 17 percent (22.95 degrees) scheduled permanent disability for loss of use or function of the left foot. Subsequently, on April 5, 1996, claimant's treating physician, Dr. Malkin, excised the Morton's neuroma.

On July 16, 1996, the claim was again closed by a Determination Order that found claimant to be medically stationary on May 29, 1996, and awarded no additional permanent disability. On August 16, 1996, claimant requested reconsideration, and Dr. Neumann performed a medical arbiter's examination on September 23, 1996 as part of the reconsideration process. An Order on Reconsideration issued on October 8, 1996 affirming the Determination Order in all respects. On reconsideration, the Appellate Review staff of the Workers' Compensation Division relied on the treating physician's closing examination, rather than the medical arbiter's findings.

Claimant requested a hearing. The ALJ relied on the medical arbiter's findings and concluded that claimant was entitled to an additional 16 percent (21.60 degrees) scheduled permanent disability. The insurer requested Board review. On review, we agree that the ALJ properly relied on the medical arbiter's findings in determining the extent of claimant's permanent disability.

Because claimant became medically stationary after June 7, 1995, the claim was closed on July 16, 1996, and the permanent disability rating had not become final by August 19, 1996, the extent of disability is determined pursuant to the Director's disability standards found in WCD Administrative Order 96-051, effective February 17, 1996, as modified by WCD Administrative Order 96-068 (temporary), effective August 19, 1996. OAR 436-035-0003(1), (2); see also Order of Adoption of Temporary Rules, WCD Administrative Order 96-068.

ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." The determination of impairment is further explained in OAR 436-035-0007(13), which provides in material part, that "[o]n reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence."

In analyzing former OAR 436-35-007(9),[1] which is substantively similar to the above-cited rule, the court explained that the rule sets forth the methodology for analysis when there are multiple, conflicting reports about impairment. Snyder v. Barrett Business Services, Inc., 147 Or App 619, 624 (1997). However, when there is no other report evaluating a particular impairment that can be weighed against the arbiter's report, it is inappropriate to rely on the other report's failure to address impairment. 147 Or App at 625.

Here, Dr. Malkin performed a brief final examination, concluding only that claimant had no impairment due to the Morton's neuroma. (Ex. 20). Unlike the medical arbiter, Dr. Malkin did not perform any range of motion measurements or other tests necessary to determine impairment under the Director's rules. Only Dr. Neumann, the medical arbiter, examined claimant and performed tests and measurements to determine impairment. Thus, there is no other report of impairment to weigh against Dr. Neumann's report. Therefore, it is appropriate to rely on the medical arbiter's report of impairment in this case.

Moreover, even if Dr. Malkin's final examination can be considered a report concerning impairment, it does not constitute the preponderance of medical opinion when weighed against Dr. Neumann's report. Dr. Malkin's report is conclusory and was not based on any measurement of impairment. (See Ex. 20). Therefore, Dr. Malkin's report is not persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986). Accordingly, the extent of claimant's scheduled disability is rated based on Dr. Neumann's report.

1. Range of Motion in the Toes

We find, based on Dr. Neumann's report, that claimant is entitled to impairment values for lost range of motion in the toes. (Ex. 23-4).

For the great toe, we find that claimant has 0 degrees flexion in the IP[2] joint, equal to 45 percent impairment, and 29 degrees extension in the MP[3] joint, equal to 14.7 percent impairment. OAR 436-035-0150(1), (3). After rounding 14.7 percent up to 15 percent, and combining 45 percent with 15 percent, claimant's impairment value for the great toe is 53 percent. OAR 436-035-0007(14) and (21)(b).

For the second through fourth toes, claimant is entitled to 28 percent impairment for each toe, calculated as follows. In the MP joint of each toe, claimant has 30 degrees extension, equal to 7 percent, and 0 degrees flexion, equal to 21 percent. OAR 436-035-0160(5), (7). Adding the impairment values (7 percent + 21 percent) equals 28 percent impairment for each toe. OAR 436-035-0007(21)(a).

For the fifth toe, claimant is entitled to 34 percent impairment, calculated as follows. In the MP joint of the fifth toe, claimant has 22 degrees extension, equal to 12.6 percent impairment, and 0 degrees flexion, equal to 21 percent impairment. OAR 436-035-0160(5), (7). After rounding 12.6 percent up to 13 percent, and adding the impairment values for the MP joint (21 percent + 13 percent), the total impairment in the fifth toe is 34 percent.

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[1] Former OAR 436-35-007(9) provided, in material part, that "[o]n reconsiderations, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment."

[2] Interphalangeal.

[3] Metatarsophalangeal.

Pursuant to OAR 436-035-0180, the toe values are converted to foot values and added, for a total of 13 percent impairment in the left foot for lost range of motion.

2. Chronic condition

Pursuant to OAR 436-035-0010(5)(a), claimant is entitled to 5 percent scheduled chronic condition impairment for the lower leg (foot), due to claimant's chronic and permanent medical condition (crush injury left forefoot, fracture of proximal phalanx, and Morton's neuroma) significantly limiting claimant's ability to repetitively use her left foot. (Ex. 23-5).

3. Loss of sensation

Pursuant to OAR 436-035-0200(1), claimant is entitled to 5 percent impairment for the partial loss of plantar sensation in her left foot. (Ex. 23-3, 5).

4. Ability to stand or walk

Claimant is entitled to an award of 15 percent impairment when "objective medical evidence establishes an ability to walk or stand for a cumulative total of two hours or less, in an 8-hour period[.]" OAR 436-035-0200(4)(a). It is claimant's burden to establish entitlement to this impairment value. ORS 656.266. Dr. Neumann opined only that claimant "has no permanent preclusion from walking or standing for two hours or less in an eight hour shift." (Ex. 23-5). With respect to the issue of claimant's ability to stand or walk, Dr. Neumann's opinion is ambiguous. Read literally, Dr. Neumann is stating that claimant is able to walk for two hours or less in an eight hour shift. In any event, Dr. Neumann did not state that claimant is precluded from walking more than two hours during an eight-hour period. Dr. Malkin's opinion similarly does not assist claimant in establishing entitlement to this impairment value. (See Ex. 20). Because there is no medical opinion that identifies restrictions on walking or standing consistent with the Director's standard, claimant has failed to establish entitlement to 15 percent impairment for limitations on her ability to walk or stand.

Calculation

Claimant is entitled to impairment values of 13 percent for range of motion losses in the left foot, 5 percent for chronic condition, and 5 percent for loss of plantar sensation. The values are combined as follows: 13 percent combined with 5 percent equals 17 percent, and 17 percent combined with 5 percent equals 21 percent. OAR 436-035-0007(17). Therefore, claimant is entitled to an award of 21 percent scheduled permanent disability, or an additional award of 4 percent (5.40 degrees) above the 17 percent previously awarded. Accordingly, the ALJ's additional award of 16 percent disability is reduced to 4 percent.

ORDER

The ALJ's order dated April 3, 1997 is modified. In lieu of the ALJ's award, and in addition to claimant's prior 17 percent (22.95 degrees) award of scheduled permanent disability for loss of use or function of the left foot, claimant is awarded 4 percent (5.4 degrees) for a total award of 21 percent (28.35 degrees) scheduled permanent disability for the left foot. The out-of-compensation attorney fee awarded by the ALJ pursuant to ORS 656.386(2) is reduced accordingly.

In the Matter of the Compensation of
JERRY L. BLISS, Claimant
WCB Case No. 96-09525
ORDER ON RECONSIDERATION
Neil Jackson, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of our July 22, 1997 Order on Review that increased claimant's unscheduled permanent disability award for a dermatitis condition from 13 percent (41.6 degrees) to 23 percent (73.6 degrees). Contending that we erroneously rejected its assertion that its acceptance was limited to a transient skin disorder concerning claimant's bilateral forearms and lateral neck and that our $1,000 attorney fee award was excessive, the insurer seeks reversal or modification of our decision.

On August 18, 1997, we abated our July 22, 1997 order to allow claimant an opportunity to respond. Claimant's response to the insurer's motion has been received.

On reconsideration, the insurer renews its argument that it did not accept "dermatitis" but, instead, limited its acceptance to a transient skin disorder ("irritant dermatitis") on claimant's forearms and lateral neck, which resolved and caused no permanent disability. We continue to disagree with this argument.

A carrier is bound by the express language of its acceptance. SAIF v. Mize, 129 Or App 636 (1994). Here, the insurer expressly accepted "dermatitis - bilateral forearm and lateral neck rash." (Exs. 7, 12). Contrary to the insurer's argument, this acceptance is not limited to a transient skin disorder on claimant's forearms and lateral neck, nor is it limited to "irritant dermatitis." The insurer argues that, at the time of its acceptance, only "irritant dermatitis" was definitively diagnosed; therefore, it argues, its acceptance is limited to "irritant dermatitis" and does not include "allergic dermatitis." However, as the express language of the acceptance establishes, the type of dermatitis accepted was not specified.[1]

Furthermore, contrary to the insurer's argument, at the time of acceptance, the diagnosis was not limited to "irritant dermatitis." In this regard, Dr. Key, claimant's then-treating physician, variously considered claimant to suffer from "contact dermatitis," "allergic contact dermatitis," "contact irritant dermatitis versus true allergic sensitization" with a "strong suspicion [of] allergic sensitization," and "coolant dermatitis work exposure," finding it "unclear" whether claimant's condition "may represent a true allergic sensitization."[2] (Exs. 1, 3, 4). More importantly, if the insurer intended to limit its acceptance to a specific type of dermatitis, it should have explicitly done so. It did not. Instead, the insurer accepted "dermatitis" without qualification, except the notation of "bilateral forearm and lateral neck rash." We do not find that this notation limits the acceptance to a specific type of dermatitis.

Instead, this notation appears to describe claimant's symptoms.[3] See Georgia-Pacific v. Piwowar, 305 Or 494 (1988) (a carrier's acceptance of symptoms of an underlying condition is an acceptance of the disease causing the symptoms). Relying on Granner v. Fairview Center, 147 Or App 406 (1997), the insurer argues that the acceptance of a particular condition does not necessarily include acceptance of the cause of that condition. While we agree with that statement of law, we do not find

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[1] The insurer also argues that, if claimant thought that the "allergic dermatitis" was improperly omitted from the notice of acceptance, he was required to request in writing the insurer's acceptance of that additional condition. ORS 656.262(6)(d), (7)(a). However, given the broad language of the "dermatitis" acceptance, without limitation as to the type of dermatitis accepted, there was no reason for claimant to think that his dermatitis condition, whether diagnosed as "irritant" and/or "allergic" dermatitis, was not within the scope of the insurer's acceptance.

[2] We note that claimant began treating with Dr. Weiss, dermatologist, in January 1996. (Ex. 9-1). At that time, Dr. Weiss diagnosed "allergic vs. irritant dermatitis, probably to coolants." (Ex. 9-2). After further treatment, Dr. Weiss concluded that claimant had both allergic and irritant dermatitis. (Ex. 9-3, 11).

[3] The notation could also be interpreted to mean that the "dermatitis" refers to the "bilateral forearm," whereas the "rash" refers to the lateral neck. However, neither interpretation supports the insurer's position.

that it supports the insurer's position. Here, the insurer accepted both a condition (dermatitis) and symptoms of that condition ("bilateral forearm and lateral neck rash"). Thus, the reasoning in Granner does not preclude application of Piwowar. Therefore, to the extent that claimant's dermatitis, whether "allergic" or "irritant," might be considered an underlying condition, having accepted symptoms of that condition, the insurer has accepted that condition.

The insurer also relies on Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996), rev den 324 Or 513 (1997), in support of its argument that its acceptance was limited to a temporary skin disorder. We find Windom-Hall distinguishable. There, the acceptance was limited to "prolonged exposure to fumes from roofing -- caused dizziness and headaches." The court found that the carrier's acceptance was qualified, as a matter of law, pursuant to Piwowar, 305 Or at 501, and was limited to those symptoms caused by prolonged exposure to fumes from roofing. In contrast, here, the acceptance was not limited to an event or exposure. Rather, the insurer accepted "dermatitis" without qualification, except for the notation "bilateral forearm and lateral neck rash." That notation does not limit the acceptance to an event or exposure, nor does it limit acceptance to a temporary skin disorder.

Finally, the insurer argues that if we affirm our prior decision on the merits, the $1,000 attorney fee we awarded for services on review should be reduced. On reconsideration, we agree. After considering the factors set forth in OAR 438-015-0010(4), we find $500 is a reasonable fee for services on review. In reply to the insurer's respondent's/cross-appellant's brief, particularly considering the time devoted to the issue (as represented by claimant's reply brief), the complexity of the issue, and the value of the interest involved.

Claimant is also entitled to an additional assessed attorney fee for his counsel's services on reconsideration. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration in response to the insurer's motion for reconsideration concerning the extent of unscheduled permanent disability issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the insurer's request for reconsideration), 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 July 22, 1997 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TYRONE BLOCKER, Claimant
WCB Case No. 96-11076
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the first six paragraphs of the ALJ's "Findings of Fact and Decision" with the following change. In the first paragraph on page 2, we change the last sentence to read: "The chart note in the section regarding anticipated permanent impairment reads 'probably none.' (Ex. 9)."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted right forearm contusion. The ALJ relied on Dr. Noall's range of motion findings on May 9, 1996 to conclude that claimant was entitled to a scheduled permanent disability award of 5 percent.

The insurer argues, among other things, that there is no evidence that claimant's right elbow range of motion findings were abnormal for him. The insurer argues that the ALJ erred in failing to evaluate claimant's right elbow impairment by comparing it to the contralateral joint pursuant to OAR 436-035-0007(22).

OAR 436-035-0007(13) (WCD Admin. Order No. 96-051) provides, in part:

> "Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0080 except where a preponderance of medical opinion establishes a different level of impairment pursuant to ORS 656.726(3)(f)(B)."

On May 9, 1996, Dr. Noall, claimant's attending physician, reported that range of motion findings for the right elbow were 130-0-0 for flexion-extension. (Ex. 6). In the same report, under "[a]nticipated permanent impairment," he indicated "[p]robably none." (Id.) Dr. Noall examined claimant again on October 17, 1996, but did not mention any findings regarding the right arm. (Ex. 9). In a concurrence letter from the insurer on November 4, 1996, Dr. Noall agreed that there was no impairment in the right arm/elbow due to claimant's work injury. (Ex. 10).

In light of Dr. Noall's subsequent letter finding no impairment in claimant's right arm/elbow, we are not persuaded that claimant is entitled to a scheduled permanent disability award for the right arm. Moreover, there is no evidence that Dr. Noall measured claimant's left arm/elbow for purposes of comparison.

OAR 436-035-0007(22) provides, in part: "The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease." Here, the record contains no evidence of injury or disease in claimant's left arm/elbow so as to preclude a comparison of that joint to the injured right arm/elbow pursuant to OAR 436-035-0007(22). See William L. Fischbach, 48 Van Natta 1233 (1996). Because Dr. Noall did not record claimant's uninjured left elbow/arm range of motion findings for comparison, we are not persuaded by his range of motion findings for the right arm/elbow. We conclude that claimant is not entitled to a scheduled permanent disability award for the right arm. Consequently, we reverse the ALJ's 5 percent scheduled permanent disability award for the right arm.

ORDER

The ALJ's order dated March 27, 1997 is reversed. The Order on Reconsideration is reinstated and affirmed.

In the Matter of the Compensation of
HELEN F. ILES, Claimant
WCB Case No. 96-07741
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, Skopil, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

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

FINDINGS OF FACT

Claimant was compensably injured on November 10, 1993, when she fell from a ladder at work. Claimant was treated that same day by Dr. Ferguson, who diagnosed a left arm sprain and referred her for physical therapy. In December 1993, the employer accepted claimant's left arm strain.

On April 14, 1994, claimant treated with Dr. Hanley, on referral from Dr. Ferguson, for left shoulder pain and neck and interscapular pain. Dr. Hanley recommended an MRI.

An April 21, 1994 MRI was essentially normal with mild spondylosis at C5-6.

In July 1994, Dr. Hanley operated on claimant's left rotator cuff. Claimant underwent further physical therapy for her left shoulder.

Claimant's left arm claim was closed by a May 26, 1995 Notice of Closure that awarded temporary disability benefits and 28 percent unscheduled permanent disability for the left shoulder.

In April 1995, an MRI showed a left shoulder torn tendon. The May 1995 Notice of Closure was withdrawn. In July 1996, Dr. Hanley operated again on the left shoulder rotator cuff, and claimant underwent physical therapy.

In February 1996, Dr. Hanley referred claimant to Dr. Schmidt to evaluate her neck complaints. Dr. Schmidt found restricted cervical range of motion and significant pain behavior. Dr. Schmidt reported no evidence of a disc herniation and diagnosed cervical strain historically related to the work injury of 1993.

On March 13, 1996, Dr. Schmidt declined to answer questions of causation and reported that such inquiries were best answered by claimant's early history as recorded in her initial physician's evaluation.

Claimant was examined by the Western Medical Consultants on June 28, 1996. The Consultants found no specific cervical diagnosis.

On July 19, 1996, Dr. Hanley concurred with the Consultants' report.

On August 15, 1996, the employer issued a partial denial of claimant's cervical condition.

On August 29, 1996, a Notice of Closure closed the left arm claim with an award of temporary disability benefits and 26 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that it was unclear when claimant's neck pain began. However, the ALJ concluded that, because Dr. Hanley's opinion related claimant's cervical complaints to the injury, claimant met her burden of proof. We disagree.

For the following reasons, we conclude that, whether this matter is analyzed as a consequential condition (requiring the major contributing cause standard), or as a direct result of the accidental injury (requiring only a material contributing cause), claimant has failed to meet her burden of proof. See ORS 656.005(7)(a); 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

On review, claimant argues that this is not a case requiring expert medical opinion. We disagree. In Barnett v. SAIF, 122 Or App 279, 283 (1993), the court held that factors for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, as noted by the ALJ, it is not clear whether claimant's neck symptoms appeared immediately. Claimant's left shoulder injury was reported immediately after the November 1993 injury, but the neck symptoms were not initially reported. Claimant's neck complaints were first documented approximately six months after the injury, and after an essentially normal MRI, claimant did not receive further treatment for her neck until February 1996.

Next, we find no evidence that claimant had experienced neck problems in the past. Nevertheless, the Consultants have not related claimant's neck symptoms to the injury, and have cited to claimant's pain behavior and degenerative changes as a possible explanation for her complaints. Finally, Dr. Hanley, the only doctor whose opinion arguably supports compensability, has testified that claimant's signs and symptoms have been "perplexing" from the start, and things "were not adding up very clearly from the very beginning...". (Ex. 151-17). At the time of his deposition, Dr. Hanley stated that he still did not "know exactly what's going on" and although Dr. Schmidt had diagnosed a cervical strain, Dr. Hanley was "not sure that is what's causing all of her symptoms." (Ex. 151-19).

Under the circumstances, we conclude an expert medical opinion is necessary in order to determine whether claimant's current cervical condition is related to the compensable left shoulder condition. Specifically, we conclude that Dr. Hanley's opinion supports a finding that the situation is complicated. Additionally, the Consultants' report does not relate claimant's cervical condition to the injury, and it is not clear whether claimant's neck symptoms appeared immediately.

There are three medical opinions that discuss claimant's current neck condition. The Consultants, who examined claimant on behalf of the employer, found no specific diagnosis of a cervical condition. The Consultants reported some tightness and stiffness in claimant's neck musculature, but believed that it was limited by her pain behavior and the fact that she had not done any cervical spine exercises. The Consultants also found that claimant had some degenerative change, which played a role. (Ex. 144).

Dr. Schmidt examined claimant on referral from Dr. Hanley for an evaluation of her neck complaints. However, when asked, Dr. Schmidt deferred questions of causation to claimant's earlier treating physicians because he did not see claimant until three years after the injury. Dr. Schmidt reported that the issue was "best answered by [claimant's] early history as recorded in her initial physician's evaluation." (Ex. 142a).

Finally, Dr. Hanley, who performed claimant's left shoulder surgery, initially concurred with the opinion of the Consultants. (Ex. 145). Dr. Hanley later reported that, based on the history that was given to him, the cervical pain was caused by the original work injury. (Ex. 150).

Accordingly, only Dr. Hanley's opinion can be construed to support compensability. However, after reviewing Dr. Hanley's reports and deposition, we do not find his opinion to be persuasive.

First, we note that, in relating claimant's current neck condition to the 1993 injury, Dr. Hanley has primarily relied on a history of claimant developing neck pain within a "couple of days" after the injury. (Ex. 149-1). Claimant testified at hearing that she began having neck pain about a week after the injury. However, claimant also testified that, in the months following the injury, she mentioned her neck pain to Dr. Ferguson "many times." Claimant could not remember how many times she told Dr. Ferguson about her neck pain, but she agreed that she told him "over and over again." (Tr. 19).

As previously noted, there is no documentation in the record of neck pain until four months after the injury. Furthermore, there is no report of neck pain in Dr. Ferguson's chartnotes, although claimant treated with Dr. Ferguson on at least eight occasions after the injury. Additionally, Dr. Hanley testified that he "certainly would think" that Dr. Ferguson would have written such complaints down if claimant had informed him of neck problems. (Ex. 150-39, 40).

Under the circumstances, we are unable to find that Dr. Hanley's history of neck pain developing within days after the injury is accurate.[1] For that reason, we do not find that his opinion is persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

Additionally, Dr. Hanley's opinion is based on a temporal analysis. In this regard, Dr. Hanley testified that he had found claimant's symptoms and signs to be "perplexing" from the start, and "[t]hings were not adding up very clearly...". (Ex. 151-17). Dr. Hanley deferred to Dr. Schmidt's diagnosis, but nevertheless, testified that he still did not know "exactly what's going on" and did not have a good explanation for her symptoms. (Ex. 151-19). Finally, Dr. Hanley testified that he was not certain that the cervical strain diagnosed by Dr. Schmidt was causing all of claimant's symptoms. (Ex. 151-19). Despite these statements, Dr. Hanley testified that the only thing he could conclude was that if claimant did not have prior problems with regard to her neck and shoulder prior to the injury, he could safely say that her current neck and shoulder problems were "in some way related" to the injury. (Ex. 151-3).

Consequently, because Dr. Hanley's opinion is based on a temporal analysis, we do not find it persuasive. See Allie v. SAIF, 79 Or App 284 (1986). Additionally, claimant may not solely rely on the deductive reasoning that, because her conditions did not occur until after work exposure and cannot be proven to have been caused by another causative agent, it must have been caused by the work exposure. ORS 656.266; Bronco Cleaners v. Velazquez, 141 Or App 295, 299 (1996).

We are also unable to rely on Dr. Hanley's opinion as we find that he has not discussed the other possible causes of claimant's neck condition. For example, both Dr. Schmidt (who Dr. Hanley referred claimant to because of his expertise and in order to directly address claimant's neck condition) and the Consultants found significant pain behavior. (Exs. 141-2; 144-5). Additionally, the Consultants noted degenerative changes as playing a role in claimant's condition. (Ex. 144-5). However, in reaching his conclusion that the 1993 injury caused claimant's current neck condition, Dr. Hanley did not discuss other possible contributors. See Jimmie L. McCartney, 48 Van Natta 2589 (1996) (Medical opinion lacked persuasiveness where other potential contributing causes were not weighed).

Finally, Dr. Hanley concurred in the opinion of the Consultants, who did not find that claimant's current condition was work-related. Dr. Hanley attempted to explain how he believed that the Consultants' finding of no cervical condition could be reconciled with Dr. Schmidt's diagnosis. However, Dr. Hanley did not explain why he had originally agreed with the remainder of the Consultants' report which found no work connection and possible contribution from pain behavior and degenerative changes. Consequently, without further explanation, we do not find Dr. Hanley's changed opinion to be persuasive.

For the above reasons, we find that the record lacks expert medical evidence to meet claimant's burden of proof under either a material or the major contributing cause standard. Accordingly, we reverse the ALJ's order.

ORDER

The ALJ's order dated February 27, 1997 is reversed. The self-insured employer's August 15, 1996 partial denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Despite claimant's testimony that she had neck complaints days after the injury, we do not find that claimant's testimony is sufficient. The ALJ did not make a credibility finding. Furthermore, based on Dr. Hanley's testimony and the number of times claimant described complaining about a condition which was never documented by Dr. Ferguson, we are unable to accept claimant's testimony regarding the onset of neck symptoms.

In the Matter of the Compensation of
EDWARD M. JANUARY, Claimant
WCB Case No. 96-08893
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial of claimant's aggravation claim. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ held that claimant had failed to establish an actual/pathological worsening of his compensable low back condition. On this basis, the ALJ upheld SAIF's aggravation denial.

On review, claimant asserts that the opinion of his attending physician, Dr. Kelly, establishes that he has sustained an actual worsening of his low back condition under ORS 656.273(1). Based on the following reasoning, we agree.

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 alone. 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, based upon the conclusion of a medical expert, that the compensable condition has worsened. Specifically, the court in Walker stated:

> "Under the amended statute, in order for a symptomatic worsening to constitute an 'actual worsening,' a medical expert must conclude 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 * * *. We hold that proof of a pathological worsening is required." (Emphasis in original). Id at 236.

It stands to reason that what constitutes a "pathological worsening" depends on the nature of the compensable condition. For example, what constitutes a pathological worsening of a strain is not the same as what constitutes a pathological worsening of a herniated disc. In the present case, the accepted conditions are L1 burst fracture, left fibula fracture, fractured left calcaneous, lumbar strain, coccyx contusion and right wrist strain. At issue in this aggravation claim is whether or not the accepted lumbar strain condition has compensably worsened.

There are two medical opinions that address whether claimant's compensable lumbar strain condition has worsened. Drs. Wilson and Arbeene examined claimant on behalf of SAIF. They opined that claimant had a symptomatic flare up of his lower back pain, which claimant relates to his May 22, 1996 compensable injury. The physicians stated that claimant had no objective findings supporting his symptomatic flare up. (Ex. 27).

Dr. Kelly, claimant's attending physician, concurred with the report of Drs. Wilson and Arbeene. With regard to objective findings, however, Dr. Kelly indicated that her examinations revealed limited forward flexion secondary to claimant's voluntary guarding and muscle tightness in the paraspinous muscles beginning at about L3 and extending to the sacrum. Claimant's subjective findings included diffuse pattern of back tenderness extending bilaterally from L3 to across the sacrum.

Claimant's neurological and motor exams were normal. Dr. Kelly indicated that claimant's subjective findings outweighed his objective findings. (Ex. 38). Dr. Kelly later clarified that claimant's "voluntary guarding" on forward flexion was not secondary to pain. (Ex. 42-2).

Dr. Kelly also answered the following question in the affirmative: "In your opinion, in a situation such as this where the accepted condition is one of lumbar strain, do the increased symptoms which [claimant] experienced in the lumbar region following the 5/22/96 incident represent a worsening, although perhaps only a temporary worsening, of that chronic lumbar strain?" We interpret Dr. Kelly's opinion to be that claimant's lumbar strain condition has temporarily worsened.

We normally defer to the opinion of the treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to Dr. Kelly's opinion. Under the legal standard set forth in Walker, Dr. Kelly's opinion is sufficient to establish an "actual" worsening of claimant's low back condition because Dr. Kelly has concluded that claimant's "symptoms have increased to the point that it can be said that the *condition* has worsened." Such an opinion satisfies the legal definition of an "actual worsening."

Moreover, we also find that claimant's actual worsening is supported by "objective findings." Although the evidence of "objective findings" is sparse, we conclude that Dr. Kelly's findings of muscle tightness in the paraspinous muscles constitutes an "objective finding" because it is a verifiable indication of injury that is observable. See ORS 656.005(19); Tony D. Houck, 48 Van Natta 2443 (1996).

Accordingly, we conclude that claimant has established a compensable aggravation claim under ORS 656.273(1). Therefore, we set aside the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services 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 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated January 15, 1997 is reversed. SAIF's denial is set aside and the claim remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,000, payable by SAIF.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that an actual, i.e., pathological worsening has been established. In addition, I find that there are no "objective findings" to support a compensable aggravation under ORS 656.273(1).

Under SAIF v. Walker, 145 Or App 294 (1996), proof of a pathological worsening is required to establish a compensable aggravation claim. In order for a symptomatic worsening to constitute an actual worsening, there must be medical evidence that the condition has worsened.

Dr. Kelly's conclusory and unexplained agreement that claimant's increased symptoms constituted a "temporary worsening" of the strain is not sufficient to establish a pathological worsening. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). This is especially true when read in conjunction with Dr. Kelly's prior concurrence with the examining physicians' report which found, among other things, that there were no objective findings to support claimant's symptomatic flare-up. Inasmuch as Dr. Kelly provided no explanation for the apparent change of opinion, I do not consider it persuasive evidence that claimant's strain condition has worsened. See Kelso v. City of Salem, 87 Or App 630 (1987).

Dr. Kelly also indicated that claimant's subjective findings outweighed his objective findings. At the very least, Dr. Kelly should have explained how claimant's worsened symptoms (without objective findings) represented a pathological worsening of the compensable strain. In the absence of such an explanation, Dr. Kelly's opinion does not carry claimant's burden of proof with regard to either an actual worsening or the requirement that the actual worsening be supported by "objective findings."

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case Nos. 95-13275 & 95-13274
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) affirmed a "post-authorized training program" Determination Order that awarded no unscheduled permanent disability for a psychological condition; and (2) did not award "substantive" temporary disability beyond that granted by the Determination Order. The self-insured employer cross-requests review, seeking clarification of the ALJ's procedural temporary disability and penalty awards. On review, the issues are extent of unscheduled permanent disability, temporary disability and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's reasoning and conclusions regarding the issue with the following supplementation.

Claimant seeks an award of unscheduled permanent disability for her compensable psychological condition. However, claimant's current psychological condition was denied on April 25, 1995. We agree with the ALJ's conclusion that claimant's current psychological condition is not different from claimant's compensable psychological condition. That denial was never appealed and has become final. Under such circumstances, claimant has not established entitlement to an award of permanent disability due to the compensable injury.

Moreover, even if the denial of claimant's current psychological condition is for a condition different than the compensable psychological condition, the record lacks evidence of permanent disability from the compensable psychological condition. In this regard, claimant's attending physician made no findings of permanent disability due to the compensable psychological condition. There was no medical arbiter exam; therefore, there is no evidence of ratable impairment in the record. See ORS 656.214(5); OAR 436-035-0270(2) (if no measurable impairment under the standards, no award of unscheduled permanent disability shall be allowed). Under such circumstances, claimant is not entitled to an award of unscheduled permanent disability for the psychological condition.

Substantive Temporary Disability

We adopt and affirm the ALJ's reasoning and conclusions regarding claimant's entitlement to substantive temporary disability with the following supplementation.

Claimant seeks an award of substantive temporary disability greater than that awarded by the August 25, 1995 Determination Order. The record contains no medical evidence that claimant was disabled by the compensable psychological condition after May 16, 1990.

Procedural Temporary Disability

We adopt the ALJ's reasoning and conclusion regarding claimant's entitlement to procedural temporary total disability with the following supplementation and modification.

The employer seeks clarification of the ALJ's order directing it to pay previously awarded temporary total disability benefits under ORS 656.313(1)(a)(A). Specifically, the employer contends that claimant is not entitled to procedural temporary total disability from May 7, 1993 (the date of the

previous Determination Order) until September 6, 1994 (the day prior to ALJ Thye's order setting aside the May 7, 1993 Determination Order and directing the employer to begin temporary disability payments). We agree that the employer was only required to pay temporary disability benefits that accrued from the date of ALJ Thye's order awarding temporary disability benefits.

In previous litigation, we held that the employer was obligated to make temporary disability payments until the claim was closed on May 7, 1993. Mary J. McKenzie, 46 Van Natta 187, 189 (1994). That order was affirmed by the court and has now become final. Subsequently, ALJ Thye's September 7, 1994 order set aside the May 7, 1993 Determination Order and directed the employer to pay temporary disability from May 17, 1990 until termination was authorized by law. The employer appealed ALJ Thye's order and stayed payment of prospective temporary disability benefits as permitted by ORS 656.313(1)(a). By the time the appeal of ALJ Thye's order became final (which was February 12, 1997) and the stay was lifted, claimant's claim had been closed by an August 25, 1995 Determination Order which awarded no temporary disability past May 16, 1990. Thus, by the time the "stay" was lifted, the August 25, 1995 Determination Order had determined that claimant had no "substantive" entitlement to temporary disability for the period between May 7, 1993 and September 6, 1994. Accordingly, the employer is under no statutory obligation to pay temporary disability for that period.

Finally, the employer acknowledges that the award of temporary disability running from September 7, 1994 until those benefits are appropriately terminated is final. However, the employer asserts that procedural temporary disability benefits should terminate on April 25, 1995, the date on which the employer denied claimant's current psychological condition. We disagree.

ORS 656.268(3) provides the bases for termination of procedural temporary total disability. A pre-closure denial of the claim is not a basis under the statute for termination of procedural temporary disability benefits. Thus, we conclude that the benefits must legally continue until August 25, 1995, the date the claim was closed.[1] See Robert W. North, 46 Van Natta 1869 (1994).

Penalty

We adopt the ALJ's penalty assessment with the following modification.[2]

The ALJ assessed a new penalty if the previously awarded temporary disability benefits were not paid within 14 days of the date of the court's December 4, 1996 opinion affirming our prior order. We modify the ALJ's order to provide that a new penalty is assessed if the temporary disability benefits were not paid within 14 days of February 12, 1997, the date of the court's appellate judgment in WCB Case Nos. 94-15132 and 95131. See SAIF v. Castro, 60 Or App 112, rev den 294 Or 491 (1982); Meridee A. Kaiel, 47 Van Natta 2058 (1995).

ORDER

The ALJ's order dated January 23, 1997 is modified in part and affirmed in part. In lieu of the ALJ's procedural temporary disability award, claimant is awarded temporary disability from November 17, 1992 to May 7, 1993 and from September 7, 1994 until the August 25, 1995 Determination Order. The ALJ's penalty award is modified. In lieu of the ALJ's penalty assessment, the employer shall pay a 25 percent penalty based on any amounts due which were not paid within 14 days of the court's February 12, 1997 appellate judgment. This penalty shall be equally shared by claimant and her counsel. The remainder of the order is affirmed.

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[1] In reaching this conclusion, we emphasize that we are offering no comments on the procedural validity of the employer's "pre-closure" denial on its merits. Because the denial was not appealed, that issue is not properly before us. Instead, our ruling is solely confined to a determination that the employer's "pre-closure" denial of claimant's then-current psychological condition does not entitle it to terminate temporary disability payable on an open claim.

[2] The penalty in this case is not to be confused with the penalties that have been assessed in prior litigation.

In the Matter of the Compensation of
DEAN A. STUBBS, Claimant
WCB Case No. 96-07689
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 14, 1997 Order on Review which: (1) found that claimant's temporary disability rate was to be determined using "the intent of the most recent wage earning agreement as confirmed by the employer and worker" pursuant to former OAR 436-60-025(5)(a); and (2) determined that the employer's "801" form represented the parties' intent at the time of claimant's rehire on September 12, 1995. In its request for reconsideration, SAIF notes that there are two "801" forms in the record, with the employer filling out the "801" form found at Exhibit 10-1 and claimant apparently filling out the "801" form found at Exhibit 10-2. SAIF also asserts that our final order language is inconsistent with the parties' intent as expressed in these two "801" forms.

On July 29, 1997, we abated our July 14, 1997 order to allow claimant an opportunity to respond. Subsequently, we received claimant's response which opposed SAIF's motion for reconsideration. Specifically, claimant disputed SAIF's interpretation of the parties' intent as expressed in the 801 forms.

On reconsideration, SAIF neither disputes the applicability of former OAR 436-60-025(5) nor contends that the "801" forms do not represent the parties' intent at the time of claimant's rehire. Instead, SAIF basically makes two contentions regarding these "801" forms. First, SAIF notes that we initially stated in the opinion portion of our prior order that "the '801' form completed by the employer stated that claimant worked five days per week, 10 to 18 hours per shift (on a 70 hour, eight day log book), at $10 per hour." (Order on Review, page 6 (emphasis added)). However, we later abbreviated this language by stating that the parties' intent at the time of rehire was for claimant to "work five days per week, 10 to 18 hours per day, at $10 per hour." Id. (Emphasis added). In addition, we restated this abbreviated language in the order language portion of our prior order. SAIF notes that both "801" forms state that claimant worked "10 to 18 hours per shift" and our references to "10 to 18 hours per day" is in error. (Ex. 10). We agree and correct our language to read "10 to 18 hours per shift." Id.

Second, SAIF notes that portions of the "801" form filled out by the employer differ from that apparently filled out by claimant. In this regard, the employer explained the varying hours per shift by stating that claimant worked on a 70 hour, eight day log book and indicated claimant worked five days per week, with Saturdays and Sundays off. (Ex. 10-1). In contrast, claimant explained the varying hours per shift by stating that he worked on a 70 hour per week log book, seven days per week. (Ex. 10-2). The employer listed a wage of $10 per hour; claimant did not list a wage. (Ex. 10-1, -2). Based on this, SAIF contends that "claimant worked 10 to 18 hours per shift, with a maximum of 70 hours over the course of an 8-day 'log book.' This amounts to 8.75 hours per day (70 hours divided by 8 days equals 8.75 hours per day)." Motion for Abatement and Reconsideration, page 2 (emphasis in original). SAIF further contends that we should direct it "to calculate claimant's temporary disability rate based on a five-day work week, averaging 8.75 hours per day, at $10 per hour[,]" which results "in an average weekly wage of $437.50." Id.

Although claimant agrees that, at the time of his rehire, his wage was $10 per hour on a five day work week, he disputes SAIF's interpretation of the parties' intent regarding the number of hours worked per week and its resulting calculation of an average weekly wage of $437.50. We agree with claimant.

Nothing in the record supports SAIF's speculation that the reference to a 70 hour, eight day log book in the employer's 801 form results in an average work week of 43.75 hours [8.75 hours per day times five days per week] and an average weekly wage of $437.50 [43.75 hours per week times $10 per hour]. Furthermore, such speculation disregards the employer's explicit statement that claimant worked 10 to 18 hours per shift, five days per week. (Ex. 10-1). Moreover, the 48 hours[1] claimant actually

[1] We arrive at this 48 hour period based on the following. Claimant was rehired on September 12, 1995, and was unable to continue working after his injury on September 14, 1995, a period of three days. During this period, claimant was paid $480, which results in 48 hours of work at $10 per hour. (Exs. 10, 12-2).

worked during the three days between his rehire date, September 12, 1995, and the date of injury, September 14, 1995, results in an average of 16 hours per shift, which is within the parties' agreement that claimant worked between 10 to 18 hours per shift. (Ex. 10).

Given a shift duration of between 10 to 18 hours, it is reasonable to assume that claimant was unable to work more than one shift per day. Therefore, over a five day work week, claimant would work between 50 and 90 hours, which results in an average work week of 70 hours.[2] Consequently, SAIF is directed to calculate claimant's time loss rate based on these findings and conclusions regarding the parties' intentions concerning claimant's employment.

Claimant's attorney is entitled to an additional assessed attorney fee for his services on reconsideration. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration concerning the rate of temporary disability issue is $300, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the insurer's request for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our July 14, 1997 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] We note that our calculation of an average work week of 70 hours work is consistent with the parties' reference to a 70 hour log book. (Ex. 10).

In the Matter of the Compensation of
DAN A. STURTEVANT, Claimant
WCB Case No. 96-05158
ORDER ON RECONSIDERATION
Cole, Cary & Wing, Claimant Attorneys
Stoel Rives, Defense Attorneys

On June 5, 1997, we abated our May 7, 1997 Order on Review which affirmed Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's occupational disease claim for osteoarthritis of the lumbosacral spine and left L5-S1 foraminal stenosis. We took this action to consider the self-insured employer's motion for reconsideration. We have received claimant's response to the motion, including his "cross-request" for an additional assessed fee award for his attorney's services on reconsideration, and the employer's reply. We now proceed with our reconsideration.

Before considering the merits of the motion, we first address claimant's motion to strike the employer's "reconsideration brief" pursuant to OAR 438-011-0035(2), which provides that "[a] request for reconsideration of a Board order shall include a concise statement of the reason(s) reconsideration is requested." Noting that the employer did not submit an appellant's brief on Board review, claimant argues that the employer's reconsideration brief constitutes nothing more than an (untimely filed) appellant's brief that is directed solely to the ALJ's order. Asserting that the reconsideration brief does not contain a concise statement of the reason(s) reconsideration is requested concerning the Board's order, claimant contends that the motion should not be considered. In addition, claimant contends that, because the employer did not file an appellant's brief on Board review, it should not be allowed to file its brief on reconsideration.

Claimant's motion to strike is denied. Although the employer's reconsideration brief is directed to the findings and conclusions contained in the ALJ's order, because our Order on Review "adopted and affirmed" the ALJ's order in its entirety, the employer's challenge to the ALJ's findings and conclusions amounts to a challenge to our findings and conclusions. Furthermore, in its reconsideration brief, the employer set forth in a succinct manner three main arguments to support its challenge to our

(and the ALJ's) findings and conclusions. Those arguments provide "a concise statement of the reason(s) reconsideration is requested," within the meaning of OAR 438-011-0035(2). Accordingly, we find no authority for striking the employer's motion and reconsideration brief.[1] See Marie E. Kendall, 47 Van Natta 335 (1995) (waiver of respondent's brief did not preclude carrier from seeking reconsideration of Board order by contesting findings and conclusions reached in that decision).

We turn to the merits of the employer's motion. It contends that claimant's occupational disease claim for osteoarthritis of the lumbosacral spine and left L5-S1 foraminal stenosis should be analyzed under 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." The employer argues that claimant had degenerative disc disease which preexisted the commencement of his employment in 1973. It points to claimant's testimony that he has had low back problems for about 25 years. (Tr. 32). We note claimant's additional testimony that his problems were "mostly" in the upper back. (Id.) Furthermore, there is no medical evidence to support a finding that the "low back problems" which claimant had 25 years ago were due to degenerative disc disease. Without such evidence, claimant's testimony of "low back problems" is not sufficient to establish there was preexisting degenerative disc disease.

Although there are medical opinions in the record which described claimant's spinal condition as preexisting or longstanding, (see Exs. 21, 27-2, 30-7), those opinions were apparently based on the erroneous assumption that a condition which developed during the previous 20 years (or before 1996) was a "preexisting condition." Because claimant's occupational disease claim is based on his exposure to "employment conditions," however, and not based on a discrete injurious event, a "preexisting condition" in this context is one that preceded his employment with the employer. Therefore, only conditions that were in existence prior to the commencement of his employment in 1973 may be deemed "preexisting conditions" within the meaning of ORS 656.005(24). For the reasons discussed above, we do not find sufficient evidence in the record to prove, by a preponderance of the evidence, that claimant's degenerative disc disease was in existence before his employment began in 1973.

The employer next argues that the ALJ made a finding of a "preexisting condition" when noting that claimant had a hereditary "predisposition" to the development of degenerative disc disease. Based on that finding, the employer asserts that claimant's claim is "based on the worsening of a preexisting disease or condition" and must therefore meet the compensability standard set forth in ORS 656.802(2)(b). Even assuming that claimant had a hereditary predisposition, we do not find that claimant's claim is based on a worsening of the "predisposition" itself. Rather, his claim is for the development of lumbosacral osteoarthritis and foraminal stenosis, conditions that appear to be separate and distinct from a hereditary "predisposition." Nonetheless, even if we assumed that the development of osteoarthritis and foraminal stenosis constituted a "worsening" of the hereditary predisposition, we conclude that the medical evidence carried claimant's burden of proof under ORS 656.802(2)(b).

For the reasons discussed by the ALJ, we find the medical opinion of the treating physician, Dr. Miller, to be more persuasive than the opinions of the examining physicians, Drs. Stanford, Brooks and Platt. In this regard, we reject the employer's contention that only Drs. Stanford, Brooks and Platt evaluated the relative contribution of different causes to the development of claimant's back condition. Dr. Miller reviewed the reports by Drs. Stanford, Brooks and Platt, including their evaluation of causal factors such as heredity, obesity, and physical activities. (Exs. 20, 27, 34). Although he agreed that claimant's condition was multi-factorial in origin, he maintained that "51 percent" of the cause was attributable to work activities. (Ex. 34). Reasoning that such degenerative conditions result from physical activities, he noted that claimant's work activities, specifically repetitive bending and lifting, were the most significant stress-related activities that claimant performed during the development of his degenerative condition. (Exs. 20, 27, 34).

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[1] Had we considered the employer's reconsideration brief to merely represent a submission of an untimely filed appellant's brief, we might have declined to review its contentions. See Deryl E. Fisher, 38 Van Natta 982 (1986) (untimely appellant's brief rejected when resubmitted as reply brief). However, because we interpret the employer's arguments to be primarily directed toward our affirmance of the ALJ's order, we consider its submission to represent a motion for reconsideration of our decision. In reaching this conclusion, we trust that the parties attempt to file their appellate arguments in a timely manner. If followed, such a practice allows the Board to address all of the parties' issues in an efficient manner without the need for additional arguments and orders.

Dr. Miller's opinion was supported by claimant's testimony describing his physical activities during 23 years of employment in various positions for the employer. (Tr. 9-20). Those physical activities included extensive, repetitive bending and lifting. (Id.) Although claimant also engaged in off-work physical activities, including cutting brush and firewood on his 150 acres of timber land, (Tr. 37-39), we are persuaded that his most physically strenuous activities during the development of his degenerative back condition were his work activities. Thus, Dr. Miller's opinion is supported by claimant's testimony.

In contrast to Dr. Miller's opinion, Drs. Brooks and Stanford's opinion is not as well-reasoned. They reported the absence of a single work activity or injurious event which caused claimant's condition. (Exs. 17-7, 21-2). In so doing, they appeared to overlook the causative impact of claimant's work activities as a whole. Inasmuch as claimant's claim is based on his work activities during 23 years of employment, not on a discrete injurious event, Drs. Stanford and Brooks' opinion must be discounted.

Dr. Platt considered claimant's physical activities as a causative factor, but concluded that heredity was the primary cause of claimant's condition. (Ex. 30-7; Tr. 63). In explaining his opinion on cross-examination, however, he appeared to make the same error as Drs. Brooks and Stanford by pointing to the absence of a specific injury. (Tr. 72-73). Moreover, Dr. Platt's conclusion appeared somewhat speculative as he did not persuasively rebut Dr. Miller's opinion that physical activities were a causal factor in claimant's condition and that, as between claimant's activities on and off the job, his work activities were the most physically strenuous and therefore the primary causal factor in his condition. For these reasons, as well as those discussed by the ALJ, we find Dr. Miller's opinion most persuasive. Accordingly, claimant has proven his occupational disease claim under either ORS 656.802(2)(a) or (2)(b).

Claimant is entitled to an increased assessed fee award for his attorney's services on review and now on reconsideration. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for services on review and on reconsideration is $1,500, to be paid by the employer. This fee is in lieu of the $150 attorney fee award granted in our prior order. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's response letter on review and his response to the employer's reconsideration brief), the complexity of the issues, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our May 7, 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
LEAH M. COLUMBUS, Claimant
WCB Case Nos. 97-00898 & 95-09411
ORDER ON RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorney

Claimant requested reconsideration of our July 25, 1997 Order on Review which reversed the Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's low back injury claim for internal disc disruption (IDD). Claimant contends that she has proven her injury claim and that the ALJ's order should be affirmed. Specifically, claimant contends that we should defer to the ALJ's finding that claimant was credible and that certain of our findings of fact are not supported by the record.

In order to consider claimant's motion, we withdrew our prior order on August 25, 1997. The insurer has now submitted a response. We now address claimant's motion.

Although we generally defer to the ALJ's credibility findings based on attitude, appearance and demeanor, International Paper Co. v. McElroy, 101 Or App 61 (1990), it has long been established that, in exercising de novo review, we may assess credibility based upon our evaluation of the substance of a witness's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review of the record, we find that claimant's testimony regarding the circumstances of her December 1994 injury, which was not corroborated by contemporaneous reports to each doctor at the time she was treating with them, is not credible.

Claimant contends that there is no support for our finding that she sought treatment in November 1994 for her worsened pain condition. Claimant testified that she first scheduled an appointment to see Dr. Jensen in November 1994 (Tr. 10), because her pain and fatigue had returned and worsened (Tr. 38).

Claimant also contends that she did not fall while pulling laundry out of the dryer. The May 17, 1995 report from the physical therapist indicates that claimant "fell" and heard a pop, just as the May 10, 1995 report indicates that claimant fell on the weekend and again on Monday at home, resulting in a large right hip contusion. (Ex. 4-2). Moreover, the report noted that claimant had an acute exacerbation of her low back and right leg pain.

Finally, we continue to find Dr. Hacker's opinion unpersuasive, as it was based on an incomplete and inaccurate history which was not consistent with the contemporaneous medical records.

On reconsideration, as supplemented herein, we adhere to and republish our July 25, 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
CRYSTAL L. DOUGHERTY, Claimant
WCB Case No. 96-10249
ORDER ON REVIEW
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that increased claimant's unscheduled permanent disability award for back and right jaw conditions from 2 percent (6.4 degrees), as awarded by an Order on Reconsideration, to 8 percent (25.6 degrees). The SAIF Corporation cross-requests review of the ALJ's order, contending that the Order on Reconsideration should be affirmed. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant 10 percent unscheduled permanent disability, based on 8 percent permanent disability for the jaw, in addition to the 2 percent awarded by the Order on Reconsideration for range of motion loss in the thoracic spine. On review, claimant contends that she is entitled to impairment for lumbar and cervical range of motion losses, as well as rating for non-impairment factors. SAIF contends that claimant is not entitled to any disability for her jaw. We agree with claimant's argument regarding additional impairment. Therefore, we modify the ALJ's order.

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).

Spine impairment

Relying on the examination of medical arbiters Drs. Green and Dr. Mayhall, the ALJ found that claimant failed to establish any impairment due to lumbar and cervical range of motion losses, because the arbiters determined that the lumbar and certain cervical range of motion measurements were "possibly" invalid. Claimant contends that she is entitled to impairment for the range of motion measurements that the arbiters found only "possibly" invalid. We agree with claimant.

OAR 436-035-0007(27) provides:

> "Validity shall be established for findings of impairment according to the criterion noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990,** unless the validity criterion for a particular finding is not addressed in this reference or is not pertinent to these rules. 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. When findings are determined invalid, the findings shall receive a value of zero."

Here, medical arbiters Green and Mayhall measured claimant's lumbar ranges of motion and commented:

> "The ranges of motion described are possibly invalid because of greater than 10 degree discrepancy between straight leg raise and maximum mid sacral motion, as well as possible incomplete effort. It would appear that she may have some limitation of her range of motion compared to accepted norms secondary to her obesity." (Ex. 31 at 1-2).

We find that an assessment that range of motion measurements may "possibly" be invalid does not constitute a finding that the measurements **are** invalid. Pursuant to the Director's rule, OAR 436-035-0007(27), ratable impairment **shall** be rated, unless the physician determines that the findings **are invalid** and explains the basis for that determination. See Justeen L. Parker, 49 Van Natta 334 (1997).

Here, the arbiters did not determine, within reasonable medical probability, that the lumbar range of motion measurements were invalid. See Gormley v. SAIF, 52 Or App 1055 (1981) (medical opinion must be stated in terms of reasonable medical probability, not mere possibility). Nor did they provide a written opinion, based on sound medical principles, that explains why the measurements are invalid. The arbiters stated that the lumbar ranges of motion are "possibly invalid" due to a greater than 10 degree discrepancy between straight leg raise and maximum mid sacral motion, and due to "possible" incomplete effort. (Ex. 31-1-2). Neither of these explanations is stated in terms of reasonable medical probability. Therefore, inasmuch as the explanations are not based on reasonable medical probability, we find that the explanations are not based on sound medical principles. Furthermore, to the extent that claimant's range of motion limitations were due to her obesity, it would have been appropriate to apportion the range of motion limitations. (Ex. 28A-3); OAR 436-035-0007(2). However, the arbiters did not apportion their findings. Under such circumstances, we conclude that claimant is entitled to impairment ratings based on the lumbar range of motion measurements. See Justeen L. Parker.

With respect to cervical ranges of motion, the arbiters identified two measurements as invalid (flexion and left rotation), and claimant does not claim impairment on the basis of these two measurements. The arbiters did not, however, identify the remaining cervical measurements as invalid. Therefore, we find no basis for rejecting the remaining cervical range of motion measurements. Accordingly, claimant is entitled to impairment based on the arbiters' cervical extension, right and left lateral flexion, and right rotation measurements. (Ex. 31-2).

Pursuant to OAR 436-035-0360(14), (15) and (16), claimant is entitled to 4 percent cervical impairment, based on the arbiters' measurements (40 degrees extension = 2.8%; 36 degrees right lateral flexion = .6%; 40 degrees left lateral flexion = .33%; and 65 degrees right rotation = .75%; for a total of 4.48%, which is rounded down to 4%). (Ex. 31-2). Claimant is also entitled to 13 percent lumbar impairment, based on OAR 436-035-0360(19), (20), (21) and the arbiters' measurements (40 degrees flexion = 4%; 10 degrees extension = 5%; 10 degrees right lateral flexion = 3 percent; 20 degrees left lateral flexion = 1%; for a total of 13%). (Ex. 31-1). The parties do not dispute that claimant is entitled to 2 percent impairment for loss of thoracic range of motion. Therefore, after combining 13 percent, 4 percent and 2 percent, claimant is entitled to 18 percent impairment for her spine.

Jaw impairment

The ALJ found, based on the opinion of claimant's treating oral surgeon, Dr. Howerton, as well as the opinion of Dr. Bouneff, the medical arbiter who examined claimant's jaw, that claimant is entitled to 8 percent impairment for her jaw because she has had to modify her diet. SAIF contends that there is no medical opinion indicating that claimant's diet is limited to semi-solid or soft food, as required by the standards. Therefore, SAIF contends that claimant is not entitled to 8 percent impairment for her jaw. We disagree.

OAR 436-035-0420(1)(a) provides for 8 percent impairment in mastication (chewing) or deglutination (swallowing) if the worker's diet is limited to semi-solid or soft foods. Here, claimant's treating oral surgeon, Dr. Howerton, placed claimant on a modified diet, explaining that she has alterations in her ability to chew. (Ex. 23). Although Dr. Howerton did not specifically state that claimant's diet was limited to semi-solid or soft foods, that is the only reasonable inference we can make from his recommendation for a modified diet, based on the alteration in claimant's ability to chew. Dr. Bouneff, the medical arbiter, agreed that claimant's treatment should include a modified diet. (Ex. 32-2). There is no contrary evidence. Therefore, we agree with the ALJ that claimant has established 8 percent impairment of the jaw under OAR 436-035-0420(1)(a).

Non-impairment factors

The ALJ found that claimant was entitled to rating only for impairment because she was released to return to regular work. Claimant contends that she is entitled to a rating under the non-impairment factors because she was not released to her prior job where she worked with combative patients.

Pursuant to ORS 656.726(3)(f)(D), impairment is the only factor to be considered in evaluating the worker's disability 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."

See also OAR 436-035-0270(3).

Here, the preponderance of evidence establishes that claimant was released to her regular job as an Habilitative Training Technician effective April 25, 1997. (Ex. 10). Claimant also was employed as an Habilitative Training Technician at the time of her injury on January 20, 1995 at Fairview Training Center. (Ex. 1). Although claimant was no longer working at Fairview Training Center on April 25, 1997, she was apparently working in the same capacity with another employer. (See Exs. 7D, 7F). Thus, the ALJ correctly concluded that claimant was released to regular work and is entitled only to impairment rating.

Claimant contends that because her new job does not involve working with combative patients, she was not released to return to her regular work. However, claimant points to no evidence that she was specifically restricted from working with combative patients. Although Dr. Bolin pointed out that the difference between claimant's new job and her at-injury job is that she is not currently working with combative patients, he did not restrict her from such work. (See Ex. 8B-2). Rather, Dr. Bolin simply released claimant to perform her regular job as an Habilitative Training Technician, without any restrictions. (Ex. 10-2). Therefore, we are persuaded that claimant was released to return to her regular work. Accordingly, claimant is entitled to rating only for impairment.

Based on our discussion above, claimant is entitled to 18 percent impairment for her spine and 8 percent impairment for her jaw. Combining these two values results in 25 percent permanent disability. We modify the ALJ's order accordingly.

Attorney fees

Claimant is entitled to an out-of-compensation fee equal to 25 percent of the increased award created by this order, provided that the total of fees awarded by the ALJ and the Board shall not exceed $3,800. OAR 438-015-0055.

Claimant is entitled to an assessed attorney fee under ORS 656.382(2) if the Board finds on review that the compensation awarded to claimant should not be disallowed or reduced. See also OAR 438-015-0070. Here, SAIF appealed the ALJ's award of compensation for claimant's jaw, and we have not disallowed or reduced that award on review. Therefore, claimant is entitled to an assessed attorney fee under ORS 656.382(2) for services on review.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 10, 1997 is modified. In addition to the Order on Reconsideration and ALJ's awards totalling 8 percent (25.6 degrees) unscheduled permanent disability award, claimant is awarded 17 percent (54.4 degrees), giving her a total award to date of 25 percent (80 degrees) unscheduled permanent disability for her back and jaw conditions. Claimant's counsel is awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased compensation created by this order, provided that the total of fees approved by the ALJ and Board does not exceed $3,800. That attorney fee shall be payable directly to claimant's counsel. For her counsel's services on review, claimant is awarded a $750 attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
JULIE HALSTEAD, Claimant
WCB Case No. 96-07812
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Thomas A. Anderson, Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld Wausau Insurance company's responsibility denial of claimant's occupational disease claim for a bilateral wrist condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the factual background of the claim. Claimant, a waitress, began working for the employer (Peartree Restaurant) in 1988 or 1989. Wausau provided workers' compensation coverage for the employer from January 31, 1989 through February 1, 1995.

In 1992, claimant sought treatment from her family physician, Dr. Brummer, for tingling and numbness in the left hand. Dr. Brummer diagnosed carpal tunnel syndrome. (Ex. OA-2). Prior to June 1993, claimant began to experience symptoms in her right hand. Claimant returned to Dr. Brummer in June 1993 with increased wrist and hand symptoms, worse on the left. Nerve conduction studies revealed mild left carpal tunnel syndrome, but were normal on the right side. (OC-2).

Claimant continued to work for the employer. In early 1995, the Peartree restaurant was sold and then became "Petro Stopping Centers" (Petro). Its insurer was the Travelers Insurance company (Travelers).

After sale of the restaurant, the manner in which claimant served meals changed. She began carrying trays holding skillets with her left arm at shoulder height and with the left wrist extended. Claimant soon began experiencing neck and shoulder symptoms while her hand symptoms remained mostly unchanged.

In late November or early December 1995, claimant experienced a significant increase in symptoms in both wrists and hands. After examining claimant on December 4, 1995, Dr. Brummer diagnosed tendinitis and prescribed medication. (Ex. 1). Additional electrodiagnostic studies were conducted on December 26, 1995. They again showed mild carpal tunnel syndrome on the left, but no carpal tunnel syndrome on the right. (Ex. 2).

Claimant transferred her care to Dr. Johnson, who diagnosed left carpal tunnel syndrome and right tenosynovitis. (Ex. 6-2). Dr. Johnson referred claimant to an orthopedist, Dr. James, who, on January 8, 1996, diagnosed work-related bilateral carpal tunnel syndrome. (Ex. 4). Dr. James eventually performed left and right carpal tunnel releases in March and April 1996. (Ex. 22-16).

Claimant filed claims against both the Travelers and Wausau. The Travelers denied the bilateral wrist claim on March 8, 1996. (Ex. 12). On August 15, 1996, Wausau issued its denial. (Ex. 20). Claimant requested a hearing from both denials.

Prior to the hearing, claimant and the Travelers agreed to settle all issues between them through a Disputed Claim Settlement (DCS). By entering into this settlement, claimant was deemed to have accepted the possible consequence that she would not receive compensation from the only other potentially causal carrier (Wausau). See Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 78 (1994); E.C.D., Inc. v. Snider, 105 Or App 416 (1991).

At the hearing, Wausau conceded that claimant's bilateral wrist condition was compensable. The ALJ reasoned that, because claimant first sought treatment for her bilateral carpal tunnel syndrome while working for Peartree Restaurant, Wausau was presumptively responsible for claimant's bilateral wrist condition. See Timm v. Maley, 125 Or App 396 (1993). The ALJ then determined that Wausau could escape responsibly if it could show that claimant's subsequent employment activities with Petro independently contributed to a worsening of her bilateral wrist condition. Concluding that the medical opinions of the two physicians (Dr. James and Dr. Melson, an examining physician) who addressed the issue satisfied Wausau's burden of proof, the ALJ upheld Wausau's denial of responsibility.

On review, claimant contends that her work for Petro did not independently contribute to a worsening of claimant's underlying bilateral wrist condition. For the following reasons, we agree.

The last injurious exposure rule (LIER) provides that, where a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984), rev den 299 Or 203 (1985). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 25 Or App at 401. The dispositive date is the date the claimant first sought treatment for symptoms of the compensable condition, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Claimant first sought medical treatment for the symptoms of her bilateral wrist condition in 1992 and 1993, while employed by Peartree Restaurant. Thus, initial responsibility was properly assigned to

Wausau. Because Wausau is presumptively responsible for claimant's bilateral wrist condition, it can shift responsibility to Petro/Travelers only if employment conditions at Petro contributed to the cause of, aggravated or exacerbated the underlying disease. Bracke v. Baza'r, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must actually contribute to a worsening of the condition). A claimant must experience more than a mere increase in symptoms. Timm v. Maley, 134 Or App at 249. A pathological worsening is required. See Elizabeth H. Nutter, 49 Van Natta 829, 830 (1997).

We agree with claimant that the medical evidence from Dr. James and Dr. Melson, the two physicians who addressed the issue, do not establish that claimant's employment aggravated, contributed to the cause of, or exacerbated the underlying bilateral wrist condition. Dr. Melson gave extensive testimony in a deposition. After reviewing EMG studies conducted in 1993 and 1995, Dr. Melson testified that there was "no significant change" between the two studies. (Ex. 21-6). Dr. Melson further testified that, clinically, the left wrist was more "symptomatic," but he could not document any change in her condition. (Ex. 21-5). Dr. Melson agreed that work activities since January 1996 merely made symptoms of the left wrist worse, but were not necessarily changing her condition. (Ex. 21-23). Later in the deposition, Dr. Melson again agreed that claimant's employment worsened her "symptoms" of carpal tunnel syndrome. (Ex. 21-8). However, Dr. Melson never testified that claimant's employment pathologically worsened her bilateral carpal tunnel condition.

Dr. James was also deposed. When asked whether the change in claimant's duties in 1995 worsened the underlying carpal tunnel pathology, Dr. James testified that, while it was "possible," there were "too many variables there to really make a comment about that." (Ex. 22-4). Dr. James further testified that, in order to render an opinion about an objective worsening, he would have had to examine claimant in 1993 and 1996. (Ex. 22-7). The most Dr. James could say about the effect of claimant's change in job duties was that it "could have aggravated" her carpal tunnel syndrome. (Ex. 22-7). However, such expressions of medical possibility are insufficient to establish a pathological worsening of claimant's bilateral wrist condition. See Miller v. SAIF, 60 Or App 557, 562 (1982).

Accordingly, based on our de novo review of the medical record, we find that Wausau failed to establish that claimant's employment at Petro independently contributed to a worsening of claimant's bilateral wrist condition. Thus, we conclude that Wausau is responsible for that condition. Because the ALJ concluded otherwise, we reverse.

For finally prevailing over Wausau's responsibility denial, claimant's counsel is entitled to an attorney fee for services at hearing and on review. See ORS 656.308(2)(d); Paul R. Huddleston, 48 Van Natta 4, on recon 48 Van Natta 203 (1996); Julie M. Baldie, 47 Van Natta 2249 (1995). Claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee. See Jack L. Barbee, 48 Van Natta 1855, 1858 (1996). Therefore, claimant's counsel is awarded a $1,000 attorney fee for services at hearing and on review, payable by Wausau. See Tammy Locke, 48 Van Natta 250 (1996) ($1,000 attorney fee limitation under ORS 656.308(2)(d) is cumulative for all levels of litigation).

ORDER

The ALJ's order dated April 23, 1997 is reversed. Wausau's denial is set aside and the claim is remanded to Wausau for processing according to law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $1,000, to be paid by Wausau. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
LINDA K. HOLCOMB, Claimant
WCB Case No. 96-08941
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) declined to award temporary disability from February 8, 1995 through March 28, 1995; (2) declined to assess a penalty against the insurer for its allegedly unreasonable claim processing; and (3) awarded claimant's counsel an approved attorney fee payable out of the "substantively" increased, but previously procedurally paid, temporary disability. The insurer cross-requests review of those portions of the ALJ's order that: (1) admitted a "post-reconsideration" medical report from claimant's attending physician; and (2) awarded temporary disability from December 22, 1994 through February 7, 1995. On review, the issues are evidence, temporary disability, penalties, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's second paragraph under "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Following an August 25, 1993 injury, the insurer accepted the following conditions: concussion, contusion of the left hip, and hand abrasions. Claimant returned to work. Claimant was off work from December 19, 1994 through July 30, 1995, during which the insurer paid time loss.

On January 27, 1995, Dr. Miller, neurosurgeon, examined claimant and recommended a lumbar laminectomy to treat claimant's continuing leg and low back symptoms. On February 7, 1995, Dr. Miller confirmed in writing to the insurer that the need for surgery was related to claimant's compensable injury. Dr. Miller performed the surgery on March 29, 1995.

During preoperative testing, a lung lesion was discovered which required surgical treatment (thoracotomy) before Dr. Miller could perform the back surgery.

On May 8, 1996, a Determination Order awarded temporary disability from December 19, 1994 through December 21, 1994, and from March 29, 1995 through July 30, 1995. The insurer deducted $4,820.91 as an overpayment from claimant's permanent disability award granted by the Determination Order for time loss paid for the period December 22, 1994 through March 28, 1995.

Claimant requested reconsideration. On reconsideration, claimant's permanent disability award was increased, but the temporary disability award was affirmed. Claimant requested a hearing. At the hearing, without objection from either party, the ALJ admitted a November 5, 1996 "post-reconsideration order" medical report from Dr. Miller. In that report, Dr. Miller stated that claimant's time loss from December 22, 1994 through March 28, 1995 was due to her compensable back condition.

The ALJ determined that claimant was entitled to temporary disability for the period December 22, 1994 through February 7, 1995, based on Dr. Miller's November 5, 1996 report. That report was not considered during the reconsideration process. The ALJ also determined that claimant was not entitled to temporary disability during the period February 8, 1995 through March 28, 1995 because she was unable to work due to the noncompensable lung lesion and thoracotomy.

Claimant requested review of the ALJ's order, contending, among other issues, that she is entitled to temporary disability for the period February 8, 1995 through March 28, 1995. The insurer cross-requested review, contending that claimant is entitled to no temporary disability for the period December 22, 1994 through March 28, 1995. The insurer also contends on review that the ALJ erred in considering Dr. Miller's "post-reconsideration" report.

Evidence

Dr. Miller's November 5, 1996 report (Exhibit 49) was generated after the reconsideration process, which concluded with the issuance of an Order on Reconsideration on September 12, 1996. (Ex. 48). ORS 656.283(7) provides, in material part, that "[e]vidence on an issue regarding a . . . determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing[.]"

Although the insurer alludes to a pre-hearing discussion of the admissibility of Exhibit 49, there is nothing in the **record** indicating that the insurer objected to the admission of Exhibit 49. To the contrary, when the ALJ asked the parties whether the exhibits had been correctly identified, both attorneys answered in the affirmative. (See Tr. 2). Thus, the record supports a conclusion that Exhibit 49 was admitted into evidence without objection.

Under similar circumstances, the Court of Appeals recently held that the Board should not consider an objection to "post-reconsideration" evidence that was raised for the first time on review. See Fister v. South Hills Health Care, 149 Or App 214 (1997). Reasoning that there was no adequate reason to depart from the Board's usual rule to consider only those issues raised by the parties at hearing, the court concluded that we erred in considering the employer's objection to evidence that was raised for the first time on Board review. Since the employer did not object to the "post-reconsideration" evidence at hearing, the court determined that the evidence should have been considered.

Here, there is no evidence in the record that the insurer objected to the admission of Exhibit 49 prior to the close of the hearing. Therefore, the insurer's untimely objection to the exhibit will not be considered. Likewise, we will consider the exhibit in conducting our review.

Temporary Disability

The ALJ found, based on Dr. Miller's November 5, 1996 report, that claimant was entitled to temporary disability for the period December 22, 1994 through February 7, 1995. The ALJ also found that claimant was not entitled to temporary disability for the period February 8, 1995 through March 28, 1995, because her disability was due to a noncompensable condition (lung lesion and thoracotomy). Claimant contends that she is entitled to temporary disability for the entire period in dispute, while the insurer contends that claimant is not entitled to any temporary disability for that period. We agree with claimant and, therefore, modify the ALJ's order.

Since this dispute concerns claimant's entitlement to temporary disability upon claim closure, the issue is claimant's entitlement to substantive, rather than procedural, temporary disability. A worker's substantive entitlement to temporary disability is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the worker was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651 (1992); Kenneth P. Bundy, 48 Van Natta 2501 (1996); Dorothy E. Bruce, 48 Van Natta 518 (1996).

Here, the only evidence concerning claimant's disability during the period in dispute is from Dr. Miller, claimant's treating neurosurgeon. On November 5, 1996, Dr. Miller stated, "It is my opinion that the time loss between December 22, 1994 through March 28, 1995 was a direct result of the patient's back injury." (Ex. 49). Dr. Miller goes on to explain that claimant had a lung lesion which had to be treated prior to performing the compensable back surgery. Although the remainder of Dr. Miller's report, following the above-quoted sentence, is somewhat ambiguous, we believe it is reasonable to infer that it is Dr. Miller's opinion that claimant's time loss from December 22, 1994 through March 28, 1995 was directly due to her compensable back injury, despite the fact that claimant was also treated for a lung lesion prior to undergoing the compensable back surgery. Therefore, based on Dr. Miller's November 5, 1996 report, we find that claimant's disability from December 22, 1994 through March 28, 1995 was due to her compensable back injury. Consequently, we conclude that claimant is entitled to temporary disability for that entire period.

The insurer argues that claimant is not entitled to any additional temporary disability because the attending physician failed to contemporaneously authorize time loss, as provided in ORS

656.262(4)(f).[1] In other words, the insurer contends that ORS 656.262(4)(f) prohibits retroactive authorization of substantive, as well as procedural, temporary disability. As the insurer acknowledges, we rejected such an argument in Kenneth P. Bundy.

The Bundy decision applies in this case, as well. Thus, we conclude here, as we did in Bundy, that claimant is entitled to substantive temporary disability benefits for those periods during which she has proven that she was unable to work due to her compensable injury, and that her entitlement is not contingent upon her attending physician's contemporaneous authorization of time loss. We find that Dr. Miller's November 5, 1996 report (Ex. 49) is sufficient to establish that claimant was disabled from December 22, 1994 through March 28, 1995, due to her compensable back injury.

In the alternative, the insurer contends that if claimant is entitled to any additional temporary disability, she is not entitled to such benefits for the period February 8, 1995 through March 28, 1995 because she was disabled due to a lung lesion and thoracotomy, neither of which is compensable. In so arguing, the insurer relies on ORS 656.225[2] and Roseburg Forest Products v. Wofford, 138 Or App 560 (1996), as well as our decisions in Michael L. Wofford, 48 Van Natta 1087, second order on remand, 48 Van Natta 1313 (1996). We reject the insurer's argument because we find that neither ORS 656.225 nor the Wofford decisions apply in this case.

In Wofford, the court reversed our prior order which affirmed an ALJ's order that relied on Williams v. Gates, McDonald & Co., 300 Or 278 (1985), to uphold the compensability of medical treatment for a non-work related preexisting condition as a prelude to treatment of a compensable condition. Citing ORS 656.225, the court remanded for reconsideration.

On remand in Michael L. Wofford, supra, the claimant sought to establish, relying on Williams v. Gates, McDonald & Co., that treatment for a noncompensable fungal condition on his left hand was compensable because the treatment was necessary before he could proceed with compensable left carpal tunnel surgery. We held that ORS 656.225, added by the 1995 legislature, overruled Williams v. Gates, McDonald & Co. We held that, inasmuch as the claimant's left fungal condition preceded his claim for a worsening, and the disputed treatment was solely directed to the left fungal condition, the fungal treatment was compensable only if it was prescribed to treat a change in the fungal condition, and not merely as an incident to the treatment of claimant's compensable condition. See ORS 656.225(3).

At the outset, we note that the Wofford decisions are not directly applicable, since the present case concerns entitlement to temporary disability, not medical services. Nevertheless, assuming that the Wofford decisions provide guidance by analogy, we still find that the Wofford decisions and ORS 656.225 are inapplicable. ORS 656.225 by its terms applies only where disability is **solely** caused by a worker's preexisting condition. Likewise, in Wofford, the disputed treatment was **solely** directed to a noncompensable condition. Here, however, claimant's disability during the period February 8, 1995 through March 28, 1995 was caused by both her compensable condition and the noncompensable lung lesion and thoracotomy. (Ex. 49). Thus, ORS 656.225 and the Wofford decisions provide no authority for disallowing claimant's temporary disability for the period February 8, 1995 through March 28, 1995.

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[1] ORS 656.262(4)(f) provides:

"Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

[2] ORS 656.225 provides, in material part:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

"* * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

Penalty

On review, claimant contends that she is entitled to a penalty for the insurer's allegedly unreasonable deduction of an overpayment in the amount of $4,820.91 from her permanent disability award. We disagree.

The May 8, 1996 Determination Order did not award temporary disability between December 22, 1994 through March 28, 1995, a period for which it is undisputed that the insurer had already paid time loss. The Determination Order specifically authorized the insurer to deduct any overpaid temporary disability from the unpaid permanent disability award, consistent with ORS 656.268(13).[3] (Ex. 41-1). Claimant does not contend that the amount of the deducted overpayment was incorrect, or that it did not reflect the amount of temporary disability already paid for the period December 22, 1994 through March 28, 1995. The insurer did no more than it was authorized to do by deducting overpaid temporary disability from the unpaid permanent disability award. ORS 656.268(13); OAR 436-030-0030(11), (12). Therefore, the insurer's conduct was not unreasonable, and claimant is not entitled to a penalty.

Attorney fees

The ALJ awarded claimant an out-of-compensation attorney fee equal to 25 percent of the increased compensation awarded by the ALJ's order. On reconsideration, the ALJ specified that, because the time loss had already been paid on a procedural basis, the attorney fee may be recovered directly from claimant or through the "lien recovery" procedure outlined in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995). On review, claimant contends that she is entitled to an assessed attorney fee payable by the insurer for services at hearing, and that the attorney fee recovery procedure set forth in Volk is not applicable. We agree that recovery of the attorney fee is not limited to the procedure set forth in Volk, but we disagree that claimant is entitled to an assessed attorney fee for her attorney's services at hearing.

The award of attorney fees in workers' compensation matters is governed by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). ORS 656.386(2)[4] provides for attorney fees when an attorney's services result in increased compensation for claimant. Compare ORS 656.382(1) (provides for attorney fees when a carrier refuses to pay compensation pursuant to an order or unreasonably resists payment of compensation), ORS 656.382(2) (provides for attorney fee when **carrier** requests hearing and compensation awarded to claimant is not disallowed or reduced), ORS 656.386(1) (provides for attorney fee when claimant finally prevails on **denied claim**); see also OAR 438-015-0045.[5]

As discussed above, the insurer did not unreasonably refuse or resist payment of compensation pursuant to an order; rather, it deducted an overpayment consistent with the Determination Order which authorized deduction of any overpayment. Therefore, attorney fees are not due under ORS 656.382(1). The issue at hearing concerned the amount of compensation due on an accepted claim, not compensability of a denied claim. Therefore, attorney fees are not due under ORS 656.386(1). Claimant, not the insurer, requested the hearing from the Order on Reconsideration. Therefore, attorney fees are not due under ORS 656.382(2). Thus, because claimant requested the hearing and the issue concerned the amount of compensation due on an accepted claim, the ALJ properly awarded an out-of-compensation attorney fee under ORS 656.386(2) and OAR 438-015-0045.

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[3] ORS 656.268(13) provides:

"Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid."

[4] ORS 656.386(2) provides: "In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter."

[5] OAR 438-015-0045 provides: "If the Administrative Law Judge awards additional compensation for temporary disability the Administrative Law Judge shall approve a fee of 25 percent of the increased compensation, but not more than $1,050, to be paid out of the increased compensation."

The ALJ further provided that, because claimant's compensation had already been paid, claimant's attorney could recover the fee only directly from claimant or via the attorney fee recovery procedure set forth in Volk. We disagree.

In Volk, the court approved the attorney fee recovery procedure outlined by the Board because ORS 656.382(2) provides that out-of-compensation attorney fees cannot be paid from any source other than the claimant's compensation, and the insurer had already paid the full amount of compensation due to the claimant. In that situation, the court agreed that the Board did not have authority to order the insurer to pay the attorney fee directly to claimant's attorney. 135 Or App at 573.

Here, the insurer initially paid claimant all temporary disability benefits due. Upon closure, however, the insurer deducted overpaid temporary disability benefits from claimant's permanent disability award. Therefore, pursuant to the ALJ's order, the insurer is required to **repay** claimant the previously deducted amount for the period December 22, 1994 through February 7, 1995. In addition, in accordance with our order, the insurer must repay claimant the previously deducted "overpaid" temporary disability paid between February 8, 1995 and March 28, 1995. Consequently, the insurer can pay the "out-of-compensation" attorney fee directly to claimant's attorney out of the permanent disability benefits it previously offset against the alleged overpayment.

Accordingly, claimant is awarded an out-of-compensation attorney fee pursuant to ORS 656.386(2), equal to 25 percent of the increased compensation created by this order, provided the total of fees approved by the ALJ and the Board shall not exceed $3,800. OAR 438-015-0055(1). To the extent that this attorney fee award can be recovered from the previously withheld portion of claimant's permanent disability award, the insurer is directed to pay that award directly to claimant's counsel. If claimant's counsel's attorney fee award is not satisfied through this payment procedure, claimant's counsel may seek recovery of the remainder of the award in the manner prescribed in Volk.

The insurer cross-requested review regarding claimant's entitlement to the temporary disability awarded by the ALJ. On review, we have affirmed the ALJ's determination that claimant is entitled to an award of temporary disability from December 22, 1994 through February 7, 1995. Therefore, claimant's compensation as awarded by the ALJ has not been disallowed or reduced on review. Thus, claimant's attorney is entitled to an assessed fee for services on review regarding the temporary disability issue. ORS 656.382(2).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's appellant's brief that addressed the issue raised by the insurer's cross-appeal), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 15, 1997, as amended February 4, 1997, is affirmed in part and modified in part. In lieu of the ALJ's temporary disability award, claimant is awarded temporary disability from December 22, 1994 through March 28, 1995. Claimant is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, provided the total of out-of-compensation attorney fees awarded by the ALJ and the Board shall not exceed $3,800. The attorney fee shall be paid and recovered in the manner previously set forth in this order. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded an assessed attorney fee of $500 for his services on review, payable by the insurer.

In the Matter of the Compensation of
ANDY MILLER, Claimant
WCB Case No. 96-07922
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration which increased claimant's award of unscheduled permanent disability for a low back injury from 14 percent (44.8 degrees), as granted by a Notice of Closure, to 15 percent (48 degrees). On review, the issue is extent of unscheduled permanent disability.

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

With respect to unscheduled permanent disability, the only dispute at hearing concerned the calculation of claimant's adaptability factor, specifically, his residual functional capacity (RFC). The ALJ approved the reconsideration order's determination of claimant's RFC as light/medium, relying on the assessment of Dr. Carvalho, claimant's attending physician, who opined after claimant's closing examination that claimant could do light to medium work. (Ex. 21-1). The ALJ also relied on the opinion of the medical arbiter, Dr. Martens, who provided lifting limitations consisting with light to medium work. (Ex. 25-4).

On review, claimant contends that, if allowed to testify, he would have provided a sufficient basis for the ALJ to find that his RFC was "light." Claimant asserts that the limitation on "post-reconsideration" evidence in ORS 656.283(7) unconstitutionally deprives him of due process of law in violation of the Fourteenth Amendment of the United States Constitution. In response, the insurer argues that we cannot consider claimant's constitutional argument because it was not properly raised at hearing.

We need not decide whether the constitutional issue was properly raised because, even if it was, we have previously rejected claimant's argument in George D. Koskela, 49 Van Natta 529 (1997) and Joe R. Ray, 48 Van Natta 325, 333 (1996). Moreover, even if claimant testified as counsel represented he would at hearing (Tr. 5), this would not change the result because we agree with the ALJ's reasoning that claimant's RFC is light/medium.[1]

ORDER

The ALJ's order dated May 27, 1997 is affirmed.

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[1] Claimant's counsel represented at hearing that claimant would have testified to deficiencies in the medical arbiter's examination. (Tr. 5). However, even if we considered claimant's likely testimony regarding the arbiter's examination, we would still find persuasive the opinion of Dr. Carvalho that claimant was capable of light to medium work (Ex. 20). This opinion, which was given at the time that claimant was medically stationary, is more persuasive than the assessment of a physical capacities evaluation that determined that claimant could perform light work, but was made at a time when claimant was not medically stationary. (Ex. 17).

In the Matter of the Compensation of
ROBERT W. NELSON, Claimant
WCB Case No. 96-08090
ORDER ON REVIEW
Schneider, 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) Peterson's order that set aside its denial of claimant's injury claim for an L5-S1 disc herniation. On review, the issue is compensability.

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

Relying on the opinion of Dr. Hill, claimant's attending physician, the ALJ concluded that the May 9, 1996 injury at work was the major contributing cause of claimant's combined condition. See ORS 656.005(7)(a)(b).

On review, SAIF argues that Dr. Hill's opinion is unpersuasive. In particular, SAIF asserts that Dr. Hill did not adequately account for the contribution of claimant's preexisting degenerative disc disease and that Dr. Hill did not refute Dr. Dickerman's assertion that Dr. Hill's operative findings suggested significant preexisting disc degeneration. For the following reasons, we do not agree that Dr. Hill's opinion is unpersuasive.

Dr. Dickerman reviewed some, but not all, of claimant's medical records. In rendering his opinions, Dr. Dickerman suspected that claimant had "very significant preexisting degenerative disc disease" and that the major contributing cause of claimant's need for treatment and surgery was probably the preexisting condition. However, Dr. Dickerman's suspicions regarding the extent of claimant's preexisting degenerative disease were brought into question by the report of Dr. Morgan, radiologist, who indicated that claimant's MRI showed only mild to moderate degenerative changes. Dr. Dickerman also opined that Dr. Hill's finding at surgery of a hard calcified disc fragment suggested that the calcification had taken place previously. However, Dr. Dickerman could not rule out the possibility of an acute herniation of a previously calcified disc. Dr. Dickerman emphasized the need to obtain claimant's medical records to confirm his beliefs regarding claimant's preexisting condition.

Dr. Hill, who performed claimant's back surgery, was aware of Dr. Dickerman's report and opinions. Dr. Hill explained that, although claimant had been treated by a chiropractor in the past, claimant began experiencing radiation of pain down the left leg after the May 1996 injury and had not experienced such symptoms prior to the injury.[1] (Ex. 6). In addition, Dr. Hill indicated that Dr. Morgan's review of claimant's MRI did not demonstrate "advanced" or "very significant" degenerative disease. Finally, Dr. Hill opined that the May 6, 1996 injury was the major contributing cause of claimant's L5-S1 herniated disc and subsequent disability and need for treatment. (Ex. 13).

After reviewing the medical opinions of Drs. Hill and Dickerman, we find that Dr. Dickerman's belief that claimant's preexisting degenerative disease was very significant or advanced is not borne out by the medical evidence. By contrast, Dr. Hill, as the surgeon who performed claimant's surgery, had an accurate understanding of the extent of claimant's preexisting degenerative disease. We disagree with SAIF's argument that Dr. Hill's opinion is not persuasive because he did not refute Dr. Dickerman's assertion that Dr. Hill's operative findings suggested that claimant had significant preexisting disc degeneration. Dr. Hill, as the surgeon who performed claimant's surgery, is in the best position to evaluate his own surgical findings. Moreover, Dr. Dickerman's underlying premise that claimant had significant degenerative disease was not confirmed by the evidence. In addition, Dr. Dickerman stated he could not rule out that the injury might have herniated a previously calcified disc. Under these circumstances, we do not find Dr. Hill's opinion unpersuasive.

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[1] According to the record, claimant had not received any chiropractic treatment for more than a year and a half prior to the May 6, 1996 injury.

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

ORDER

The ALJ's order dated March 26, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

September 16, 1997 Cite as 49 Van Natta 1498 (1997)

In the Matter of the Compensation of
JESSE M. WRIGHT, Claimant
WCB Case No. 96-07498
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

On August 1, 1997, we abated our July 18, 1997 order that affirmed the order of Administrative Law Judge (ALJ) Poland upholding the SAIF Corporation's denial of responsibility for claimant's low back injury. We took this action to consider claimant's motion for reconsideration. Having received SAIF's response, we proceed with our reconsideration.

In his motion for reconsideration, claimant contends that some of the ALJ's findings of fact which we adopted are inaccurate. We agree that the findings of fact we adopted may be misleading. Therefore, we modify the ALJ's findings of fact as follows.

In lieu of the first sentence of the first paragraph of the ALJ's findings of fact, we make the following findings: "Claimant began working for the employer as a plumber's apprentice in the summer of 1991. (Tr. 12). After a period of employment elsewhere, claimant returned to Watco in April 1996. (Id.; Ex. 24)."

In lieu of the second sentence of the first paragraph of the ALJ's findings of fact, we make the following finding: "In 1988, claimant developed low back pain and left leg pain, weakness and numbness. (Tr. 9-10; Exs. 1, 2, 4)."

At the end of the fourth paragraph of the ALJ's findings of fact, we add the following finding: "Claimant experienced no back or leg problems from the time he started plumbing work in 1991 until his injury in June 1996. (Tr. 13)."

Claimant further contends that the following statement in our original order is not supported by the record:

> "Dr. Collada, treating surgeon, expressly stated that neither his firsthand examination of claimant's back during surgery nor his knowledge of claimant's pre-1996 period of working without back symptoms helped him compare the causal contributions from claimant's preexisting condition and his 1996 injury. (See Ex. 34-18-22)."

Recognizing that Dr. Collada did not "expressly state" the above-quoted matter, we withdraw our statement. Instead, we offer the following discussion.

In determining the major contributing cause of claimant's 1996 low back condition and need for surgery, Dr. Collada recognized that the severity of the preexisting L4-5 disc protrusion immediately prior to claimant's June 1996 injury was crucial. That is, if claimant's documented L4-5 disc protrusion had remained protruded between 1990 and 1996, then the preexisting disc protrusion would be the major contributing cause of claimant's current low back condition and need for surgery. (Ex. 34 at 15-16). On the other hand, if the disc had healed significantly between 1990 and 1996, then the June 1996 work injury would "clearly" be the major contributing cause of the current condition and need for surgery. (Ex. 34-16). However, Dr. Collada acknowledged that neither claimant's history of heavy work

between 1991 and 1996, nor Dr. Collada's first-hand observations during the 1996 surgery were helpful in determining the severity of the L4-5 disc protrusion prior to the 1996 injury. (See Ex. 34 at 16, 18-22, 25-27). We find that, although Dr. Collada weighed various factors that could have a bearing on the severity of the L4-5 disc pathology, Dr. Collada was unable to state, with reasonable medical probability, what the status of claimant's L4-5 disc pathology was immediately prior to claimant's 1996 injury.

Finally, claimant contends that Dr. Collada's opinion that claimant's need for surgery was due in major part to his June 1996 injury is not based solely on a temporal relationship between the injury and the onset of claimant's right leg symptoms. We respond to claimant's argument with the following discussion.

Dr. Collada did state that the 1996 work injury was the major contributing cause of claimant's need for treatment for the combined condition. (Ex. 34 at 17-18). Dr. Collada explained that claimant's need for surgery arose because he developed L5 nerve root findings, whereas Dr. Collada would not have performed (and did not perform) surgery simply because claimant had an asymptomatic L4-5 disc protrusion. (Ex. 34 at 10-11, 17). Dr. Collada explained that the injury affected claimant's preexisting L4-5 disc and caused the L5 nerve root finding. (Ex. 34-18). Dr. Collada opined that because the 1996 injury "triggered" L5 nerve root findings, the injury is the major contributing cause of claimant's need for treatment for his combined condition. (Ex. 34-17).

We acknowledge that Dr. Collada's opinion may not be based **solely** on a temporal relationship between the 1996 injury and the onset of claimant's right leg symptoms. Nevertheless, we interpret Dr. Collada's opinion regarding the major contributing cause of claimant's need for treatment as being no more than an opinion that the 1996 work injury was the "precipitating" cause of claimant's need for surgery. The precipitating cause is not necessarily the major cause. In order to determine the major cause, the relative contribution of different causes must be evaluated to determine the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta 764 (1997); accord SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309, 312 (1997). We find that when Dr. Collada determined that the 1996 injury was the major contributing cause of claimant's need for treatment, Dr. Collada failed to address the relative contribution of the other cause he had identified - the preexisting L4-5 disc protrusion. Therefore, because Dr. Collada's opinion failed to evaluate the relative contribution of different causes, we agree with the ALJ that Dr. Collada's opinion fails to establish that the 1996 injury was the major contributing cause of claimant's need for treatment for his combined condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 18, 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
JERRY E. BISHOP, Claimant
WCB Case No. 94-14311
ORDER ON REVIEW
David C. Force, Claimant Attorney
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Black's order which: (1) found that claimant had not been furnished with the insurer's denial of his occupational disease claim; and (2) awarded interim compensation. On review, the issues are claim processing and interim compensation. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Finding that the insurer did not properly serve claimant with its October 19, 1992 denial of his occupational disease claim for a psychological condition, the ALJ determined that issuance of the denial never terminated claimant's entitlement to interim compensation. Thus, the ALJ found that claimant was entitled to interim compensation from May 1, 1992 (the stipulated date of knowledge of medically verified inability to work) through June 20, 1995.[1]

On review, the insurer contends that it issued an effective denial on October 19, 1992 that terminated its obligation to pay interim compensation. For the following reasons, we conclude that the insurer's denial did not become effective until December 15, 1993, when claimant had actual knowledge of the denial. Thus, we modify the ALJ's order and find that the insurer's obligation to pay interim compensation ceased on that date.

We begin by briefly recounting the factual and procedural background of the case. In June 1992, claimant, a partner in an engineering business, made a claim through his employer for a work-related psychological condition.[2] At that time, claimant was represented by an associate attorney (Cohen) in a law firm (Gildea and Facaros) which was handling matters related to claimant's ownership interest in the engineering business. The Gildea firm, however, had no retainer agreement (Tr. 18), although Cohen's correspondence with the insurer described claimant as her "client." (Exs. 3, 5, 5A).

In the fall of 1992, Cohen took a leave of absence and apparently requested another attorney (Warshafsky) to monitor claimant's workers' compensation file in her absence. (Tr. 20). Warshafsky was not a member of the Gildea firm, but did share office space with the firm and sometimes associated with Gildea on specific cases.

Warshafsky and counsel for the insurer had a telephone conversation in October 1992. Apparently believing that Warshafsky represented claimant, insurer's counsel wrote a letter to Warshafsky on October 19, 1992, enclosing a copy of a denial of claimant's psychological claim. (Ex. 9). The letter explained that the denial was being sent to Warshafsky rather than to claimant's home because insurer's counsel felt that it was best to do so under the circumstances. Id. Counsel for the insurer urged that all civil and workers' compensation issues be settled through mediation.

The parties stipulated that claimant would have testified that he first became aware of the denial in December 1993, when he became dissatisfied with his legal representation and obtained his file from the Gildea law firm. (App B-3, C-1).[3] Claimant did not request a hearing from the denial. Claimant retained his present counsel in November 1994. A request for hearing was filed at that time alleging "de facto" denial and entitlement to interim compensation.

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[1] The ALJ's order does not state the basis for choosing June 20, 1995 as the date to terminate interim compensation. We need not decide whether this was an appropriate date to terminate temporary disability given our resolution of the interim compensation issue.

[2] The parties later stipulated that his claim was not compensable. (App B-1).

[3] Claimant attended the hearing but did not testify.

The ALJ initially determined that the insurer's denial of claimant's claim was constructively served on claimant, as the denial was sent to an attorney who represented him. Therefore, the ALJ found that the insurer's denial was effective to terminate interim compensation, and that claimant was not entitled to the relief sought. Board review was sought.

On first review, we did not address the issue of whether or not claimant or his attorney received the denial. Rather, we found that the parties' stipulation that "claimant was incapable of returning to his employment" did not constitute an authorization by an attending physician for the payment of temporary disability under the "new" law. Consequently, we affirmed the ALJ's order. Jerry E. Bishop, 48 Van Natta 1090 (1996).

On reconsideration, however, we vacated the ALJ's order and remanded the matter to the ALJ for admission of the reports/documents submitted regarding the issue of whether claimant's attending physician authorized temporary disability, and for the ALJ's determination of the effect, if any, that the Board's "attending physician/interim compensation" cases might have on this matter. Jerry E. Bishop, 48 Van Natta 1533 (1996).

On remand, the ALJ determined that the insurer's denial was ineffectively served on the claimant and, thus, claimant was entitled to interim compensation. As previously noted, the ALJ awarded interim compensation from May 1, 1992 to June 20, 1995.

"Interim compensation" is temporary disability payments made between the employer's notice of injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). In this case, the issue is whether the insurer's October 1992 denial was sufficient to terminate its obligation to pay interim compensation. ORS 656.262(9) provides that written notice of a denial "shall be given to the claimant." ORS 656.262(6)(a) also provides that written notice of acceptance or denial "shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice of knowledge of the claim."

For unspecified reasons, the insurer did not send claimant a copy of the insurer's denial by registered or certified mail as required by OAR 438-005-0065.[4] Nor did the insurer personally serve claimant.[5] Instead, the insurer chose to attach a copy of its denial to correspondence between its counsel and an attorney (Warshafsky). However, attorney Warshafsky testified that at no time did he represent claimant in his workers' compensation claim. (Tr. 22). Neither Warshafsky nor any attorney in the Gildea law firm ever executed a valid retainer agreement, signifying that they were entitled to represent the claimant. Thus, there was no authorization for an attorney to accept service of a denial for claimant. Inasmuch as it is undisputed that the denial was not furnished to claimant, himself, when it was issued, we find that, under these circumstances, the October 19, 1992 denial did not terminate the insurer's obligation to pay interim compensation on the date the denial was issued.[6]

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[4] OAR 438-005-0065 provides that:

"Notice of denial or other notice from which statutory time runs against a claimant shall be in writing and shall be delivered by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons."

[5] ORCP 7D(1) provides:

"Summons shall be served, either within or without this state, in any manner reasonably calculated, under all the circumstances, to apprise the defendant of the existence and pendency of the action and to afford a reasonable opportunity to appear and defend. Summons may be served in a manner specified in this rule or by any other rule or statute on the defendant or upon an agent authorized by appointment or law to accept service of summons for the defendant. Service may be made, subject to the restrictions and requirements of this rule, by the following methods: personal service of summons upon defendant or an agent of defendant authorized to receive process; substituted service by leaving a copy of summons and complaint at a person's dwelling house or usual place of abode; office service by leaving with a person who is apparently in charge of an office; service by mail; or, service by publication."

[6] Although the insurer argues that its service on claimant was done in a manner reasonably calculated to apprise claimant of the denial within the meaning of ORCP 7(D)(1), we disagree. Under the circumstances of this claim, where the denial was apparently sent by ordinary mail to an attorney who not only never represented claimant, but also never discussed claimant's legal business with him (Ex. D-1), we are not persuaded that the insurer's method of service was reasonably calculated to apprise claimant of the denial.

However, the parties stipulated that, if called to testify, claimant would have testified that he received actual knowledge of the denial on or about December 15, 1993. (App B-3). Claimant also represented in an affidavit that he discovered the denial in late November or early December 1993. (Ex. C-1). Based on this undisputed evidence, we conclude that claimant had actual knowledge of the denial on or about December 15, 1993. Because claimant had actual knowledge of the denial at that time, we conclude that his entitlement to interim compensation ceased on December 15, 1993.[7]

Accordingly, we conclude that claimant is entitled to interim compensation from May 1, 1992 through December 15, 1993, less any amounts of temporary disability already paid during this period. Because we have reduced claimant's compensation on review, claimant's attorney is not entitled to an attorney fee on review. See ORS 656.382(2).

ORDER

The ALJ's order dated April 18, 1997 is modified. In lieu of the ALJ's award of temporary disability from May 1, 1992 through June 20, 1995, claimant is awarded interim compensation from May 1, 1992 through December 15, 1993, less any amounts previously paid. The ALJ's "out-of-compensation" attorney fee award is modified accordingly.

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[7] Attorney Gildea testified at the hearing. Counsel for the insurer asked whether there was any indication in claimant's file that information about the denial was communicated to claimant. The attorney declined to answer the question on the ground that it might violate attorney-client privilege. (Tr. 14). The insurer moves in its reply brief for remand to the ALJ for production of documents that bear on the issue of whether claimant had actual knowledge of the denial prior to expiration of the period in which to appeal the denial. Based on the following reasoning, we hold that remand is not warranted.

We may remand to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. 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). In this case, we find no compelling reason to remand where the insurer did not challenge claimant's stipulated testimony that he did not receive actual knowledge until December 1993. Moreover, the insurer did not call claimant to testify to determine whether he in fact had actual knowledge earlier than the December 15, 1993 stipulated date. Under these circumstances, we find no compelling reason to remand where the insurer had the opportunity to clarify the issue of when claimant received actual knowledge of the denial.

In the Matter of the Compensation of
MELISSA M. DONOVAN, Claimant
WCB Case No. 96-11174
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded claimant an attorney fee under ORS 656.386(1) for her attorney's efforts in obtaining rescission of a denied claim before hearing. On review, the issue is attorney fees.

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

After the second sentence of the third paragraph of the ALJ's "Findings of Fact and Decision," we add the following finding: "In its response to issues, the insurer also denied that claimant had sustained an aggravation, and that a condition had been incorrectly omitted from the acceptance. (Administrative Record)."

In lieu of the last sentence in the sixth paragraph of the ALJ's "Findings of Fact and Decision," we make the following finding: "There is no evidence that benefits related to the left forearm condition were unpaid."

We briefly summarize the relevant facts. Claimant sustained a right arm injury on August 24, 1995, which the insurer accepted on September 20, 1995 as right wrist/forearm tendinitis. On May 9, 1996, claimant had surgery for right carpal tunnel syndrome.

On September 3, 1996, claimant's attorney wrote to the insurer requesting formal acceptance of a new medical condition, "left forearm ventral tendonitis, carpal tunnel syndrome, right." (Ex. 49A). On September 19, 1996, the insurer accepted the right carpal tunnel syndrome, but did not mention the left forearm condition. (Ex. 50).

On December 16, 1996, claimant requested a hearing on the insurer's "de facto" denial of claimant's left forearm tendinitis condition. The insurer responded to the hearing issues by denying that it had denied compensability of the left forearm ventral tendinitis condition, as well as by denying that claimant had sustained an aggravation and that a condition had been incorrectly omitted from the acceptance. (Administrative Record). There is no evidence that benefits related to the left forearm condition were unpaid.

Subsequently, the insurer obtained medical reports that did not support a causal connection between claimant's work injury and her left forearm condition. (Exs. 53, 54, 57). Two of these reports were obtained and submitted prior to the March 13, 1997 hearing (Exs. 53, 54), while the last report was submitted at the hearing (Ex. 57). Claimant responded by obtaining and submitting medical reports that supported a causal relationship between claimant's work injury and her left forearm condition. (Exs. 55, 55A).

On March 13, 1997, prior to the hearing, the insurer issued a written notice accepting the left forearm ventral tendinitis. (Ex. 56). Reasoning that claimant's counsel was instrumental in obtaining rescission of a denied claim prior to hearing, the ALJ awarded claimant an attorney fee in the amount of $2,500. The insurer requested Board review, contending that claimant is not entitled to an attorney fee under ORS 656.386(1) because there was no "denied claim."

The ALJ found that the insurer's conduct in obtaining medical reports that tended to refute a causal relationship between the work injury and claimant's left forearm condition evidenced an effort to marshall evidence against compensability, and was not merely claims processing. The ALJ concluded, relying on our decision in Shamyia M. Ford, 49 Van Natta 2 (1997), that the insurer's conduct constituted a refusal to pay compensation on the express ground that the claimed condition was not compensable or otherwise did not give rise to an entitlement to compensation, consistent with the definition of a "denied claim" set forth in ORS 656.386(1).

On review, the insurer contends that Shamyia M. Ford is distinguishable, because in that case the insurer wrote a letter to the claimant's attorney questioning the diagnosis, while in this case, the insurer never wrote to claimant indicating a problem with the diagnosis. Furthermore, the insurer contends that because a denied claim is one where the insurer refuses to pay on the **express** ground that a claim is not compensable, a denial cannot be implied from conduct. We disagree with the insurer, based on the following reasoning.

While the insurer may be correct in its assertion that its conduct alone cannot create a "denied claim" within the meaning of ORS 656.386(1), we need not reach that issue in this case. In Kimberly Quality Care v. Bowman, 148 Or App 292 (1997), the court held that a "check the box" notation on a response to issues form indicating that claimant sustained no work-related injury or disease constitutes an express denial of compensability under ORS 656.386(1).

Here, the insurer, through its counsel, indicated on its response to issues form that it denied that claimant had sustained an aggravation and that a condition had been incorrectly omitted from the acceptance. The insurer's "check-the-box" notation on the response to issues form indicating that a condition had not been incorrectly omitted amounts to a denial of claimant's claim for the condition that claimant contends should have been included in the acceptance. We find that the insurer's assertions on the response to issues form, particularly the latter assertion, challenge the compensability of the claim, as well as claimant's entitlement to compensation, and, as such, constitute an express denial of the compensability of the claim.

We note that the compensability "denials" are inconsistent with the insurer's third assertion on the response to issues form, which was that it has not denied the compensability of the claim. In light of the insurer's conduct in preparing for the hearing, however, we give greater credence to the portions of the insurer's hearing response that deny that claimant has sustained an aggravation and that a condition has been incorrectly omitted from the acceptance. Specifically, the insurer obtained reports that questioned the existence of a left forearm condition, as well as reports that indicated there was no causal relationship between claimant's work injury and her left forearm complaints. (Exs. 53, 54, 57). Under such circumstances, we find that the insurer's "check-the-box" response to the issues for the hearing constitutes an express denial of the compensability of the claim.

Accordingly, we agree with the ALJ that claimant is entitled to an attorney fee under ORS 656.386(1) for her attorney's efforts in obtaining rescission of a denied claim prior to hearing. Because attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 27, 1997 is affirmed.

In the Matter of the Compensation of
JOE A. GALLARDO, SR., Claimant
WCB Case No. 94-10886
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer'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.

In his reply brief, claimant cites to SAIF v. Nehl, 148 Or App 101 (1997), and the following quote from that case.

> "We conclude that, regardless of the extent of claimant's underlying condition, if the immediate cause of claimant's need for treatment is an on-the-job accident, the treatment is compensable." 148 Or App at 106.

Claimant contends that "[t]his case must be analyzed under the above standard."

Following claimant's filing of his reply brief, the court allowed reconsideration in Nehl and specifically modified the language quoted above to read:

> "We conclude that, regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment, the combined condition is compensable." SAIF v. Nehl, 149 Or App 309, 311 (1997).

Here, because the ALJ weighed whether claimant's work injury or preexisting condition was the major contributing cause of his disability or need for treatment, we find such reasoning conforms with the test provided in the modified Nehl decision. Furthermore, we agree with the ALJ that claimant did not prove that his work injury was the major contributing cause of his disability or need for treatment and, consequently, he did not prove compensability. ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated February 14, 1997 is affirmed.

In the Matter of the Compensation of
GERALD A. MACK, Claimant
WCB Case No. 95-10502
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that affirmed a Determination Order which reversed claimant's permanent total disability (PTD) award as of October 5, 1994 and awarded 39 percent (124.80 degrees) unscheduled permanent disability for a low back condition. On review, the issues are permanent total disability and, alternatively, extent of unscheduled permanent partial disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant, age 52 at the time of hearing, compensably injured his low back in August 1983 while working as a logger. While working for a different employer in August 1984, claimant experienced a sharp, hot, stabbing pain from the left hip to foot. Although he continued to work for several days, the pain later became severe enough that he stopped working and returned for treatment.

Claimant was diagnosed with recurrent and episodic back strains superimposed on preexisting grade I spondylolisthesis. His back pain persisted and he developed pain radiating into the left hip, thigh and leg. In June 1986, at the recommendation of Dr. Heusch, claimant underwent a bilateral lumbar fusion.

Claimant continued to complain of back pain although his left leg pain improved following the surgery. By March 1987, claimant began experiencing right leg pain, and Dr. Stewart recommended a body cast to see if repeat fusion surgery would be helpful. The casting did not provide relief. Claimant decided against further fusion surgery despite his continuing back and leg pain.

The claim was closed by Determination Order on August 10, 1988 which awarded 53 percent unscheduled permanent disability. Claimant requested a hearing, and was determined to be permanently and totally disabled as of June 1, 1988 by virtue of a May 26, 1989 Opinion and Order. That order was affirmed by the Board in July 1990.

In November 1991, claimant began treating with Dr. Lundquist, who noted tenderness of the right perilumbar muscles and some limitation of motion of the back. In 1992, Dr. Lundquist reported that claimant's work options were very limited, but that some kind of work would be possible with appropriate training.

In October 1994, claimant was seen by a physiatrist, a clinical psychologist and an occupational therapist for a reevaluation of his permanent total disability status. The physical capacity evaluation indicated that claimant was able to function in the light range, with significant limitations on lifting, carrying and bending. The employer sought redetermination of his permanent disability and a March 27, 1995 Determination Order found that claimant was no longer permanently and totally disabled as of October 4, 1994, and awarded unscheduled permanent partial disability of 39 percent (124.80 degrees).

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We adopt and affirm the ALJ's determination that claimant is presently able to perform at a gainful and suitable occupation.

Extent of Permanent Disability

The ALJ determined that claimant was entitled to a value of 1 for age, 1 for education, 3 for skills (based on DOT 454.684.010) and 1 for training, for an age/education/skills total of 6. The ALJ further determined that claimant was entitled to an adaptability value of 3 under former OAR 436-35-310(3)(a) (from a heavy base functional capacity to sedentary/light residual functional capacity) and an impairment value of 20,[1] for a total unscheduled permanent disability award of 38 percent.

On review, claimant asserts that the ALJ applied the wrong rule in determining his adaptability factor, and that the ALJ should have relied upon former OAR 436-35-310(4)(c) and (d), rather than the table at former OAR 436-35-310(3). Pursuant to the table set forth in subsection (4), claimant asserts that his adaptability factor should be 6. Claimant further urges us to rely on the impairment findings of Dr. Becker, the medical arbiter, or the findings of claimant's former treating physician, Dr. Heusch, rather than the findings of Dr. Jensen. Claimant argues that his unscheduled permanent disability award should be increased to at least 56 percent, if not 59 or 60 percent.[2]

In response, SAIF concedes that claimant's adaptability value should be 6 and asserts that the ALJ properly relied on the impairment findings of Dr. Jensen. SAIF argues, however, that the ALJ erred in granting claimant a value of 1 for training and a skills value of 3. Specifically, SAIF contends that because claimant had performed the job of cutter for at least 12 years prior to his injury, he should not be given a value for lack of training. SAIF further asserts that because claimant had his own timber cutting business, in which he acted as a supervisor, his appropriate DOT Code should be 454.134-010 ("Supervisor, Felling-Bucking," SVP 7). SAIF concludes that claimant's age/education/skills value should only total 3, and that when that value is multiplied by the adaptability factor of 6 and added to his impairment value of 20, (6 x 3 = 18 + 20 = 38) claimant is not entitled to any additional permanent impairment over the 39 percent awarded by the March 27, 1995 Determination Order.

After considering the applicable administrative rules, we conclude that claimant is entitled to a total unscheduled permanent disability award of 44 percent. We base our determination on the following reasoning:

As SAIF notes, the standards set forth in WCD Admin. Order 6-1988 apply to the rating of claimant's permanent disability.[3] Under these standards, claimant is entitled to a value of 1 for age and a value of 1 for formal education. See former OAR 436-35-290(4), OAR 436-35-300(3)(b). Claimant is not, however, entitled to a value for training because the record establishes that, prior to his injury, he had attained competence in the specific vocational pursuit of timber cutter.[4] As for job skills, the record establishes that for years prior to, and at the time of his injury, claimant was working as a cutter (DOT 454.384-010, SVP 6). (See Ex. 18-3). Pursuant to the table set forth in former OAR 436-35-300(4), claimant is entitled to a value of 2 for his SVP level of 6. Consequently, claimant is entitled to an age/education/skills value of 4 (1+1+2=4). Multiplying that result by an adaptability factor of 6 (as the parties agree is appropriate) results in a value of 24.

As for impairment, we agree with the ALJ's reliance on the findings of Dr. Jensen, which were approved by claimant's attending physician Dr. Lundquist. The parties concur that, based upon Dr. Jensen's impairment findings and the applicable standards, claimant is entitled to an impairment value of 20 (consisting of the combined value of 11 percent for the fusion and 10 percent for loss of motion). Adding the impairment value (20) to the age/education/skills and adaptability value (24) entitles claimant to a total unscheduled permanent disability award of 44 percent.

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[1] Like the Department evaluator, the ALJ relied on the impairment findings of Dr. Jensen, findings with which Dr. Lundquist concurred.

[2] Claimant argues that, assuming a age/education/skills value of 6 and an adaptability value of 6, his total award should be 56 percent if we rely on Dr. Jensen's impairment findings, 59 percent if we rely on Dr. Heusch's findings and 60 percent if we utilize Dr. Becker's findings.

[3] Pursuant to former OAR 436-35-003(1) (WCD Admin. Order 93-056), workers who became medically stationary prior to July 1, 1990 shall be rated pursuant to WCD Admin. Order 6-1988.

[4] Unlike the prior standards, which required documentation demonstrating competence in some specific vocational pursuit, former OAR 436-35-300(5) (WCD Admin. Order 6-1988) does not require documentation of such competence.

ORDER

The ALJ's order dated August 28, 1996, as amended January 2, 1997 and January 6, 1997, is affirmed in part and modified in part. In addition to the 39 percent (124.8 degrees) unscheduled permanent disability awarded by the Determination Order and the ALJ's order, claimant is awarded an additional 5 percent (16 degrees) unscheduled permanent disability for a total unscheduled permanent disability award of 44 percent (140.8 degrees). Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

In the Matter of the Compensation of
DONALD T. SHAW, Claimant
WCB Case No. 96-01751
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's current low back condition. Claimant has submitted a medical report, seeking inclusion of the report in the record. We treat the submission of the medical report as a motion for remand. On review, the issues are claim preclusion, compensability and remand. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

We summarize the facts. Claimant was compensably injured on May 9, 1991 while working for this employer. He was operating a scrubber that started to turn to the right and his left hand came off the handle. The scrubber kept turning and claimant's left leg slipped and he fell on his right knee with the right leg caught under the wheel of the scrubber.

Claimant first sought medical treatment on May 21, 1991 complaining of right knee pain and swelling. Claimant was treated by Dr. Puziss for his right knee condition. Dr. Puziss ultimately performed arthroscopic surgery on the right knee (a sub-total lateral meniscectomy) on July 25, 1991.

The first time that back pain is noted in the record is in a July 1, 1991 evaluation of claimant's right knee condition by Dr. Puziss. In describing claimant's present complaints, Dr. Puziss noted that: "There is some right lower back pain in the sacroiliac area." (Ex. 10-2).

On August 23, 1991, Dr. Puziss noted that claimant complained of right lower back pain, radiating to the buttock and leg. Dr. Puziss diagnosed "right lower back pain, with possible mild sciatic irritation." On September 16, 1991, Dr. Puziss noted that he was not relating claimant's present back problems to his industrial injury, although claimant had stated that he had some right lower back and buttock pain since he injured his right knee. On September 24, 1991, Dr. Puziss indicated that claimant was relating his back problems to the May 9, 1991 injury, although claimant did not complain of back or buttock pain when he was initially seen by Dr. Puziss.

Claimant filed a claim on September 25, 1991 for his "right hip" condition. Claimant indicated that he had some prior pain in his hip since 1986 or 1987 which was not severe.

On October 14, 1991, Dr. Puziss indicated that claimant had had some right hip or buttock pain since about 1984 or thereabouts, worsened by his hyperextension hip injury of May 9, 1991. (Ex. 20-2). Dr. Puziss was unable to make a more specific diagnosis, but believed that claimant may have stretched

the anterior capsule of the right hip when he hyperextended it. Dr. Puziss diagnosed: "severe preexisting lumbar and lumbosacral spondylosis" and "right sciatica, cannot rule out herniated lumbar disc." Id. Dr. Puziss continued to evaluate claimant's low back condition and claimant underwent MRI and CT scans.

In December 1991, Dr. Puziss sent claimant to Dr. Berkeley, a neurosurgeon for another opinion. (Ex. 30). Dr. Berkeley diagnosed "severe lumbar spondylosis with canal stenosis maximal at L3-4 and L4-5." Dr. Berkeley recommended bilateral and extensive L3-4 and L4-5 microdecompression. (Ex. 32). On March 3, 1992, Dr. Berkeley performed a bilateral L3-4 and L4-5 microdecompression surgery. (Ex. 37). The post-operative diagnosis was lumbar spondylosis L3-4, L4-5 with canal stenosis at both levels and degenerative changes L2-3.

After his surgery, claimant returned to modified work for the employer, but left in January 1993 because of increased low back pain. Claimant's right knee condition became medically stationary on April 16, 1993. On July 29, 1993, Dr. Puziss reported that the low back was medically stationary. Dr. Puziss' diagnosis was status post lumbar decompression.

No formal written acceptance notices of the right knee or low back condition were ever issued. On September 3, 1993, the employer filed forms 1503 and 2195 with the Workers' Compensation Division requesting a Determination Order. The employer listed the compensable conditions as "torn medial meniscus left [sic] knee, lumbar strain." A September 22, 1993 Determination Order awarded claimant 57 percent unscheduled permanent disability and 22 percent scheduled permanent disability for the right knee. The unscheduled award included impairment of 10 percent for the L3-4, L4-5 decompression surgery and 13 percent loss of range of motion of the low back as reported by Dr. Puziss. The employer did not challenge the Determination Order and it became final.

After the September 22, 1993 Determination Order issued, claimant continued to undergo numerous evaluations of the low back and consideration of further surgery.

On February 9, 1996, the employer denied claimant's claim. Specifically, the employer denied that the May 9, 1991 injury was the major contributing cause of claimant's current low back conditions, specifically including, but not limited to, L3-4 and L4-5 foraminal stenosis. The denial also stated claimant's back condition was preexisting in nature and was not caused or worsened by the May 9, 1991 injury.

On February 9, 1996, claimant was also notified by the employer that it had chosen an MCO and that Dr. Puziss could no longer qualify to serve as attending physician under the MCO. Dr. Berselli became claimant's new attending physician on March 6, 1996.

CONCLUSIONS OF LAW AND OPINION

Motion for Remand

Prior to implementation of the briefing schedule, claimant submitted, for inclusion in the record, an April 28, 1997 letter from Dr. Grewe addressing claimant's need for further low back surgery. We treat the submission of this report 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). 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, it has not been shown that the evidence contained in Dr. Grewe's report was unobtainable with due diligence at the time of hearing. In addition, the record already contains multiple opinions of other physicians which address claimant's low back condition and the possible need for further low back surgery. Thus, the evidence from Dr. Grewe is cumulative. Under such circumstances, we deny the motion for remand.

Claim Preclusion/Compensability

The ALJ found that the employer had not challenged a Determination Order which awarded claimant permanent disability for surgery which was in part for claimant's lumbar spondylosis at L3-4 and L4-5 with canal stenosis. On this basis, the ALJ held that the employer was precluded from denying claimant's low back condition. See Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (reaffirming Deluxe Cabinet Works v. Messmer, 130 Or App 254 (1994)).

Subsequent to the date of the ALJ's order, the 1997 legislature passed HB 2971 which amended ORS 656.262(10). As amended, the statute now provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (New portions of the statute are underlined).

Because we find claimant's current low back condition compensable on the merits, we find it unnecessary to resolve the issue of whether claimant's current condition was included within the scope of the employer's acceptance or to determine whether amended ORS 656.262(10) legislatively overrules the court's decisions in Messmer.

The parties agree that ORS 656.005(7)(a)(B) applies to this case. Under ORS 656.005(7)(a)(B), if an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only 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.

Several physicians address the cause of claimant's current low back condition. Dr. Steinhauer, a specialist in physical medicine and rehabilitation, opined that claimant's low back condition was not caused in major part by the May 9, 1991 injury. Dr. Steinhauer attributed claimant's low back condition to preexisting degenerative changes which could not have developed since the injury. (Ex. 119).

Drs. Watson, neurologist, and Laycoe, orthopedist, examined claimant on behalf of the employer. They opined that the major contributing cause of claimant's low back condition was claimant's preexisting degenerative spondylosis. (Ex. 150).

Dr. Puziss, an orthopedist, treated claimant for both his right knee injury and his low back condition. Dr. Puziss was claimant's attending physician from soon after the compensable injury until March 1996 when claimant was required to choose an attending physician who was a member of the employer's MCO. Dr. Puziss opined that claimant's May 9, 1991 injury remained the major contributing cause of claimant's current low back condition. Dr. Puziss further indicated that claimant's preexisting stenosis condition was objectively worsened by the May 9, 1991 injury and that the right knee condition caused by the May 9, 1991 injury caused an altered gait which contributed to claimant's low back condition, disability and need for treatment. (Ex. 137).

Dr. Berkeley, a neurosurgeon, performed claimant's low back surgery and provided additional treatment for claimant's low back condition. Dr. Berkeley opined that claimant's May 9, 1991 injury remained the major contributing cause of claimant's low back condition, disability and need for treatment. (Ex. 136).

Dr. Berselli became claimant's new attending physician for the May 1991 injury in 1996. Dr. Berselli also opined that claimant's May 9, 1991 compensable injury remained the major contributing cause of his current low back condition and that claimant's right knee condition contributed to claimant's low back condition, disability and need for treatment. (Ex. 140).

We give greater weight to the opinion of claimant's treating doctor unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Based on this record, we find no persuasive reasons not to rely on the opinions of claimant's treating physicians, Drs. Puziss,[1] Berselli[2] and Berkeley. Drs. Watson and Laycoe and Steinhauer apparently only examined claimant on one occasion, whereas the physicians who treated claimant had extensive contact with claimant and familiarity with his low back condition. Dr. Puziss began treating claimant soon after the May 9, 1991 injury and was able to observe the progression of the back condition. Dr. Berkeley performed claimant's low back surgery and is in a good position to address the cause of that condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Accordingly, based on this record, we find that claimant has established compensability of his current low back condition.[3]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,300, 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 7, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by the self-insured employer.

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[1] The employer argues that Dr. Puziss' opinions are inconsistent with his earlier statements that a work-connection between claimant's back condition and the May 9, 1991 injury was uncertain. Because claimant did not initially report the back symptoms, but only reported the right knee problems, Dr. Puziss was initially unsure of the relationship of the back pain to the May 9, 1991 compensable injury. (Ex. 16). However, other than his initial uncertainty because of the lack of documentation of low back pain from the May 9, 1991 injury, Dr. Puziss did not render an opinion that the low back condition was not related to the compensable injury. Accordingly, we do not find his opinions regarding the cause of claimant's low back condition to be inconsistent.

[2] The employer argues that Dr. Berselli's opinion is called into the question by a statement in a note made by Dr. Wong, the MCO's medical director. Dr. Wong stated that he had reviewed the case with Dr. Berselli and that the reason for claimant's continued medical care was claimant's back condition which "is not an on the job injury." It is not clear whether this statement is a reference to the fact that the back condition was denied or whether it was Dr. Wong's or Dr. Berselli's opinion that the back condition was not an on the job injury. Because the only direct opinion from Dr. Berselli in the record is that the low back condition is causally related to the May 9, 1991 compensable injury, the note from Dr. Wong alone does not persuade us that Dr. Berselli changed his opinion or rendered an inconsistent opinion.

[3] We reject the employer's arguments that Drs. Puziss, Berselli and Berkeley failed to weigh the contribution to claimant's current low back condition of claimant's preexisting condition. Based on these physicians' numerous chart notes, medical reports, evaluations, diagnostic tests and examinations of claimant in the record, we find that the three treating physicians were well aware of claimant's preexisting low back condition. Moreover, based on the context of their opinions, we conclude that they weighed the contribution from the preexisting condition in rendering their opinions regarding the major contributing cause of claimant's current low back condition.

In the Matter of the Compensation of
VERONICA M. STRACKBEIN, Claimant
WCB Case No. 96-03694
ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

On July 24, 1997, we abated our June 27, 1997 order that reversed the Administrative Law Judge's (ALJ's) order that granted claimant permanent total disability. We took this action to consider Claimant 's motion for reconsideration. Having received the SAIF Corporation's response, we now proceed with our reconsideration.

In reversing the ALJ's award of permanent total disability, we found that claimant's current disability was not related to her compensable 1985 injury. Moreover, based on claimant's compensable injury (cervical and lumbar strains, inner ear concussion syndrome and adjustment disorder with anxiety and depression) and any preexisting disability, we were not persuaded that claimant was permanently incapacitated from regularly performing gainful employment.

In her reconsideration request, claimant requests that we take administrative notice of ALJ Galton's order in WCB Case No. 96-08239, which determined that claimant's compensable injury is the major contributing cause of her "post-concussive syndrome." Noting that this is the diagnosis of her current condition, claimant contends that our order finding that her current disability is not injury-related is directly at odds with the "law of the case." Claimant also asserts that our order failed to consider the effect of the October 5, 1992 order of a prior ALJ, who determined that claimant's inner ear concussion syndrome was compensable. Arguing that her condition has not materially changed since that order, claimant further asserts that our causation finding is contrary to principles of res judicata. Finally, claimant argues that our order is deficient in that it improperly determined the compensablity of her current condition within the context of a hearing on extent of disability in violation of our holding in Robin W. Spivey, 48 Van Natta 2363 (1996). For the following reasons, we disagree with claimant's contentions.

We first address what effect, if any, ALJ Galton's order has on this case. We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders and docketed appeals. See, e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as ALJ Galton's order meets the aforementioned standard, we take administrative notice of it, as well as the fact that SAIF's request for review of that order is pending before the Board. Inasmuch as SAIF has requested review of ALJ's Galton's order, that order has not become final. Because it is not final, it does not constitute the "law of the case." Cf. Patricia A. Hinsen, 45 Van Natta 1467, on recon 45 Van Natta 1563, 1564 (1993), aff'd mem Merry Maids v. Hinsen 127 Or App 753 (1994) (where a Department's subjectivity order was not timely appealed and became final, its subjectivity finding became the law of the case).

Although claimant cites Kuhn v. SAIF, 73 Or App 768 (1985) as support for his "law-of-the-case" argument, that case is distinguishable. In contrast to this case, where the order that allegedly provides the "law of the case" has not become final, the order in Kuhns, which the court found constituted the law of the case, had become final. 73 Or App at 770.[1]

Claimant also contends that, because her inner ear concusion syndrome was found compensable by a prior ALJ in October 1992, we are precluded from finding that her current disability is not related to her compensable injury. We disagree. Dr. Tobin, claimant's current attending physician, and the physician on whom claimant primarily relies for her contention that she is permanently and totally disabled, opined that claimant's inner ear concusion had resolved and that claimant was experiencing a post-concussive syndrome secondary to her 1985 motor vehicle accident. (Ex. 117). Because we find that claimant's current condition is different from the condition found compensable in 1992, the prior ALJ's order has no preclusive effect on our determination that claimant's current disability is not related to her compensable 1985 injury.

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[1] Given our resolution of the "law of the case" argument, we need not address SAIF's contention that claimant did not exercise due diligence in raising the allegedly preclusive effect of ALJ Galton's order.

Claimant next contends that we improperly determined the compensability of her current conditon within the context of a hearing on extent of disability. In Robin M. Spivey, we held that the requirements concerning a "pre-closure" denial of a combined condition pursuant to ORS 656.262(7)(b) are applicable only when a "combined condition" has been accepted, either voluntarily or by means of a litigation order. 48 Van Natta at 2365. The claimant in that case had an accepted cervical strain. A medical arbiter's report indicated that 90 percent of the claimant's lost range of cervical motion was due to a preexisting degenerative condition and 10 percent due to the compensable cervical strain. Noting that the carrier had not issued a denial of the "combined condition" prior to closure under ORS 656.262(7)(b), the claimant asserted that his entire impairment must be attributed to his compensable injury.

We disagreed with the claimant's contention. Because neither the preexisting condition nor a combined condition had been accepted, we reasoned that the carrier was not precluded from asserting that a portion of the claimant's permanent disability was due to the non-accepted degenerative condition and, therefore, should not be considered in rating the claimant's permanent disability.

In this case, SAIF did not accept a "combined condition." Therefore, in accordance with the Spivey rationale, SAIF was not precluded from asserting that claimant's permanent disability was unrelated to the compensable injury and that claimant's alleged post-concussive condition should not be considered in determing whether she was permanently and totally disabled and in rating claimant's unscheduled permanent disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 27, 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
SYLVIA EBERLEI, Claimant
WCB Case No. 96-08140 & 96-06881
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

On August 14, 1997, we abated our July 18, 1997 order that: (1) determined that the self-insured employer was precluded from denying claimant's current low back and cervical condition; (2) set aside the employer's denial of claimant's current condition; and (3) reinstated and affirmed an Order on Reconsideration that awarded 4 percent (12.8 degrees) unscheduled permanent disability for claimant's neck and back condition. We took this action to consider the self-insured employer's motion for reconsideration. Having received claimant's response, we now proceed with our reconsideration.

In its reply to claimant's response to its motion for reconsideration, the insurer 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 find that this case does not meet this standard for en banc review, the insurer's request is denied.

In our prior order, we held that the employer was barred by res judicata from issuing a "current condition" denial because claimant's current condition was the same condition which had been previously found compensable in an earlier proceeding. Relying on Katherine A. Wood, 48 Van Natta 2196 (1996), we noted that the carrier relied on the same medical evidence (a report from an examining physician, Dr. Wilson) that had been previously considered in the prior compensability determination. Moreover, we found no evidence of any change in claimant's condition since the earlier compensability

determination. Concluding that the carrier was seeking to avoid the earlier final compensability determination, we set aside the employer's current condition denial.

Our decision was not unanimous. The dissent reasoned that the case was legally and factually distinguishable from Wood. In particular, the dissent noted that the issue in the current proceeding (compensability of the current condition) was different from the issue litigated in the earlier proceeding (compensability of initial injury claim). The dissent also noted that the essential finding in the earlier proceeding was whether claimant experienced an accidental injury arising out of and in the course of employment that required medical services or resulted in disability, whereas the issue in the current proceeding was whether claimant's current condition was compensably related to the work injury. Finding that the medical evidence established that claimant's condition had changed subsequent to the compensable injury, and noting that the prior ALJ did not consider the portion of Dr. Wilson's report that addressed claimant's current condition, the dissent concluded that the employer's current condition denial was not precluded.

In its reconsideration request, the employer takes an approach similar to the dissent's in contending that we incorrectly determined that it was barred from issuing its current condition denial. Emphasizing that the prior ALJ had only considered the portion of Dr. Wilson's report that addressed whether claimant had sustained a work-related injury, and not that portion concerning the compensability of her current condition, the employer argues that the fact that its current condition denial was based on a report was in existence at the time of the first hearing was irrelevant to determining the compensability of claimant's current condition. Moreover, the employer asserts that claimant developed a new condition after the initial hearing which was unrelated to her original compensable injury.

After further consideration of the employer's arguments, we continue to conclude that Katherine A. Wood is controlling. Moreover, we are not persuaded that the medical evidence establishes that claimant developed a new condition after her compensable injury in March 1994.

In this regard, we note that claimant consulted Dr. Long in April 1994. (Ex. 30). Over a year later, in August 1995, claimant returned to Dr. Long. (Ex. 34-3). Dr. Long's diagnoses remained the same. In November 1995, Dr. Wilson attributed claimant's current condition to unspecified "nonorganic" causes, but we are not persuaded that Dr. Wilson's report establishes a change in claimant's condition. Functional overlay was reported in the contemporaneous medical records. (Exs. 17, 20, 28). However, in spite of these nonorganic findings, the prior ALJ determined that the claim was compensable, a determination that the Board affirmed on review. Sylvia Eberlei, 48 Van Natta 1794 (1996). Although the employer suggests that claimant has developed a new condition based on functional overlay and nonorganic factors unrelated to the injury, we are not persuaded that claimant has developed a condition different from what has been present since the compensable injury occurred in March 1994. Inasmuch as we continue to find that there has been no change in claimant's cervical and low back condition, we adhere to our previous conclusion that the employer is precluded from denying claimant's current condition. Katherine Wood, 48 Van Natta at 2197.

Finally, even if the employer were not precluded from denying claimant's current condition, we would find that a preponderance of the medical evidence establishes that claimant's current condition is materially related to her original compensable injury.[1] Dr. Smith, the medical arbiter, diagnosed cervical and lumbar sprains that he related to the original compensable injury. (Ex. 43-6). Dr. Long was "suspicious" that there was some element of sacroiliac instability or mechanical pelvic pain causing claimant's recurring symptoms. Dr. Long noted that this would be consistent with claimant's mechanism of injury. (Ex. 34-2). Dr. Long did not attribute claimant's complaints to functional overlay or nonorganic causes. There is nothing in Dr. Long's August 1995 report to indicate that he believed claimant's current low back and cervical condition was related to anything other than the compensable

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[1] We agree with the ALJ's finding that there was no evidence that claimant's injury "combined" with a preexisting condition. See ORS 656.005(7)(a)(B). Thus, we conclude that the appropriate legal standard is material contributing cause. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition).

injury. Based on the medical reports from Dr. Smith and Dr. Long, we are persuaded that claimant's current condition is compensable.[2]

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 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. This award is in addition to claimant's previous attorney fee awards.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 18, 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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[2] In reaching this conclusion, we are not persuaded by Dr. Wilson's opinion that claimant's current condition is unrelated to her original compensable injury. Although Dr. Wilson attributes claimant's current condition to "nonorganic" causes, he does not specify what those causes might be. (Ex. 35-6). In addition, Dr. Wilson opined that claimant's low back strain should have resolved within a matter of days or weeks. Regardless of what Dr. Wilson "normally" believes occurs in cases of back strain, the fact remains that claimant has consistently reported neck and low back complaints ever since her compensable injury. Again, neither Dr. Smith nor Dr. Long questioned the legitimacy of claimant's current pain complaints or their casual relationship to the original injury. Based on this record, we are persuaded that claimant sustained her burden of proof.

In the Matter of the Compensation of
SILVERIO FRIAS, SR., Claimant
WCB Case No. 96-02946
ORDER ON REVIEW (REMANDING)
Rodolfo A. Camacho, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

By cover letter dated March 5, 1996, attorney Hilda Galaviz-Stoller indicated that a retainer agreement and a hearing request were being submitted on behalf of claimant. Although a hearing request was submitted with this cover letter, no retainer agreement was submitted. The hearing request raised the issues of compensability regarding a February 13, 1996 partial denial, penalties, and attorney fees. A hearing was scheduled for November 21, 1996. (WCB Case No. 96-02946).

According to a November 20, 1996 "Docketing Action Worksheet," the hearing request was withdrawn "through Carol S. per Hilda Galaviz." On February 13, 1997, the ALJ's secretary wrote to Ms. Galaviz-Stoller that the case was "reported withdrawn on November 20, 1996" and, in order to avoid a show cause order, asked her to "submit written verification within the next ten (10) days that this case has been withdrawn." On February 18, 1997, Ms. Galaviz-Stoller notified the ALJ by letter that claimant "hereby withdraws his Request for Hearing[.]"

On February 27, 1997, the ALJ issued an Order of Dismissal, stating that "[o]n February 18, 1997, counsel for claimant, Hilda Galaviz, withdrew the March 5, 1996, Request for Hearing[.]"

On March 24, 1997, attorney Rodolfo A. Camacho requested review of the Order of Dismissal on behalf of claimant, contending that the "request for withdrawal was not made by counsel of record." Subsequently, Mr. Camacho submitted a copy of an executed December 16, 1996 retainer agreement. That retainer agreement stated that "[m]y attorneys are authorized to sign my name and in all other respects to act for me in connection with my [workers' compensation] claim."

CONCLUSIONS OF LAW AND OPINION

The issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find that the record is insufficiently developed to decide this issue and remand to the ALJ.

In previous cases regarding the issue of whether a hearing request should have been dismissed, we have held that, where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. Robert S. Ceballos, 49 Van Natta 617 (1997); Gilberto Garcia-Ortega, 48 Van Natta 2201 (1996). However, in those cases, there was no indication that the record lacked an executed retainer agreement between the claimant and the prior attorney and the claimant did not dispute his attorney's authority to act on his behalf.

Here, claimant contends that Ms. Galaviz-Stoller did not have authority to withdraw the hearing request on claimant's behalf. The record contains no retainer agreement that would document claimant's employment of Ms. Galaviz-Stoller to represent him. In addition, considering the "pre-dismissal order" December 16, 1996 retainer agreement employing Mr. Camacho, claimant's current attorney, and authorizing him to act on claimant's behalf, it would appear that Ms. Galaviz-Stoller was not authorized to formally withdraw claimant's hearing request on February 18, 1997, which was the action that prompted the ALJ's dismissal order.

SAIF argues that the withdrawal of claimant's hearing request was effective when Ms. Galaviz-Stoller communicated it to the ALJ on November 20, 1996. SAIF notes that claimant does not contend that Ms. Galaviz-Stoller lacked authority to withdraw the request as of that date. Therefore, SAIF argues, the dismissal order should be affirmed. We disagree.

If the ALJ's dismissal order had issued in response to Ms. Galaviz-Stoller's November 20, 1996 "withdrawal," SAIF might have a point. However, the ALJ issued the dismissal order in specific response to Ms. Galaviz-Stoller's February 1997 express written withdrawal of claimant's hearing request. At the time of that withdrawal letter, according to claimant's current attorney's retainer agreement, Ms. Galaviz-Stoller no longer represented claimant.

We may remand to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Where an ALJ has dismissed a claimant's request for hearing and the record does not contain sufficient evidence regarding the dismissal of claimant's hearing request to allow us to reach an adequate determination concerning the propiety of the ALJ's dismissal order, we have found a compelling reason to remand for further development of an incomplete and insufficient record. Tamara Riddle, 41 Van Natta 971 (1989); Robert J. Buckley, 41 Van Natta 1761 (1989); Donald R. Roth, 42 Van Natta 1091 (1990).

Here, based on claimant's executed December 16, 1996 retainer agreement, it appears that Ms. Galaviz-Stoller was not authorized to withdraw claimant's hearing request at the time of her February 18, 1997 letter. Under these circumstances, we find that the record has been incompletely and insufficiently developed.

Therefore, we vacate the ALJ's February 27, 1997 dismissal order and remand this matter to ALJ Crumme' with instructions to determine whether the dismissal was justified.[1] If the ALJ finds that the hearing request should be dismissed, a final order shall issue setting forth the ALJ's reasoning. Should the ALJ find that the hearing should not be dismissed, the case shall proceed to hearing on the merits. Thereafter, the ALJ shall issue a final order.

IT IS SO ORDERED.

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[1] We note that SAIF also argues that the dismissal order should be upheld under OAR 438-006-0071 on the ground that claimant abandoned his request for hearing, either through inaction on the part of his current attorney or through the unjustified failure of claimant or his representative to attend the scheduled November 21, 1996 hearing. However, the dismissal order was not based on an "abandonment" theory; instead, it was based on claimant's former attorney's February 18, 1997 letter withdrawing the hearing request. Therefore, it appears that SAIF's argument is not applicable. Nevertheless, because we are remanding this case to the ALJ to determine whether the dismissal was justified, SAIF may raise this "abandonment" argument to the ALJ.

In the Matter of the Compensation of
ELLEN J. RAPALJE, Claimant
WCB Case No. 96-10139
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its denial of claimant's injury claim for bilateral anterior shoulder dislocation; and (2) awarded a $3,250 attorney fee pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation and modification. We replace the first sentence of the ALJ's findings of fact with the following sentence: "Claimant is a forthright 27 year old woman."

SAIF argues that the $3,250 attorney fee awarded by the ALJ is excessive. In any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered: (a) The time devoted to the case; (b) The complexity of the issue(s) involved; (c) The value of the interest involved; (d) The skill of the attorneys; (e) The nature of the proceedings; (f) The benefit secured for the represented party; (g) The risk in a particular case that an attorney's efforts may go uncompensated; and (h) The assertion of frivolous issues or defenses. OAR 438-015-0010(4).

Here, after reviewing the factors listed in OAR 438-015-0010(4), we find that $3,250 constitutes a reasonable attorney fee for services at the hearing level. The issue in dispute was whether claimant's injury occurred in the course and scope of employment. The hearing lasted approximately 40 minutes and one witness, claimant, testified. Seven exhibits were received into evidence, none of which were generated by claimant's attorney. At the hearing, claimant's attorney submitted a six page hearing memorandum to the ALJ. The course and scope issue presents factual and medical questions of a complexity similar to those generally submitted for Board consideration. Because a compensable claim has been established which entitles claimant to workers' compensation benefits, the value of the interest involved and the benefit secured for claimant are significant. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might go uncompensated.

Based upon our application of the factors listed in OAR 438-015-0010(4), we find that the ALJ's $3,250 attorney fee was reasonable. In reaching this conclusion, we have particularly considered the time devoted to the course and scope issue (as represented by the record and claimant's counsel's hearing memorandum), the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the course and scope issue is $2,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to a fee on review for services devoted to the attorney fee issue. Dotson v. Bohemia Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 12, 1997 is affirmed. For services on Board review, claimant's attorney is awarded $2,000, payable by SAIF.

In the Matter of the Compensation of
JAMES E. SCHEUFFELE, Claimant
WCB Case No. 96-08503
ORDER ON REVIEW
J.R. Perkins III, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the insurer's denial of his claim for multiple injuries resulting from a workplace altercation. On review, the issue is whether claimant's injuries arose in the course and scope of employment. We reverse.[1]

FINDINGS OF FACT

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

Claimant worked for the employer as a miner, digging on the Portland west side light rail project. Al Torzilli and his girlfriend, Amy Neale, also worked on the light rail project, although on different shifts and usually in different areas than claimant.

In late July or early August 1996, false rumors were spread about claimant having a sexual liaison with Mr. Torzilli and Ms. Neale. Claimant heard co-worker Fred Lang joke about the rumors to foreman Rick Leever. He indicated that the rumors were untrue.

On August 9, 1996, Mr. Torzilli went looking for claimant after he finished his shift. He found claimant talking to another co-worker, a concrete truck driver. Mr. Torzilli came up behind claimant, attacked him and knocked him to the ground. As a result of the attack, claimant sustained multiple injuries, including contusions and abrasions, right-sided thoracic strain, lumbosacral strain and a chest wall contusion/strain. Claimant, Mr. Torzilli and Mr. Lang were all fired as a result of Mr. Torzilli's assault on claimant.

In September 1996, the insurer denied claimant's claim asserting that his injuries did not occur within the scope of his employment.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial finding that, although claimant was not an active participant in the assault, there was an insufficient causal connection between the assault and claimant's employment. Reasoning that the attack was motivated by Torzilli's anger over the rumor and not a matter related to claimant's job assignment or customary duties, the ALJ concluded that claimant's injuries arose from a personal matter between claimant and his co-worker.

On review, claimant asserts that his injuries, resulting from the unprovoked attack by a co-worker, arose out of and in the course of his employment.[2] We agree, for the reasons set forth below.

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[1] Both claimant and the insurer have moved to correct errors in the hearing transcript. We grant the joint motion and have corrected the transcript in accordance with the parties' requests.

[2] On review, claimant asserts that certain facts regarding the assault have been previously litigated and determined in a prior proceeding before the Employment Department, and the insurer is therefore barred by the doctrine of issue preclusion from relitigating those facts. The insurer argues that, pursuant to ORS 657.273, the findings of the Employment Department may not be used for the purpose of claim preclusion or issue preclusion in this proceeding and are not admissible as evidence in this proceeding. In response, claimant contends that ORS 657.273 is violative of the separation of powers provision of the Oregon Constitution. We need not address these "issue preclusion/constitutional" issues because we conclude, based on the record before us (without considering Exs. 11, 12 and 13, the Employment Department orders), that claimant was not an active participant in the assault.

Subsequent to the ALJ's order, the Supreme Court issued its opinion in Redman Industries v. Lang, 326 Or 32 (1997). Specfically, the Supreme Court addressed the compensability of injuries caused by an assault by a co-worker at the work place. The Court held that an assault-related injury arises out of employment if it results from the nature of the claimant's work or from the work environment. The assault need not, however, be directly precipitated by "work-related" factors, such as a co-worker's critique of another employee's job performance. The relevant inquiry is whether the risk was "associated with the employment" (which would be compensable) or whether it was "personal to the claimant" (which would not be compensable). The Court recognized that the risk of an assault by a co-worker in the work place is a risk to which the work environment exposes an employee.

In Lang, the claimant was assaulted by a co-worker because the co-worker was angry with claimant for calling him racially derogatory names. The co-worker also believed that he would be fired for having assaulted another employee moments earlier and that he had nothing to lose by assaulting the claimant. The Court found no evidence that claimant and his assailant had any relationship outside of work or that the motivation for the assault was fueled by an occurrence involving them outside of work. The Court further determined that all events or circumstances pertaining to the assault occurred at the workplace and concluded that the claimant's injury arose out of his employment. The Court further noted that the reasonableness or offensiveness of the claimant's racially derogatory comments were irrelevant to the compensability inquiry.[3]

In this case, as in Lang, there is no evidence that claimant and Mr. Torzilli (or claimant and Ms. Neale) had any relationship outside of work. The undisputed motivation for the assault was Mr. Torzilli's anger over a rumor being spread throughout the work site involving him, his girlfriend and claimant that he knew to be untrue. Rather than being based on contact with claimant outside of the employment, his assault on claimant was fueled by a workplace event, i.e. the circulation of a rumor among the employees.[4]

Consequently, we find, based on the analysis set forth in Lang, that claimant's injuries were caused by circumstances associated with the work environment, and therefore arose within the course and scope of his employment. We further find, as did the ALJ, that claimant was not an active participant in the assault, which would exclude compensability under ORS 656.005(7)(b)(A). The record establishes that claimant did not verbally provoke Mr. Torzilli into combat, nor did he initiate the attack.[5] Mr. Torzilli admitted that he went to look for claimant at the Markam Bridge batch plant, found him, knocked him down and beat on him for maybe five minutes. Under these circumstances, claimant's injuries are compensable under ORS 656.005(7)(a).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 13, 1997 is reversed. The insurer's denial is set aside and claimant's injury claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded $4,200, payable by the insurer.

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[3] The Lang Court also rejected the carrier's contention that claimant's derogatory racial comments made him an active participant in the assault, noting that there was an intervening time period between the comments and the assault.

[4] Indeed, the record establishes that Mr. Leever heard the rumor from Mr. Lang, that Mr. Torzilli's supervisor had apparently heard the rumor from other employees and that Mr. Torzilli believed the rumor was being spread by workers at the Markam Bridge batch plant. (See Tr. 18, 22, 24).

[5] Even if, as Mr. Torzilli apparently believed, claimant had started or participated in the rumor, that would not make claimant an active participant in the assault. As the Court noted in Lang, "the statutory provision [ORS 656.005(7)(b)(A)] expressly requires that a claimant be an 'active participant in assaults and combats.' (Emphasis added). Those terms require more than that a claimant anger an assailant in such a way that the assailant later assaults the claimant."

In the Matter of the Compensation of
JACK W. SWINFORD, Claimant
WCB Case No. 96-06696
ORDER ON REVIEW (REMANDING)
Schneider, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that dismissed, pursuant to ORS 656.308(2)(c), his hearing request concerning SAFECO's responsibility denial for his current low back condition. On review, the issue is the propriety of the ALJ's dismissal order.[1] We vacate and remand.

FINDINGS OF FACT

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

Claimant compensably injured his low back in October 1986, while working for SAFECO's insured. The claim was closed by a February 1989 Determination Order awarding claimant 17 percent unscheduled permanent disability.

In February 1994, claimant reinjured his low back while employed by Travelers' insured. A November 4, 1994 Stipulated Order on Settlement ordered Travelers to accept claimant's injury claim and upheld SAFECO's current condition and responsibility denials.

On July 29, 1995, claimant reinjured his back while employed by the SAIF Corporation's insured. SAIF accepted a lumbosacral strain.

In February and May 1996, SAIF issued partial denials, denying the compensability of, and responsibility for, claimant's current low back condition. On July 11, 1996, SAFECO denied responsibility for claimant's current condition.

Claimant requested a hearing on both SAIF's and SAFECO's denials. Prior to the consolidated hearing, SAFECO moved to be dismissed pursuant to ORS 656.308(2)(c).[2]

CONCLUSIONS OF LAW AND OPINION

The ALJ found the record did not contain substantial evidence to support a finding of responsibility against SAFECO and dismissed SAFECO from the hearing pursuant to ORS 656.308(2)(c). On review, claimant asserts that ORS 656.308(2)(c) is inapplicable where compensability remains at issue and that the ALJ should not have dismissed SAFECO from the proceeding. We agree.

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[1] SAFECO has submitted a July 1997 Disputed Claim Settlement between claimant and the SAIF Corporation. In light of this recent dismissal of claimant's hearing request from SAIF's compensability denial, SAFECO contends that claimant's argument that ORS 656.308(2)(c) requires all carriers to have conceded compensability before a dismissal motion may be granted has been rendered moot because it is the only remaining carrier in the proceeding and its denial was limited to responsibility. In response, claimant asks that SAFECO's submission either be stricken or that we implement a supplemental briefing schedule. Because SAFECO's submission has no effect on our decision, we need not address claimant's response. The issue before us is whether the ALJ properly dismissed SAFECO as a party to the proceeding which pertained to claimant's hearing request from SAFECO's responsibility denial and SAIF's compensability / responsibility denial. The fact that claimant has subsequently settled his dispute with SAIF does not resolve the question of whether ORS 656.308(2)(c) authorized the ALJ to dismiss SAFECO as a party to the proceeding prior to the convening of the hearing when SAIF had not conceded the compensability of the denied claim. Moreover, by reaching a settlement with SAIF, claimant accepts the risk that he may not receive compensation for his claim should the evidence fail to establish that SAFECO is responsible for the claim. See ECD, Inc. v. Snider, 105 Or App 416 (1991).

[2] In granting SAFECO's motion, the ALJ ordered that claimant's request for hearing against SAIF be bifurcated and preserved under another WCB case number.

ORS 656.308(2)(c) provides, in pertinent part, as follows: "Upon written notice by an insurer or self-insured employer * * *, the Administrative Law Judge shall dismiss that party from the proceeding if the record does not contain substantial evidence to support a finding of responsibility against that party." The issue we must decide is whether this statute applies to a proceeding where compensability remains at issue.

Our task in interpreting a statute is to discern the intent of the legislature. PGE v. Bureau of Labor and Industries, 317 Or 606 (1993). At the first level of analysis, we examine both the text and context of the statute. Id. at 610. If the legislative intent is not clear from that inquiry, we then examine the legislative history or other extrinsic aids. Id. at 611-12.

By its express terms, ORS 656.308(2)(c) refers only to responsibility disputes. It requires the dismissal of a party if there is no substantial evidence to support a "finding of responsibility" against that party. Moreover, the statute subsection does not refer to findings of compensability or compensability denials.

In Ernest L. Chavez, 48 Van Natta 529 (1996), we specifically held that the dismissal procedures of ORS 656.308(2)(c) apply only in responsibility cases and cannot be applied when a carrier has denied both compensability and responsibility. See also Katherine D. Knigge, 48 Van Natta 1056 (1996) (ALJ did not err in denying motion to dismiss where compensability and responsibility were in issue at hearing); Theresa A. Szeremi, 48 Van Natta 942 (1996) (ALJ had no authority to dismiss claimant's hearing requests where the carriers did not concede compensability). In Chavez, we also examined the other provisions of ORS 656.308(2) and determined that the entire subsection relates solely to responsibility proceedings. We noted that subsection (2)(a) of ORS 656.308 concerns the procedures for responsibility denials and requires that all requests for hearing on such denials be consolidated into one proceeding. We explained that ORS 656.308(2)(b) pertains to joinder issues in responsibility proceedings and that subsection (2)(d) sets forth the standard for attorney fee awards in prevailing over a responsibility denial. We concluded that neither the text nor the context of ORS 656.308(2)(c) authorized the ALJ to dismiss a carrier when the compensability of claimant's condition remained in dispute. Id.

Subsequent to our decisions in Chavez, Knigge and Szeremi and the ALJ's order in this case, the Court of Appeals interpreted the 1990 version of ORS 656.308 in two cases, Norstadt v. Murphy Plywood, 148 Or App 484 (1997) and Garibay v. Barrett Business Services, 148 Or App 496 (1997). In Norstadt, the court declined to apply the 1995 amendments to ORS 656.308(2) retroactively to relieve a carrier of the requirement (under former ORS 656.308(2)) that it issue a notice of disclaimer before it may argue that another carrier is responsible for a claim. Under former ORS 656.308(2), which was adopted in 1990, if a carrier failed to comply with the disclaimer requirement, the carrier was prohibited from arguing that another carrier was responsible for the claim.[3] The 1995 amendments eliminated the separate disclaimer requirement and extended the time period for a carrier to issue a denial of responsibility. The Norstadt court held that, because retroactive application of amended ORS 656.308(2) would have the effect of altering procedural time limitations for the filing of a claim, the amended statute did not apply retroactively.

Turning to construction of former ORS 656.308, the Norstadt court rejected the carrier's contention that the disclaimer requirements of subsection (2) were applicable only if there is an accepted

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[3] Former ORS 656.308(2) (1990) provided, in part:

"Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."

claim pursuant to subsection (1).[4] The court noted that, although subsection (1) is limited to claims involving previously processed claims, the language of subsection (2) unambiguously applies to all cases in which an employer or insurer intends to deny responsibility. In particular, the court relied on the first sentence of subsection (2) that refers to "any workers' compensation proceeding," and the second sentence of the same subsection that refers to "any employer or insurer which intends to disclaim responsibility for a given injury or disease claim." By its terms, the court concluded, subsection (2) functions independently of subsection (1) and, thus, is not limited to disclaimers of claims or injuries subject to subsection (1).

In Garibay, the court also concluded that the 1995 amendments to ORS 656.308(2) did not apply retroactively to relieve the carrier of the obligation to issue a responsibility disclaimer. Because the carrier in Garibay did not issue a responsibility disclaimer, the court held that the carrier was barred from asserting that another carrier was responsible for the claim. In so holding, the court rejected our view, enunciated in Joyce A. Crump, 47 Van Natta 466 (1995), that the obligation to disclaim responsibility under former ORS 656.308(2) does not exist if there is a dispute as to the compensability of the claim. Reasoning that the disclaimer requirement expressly applies to "[a]ny employer. . .which intends to disclaim responsibility for a given injury or disease claim," the court stated that the statute does not distinguish between cases involving responsibility only and cases involving both responsibility and compensability. The court ruled that the disclaimer requirement in former ORS 656.308(2) is not contingent on a concession of compensability by a carrier.

At first glance, Norstadt and Garibay would seem to impact our holding in Chavez that the dismissal procedure in ORS 656.308(2)(c) applies solely to responsibility proceedings. Upon closer inspection, however, we find that Norstadt and Garibay are distinguishable and, hence, not inconsistent with our holding in Chavez. Both Norstadt and Garibay, in addition to being decided under the 1990 version of ORS 656.308(2), addressed the requirement that a carrier issue a responsibility disclaimer, holding that a carrier must issue a disclaimer regardless of whether the case involves compensability and responsibility or responsibility only. In either case, the court reasoned that the failure to issue the disclaimer barred the carrier from arguing that another carrier is responsible for the claim. Thus, when the court in Norstadt stated that former ORS 656.308(2) is not limited to claims that were accepted pursuant to former ORS 656.308(1), that statement was made in the context of deciding when the disclaimer requirement applies. When viewed in their limited "responsibility disclaimer" context, Norstadt and Garibay do not contradict our holding in Chavez.

In addition, the Norstadt and Garibay decisions were interpreting a former version of a different subsection of ORS 656.308. In other words, the court was analyzing subsection (2)(a), which pertained to a carrier's obligations to issue a responsibility disclaimer, as well as the conditions for joining a carrier "in any workers' compensation proceeding." (Emphasis supplied.) Such terminology suggests a broad application of the former disclaimer requirement to any proceeding.

In contrast, subsection (2)(c), which was added to ORS 656.308 several years after the 1990 enactment of subsection (2)(a), indicates a more limited application in that the provision addresses the circumstances in which a carrier may be dismissed from "the proceeding." (Emphasis supplied.) Specifically, the "dismissal" provisions in ORS 656.308(2)(c) provide that, upon a carrier's motion, an ALJ must dismiss the carrier "if the record does not contain substantial evidence to support a finding of responsibility against that party." (Emphasis supplied.) By its terms, therefore, ORS 656.308(2)(c) refers to a finding of responsibility only.[5] As we noted in Chavez, the dismissal provision does not refer to

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[4] Former ORS 656.308(1) (1990) provided:

"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."

[5] Consistent with this analysis, we further note that subsection (2)(d), which pertains to attorney fee awards, is expressly limited to "prevailing against a responsibility denial." This statutory provision, which is directed solely to "responsibility" denials, provides additional support for our conclusion that, based on its context, ORS 656.308(2)(c) is applicable only when the proceeding is limited to responsibility denials.

findings of compensability or compensability denials. It appears, therefore, that in adopting the dismissal provision, the legislature did not contemplate the dismissal of a carrier-party from a proceeding where compensability remains at issue.

Our interpretation of ORS 656.308(2)(c) is also supported by the legislative history. In describing the 1995 amendments to subparagraph (2) of ORS 656.308, Representative Mannix noted that the statute applied when "[t]he worker's got a compensable condition" and "all these employers and insurers are in [the proceeding] and *they're all agreeing it's a compensable condition.*" See Tape Recording, House Committee on Labor, March 6, 1995, Tape 45B (emphasis added). See also March 3, 1995 Senate Committee on Labor and Government Operations, Exhibit A, Staff Measure Summary (amendments to ORS 656.308(2) and (3) relate to disputes about which insurer or employer is responsible for an otherwise compensable claim).[6]

In our view, there is a strong policy reason not to expand application of the dismissal procedure beyond what was contemplated by the legislature. We have consistently held that compensability must be proven as a threshold to determining responsibility. E.g., Joseph L. Woodward, 39 Van Natta 1163 (1987). Thus, a finding of responsibility (as to a particular carrier) is not made until the claim is determined to be compensably related to work exposure with all potentially responsible carriers. The threshold finding of compensability establishes the claimant's right to compensation for an injury or disease claim. Once that right is established, then the determination as to which carrier is responsible can be made. The reversal of this process to allow a carrier to be dismissed as not potentially responsible before the finding of compensability has been made places the claimant's right to compensation at risk prematurely, even before the hearing has been convened and the evidentiary record has been closed. We do not believe that the legislature intended claimants to bear that risk under the dismissal procedure in ORS 656.308(2)(c).

As noted above, ORS 656.308(2)(a) provides that all requests for hearing from responsibility denials "shall be consolidated into one proceeding." Thus, the "proceeding" referred to in ORS 656.308(2)(c)[7] is one in which all employers or insurers who have denied responsibility are joined for a determination as to which is responsible for claimant's new *compensable* condition.[8] Where, as here, one carrier continues to dispute the compensability of claimant's condition, no responsibility issue is ripe for adjudication. Consequently, we conclude that *all* carriers joined in the proceeding must concede the compensability of claimant's condition[9] as a prerequisite to applying the provisions of ORS 656.308(2)(c).

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[6] We disagree with the dissent's assertion that our interpretation of the statute defeats the legislature's intentions to fix an "unwieldy process." To the contrary, as demonstrated by our citations to Representative Mannix's comments, our construction of the statute is consistent with legislative intent. Moreover, the dissent does not offer any history to contradict Representative Mannix's statements; indeed, the additional statements from Representative Mannix cited by the dissent refer to "responsibility." Finally, and of most importance, our interpretation of ORS 656.308(2)(c) allows, once compensability of the claim has been established, full use of the summary dismissal proceeding to accomplish exactly what the legislature intended. We further disagree with the dissent that our interpretation of the statute violates basic principles of statutory construction in that we do give full effect to all provisions of ORS 656.308(2) and we are not inserting language the legislature omitted.

[7] ORS 656.308(2)(c) provides that the ALJ "shall dismiss that party from *the proceeding* if the record does not contain substantial evidence to support a finding of responsibility against that party." (Emphasis added). Our interpretation of the term "proceeding" is also consistent with the use of the same term in ORS 656.307. Subsections (2), (4), (5) and (6) of ORS 656.307 all refer to "proceeding" in the context of a hearing to determine responsibility for a compensable claim.

[8] As noted at the outset, we construe all of ORS 656.308(2) in the context of ORS 656.308(1), which only applies "when a worker sustains a *compensable* injury." See Sanford v. Balteau Standard, 140 Or App 177 (1996); Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993) ("ORS 656.308 is applicable if it is determined that the 'further' disability or treatment for which benefits are sought is compensable"). Thus, the entire statute is predicated on a finding of compensability.

[9] See Castle & Cook v. Alcantar, 112 Or App 392, 395 (1992) (a concession of compensability in relation to a ".307" order admits only that a claimant's condition resulted from a work exposure and does not waive a carrier's right to argue that the claimant's disability is not related to a work exposure in its employment).

For all of these reasons, we adhere to our construction of ORS 656.308(2)(c) in Chavez and conclude that the court's decisions in Norstadt and Garibay do not contradict our conclusion that the dismissal procedure applies solely to responsibility proceedings. Therefore, consistent with our construction of ORS 656.308(2)(c) in Ernest L. Chavez and its progeny, we remain persuaded that a carrier may not take advantage of the dismissal procedure until the compensability of the new injury or condition has been determined. Stated differently, the statute's dismissal procedure is contingent on a finding or concession of compensability by all carriers joined in the proceeding and is not available outside the context of a consolidated hearing under ORS 656.308(2)(a) in which responsibility is the only issue.

Here, even though SAFECO conceded the compensability of claimant's condition, compensability remained in issue because of SAIF's denial. So long as compensability remained in issue, claimant had the burden of proving the compensability *as a threshold* to any responsibility determination.[10] ORS 656.266; Rodney L. Kosta, 43 Van Natta 180 (1991); Joseph L. Woodward, 39 Van Natta at 1164. Because responsibility becomes an issue only when the claim is proved to be compensable, SAFECO should not have been dismissed under ORS 656.308(2)(c) prior to the hearing.

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

Here, as in Ernest L. Chavez, no hearing was convened and the parties did not have the opportunity to litigate the compensability of claimant's current condition. Accordingly, we vacate the ALJ's order and remand this case to ALJ Myzak for further proceedings consistent with this order. These proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[10] In concluding that any carrier who has conceded compensability or issued a "responsibility only" denial may seek dismissal under ORS 656.308(2)(c), the dissent's approach disregards this long-standing principle.

Board Members Haynes and Biehl dissenting.

The majority concludes that the dismissal procedure under ORS 656.308(2)(c) is contingent on a finding or a concession of compensability by all carriers joined in the proceeding. Because we believe the majority has misconstrued the text and context of the statute, we respectfully dissent.

The majority states, correctly, that our task in construing legislation begins with the language of the statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). It also acknowledges, correctly, that we must consider other provisions of the same statute and other related statutes. Id. at 611. Although the majority purports to examine the full context of ORS 656.308, we submit that it has not done so. Moreover, the majority ignores a related statute, ORS 656.307. The majority's statutory analysis results in amending ORS 656.308(2)(c) to say what it thinks it ought to say instead of what the legislature did say.

The majority's reliance on Ernest L. Chavez, 48 Van Natta 529 (1996), and its progeny is misplaced. At a minimum, Chavez is distinguishable from this case. Moreover, we believe that Chavez was wrongly decided.

In Chavez, we held that the "motion to dismiss" provision in ORS 656.308(2)(c) did not apply to a carrier which had issued a compensability denial and had not conceded compensability prior to the proceeding. Based on the text of ORS 656.308(2)(c), we concluded that the subsection related only to responsibility. Since the text of ORS 656.308(2)(c) did not refer to findings of compensability or compensability denials, we concluded that the dismissal procedures applied only to responsibility

disputes. 48 Van Natta at 530. Turning to the context of the statute, we pointed out that subsections (a), (b), and (d) of ORS 656.308 all focused on responsibility issues. Finally, we found no reference in ORS 656.308 or elsewhere in Chapter 656 to a procedure for dismissing a hearing request on the basis that the record does not contain substantial evidence to support a finding of compensability. Under such circumstances, we concluded that the dismissal procedures of ORS 656.308(2)(c) apply only to responsibility issues.

Our first mistake in Chavez was concluding that, because the text of ORS 656.308(2)(c) did not refer to findings of compensability or compensability denials, the dismissal procedures applied only to responsibility disputes. In reaching that conclusion, we did not discuss ORS 656.307, which applies in "responsibility only" disputes. ORS 656.307(1) provides, in part:

> "(1) Where there is an issue regarding:
>
> " * * * * *
>
> "(c) Responsibility between two or more employers or their insurers involving payment of compensation for one or more accidental injuries; or
>
> " * * * * *
>
> "the Director of the Department of Consumer and Business Services shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable." (Emphasis added).

In contrast, ORS 656.308 applies in cases that involve disputes of responsibility, as well as compensability.[1] The majority states that compensability must be proven as a threshold to determining responsibility. In Joyce A. Crump, 47 Van Natta 466 (1995), we relied on that premise to hold that the application of former ORS 656.308(2) was contingent on the claim being proved compensable.

As the majority notes, the Court of Appeals recently rejected our conclusion in Crump. In Garibay v. Barrett Business Services, 148 Or App 496, 501 (1997), the court held that former ORS 656.308(2) did not distinguish between cases involving responsibility only and cases involving both responsibility and compensability. The court rejected the contention that the obligation to issue a disclaimer of responsibility under former ORS 656.308(2) did not exist if there was a dispute as to the compensability of the claim. The court held that the disclaimer requirement was not contingent on a concession of compensability by an employer. Id.

In Norstadt v. Murphy Plywood, 148 Or App 484, 493 (1997), the court rejected the carrier's argument that former ORS 656.308(2) only applied if there is an accepted claim under ORS 656.308(1). The court held that subsection (2) of former ORS 656.308(2) functioned independently of subsection (1). Id. Although the majority attempts to distinguish Garibay and Norstadt by viewing those cases in a limited "responsibility disclaimer" context, we are not persuaded by that narrow interpretation.

Here, the amended version of ORS 656.308(2) is applicable. The amended version of the statute, like its predecessor, does not distinguish between cases involving responsibility only and cases involving responsibility and compensability. Moreover, contrary to the majority's conclusion, the dismissal procedure under ORS 656.308(2) is not contingent on a concession of compensability by the employer.

ORS 656.308(2)(a) provides:

> "Any insurer or self-insured employer who disputes responsibility for a claim shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 90 days allowed for processing of the claim. The denial shall advise the worker to file separate, timely claims against other potentially responsible insurers or self-insured employers, including other insurers for the same employer, in order to protect the right to obtain benefits on the claim. The denial may list the names and addresses of other insurers or self-insured employers. Such denials shall be final unless the worker files a timely request for hearing pursuant to ORS 656.319. All such requests for hearing shall be consolidated into one proceeding."

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[1] We note that ORS 656.308 may apply in "responsibility only" disputes in which no order has issued under ORS 656.307.

ORS 656.308(2)(a) provides that a carrier who disputes responsibility for a claim shall so indicate "in or as part of a denial otherwise meeting the requirements of ORS 656.262[.]" (Emphasis added). Inasmuch as ORS 656.262 provides for, among other things, processing claims for compensability, it is clear that ORS 656.308(2) contemplates situations in which compensability remains at issue. Furthermore, ORS 656.308(2)(a) provides that "[a]ll such requests for hearing shall be consolidated into one proceeding." That language indicates that the legislature intended to consolidate hearings involving compensability and responsibility disputes into a single proceeding.

ORS 656.308(2)(c) provides, in part:

> "Upon written notice by an insurer or self-insured employer filed not more than 28 days or less than 14 days before the hearing, the Administrative Law Judge shall dismiss that party from the proceeding if the record does not contain substantial evidence to support a finding of responsibility against that party."

There is nothing in the text of ORS 656.308(2)(c) to suggest that it applies only when there is no dispute as to compensability. The majority acknowledges that ORS 656.308(2)(c) neither refers to findings of compensability nor compensability denials. Nevertheless, the majority concludes that the dismissal procedure under ORS 656.308(2)(c) is contingent on a finding or a concession of compensability by all carriers joined in the proceeding. The majority's analysis is inconsistent with the court's holding in Garibay and Norstadt and it ignores the language in ORS 656.308(2)(a), which indicates that the legislature contemplated that ORS 656.308(2) could apply in cases involving compensability and responsibility disputes. Moreover, the majority's interpretation violates a principle of construction to be applied in the first level of statutory analysis: "[W]here there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all." ORS 174.010; PGE, 317 Or at 611.

After further consideration, we believe that the statutory analysis in Chavez of ORS 656.308(2)(b) and 308(2)(d) was insufficiently developed. ORS 656.308(2)(b) provides that no carrier shall be joined to any workers' compensation hearing unless the worker has first filed a timely, written claim against that carrier or the carrier has consented to issuance of an order designating a paying agent pursuant to ORS 656.307. If the carrier has consented to a "307" order, the carrier has admitted that the claim is otherwise compensable. See ORS 656.307(1). On the other hand, if the worker has filed a claim against the carrier, the carrier may contest compensability and responsibility. Thus, the language of ORS 656.308(2)(b) supports the conclusion that the legislature intended ORS 656.308(2) to apply to cases involving compensability and responsibility.

Similarly, subsection (2)(d) of ORS 656.308 supports the same conclusion. Since ORS 656.308(2)(d) provides that a claimant is entitled to an attorney fee "[n]otwithstanding ORS 656.382(2), 656.386 and 656.388," the legislature indicated that an attorney fee awarded pursuant to ORS 656.308(2)(d) is separate from, and in addition to, an attorney fee awarded for finally prevailing over a compensability denial under ORS 656.386(1) or pursuant to ORS 656.382(2), when a carrier unsuccessfully appeals an ALJ's order that has addressed compensability. See Paul R. Huddleston, 48 Van Natta 4, 9, on recon 48 Van Natta 203 (1996). Therefore, the language of ORS 656.308(2)(d) indicates that the legislature contemplated that ORS 656.308 could apply to proceedings involving disputes of compensability and responsibility.

Instead of giving effect to other provisions of ORS 656.308(2) and other related statutes (ORS 656.307), the majority rewrites ORS 656.308(2)(c) to read:

> "Upon written notice by an insurer or self-insured employer filed not more than 28 days or less than 14 days before the hearing, the Administrative Law Judge shall dismiss the party from the proceeding if the record does not contain substantial evidence to support a finding of responsibility against that party[, *only if the employers and insurers admit that the claim is otherwise compensable*]."

In construing statutes, we are "simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted * * *." ORS 174.010. The majority's construction of ORS 656.308(2)(c) amends ORS 656.308(2)(c) to say what it

thinks it ought to say instead of what the legislature did say. See Deluxe Cabinet Works v. Messmer, 140 Or App 548, 553 ("[W]e are constrained by the reasonable construction of the language that the legislature actually enacted. We are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted."), rev den 324 Or 305 (1996).

The majority's amendment of ORS 656.308(2)(c) completely defeats the purpose of that provision, which was to streamline the workers' compensation hearing process by dismissing carriers from proceedings involving responsibility disputes when the record does not demonstrate substantial evidence to support a finding of responsibility against that party.[2] The dismissal procedure of ORS 656.308(2) provides efficiency for the Hearings Division/Board and the carriers, reduces the costs of litigation,[3] and allows the claimant to focus and clarify his or her arguments before the hearing.

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[2] In his remarks to the House Committee on Labor on March 6, 1995, Representative Mannix explained that the amendments to ORS 656.308(2) were designed to "clean up the litigation scene with responsibility, which has become something of a circus" and to "streamline the process and change a three-ring circus into a one ring circus." Tape Recording, House Committee on Labor, March 6, 1995, Tape 45B.

Similarly, in his remarks to the Senate Committee on Labor and Government Operations on January 30, 1995, Representative Mannix explained that ORS 656.308(2)

> "[r]evises procedures for establishing responsibility. This was an attempt at reform that failed. The process right now is unwieldy. The employer disclaims and points to all the other employers. The worker files claims against all of them. You literally have some hearings where there's 20 or 30 employers involved. Often you have with six or seven employers involved. Even though everyone agrees, there is probably one or two real targets. This gets back to a process where someone who wants to say someone else is the guilty party, so to speak, has to actually move to join that other party and returns to a process that was used before 1990."

Tape Recording, Senate Committee on Labor and Government Operations, January 30, 1995, Tape 16B.

[3] On February 1, 1995, Tom Johnson, an attorney with Liberty Northwest, spoke in favor of the amendments to ORS 656.308(2) before the Senate Committee on Labor and Government Operations. He explained how the amendments would likely reduce the costs of litigation:

> "We have a system in place right now where if an employer wants to defend a case by saying this claim shouldn't have been made against me, it should have been made against another employer over here, that employer issues a notice of disclaimer to the worker informing the worker of that, and that allows the worker to make a claim then against this other employer. And the idea is they come together in the hearing, everybody is present and the matter gets resolved.
>
> "It's not working that way, what's happened is employers, at the beginning of a case, don't know specifically which other employer they may be pointing to at the hearing. So, the tendency and the motivation has been for employers to disclaim against everyone the worker has ever worked for. The worker then feels compelled to file claims against all of those employers. Those employers in turn can investigate further, bringing other employers disclaim against them, and this whole thing just grows until we get multi-party cases in which most of the participants don't need to appear. They're not let out, so they have to have attorneys and counsel to be there.
>
> "I reviewed some of Liberty's records in 1993 and 1994, a 6-month period. Liberty was involved in 31 hearings involving at least three employers, but half of those involved five employers or more and three of them involved over 20 employers. We had a case involving 46 employers. Now that is beneficial only to my friends in the defense bar who are hired to represent these employers, and if you think about it, when they are paid, $2,000 or $3,000 for example, to appear at a case, if we have six employers there defending Liberty insureds, that's $18,000 that really is simply an excess cost to the system. It doesn't help anyone. This bill takes us back to the original system where the employer that wants to bring in another employer has to persuade the referee that there is some reasonable need to do that. And we greatly favor section 37 [ORS 656.308], and its change."

Tape Recording, Senate Committee on Labor and Government Operations, February 1, 1995, Tape 19B.

Here, the ALJ concluded that no party disputed that the evidence did not contain substantial evidence to support a finding of responsibility against SAFECO. Claimant does not contest that finding on review. Under these circumstances, SAFECO was properly dismissed from the proceeding pursuant to ORS 656.308(2)(c).

Alternatively, even if we assume that Ernest L. Chavez was correctly decided, Chavez is distinguishable from the facts in this case. In Chavez, we specifically commented that if the employer had conceded that the claimant's condition was compensable, it would have been appropriate for the ALJ to consider whether that employer should be dismissed from the proceeding pursuant to ORS 656.308(2)(c). 48 Van Natta at 531 n.3. We cited Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992) (a concession of compensability only admits that a claimant's condition resulted from a work exposure; it does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment). We reiterated that point in Kathryn D. Knigge, 48 Van Natta 1056 (1996).

Here, SAFECO has conceded the compensability of claimant's condition. Given SAFECO's concession of compensability, the responsibility issue was ripe for adjudication as to SAFECO. The majority asserts that allowing a carrier to be dismissed as not potentially responsible before the finding of compensability has been made places the claimant's right to compensation at risk prematurely. In light of SAFECO's concession of compensability, we fail to understand how claimant's right to compensation is at risk with respect to SAFECO.

Furthermore, we believe that to construe ORS 656.308(2)(c) in the manner adopted by the majority defeats the legislature's intent in enacting the statute. As we discussed earlier, in amending ORS 656.308(2) in 1995, the legislature sought to reform an unwieldy process and avoid hearings involving numerous parties where any number of the joined employers could prove that they were not responsible for the claimant's condition. Had the legislature actually intended that the dismissal procedure be available only if and when all of the joined parties concede compensability, it would have included such a provision in the statute.

In conclusion, we believe that the dismissal procedure under ORS 656.308(2)(c) should be available to any potentially responsible carrier, even if it has denied compensability of the claim. Alternatively, the dismissal procedure should be available if a carrier has conceded compensability or the claim has been found compensable. Since our review of the record reveals no substantial evidence to support a finding of responsibility against SAFECO, we would affirm the ALJ's decision to dismiss SAFECO from the litigation.

September 18, 1997 Cite as 49 Van Natta 1527 (1997)

In the Matter of the Compensation of
RUPERT D. TRIGG, Claimant
WCB Case No. 96-04299
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock, and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that: (1) denied its request to present "post-reconsideration" evidence at the hearing; and (2) awarded claimant permanent total disability benefits, whereas an Order on Reconsideration awarded 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of the right arm (elbow). On review, the issues are evidence and permanent total disability.

We adopt and affirm the order of the ALJ.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth at 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 the insurer. In reaching this conclusion, we have particularly considered the value of the interest involved, the complexity of the issues, the skill of claimant's counsel, and the time devoted to the case (as represented by claimant's respondent's brief).

ORDER

The ALJ's order dated February 26, 1997 is affirmed. For services on review, claimant's attorney is awarded a $2,000 assessed fee, to be paid by the insurer.

Board Member Haynes dissenting.

The ALJ's award of permanent and total disability is based on disability resulting from preexisting physical and psychological conditions, as well as the compensable right arm injury in December 1994. On review, the insurer argues that the record does not support an award of permanent and total disability because claimant has not shown that his preexisting conditions were disabling at the time of the compensable injury. I agree.

In determining whether a worker is permanently and totally disabled, we are required to consider disability resulting from a preexisting condition if the disability existed at the time of the injury. ORS 656.206(1)(a); Elder v. Rosboro Lumber Co., 106 Or App 16 (1991). In determining whether the preexisting condition was disabling, we consider medical and physical disability and the extent to which a claimant was unable to work. Margie J. Garcia, 46 Van Natta 1028, 1029 (1994).

Here, there is no evidence that claimant's preexisting physical conditions interfered with claimant's ability to work prior to his compensable injury. Rather, claimant acknowledges in his brief on review that he was unable to continue working because the compensable elbow/forearm injury resulted in disabling pain and caused him to drop his tools. Prior to that injury, claimant had been working as a drywaller/carpenter for the employer on a full-time basis for six months, and he had successfully performed this same type of work for other employers since 1971.

Nor is there evidence that claimant's preexisting psychological condition resulted in treatment or interfered with his ability to work prior to the work injury. (Ex. 16a). Dr. Colistro, psychiatrist, did opine that "[a]t present, [claimant's] psychologic disturbance is so extreme that it precludes participation in vocational rehabilitation efforts and likely renders him unemployable in any form of work..." (Emphasis supplied). However, this opinion addresses claimant's post-injury disability and does not establish that his psychological condition was disabling prior to the 1994 injury.

Accordingly, I conclude that claimant has not shown that, at the time of the compensable injury, his preexisting physical and psychological conditions were disabling. Without consideration of these preexisting conditions, claimant has not shown that he is permanently and totally disabled. For this reason, I respectfully dissent from the majority decision affirming the ALJ's award of permanent and total disability.

In the Matter of the Compensation of
ROBERT E. CHACON, Claimant
WCB Case No. 96-04529
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of his occupational disease claim for bilateral hearing loss. On review, the issue is compensability and, if compensable, responsibility.

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

Claimant, age 52 at the time of hearing, has worked in the employer's feed mill as a machine operator since 1988. About the time he started working, he had a hearing test that established an audiometric baseline. Beginning in 1993, claimant complained of trouble with his hearing.[1] In October 1996, claimant made an occupational disease claim for hearing loss, which the insurer denied.

At hearing, claimant asserted that his overall work exposure (including his work at the mill between 1988 and 1995) was the major contributing cause of his hearing loss. The ALJ found to the contrary. Specifically, the ALJ rejected the opinion of Dr. Epley (the only doctor to relate claimant's hearing loss to his work) as conclusory and lacking in a complete and accurate history.

Like the ALJ, we find Dr. Epley's opinion insufficient to sustain claimant's burden of proof on compensability. In July 1996, Dr. Epley opined that claimant's hearing loss was related to "chronic noise exposure without appropriate ear protection" and summarily concluded that "the hearing loss is more than 50 percent work related." In his initial examination of claimant on April 22, 1994, however, Dr. Epley recorded a noise exposure history of "positive for [claimant] having worked in an area with machinery for the past six years *with* ear protection." (Ex. 79-3, emphasis added). Dr. Epley does not explain why, if at all, claimant's ear protection might have been "inappropriate." Nor is there evidence in the record that claimant was exposed to chronic work-related noise without protection.[2] Moreover, and also contrary to Dr. Epley's opinion, the audiometric testing established that claimant's hearing did not worsen between 1988 and 1995, while he was employed at the mill. Consequently, we agree with the ALJ that Dr. Epley's causation opinion is unpersuasive.

Even if claimant could otherwise establish the compensability of his hearing loss, the insurer haws proven by a preponderance of the evidence that claimant's current employment (at the mill since 1988) did not cause or worsen his condition.[3] In Beneficiaries of Strametz v. Spectrum Motorwerks, 325 Or 439, 444 (1997), the Oregon Supreme Court held that "the last injurious exposure rule cannot impose responsibility on an employer who has proved that it could not have been the cause of a claimant's occupational disease."[4] The court also noted that "the employer that would otherwise be held responsible for a claimant's occupational disease may avoid responsibility by proving that the conditions of its employment could not have caused the disease or that the previous employment was the sole cause of the disease." Id. at 445 (citing Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984)).

Because the employer has shown that claimant's work at the mill could not have been the actual cause in fact of claimant's loss of hearing, it may not be held responsible under the law. Strametz, 325 Or at 445.

ORDER

The ALJ's order dated March 17, 1997 is affirmed.

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[1] In 1993, claimant was involved in an accident within the course and scope of his employment in which he sustained multiple injuries, including head trauma. On review, claimant does not challenge the ALJ's finding, based on a preponderance of the medical evidence, that claimant's hearing loss is not compensably related to this accident.

[2] Claimant testified that prior to starting with the mill in 1988, he worked as a cook when he was in the army, in the kitchen during the approximately 20 years he was incarcerated, and for a truck part wholesaler for the two years. (Tr. 15-17).

[3] Claimant's audiometric testing did not show any worsening of claimant's hearing loss between 1988 and 1995. (See Exs. 130, 133, 134). We are persuaded by the assessment of Dr. Brown that claimant did not experience any worsening or progression of hearing loss, either on the basis of aging or due to the toxic effects of sound between 1988 and 1995. (See Ex. 134).

[4] In his appellant's brief, claimant relies on the Court of Appeals' opinion in Strametz v. Spectrum Motorwerks, 135 Or App 67 (1995). That decision was reversed by the Oregon Supreme Court's Strametz decision after the parties' briefs were submitted.

In the Matter of the Compensation of
RONALD A. COMPTON, Claimant
WCB Case No. C702295
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Cole, et al, Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On September 8, 1997, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

Lines 17 - 20 on page 2 of the CDA provide:

> "The claim has never been closed. Claimant has been awarded a total of no scheduled or unscheduled PPD however, the parties agree this settlement contemplates an award of at least 5 percent permanent partial disability for claimant's left wrist * * *."

We do not interpret this language as granting claimant an award of permanent disability. Rather, we consider this paragraph to be an explanation for one component of the calculation of the total amount of consideration to be paid to claimant under the CDA.[1] Jon T. Strebe, 48 Van Natta 2102 (1996).

Finally, in reaching this conclusion, we recognize the parties' intention to ensure claimant's eventual eligibility as a "preferred worker" under the Reemployment Assistance Program. See ORS 656.622. Nonetheless, we would further note that, to qualify as a preferred worker, an injured worker must be unable to return to his regular employment because of "a permanent disability * * * whether or not an order has been issued awarding permanent disability." See ORS 656.622(4)(b) (Emphasis supplied).

Therefore, we conclude that the parties' agreement is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

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[1] Had the CDA been interpreted as awarding permanent disability, we would have declined to approve the disposition. It is well settled that CDAs are not designed for purposes of claim processing. See Kenneth D. Chalk, 48 Van Natta 1874, n 1 (1996); Kenneth R. Free, 47 Van Natta 1537 (1995). Under such circumstances, we would have recommended that the parties submit a stipulation to the Hearings Division awarding claimant permanent disability. Thereafter, they could submit a CDA releasing claimant's future rights to benefits, including permanent disability.

In the Matter of the Compensation of
CALVIN W. GRAHAM, Claimant
Own Motion No. 97-0390M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable left knee meniscus tear injury. Claimant's aggravation rights expired on October 28, 1996. The employer opposes the authorization of temporary disability compensation (TTD) in this claim, contending that claimant was not in the work force at the time of disability, and was not eligible for TTD as he was "off work for another workers' compensation claim to [his] back."

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 knee surgery on May 12, 1997. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

The employer contends that claimant was not in the work force because, at the time of disability, he was not working and was receiving temporary disability in another workers' compensation claim. Claimant submitted a pay receipt for TTD from July 19, 1997 through August 1, 1997, which indicates that he received TTD for those dates in claim number "96W2935."

Here, claimant underwent surgery on May 12, 1997. Therefore, claimant would be entitled to temporary disability in his 1991 injury claim beginning the date of surgery, until he was medically stationary. No evidence in the record establishes that claimant was receiving TTD on May 12, 1997.

Furthermore, even if claimant did receive temporary disability compensation in another workers' compensation claim at the time of disability in his 1991 claim (May 12, 1997), he would be considered in the work force by virtue of his eligibility for TTD in the other workers' compensation claim. See Michael C. Johnstone, 48 Van Natta 761 (1996); William L. Halbrook, 46 Van Natta 79 (1994). We conclude that claimant did not voluntarily remove himself from the work force, but, rather, has sustained another compensable injury which prevented him from working at the time of current disability. Consequently, we find that claimant has established that he was in the work force at the time of disability.

Although we find that claimant is entitled to TTD in his 1991 injury claim, we also note that an injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if any concurrent temporary disability compensation is due claimant as a result of this order, the employer may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a *pro rata* distribution of payments. OAR 436-060-0020(8) and (9); Ralph E. Meline, 49 Van Natta 676 (1997); Michael C. Johnstone, 48 Van Natta at 761.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning May 12, 1997, the date he was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD T. SHERMAN, Claimant
Own Motion No. 66-0448M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On August 5, 1997, the SAIF Corporation submitted claimant's request for medical services, including L4-5 microdiskectomy surgery, and temporary disability compensation for his compensable low back strain injury. Claimant's aggravation rights expired on November 14, 1969. SAIF opposes reopening of the claim on the grounds that: (1) claimant's current low back condition is not causally related to the compensable injury; (2) it is not responsible for claimant's current condition; and (3) surgery or hospitalization is not reasonable and necessary for the compensable injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, the Board 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).

On August 11, 1995, we requested the parties' positions regarding the compensability of claimant's current low back condition and subsequent surgery. The parties have submitted their respective positions, including medical documentation and opinion to support those positions.

SAIF contends that claimant's current need for treatment is not related to his 1962 low back strain injury. In order for claimant to prove that his current condition is a compensable portion of his 1962 injury claim, he must establish that his current condition is the same condition as his at-injury condition, or that his current condition is a consequence of his original injury.

Claimant asserts that he has suffered "chronic back problems" since his first back surgery in 1962, and that his current condition is the same condition (L4-5 disk herniation) for which he underwent his first low back surgery. SAIF indicated that claimant's accepted condition was "low back strain." Relying on claimant's and his wife's representations and Dr. Malos' operative report, we find that claimant's current condition is causally related to his compensable injury and his first surgery.

In an August 21, 1997 letter, claimant contended that:

> "In 1962 Dr. Carl Holm ordered a Myelography that showed abnormal flow of dye in my lower back. I had surgery and was told they preformed [sic] a Laminectomy, which it states on my medical records (in [SAIF's] files per claim # above)."

In a September 6, 1997 letter, claimant's wife asserted that claimant's low back pain had caused him to miss work at least three months each year since 1979 when she married him. Claimant further contends that his first surgery did not constitute a laminectomy, but, rather, "Dr. Holm just cleaned up the outside of the di[s]c #4 & 5." Claimant's assertions are validated by Dr. Malos' January 3, 1997 operative report, in which the treating physician concluded that, because the disk protrusion in the interspace was fairly full, claimant "had not had the annulus cleaned out previously."

In his January 3, 1997 operative report, Dr. Malos further noted that claimant's post-operative diagnosis was "recurrent disk herniation, left, at L4-5" (emphasis supplied). Furthermore, Dr. Malos referred to claimant's surgery as "re-exploration on the left at L4-5, micro diskectomy (emphasis supplied)." Dr. Malos' notes and findings in the operative report indicate that claimant had undergone previous surgery at the same level 34 years prior.

However, in a July 30, 1997 "check-the-box" response to SAIF, Dr. Malos agreed that claimant's 1962 industrial injury was not the cause of his current low back condition. The record does not establish that Dr. Malos was claimant's treating physician during the 1962 surgery, nor does Dr. Malos provide any explanation or reasoning to support his perfunctory "check-the-box" response.

Here, we find that claimant has carried his burden of proving that his current condition and resulting surgery occurred at the same level as his 1962 surgery. The medical evidence submitted, including Dr. Malos' operative report, indicates that claimant's current condition is the same condition for which he underwent surgery 34 years ago. Furthermore, claimant and his wife both attest that claimant has experienced similar complaints over the years. Because claimant's assertions that his previous surgery occurred at the same level as his current surgery are supported by Dr. Malos' operative report, we do not find Dr. Malos' subsequent, unexplained "check-the-box" response persuasive.

On this record, we conclude that claimant's current low back condition is the same condition as he sustained at his original compensable injury. We further find that claimant's current condition and need for treatment are compensably related to his 1962 low back strain injury claim with SAIF.[1] See Robert C. Hill, 49 Van Natta 234 (1997); Ivan J. Cvarak, 48 Van Natta 2367 (1996).

We turn to claimant's request for temporary disability compensation in his 1962 injury claim. We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

On January 3, 1997, claimant underwent a re-exploration on the left at L4-5 microdiskectomy. Inasmuch as we have found that surgery related to his compensable condition, we conclude that claimant's compensable condition has worsened.

Accordingly, we authorize the reopening of claimant's 1962 injury claim for the requested medical services and payment of temporary disability compensation. The authorization for temporary disability compensation shall commence on January 3, 1997, the date claimant underwent L4-5 disk surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] We note that SAIF has indicated by a "check-the-box" response in its recommendation that it disagrees that surgery or hospitalization is reasonable and necessary. However, SAIF submits neither argument nor evidence to support that contention. Moreover, in light of Dr. Malos' reference in the operative report to a "recurrent disc herniation," we find SAIF's question regarding the propriety of the surgery to be unpersuasive.

In the Matter of the Compensation of
KIM P. KENNEDY, Claimant
WCB Case No. 97-00202
ORDER ON REVIEW
Ann B. Witte, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of claimant's loss of consciousness and injuries sustained in a motor vehicle accident. On review, the issue is whether claimant was injured in the course and scope of employment. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a school bus driver, was injured when she lost consciousness and her bus collided with two other vehicles. Claimant treated with Dr. Karty and underwent numerous tests, which were all interpreted as normal. Dr. Karty's final diagnosis was "[h]istory of loss of consciousness, etiology still to be determined, felt perhaps to be epilepsy." (Ex. 23-2). Dr. Karty also agreed that claimant's seizure was not work related, and was due to unknown causes. (Ex. 25-1). Claimant's chiropractor, Dr. Duncan, reported that he treated claimant for headaches and other symptoms which were probably caused by a cervical strain which resulted from the bus accident. (Ex. 26).

At hearing, claimant contended that the injuries she sustained in the accident were compensable because her bus driving job placed her in a zone of danger. Claimant relied on Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991).

In Marshall, the court found that the claimant, a logging truck driver, may have blacked out due to idiopathic causes, which resulted in an accident and the claimant's injuries. The court found that the risk of serious injury from loss of consciousness was greatly increased by the fact that the claimant was driving a log truck for the employer. Accordingly, the court held that the claimant's injuries arose out of and in the course of his employment. Id at 103.

Here, the ALJ rejected claimant's argument on the ground that the legislature's enactment of ORS 656.266 effectively overruled the "increased danger rule" adopted by the court in Marshall. The ALJ reasoned that the statute now required that claimant do more than just rule out idiopathic or other non-work causes of her injuries. Rather, the ALJ concluded, claimant was required to affirmatively prove that her injuries were, in fact, related to work. See e.g. Ruben G. Rothe, 45 Van Natta 369 (1993).

In Rothe, in dicta we noted that, by enacting ORS 656.266, the legislature intended to overrule the court's decision in Phil A. Livesley Co. v. Russ, 296 Or 25 (1983) which held that, if the cause of a claimant's on the job injury was unexplained, it was compensable, provided that the claimant eliminated idiopathic causes. Specifically, in Rothe, we commented that in enacting ORS 656.266, which provides that the compensability of an injury cannot be established merely by disproving other possible explanations, the rationale set forth by the court in Livesley v. Russ had been effectively overruled. Rothe, 45 Van Natta 372. For the following reasons, we do not extend our comments in Rothe to include Marshall and the "increased risk" doctrine.

First, we note that ORS 656.266 was enacted prior to the court's decision in Marshall. Nevertheless, the court did not cite to that statute in reaching its decision. Additionally, as explained by the court in Marshall, the Livesley case involved an unexplained fall. The court noted that Professor Larson distinguishes unexplained fall cases from cases in which, due to idiopathic causes, a claimant is injured while in a moving vehicle. Specifically, the court cited to Larson's explanation that,

> "Awards are uniformly made when the employee's idiopathic loss of his faculties took place while he was in a moving vehicle***. It seems obvious that the obligations of their employment had put these employees in a position where the consequences of blacking out were markedly more dangerous than if they had not been so employed." 1 Larson, Workmen's Compensation Law 3-356, sec. 12.12 (1990)

Consequently, the Marshall court concluded that the claimant's injuries were not the result of a fall, but rather from the impact of the logging truck with the side of a mountain. The court held that the risk of serious injury from any loss of consciousness, of idiopathic origin or not, was greatly increased by the fact that the claimant was driving the employer's log truck. 109 Or App at 103.

Therefore, following the court's reasoning in Marshall, we find that the facts surrounding the unexplained falls in Livesley and Rothe are different than a case such as the present one, which involved the risk of serious injury from claimant's loss of consciousness, due to the fact that claimant was working as a bus driver.

Finally, we conclude that our decision in this case is consistent with our reasoning in Rothe. There, we specifically discussed the Marshall case and found that it was distinguishable, due to the fact that the claimant in Rothe was not subjected to risks different from those encountered by any person walking or standing on a concrete floor. In other words, in Rothe, we did not find the facts to establish an "increase" in risk sufficient to invoke the doctrine expressed in Marshall. Rothe, 45 Van Natta 369. Also see Robert C. Toth, 47 Van Natta 712 (1995) (Marshall and the increased danger doctrine not applicable where an employer's remodeling did not increase the danger that the claimant would be bitten by a spider); Emery A. Reber, 43 Van Natta 2373 (1991) (worker's injury resulting from an idiopathic fall was compensable, due to the fact that the claimant was required to work two stories above the ground, which presented an increased risk that he would be injured).

Therefore, we conclude that ORS 656.266 did not effectively overrule the court's decision in Marshall or the "increased risk" doctrine expressed in that case. Furthermore, in light of the fact that claimant's work as a bus driver subjected her to a risk of serious injury from her loss of consciousness, we find that claimant has established that her injuries arose out of her employment. See Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1993); Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994) (to analyze the "arising out of employment" prong of the work-connection test, it must be determined whether the conditions of the claimant's employment put her in a position to be injured).[1]

Claimant's counsel is entitled to an assessed attorney 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, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and 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 April 14, 1997 is reversed. The insurer's November 22, 1996 denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,500, to be paid by the insurer.

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[1] In Fred Meyer, Inc. v. Hayes, 325 Or 592 (1997), the Supreme Court recently stated that, in Livesley, the Court had specifically rejected the "peculiar-risk" and "increased-risk" considerations. However, it is readily apparent from the Court's discussion in Hayes that the concept rejected in Livesley was the "largely obsolete" requirement that an injured worker establish a "peculiar risk" or an "increased risk" in order to prevail. The Court did not hold that the existence of a work-related increased risk would defeat compensability. Rather, the Court merely reiterated that "a worker's injury is deemed to 'arise out of' employment if the risk of injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker." We conclude this statement of the law is entirely consistent with the Court of Appeals' reasoning in Marshall.

In the Matter of the Compensation of
BILLY A. SPRINGS, Claimant
Own Motion No. 95-0370M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Kasia Quillinan, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 14, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from December 19, 1996 through July 9, 1997. SAIF declared claimant medically stationary as of July 9, 1997. 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 July 14, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

In a July 10, 1997 Supplemental Medical Report, Dr. Berselli, claimant's treating physician, released claimant to modified work (light duty) effective July 15, 1997, and indicated that claimant was medically stationary as of July 9, 1997.

However, claimant sought a second opinion regarding the status of his left knee. In a July 22, 1997 medical report and evaluation, Dr. Thomas, to whom claimant was referred by Dr. Mandiberg, diagnosed claimant with a loose, unstable left total knee arthroplasty (TKA). Dr. Thomas noted that the cement mantle in claimant's left knee was broken, and that the tibial base plate was loose. Dr. Thomas further noted that the femoral component was markedly flexed and appeared malrotated. Dr. Thomas opined that:

> "I believe this knee can be salvaged with additional surgery but [claimant] will certainly not have a normal knee. I believe [claimant] needs a more constrained prosthesis and a thicker polyethylene. In addition, the malposition of the femoral component needs to be improved. Fortunately, the bone cuts were conservative and there is a considerable amount of host tibia and femoral left. There may need to be some augmentation performed of the femur as a result of recutting the Chamfer cuts. I explained that the risks of this surgery are somewhat higher than those in the past, given his multiple prior surgeries. The risks include DVT, infection and ultimate loosening in the future. [Claimant] is still quite a young man and could, in his later years, require another revision."

In his July 22, 1997 report, Dr. Thomas also opined that "[i]f revision of this prosthesis is not performed, worsening symptoms, I believe, will occur over time due to the obvious loosening present already as well as to the ligamentous instability."

Here, claimant was examined by Dr. Thomas only one week after SAIF closed his claim. We conclude that claimant's condition on July 22, 1997 was essentially the same as it was at the July 14, 1997 claim closure. See Scheuning v. J.R. Simplot & Co., 84 Or App at 622. Upon examination of x-

rays of claimant's left knee, Dr. Thomas recommended surgery to improve claimant's "loose, unstable left TKA," and opined that claimant's condition would continue to deteriorate without the knee revision. The only medical information or evaluation from Dr. Berselli is in the supplemental medical report, in which he offered only a conclusory opinion that claimant was medically stationary and does not support that opinion with any medical evidence. We find the opinion of Dr. Thomas more persuasive than that of Dr. Berselli. See Somers v. SAIF, 77 Or App at 259. On this record, we conclude that claimant's compensable knee condition was not medically stationary at claim closure.

Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by 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
ELIZABETH NIMMO-PRICE, Claimant
WCB Case No. 95-00779
ORDER OF ABATEMENT
Gatti, Gatti, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On August 21, 1997, we reversed that portion of an Administrative Law Judge's (ALJ's) order that had set aside the self-insured employer's partial denial of claimant's thoracic outlet syndrome, rotator cuff tear, and cerebral hematoma conditions, affirmed those portions of the ALJ's order that had set aside the employer's partial denial of claimant's left arm condition, thoracic strain/sprain, left hip pain, and generalized pain complaints (with related myospasms), affirmed an ALJ's $1,750 attorney fee award for the employer's "pre-hearing" acceptance of a headache and post-concussion syndrome, modified the ALJ's $3,000 attorney fee award to $2,300, and awarded a $1,200 attorney fee for services on Board review. Announcing that the parties have resolved their dispute, the employer seeks abatement of our decision so that we may retain jurisdiction to consider their forthcoming settlement.

In light of the employer's announcement, we withdraw our August 21, 1997 order. On receipt of the parties' executed settlement, we will proceed with our reconsideration. In the meantime, the parties are requested to keep us apprised of any further developments regarding this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEITH TOPITS, Claimant
WCB Case No. 96-09135
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) found that SAIF was precluded from denying claimant's thoracolumbar degenerative condition; and (2) set aside its denial of claimant's current thoracolumbar condition. On review, the issues are claim preclusion and, if the denial is not precluded, compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on May 2, 1995. He initially sought treatment from Dr. Rabin, a chiropractor, who diagnosed "thoracolumbar strain." SAIF accepted the claim as a disabling "thoracolumbar strain." A July 28, 1995 Notice of Closure awarded temporary disability, but no permanent disability. After the claim was closed, claimant saw Dr. Bert, whose impression was "aggravation from work of a thoracolumbar degenerative progressive arthritis."

Claimant requested reconsideration of the Notice of Closure and requested a medical arbiter. Medical arbiter, Dr. Smith, listed his impression as "thoraco-lumbar strain superimposed on degenerative changes." Dr. Smith indicated a probability that claimant's condition did not result from a single acute episode but was due to chronic strain, i.e., an overuse type phenomenon. Dr. Smith also made findings of reduced lumbar and thoracic range of motion. The November 17, 1995 Order on Reconsideration awarded 13 percent unscheduled permanent disability based on Dr. Smith's findings of lost range of motion.

Claimant filed a claim for aggravation in August 1996. Through his attorney, claimant also requested that SAIF amend its claim acceptance to include degenerative arthritis. On October 4, 1996, SAIF issued a partial denial of claimant's degenerative arthritis and also denied that claimant's thoracolumbar strain had compensably worsened since claim closure. On November 6, 1996, SAIF denied claimant's current condition.

The ALJ found that the Order on Reconsideration's award of permanent disability for lost ranges of motion was based, at least in part, on the preexisting degenerative condition which had combined with claimant's accepted thoracolumbar strain condition. On this basis, the ALJ concluded that the carrier was precluded from denying the preexisting degenerative condition under the holdings of Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II) and Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) (Messmer I).

Subsequent to the date of the ALJ's order in this case, the 1997 legislature amended ORS 656.262(10). HB 2971, 69th Leg., Reg. Sess., § 1 (July 25, 1997). As amended, the statute now provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Amendments to the statute are underlined).[1]

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[1] Section 2 of HB 2971 provides that the amendments to ORS 656.262 by section 1 of the Act "apply to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive." Thus, amended ORS 656.262(10) is fully retroactive and applies to this claim. See Bay Area Hospital v. Landers, 150 Or App 154 (1997).

We first address whether the changes to ORS 656.262(10) legislatively overrule the court's holdings in Messmer I and Messmer II.[2] In interpreting a statute, our first task is to discern the legislature's intent. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). In attempting to discern the intent of the legislature, the first level of analysis is to examine the text and context of the statute. 317 Or at 610-11. The context of the statute includes other provisions of the same statute and other related statutes. Id. at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. Id. Based on the following reasoning, we conclude that the newly amended statute does have the effect of overruling the Messmer decisions.

In Messmer I, the court held that an employer's failure to challenge a permanent disability award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. The court reasoned that the result was not that the degenerative condition had been accepted, but that the employer was barred by claim preclusion from denying that it was part of the compensable claim. 130 Or App at 258.

In 1995, the legislature amended ORS 656.262(10) to provide that "[p]ayment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

In Messmer II, the court held that the 1995 amendments to ORS 656.262(10) did not effectively overrule its prior decision in Messmer I. Specifically, the court held that the amended statute said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court noted that the amended statute provided only that payment of permanent disability benefits did not preclude an employer from subsequently contesting compensability. On this basis, the court concluded that the amended statute did not overrule its holding in Messmer I.

The legislature has now amended ORS 656.262(10) to provide that: "[P]ayment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." Unlike the 1995 amendments to ORS 656.262(10), the 1997 amendments specifically focus on the effect of a carrier's failure to appeal or seek review of determination, reconsideration or litigation orders or notices of closure which award permanent disability benefits. The statute now specifically and unambiguously provides that the failure to appeal or seek review of such orders or notices of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted. Accordingly, based on the plain and unambiguous language of amended ORS 656.262(10), we conclude that the carrier's failure to appeal the Order on Reconsideration award does not preclude the carrier from denying the degenerative condition. Because SAIF is not precluded from denying the degenerative condition by its failure to appeal the Order on Reconsideration award, we turn to the merits of the compensability issue.

Claimant was examined by Dr. Warburton, orthopedic surgeon, on behalf of SAIF. Dr. Warburton diagnosed thoracolumbar strain superimposed on lumbar spondylosis. Dr. Warburton opined that claimant's accepted strain had resolved and that the principal contributor to claimant's current low back condition was preexisting and ongoing spondylosis. Dr. Warburton did not believe that there was any "combination" of claimant's underlying spondylosis and his accepted strain.

Dr. Bert agreed with Dr. Warburton that the major contributing cause of claimant's current condition was preexisting spondylosis and that the accepted thoracolumbar strain had resolved. (Ex. 23). At his deposition, Dr. Bert testified that claimant's work exposure at the employer combined with

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[2] The parties' arguments on review, (made prior to the 1997 amendments to ORS 656.262(10)), focus on whether the ALJ correctly found that the 1995 Order on Reconsideration made an award for the degenerative condition. However, we need not decide whether the 1995 Order on Reconsideration awarded permanent disability based on the degenerative condition because, even if it did, we find, for the reasons given in this order, that Messmer has been overruled by the 1997 amendments to ORS 656.262(10).

his preexisting condition. Dr. Bert opined that since December 17, 1995 when claimant quit working for the employer, claimant's low back condition was due in whole or major part to the underlying degenerative osteoarthritis. Dr. Bert believed that claimant's degenerative osteoarthritis preexisted the May 2, 1995 strain injury. Dr. Bert opined that claimant's work aggravated and "worsened somewhat the underlying pathology" of claimant's arthritis. Dr. Bert agreed that claimant's work activities were "a major cause" of the "slight bit" of worsening of claimant's arthritis. (Ex. 26-20).

Claimant's theory of compensability is that the compensable thoracolumbar strain injury had combined with the preexisting degenerative arthritis to cause claimant's current low back condition and that the major contributing cause of the "combined condition" remains the compensable injury. (Tr. 1-2). Under ORS 656.005(7)(a)(B), if an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only 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. Both physicians who address the cause of claimant's current condition agree that the accepted thoracolumbar strain has resolved and that the major contributing cause of claimant's current condition is the preexisting degenerative arthritis. Under such circumstances, we conclude that claimant has failed to establish compensability of his current low back/degenerative arthritis condition under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated March 4, 1997 is reversed. SAIF's denials are reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

In the Matter of the Compensation of
ROBERTA F. BIEBER, Claimant
WCB Case No. 96-08670
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that dismissed claimant's hearing request which sought temporary disability, based on her contention that her nondisabling injury claim had become disabling. Claimant also seeks admission of Exhibit 18, an Order on Reconsideration. Following the submission of appellate briefs, claimant filed a request for consolidation of this matter with WCB Case No. 97-00554. On review, the issues are consolidation, jurisdiction and temporary disability benefits. We deny the motion to consolidate. Additionally, we reinstate claimant's hearing request, but find no entitlement to temporary disability benefits.

PRELIMINARY MATTERS

Consolidation

Following the submission of briefs in this case, claimant filed a motion to consolidate this matter with WCB Case No. 97-00554. Claimant contends that the cases should be decided together, as they involve essentially the same facts and issues. We disagree.

As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. See e.g. Greg V. Tomlinson, 47 Van Natta 1085 (1995), aff'd 139 Or App 512 (1996). Here, although the two cases arise out of the same compensable injury, we do not find that consolidation would serve either interest. While this matter involves claimant's entitlement to temporary disability benefits, the matter also raises jurisdictional issues involving the Board and Hearings Division. In WCB Case No. 97-00554, the issue is claim classification, and claimant has proceeded through reconsideration before the Department. Under such circumstances, because of the different procedural posture of each case, we conclude that there is no compelling reason to review the two cases together.

Evidence

Although it is not reflected in the ALJ's Opinion and Order, the ALJ admitted Exhibits 1 through 17 and supplemental exhibits 6A and 6B at the time of hearing. Prior to the issuance of the ALJ's order, both claimant and the insurer submitted Exhibit 18, a December 18, 1996 Order on Reconsideration. The ALJ's order does not address the parties' motions to reopen the record. On review, claimant argues that the ALJ should have reopened the record and admitted Exhibit 18, which was not available at the time of hearing.

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." This has been held to include agency orders, such as an Order on Reconsideration. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Mark A. Crawford, 46 Van Natta 725, 727 (1994). Thus, we take administrative notice of the December 18, 1996 Order on Reconsideration. In light of this fact, we do not address the issue of whether the ALJ should have reopened the record to admit Exhibit 18.[1]

FINDINGS OF FACT

Claimant compensably injured her left ankle and right hamstring on October 6, 1995. On November 9, 1995, the insurer accepted the claim as nondisabling.

On May 6, 1996, claimant was diagnosed with chronic plantar fascitis. Dr. Sampson, D.P.M., authorized time loss. No temporary disability benefits were paid.

On September 13, 1996, claimant requested a hearing on the issues of entitlement to temporary disability benefits and penalties.

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[1] We have not considered a previously submitted Exhibit 18 (an October 10, 1996 report from the Medical Consultants Northwest) which was withdrawn at the time of hearing and was not admitted into the record by the ALJ.

On October 18, 1996, a Determination Order affirmed the claim classification as nondisabling.

On December 12, 1996, a hearing was held.

On December 18, 1996, an Order on Reconsideration issued which ordered that the claim remain classified as nondisabling.

On January 7, 1997, the ALJ dismissed claimant's request for hearing based on a lack of jurisdiction.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The ALJ held that claimant was required to seek reclassification of her claim through the Department, rather than directly requesting a hearing on the issue of temporary disability benefits. Consequently, the ALJ dismissed claimant's hearing request based on a lack of jurisdiction.

On review, claimant argues that the ALJ had jurisdiction over the issue of entitlement to temporary disability benefits. Claimant cites to Alfredo Martinez, 49 Van Natta 67 (1997), which issued subsequent to the ALJ's order.

In Martinez, we noted that "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); See also Atchley v. GTE Metal Erectors, 149 Or App 581 (1997) (the general distinction between a substantive and procedural entitlement to temporary disability is that a substantive benefit is one that is made explicit and unconditional by statute, while a procedural benefit is conditional, arising solely from the vagaries of claim processing). Original jurisdiction over disputes regarding procedural entitlement to temporary disability benefits rests with the Hearings Division. ORS 656.283(1); Martinez, 49 Van Natta at 68. 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); Martinez, 49 Van Natta at 68.

Notwithstanding our decision that we have jurisdiction over "matters concerning a claim," such as entitlement to temporary disability benefits, we decided in Martinez that we had no authority to award temporary benefits in that case. Specifically, we noted that, under the court's decision in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), neither the Board nor the Hearings Division may create an overpayment of temporary disability benefits, and therefore, we lack the authority to award procedural temporary disability, in certain situations, after a claim has been closed by Notice of Closure or Determination Order. Martinez, 49 Van Natta at 68.

In the present case, the Determination Order affirmed the claim classification as nondisabling. A "disabling compensable injury" is an injury that entitles the worker to compensation for disability or death, whereas an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury. ORS 656.005(7)(c).

In affirming the claim classification as nondisabling, the Department found that Dr. Sampson was not the attending physician for purposes of authorizing temporary disability benefits and that there was no likelihood of permanent disability benefits. (Ex. 17-2). Consequently, claimant's remedy was to proceed, as she did, by appealing the claim classification and the Determination Order at the Department reconsideration level.[2] See ORS 656.277(1); 656.268.

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[2] We distinguish this case from Joseph E. Bridwell, 49 Van Natta 1061 (1997). In Bridwell, we found that we had jurisdiction over an issue involving the claimant's procedural entitlement to interim compensation. The resolution of the dispute did not depend on the claim's classification as disabling or nondisabling, or the accuracy of the classification. Consequently, we addressed the merits of the claim and awarded interim compensation. Here, however, claimant has chosen to challenge the claim classification (albeit in another proceeding) and the outcome of the temporary disability issue is dependent on whether claimant succeeds in her attempt to reclassify the claim.

Nevertheless, the proceeding currently before us does not involve claimant's appeal of the Order on Reconsideration or the nondisabling status of the claim. Rather, claimant's request for hearing in this case is simply premised on her claim that she is entitled to temporary disability benefits based on her treating doctor's authorization. Because claimant seeks temporary disability benefits payable on a nondisabling claim (a classification decision which is currently on appeal), we have no authority to award such benefits. See Lebanon Plywood v. Seiber (Board lacks authority to create overpayment by awarding procedural temporary disability benefits beyond those to which claimant is substantively entitled). The appropriate statutory route for claimant to seek relief is through her pending appeal of her reclassification request. Because this current case does not arise from a reclassification challenge, claimant's request for temporary disability benefits is denied.[3]

ORDER

The ALJ's order dated January 7, 1997 is modified. Claimant's request for hearing is reinstated. The relief requested by claimant, however, is hereby denied.

[3] On reconsideration, the Department found that Dr. Sampson was claimant's attending physician. (Ex. 18). Because of our conclusion that we lack authority to award temporary disability benefits to claimant, given the posture of this case, we do not address the question whether Dr. Sampson may authorize the payment of temporary disability benefits under ORS 656.262(4)(a).

In the Matter of the Compensation of
ROBERTA F. BIEBER, Claimant
WCB Case No. 97-00554
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration which declined to reclassify claimant's claim from nondisabling to disabling. Claimant also asks that this case be consolidated for review with WCB Case No. 96-08670, another case involving the parties that is pending Board review. We deny the motion for consolidation and affirm.

PRELIMINARY MATTER

While this case was pending Board review, claimant filed a motion to consolidate this matter with WCB Case No. 96-008670. Claimant contends that the cases should be decided together, as they involve essentially the same facts and issues. We disagree.

As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. See, e.g., Greg V. Tomlinson, 47 Van Natta 1085 (1995), aff'd 139 Or App 512 (1996). Here, although the two cases arise out of the same compensable injury, we do not find that consolidation would serve either interest. In this case, the issue is claim classification, and claimant has proceeded through reconsideration before the Department. WCB Case No. 96-08670 involves claimant's entitlement to temporary disability benefits and also raises jurisdictional issues involving the Board and Hearings Division. Under such circumstances, because of the different procedural posture of each case, we conclude that there is no compelling reason to review the two cases together.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had failed to prove that her claim should be reclassified as disabling. We agree.

For an injury to be disabling, there must be an entitlement to temporary disability or a reasonable expectation of permanent disability. ORS 656.005(7)(c); Karen S. Maldonado, 47 Van Natta 1535 (1995). Here, the parties agree that claimant can only prevail if she shows an entitlement to temporary disability benefits. Furthermore, the parties agree that such an entitlement depends on whether claimant's treating podiatrist, Dr. Sampson, DPM, qualifies as an attending physician for purposes of authorizing temporary disability.

As noted by the ALJ, ORS 656.005(12) provides that:

"(b) Except as otherwise provided for workers subject to a managed care contract, 'attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury and who is:

"(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States..." (Emphasis supplied).

Claimant contends that Dr. Sampson is a doctor of medicine who is subject to licensing and discipline by the State Board of Medical Examiners, pursuant to ORS 677.100 to 677.228. We disagree.

First, we note that chapter 677 distinguishes between physicians and podiatric physicians and surgeons. ORS 677.010(12) describes a "physician" as "any person who holds a degree of Doctor of Medicine or Doctor of Osteopathy." However, a "podiatric physician and surgeon," is separately defined as a "podiatric physician and surgeon licensed under ORS 677.805 to 677.880 to treat ailments of the human foot." ORS 677.010(13). Accordingly, in the definition section of chapter 677, a podiatrist or DPM does not fall within the definition of "physician." Therefore, a podiatrist cannot qualify as a "medical doctor" under Chapter 656 who may act as an attending physician for purposes of authorizing temporary disability benefits.

Moreover, although podiatrists may be subject to discipline under chapter 677, they are not licensed under ORS 677.100 to 677.228. Rather, podiatrists are separately licensed under ORS 677.805 to 677.880. ORS 656.005(12) requires an attending physician to be a medical doctor licensed under ORS 677.100 to 677.228. Accordingly, for this additional reason, Dr. Sampson does not qualify as an attending physician under chapter 656.

Alternatively, claimant argues that ORS 656.262(4)(a) requires an employer to begin the payment of temporary disability benefits within 14 days after notice or knowledge of the claim if the attending physician authorizes the payment of temporary disability. Furthermore, claimant cites to a Department rule which requires the carrier to notify the worker if medical services are provided by a doctor who does not qualify as an attending physician. OAR 436-010-0270(12). Claimant also relies on OAR 436-060-0020(6), which provides that an insurer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the claim. Claimant argues that, because the insurer did not follow the rules, Dr. Sampson should be "deemed" the attending physician.

We have previously rejected a similar argument in Jim R. Reed, 49 Van Natta 753 (1997). In Reed, we concluded that ORS 656.262(4)(c) did not require the insurer to obtain verification of the claimant's temporary disability status. We further concluded that insofar as OAR 436-060-0020(6) could be construed as requiring the carrier to obtain authorization of time loss from the attending physician, such a rule would be inconsistent with the statute and, therefore, could not be upheld.

Here, we do not find authority for claimant's argument that the carrier was required to notify claimant that it objected to Dr. Sampson's status as "attending physician." First, OAR 436-010-0270(12) pertains to medical services, rather than the authorization of temporary disability benefits. Additionally, OAR 436-060-0020(6) refers to verification from the "attending physician." For the reasons previously discussed, Dr. Sampson does not satisfy that description. In any event, as explained in Reed, there is no statutory requirement for a carrier to obtain time loss authorization. Consequently, we find no support for claimant's contention that she is entitled to temporary disability benefits, or that her claim should be reclassified to disabling.

We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated May 1, 1997 is affirmed.

In the Matter of the Compensation of
WINFRIED H. SEIDEL, Claimant
WCB Case No. 96-09311
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

On August 22, 1997, we abated our July 24, 1997 order that, among other things, affirmed the Administrative Law Judge's (ALJ's) order awarding claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm. We took this action to consider the SAIF Corporation's request for reconsideration. Having received claimant's response, we now proceed with our reconsideration.

In our previous order, we relied on Dr. Potter's report and agreed with the ALJ that claimant was entitled to 5 percent "chronic condition" awards for both the left and right arm. Citing William L. Fischbach, 48 Van Natta 1233 (1996), SAIF argues that, because there are no symptoms, impairment or conditions in the right arm, claimant is not entitled to a chronic condition award for the right arm.

In Fischbach, the ALJ found that the claimant was entitled to a 5 percent scheduled permanent disability award for a chronic condition in his left arm, in addition to the 8 percent unscheduled permanent disability awarded for his left shoulder condition. In so finding, the ALJ relied upon Foster v. SAIF, 259 Or 86 (1971), and Alvena Peterson, 47 Van Natta 1331 (1995), that held that a claimant is entitled to separate permanent disability awards where an injury to an unscheduled body part, such as a shoulder, also produces a loss of use or function to a scheduled body part, such as the arm.

On review, the insurer argued that Fischbach was distinguishable from Foster v. SAIF and Alvena Peterson because the claimant's inability to repeatedly use his arm overhead was simply a positional problem created by his left shoulder impairment, and not a separate condition of the left arm. We agreed with the insurer. We found that the medical arbiter did not report any arm symptoms flowing from the claimant's left shoulder injury. Rather, the arbiter explained that the claimant experienced uncomfortable snapping in the left shoulder with awkward motions and difficulty using his left arm overhead because of easy shoulder fatiguability. We noted that the arbiter did not identify any symptoms causing loss of function to the claimant's left arm. Under those circumstances, we concluded that the claimant was not entitled to a separate scheduled disability award for a chronic condition of a scheduled member.

Here, unlike Fischbach, we found in our previous order that this case was similar to Alvena Peterson. In Fischbach, we agreed with the insurer that, because the claimant's inability to repeatedly use his arm overhead was simply a positional problem created by his left shoulder impairment, and not a separate condition of the left arm, the claimant was not entitled to a separate scheduled disability award for a chronic condition of a scheduled member. 48 Van Natta at 1234. Here, in contrast, claimant's restrictions with his arms were not simply positional problems created by his shoulder impairment. Rather, Dr. Potter, the medical arbiter, specifically enumerated the arms as restricted body parts.

Claimant has accepted conditions of right shoulder strain and left shoulder impingement syndrome. (Exs. 4, 9, 25). In response to a question as to whether claimant had limited or partial loss of ability to repetitively use the shoulder, Dr. Potter responded that claimant had limited ability to repetitively use both shoulders in overhead work. (Ex. 33-4). In section 6 of his report, Dr. Potter was asked to describe claimant's residual functional capacity "with reference to the accepted condition(s) and/or sequelae[.]" (Ex. 33-5). Part c of section 6 asked Dr. Potter to state whether claimant was permanently precluded from frequently performing any or all of the following activities. (Id.) Dr. Potter responded:

"There are no permanent restrictions in stooping, twisting, climbing, reaching, crouching, kneeling, balancing, or pushing. However, he is restricted from climbing with his arms. He has restriction in repetitive pulling. He also has restriction in crawling due to his upper extremities." (Id.)

On reconsideration, we adhere to our conclusion that Dr. Potter specifically enumerated the arms as restricted body parts. Claimant is entitled to a scheduled chronic condition award for his arms, in addition to an unscheduled award for a shoulder condition. See OAR 436-035-0010(5).

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 an additional reasonable fee for claimant's attorney's services on reconsideration is $600, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the claimant's response to the reconsideration request), the complexity of the issue, and the value of the interest involved.

On reconsideration, as supplemented herein, we adhere to and republish our July 24, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

September 22, 1997 Cite as 49 Van Natta 1546 (1997)

In the Matter of the Compensation of
OLIVER P. MORGAN, Claimant
WCB Case No. 96-00625
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's denial of his occupational disease claim for bilateral hearing loss; (2) declined to address claimant's argument that the employer's responsibility denial was barred because it was untimely; and (3) declined to address responsibility. On review, the issues are compensability and, potentially, responsibility.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fourth paragraph on page 2, we change the date in the ninth sentence to "December 6, 1995." In the first full paragraph on page 3, we change the date in the first sentence to "April 4, 1996." In the first paragraph on page 5, we replace the last sentence with the following: "Ediger found that none of claimant's audiograms showed a '4,000 Hz notch' for the right ear. Although three audiograms showed a possible '4000 Hz notch' for the left ear, one audiogram did not."

Following completion of the briefing schedule, claimant submitted copies of recent court decisions in Norstadt v. Murphy Plywood, 148 Or App 484 (1997), and Garibay v. Barrett Business Services, 148 Or App 496 (1997). Claimant argues that the cases support his position regarding the employer's untimely responsibility denial. Although we accept claimant's citations regarding the above-referenced cases, we have not considered any further argument on the issue of the employer's responsibility denial. See OAR 438-011-0020(2); Betty L. Juneau, 38 Van Natta 553 (1986).

Finally, because we agree with the ALJ's decision on the issue of compensability, we do not reach the timeliness or responsibility issues argued by claimant.

ORDER

The ALJ's order dated March 10, 1997 is affirmed.

In the Matter of the Compensation of
JOYCE E. STUART, Claimant
WCB Case No. 96-00947
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reveiwed by Board Members Hall, Bock, and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order which: (1) set aside its denial of claimant's occupational disease claim for a bilateral shoulder condition; and (2) awarded an assessed fee of $19,917.25 pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees. We modify in part and affirm 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 reasoning and conclusions regarding this issue.

Attorney Fees

Claimant's counsel sought an attorney fee of $25,943.75 for his services rendered in obtaining reversal of SAIF's denial. After considering the relevant factors in OAR 438-015-0010(4), the ALJ awarded an assessed fee of $19,917.25 pursuant to ORS 656.386(1).

On review, SAIF contends that the ALJ's award was excessive. For the following reasons, we modify the ALJ's award.

We determine 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. See Schoch v. Leupold & Stevens, 325 Or 112 (1997) (the Board must explain the basis for setting a reasonable attorney fee so as to permit appellate court review of its exercise of discretion).

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's bilateral shoulder condition. Approximately 25 exhibits were received into evidence, including 11 provided by claimant's counsel. However, there is no evidence that the two medical reports from Dr. Nagel, claimant's attending physician, on which the ALJ relied in finding the bilateral shoulder condition compensable, were solicited by claimant's counsel. One letter was addressed to Providence Vantage Health Services and the other to SAIF. (Exs. 3A, 7). The hearing lasted approximately six hours (over two days) and the transcript consists of approximately 125 pages. There was one deposition of an examining physician (Dr. Filarski) lasting approximately two hours (68 pages of transcript). Three witnesses, including claimant, testified. Claimant's counsel submitted 18 pages of written closing argument to the ALJ.[1] The compensability issue presents 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, including surgery, are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned

[1] However, we do not consider in determining counsel's attorney fee the argument (5 pages) devoted to the amount of the attorney fee. See Amador Mendez, 44 Van Natta 736 (1992).

and skillful manner, identifying the relevant factual and legal issues for the ALJ's resolution.[2] Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon the application of each of the previously enumerated factors, and considering the parties' arguments, we conclude that a $11,500 attorney fee is reasonable and appropriate in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's counsel's representation of time devoted to the issue, and SAIF's objections), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.[3]

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In determining claimant's counsel's fee, we have not considered time devoted to the attorney fee issue. Dotson v. Bohemia, 80 Or App 233, 236, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated March 12, 1997 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded an assessed fee of $11,500 for services provided at hearing. For services on review regarding the compensability issue, claimant's counsel is awarded an assessed fee of $1,500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

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[2] The ALJ determined that SAIF had raised a frivolous issue when it attempted to impeach claimant concerning an issue of whether claimant was injured outside the course of her employment. SAIF contends that the issue was not frivolous. We need not decide whether SAIF's contention is correct. That is, even if the issue was not frivolous, this factor would not materially affect the amount of the attorney fee to which claimant's counsel was entitled.

[3] In reaching this conclusion, we have not used claimant's counsel's suggested "contingency multiplier" (3.5) 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 denial.

Board Member Haynes dissenting.

The majority adopts and affirms the ALJ's finding that claimant sustained her burden of proving a compensable occupational disease, but does reduce the amount of claimant's counsel's attorney fee. Although I agree with the majority that the ALJ awarded an excessive fee, I would not find it necessary to reach the attorney fee issue because I would not have found the underlying claim to be compensable. I reason as follows.

To begin, it is first necessary to set forth the background of the claim. On October 27, 1995, claimant, a self-employed, licensed tax preparer, filed a workers' compensation claim for bilateral rotator cuff tears. (Ex. 2-1). Claimant alleged that her condition was due to continuous arm movements in her long hours of work, which involved, among other duties, moving heavy boxes of files and photocopy paper, moving computers and equipment, and lifting heavy boxes of advertising material and luggage. (Ex. 2-3).

Dr. Nagel, claimant's attending physician, performed a right shoulder rotator cuff repair and decompression on November 8, 1995. On December 7, 1995, Dr. Nagel opined that claimant had weakness, limited range of motion and pain in her shoulders for years as a result of "strenuous" work she had done at an "improper work station." (Ex. 3A).

After an examining physician, Dr. Filarski, opined that "attritional change with age" was the most likely cause of claimant's bilateral rotator cuff tears (Ex. 4-4), SAIF denied the bilateral shoulder claim. (Ex. 6). Claimant requested a hearing.

The ALJ set aside SAIF's denial, finding that claimant had sustained her burden of proving a compensable occupational disease. In reaching this conclusion, the ALJ determined that Dr. Nagel's opinion was more persuasive than Dr. Filarski's.

In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of her bilateral shoulder condition. ORS 656.802(2)(a). Because of the insidious onset of claimant's condition, and because numerous factors could potentially contribute to claimant's condition, the causation question is medically complex and requires expert medical opinion to resolve. Barnett v. SAIF, 122 Or App 279, 282 (1993); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). It is claimant's burden to prove that her alleged occupational disease is compensable. ORS 656.266.

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, there are persuasive reasons not to defer to the opinion of Dr. Nagel, claimant's attending physician. As previously noted, Dr. Nagel initially opined that "strenuous work" at an "improper work station" caused claimant's shoulder condition. (Ex. 3A). However, this causation opinion is not persuasive because it contains absolutely no reasoning. In other words, Dr. Nagel does not explain what aspects of claimant's job were allegedly responsible for claimant's shoulder condition or the mechanism by which those activities caused her bilateral shoulder condition. Moreover, Dr. Nagel's reference to an "improper work station" is vague and ill-defined, especially considering that claimant's job requires considerable travel and is clearly not limited to a particular "work station." (Tr. 7).

Dr. Nagel's subsequent comment on causation on February 16, 1996 is also not availing to claimant. Dr. Nagel, after reviewing Dr. Filarski's medical report, noted that the latter physician did not obtain a history that claimant's torn rotator cuff "occurred on 1/31/91 as a result of carrying four briefcases to the court room to present financial information during a court case." (Ex. 7). Dr. Nagel concluded: "this was part of her work activities and served as the major cause for her rotator cuff tears and as such her work activities were the major cause for her rotator cuff tears." Id.

As is apparent from this opinion, Dr. Nagel identified a specific incident as the major cause of claimant's rotator cuff tears; whereas, previously, he attributed her condition to strenuous work at an improper work station. Although the ALJ and the majority do not find Dr. Nagel's opinions to be inconsistent, I agree with SAIF that they are. Moreover, the second opinion also suffers from the same defect as the first: that it, too, is unexplained.[1] See Moe v. Ceiling Systems, 44 Or App 429 (1980) (little weight given to conclusory medical opinions).

Accordingly, I would conclude that the ALJ improperly relied on Dr. Nagel's opinion in finding that claimant satisfied her burden of proof. This leaves only Dr. Filarski's opinion to be considered in determining whether claimant proved a compensable occupational disease claim. However, Dr. Filarski declined to state that work activities were the major contributing cause of her bilateral shoulder condition. (Ex. 9-51, 65).

Therefore, on this record, there is no persuasive medical evidence that satisfies claimant's burden of proof. Because the majority nevertheless affirms the ALJ's decision to set aside SAIF's denial, I must respectfully dissent.

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[1] The ALJ inferred that Dr. Nagel was no more than relating that the 1991 incident was the precipitating cause of claimant's shoulder condition. However, claimant's shoulder symptoms began at least as early as 1989; thus, it is improbable that Dr. Nagel meant that the 1991 incident precipitated claimant's shoulder condition. Moreover, even if the 1991 activity was the precipitating cause, Dr. Nagel did not weigh the various possible causes to determine what was the major contributing 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). Although claimant contends that there is no evidence of another cause of claimant's shoulder condition apart from her work activity, claimant testified that she was a lap swimmer (Tr. 13). She also reported to a physician in June 1994 that she was a lap swimmer. (Ex. 9-84). Considering Dr. Filarski's opinion that overhand swimming is a potential casual factor in rotator cuff conditions (Ex. 9-48), Dr. Nagel's failure to weigh this possible cause lessens the probative value of his opinion.

In the Matter of the Compensation of
RUBY J. WILLIAMS, Claimant
WCB Case No. 96-09877
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's left knee injury claim; (2) assessed a penalty for its allegedly unreasonable failure to provide timely discovery of documents; and (3) awarded claimant an attorney fee of $4,000 for her attorney's services at the hearing. On review, the issues are compensability, penalty, and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation to address SAIF's arguments.

Claimant sustained an injury to her left knee when she slipped and fell in the employer's parking lot as she was returning to her office at the end of her lunch period. SAIF denied claimant's claim on the ground that her injury did not occur in the course and scope of her employment, and claimant requested a hearing. The ALJ held that claimant's injury was compensable because it occurred in the course of her employment and arose out of her employment. The ALJ also assessed a penalty for SAIF's unreasonable failure to provide timely discovery of documents and awarded claimant an attorney fee in the amount of $4,000 for her attorney's services at hearing. SAIF requested review.

On review, SAIF contends that the ALJ erred in finding the claim compensable because claimant failed to prove that there was actually some substance in the parking lot on which she slipped. We disagree.

A "compensable injury" is an accidental injury that arises out of and in the course of employment. ORS 656.005(7)(a). In Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994), the court explained:

> "This court has adopted a unitary approach, in which 'arising out of' and 'in the course of' are two elements of a single inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Each element of the inquiry tests the work-connection of the injury in a different manner. The requirement that the injury occur 'in the course of employment' concerns the time, place, and circumstances of the injury. The requirement that the injury 'arise out of' the employment tests the causal connection between the injury and the employment. In assessing the compensability of an injury, we must evaluate the work-connection of both elements; neither is dispositive." (Citations omitted).

The ALJ found, and SAIF does not dispute, that claimant's injury in a parking lot controlled by the employer occurred in the course of employment. See Gilmore, 318 Or at 366-68; Margaret A. Kohl, 48 Van Natta 2492 (1996) (where employer leased a parking lot for employees and lease agreement provided that lessee could maintain premises in hazard-free condition, there was sufficient "control" of parking lot by employer to prove that injury occurred in course of employment). However, SAIF disputes that there was any hazard in the parking lot that caused claimant to slip and fall. We interpret SAIF's argument as asserting that claimant's injury did not "arise out of" her employment; that is, that there is an insufficient causal connection between claimant's injury and her employment. See Gilmore, 318 Or at 368.

An injury is deemed to "arise out of" employment when the injury "originates from some risk to which the work environment exposes the worker." Fred Meyer, Inc. v. Hayes, 325 Or 592, 601 (1997) (claimant's employment exposed her to risk of assault where claimant was required to park in poorly lit, "fringe" area of employer's parking lot; therefore, assault in employer's parking lot deemed to "arise out of" employment). Claimant need not prove that she was exposed to any "peculiar" or "increased" risk by her employment. Id. Applying this principle to the present case, we hold that if there was a substance in the parking lot that caused claimant to slip, then the injury was caused by a risk in her work environment and will be deemed to "arise out of" her employment.

After our review of the record, we agree with the ALJ's finding that claimant slipped on a "slippery substance" in the employer's parking lot. Claimant testified that she "stepped in something, slipped and fell" as she was walking across the employer's parking lot. (Tr. 25). Although claimant did not know what the substance was, she testified that "it felt slippery, because my feet just went out from under me." (Tr. 26). On cross-examination, claimant adhered to her testimony that she slipped in something on the parking lot. (Tr. 30). There was no contradictory evidence. We find claimant's uncontradicted testimony sufficient to establish that there was a substance in the employer's parking lot on which claimant slipped. Therefore, we agree with the ALJ that claimant's injury occurred not only in the course of her employment, but also arose out of her employment.

SAIF also argues that the ALJ erred in assessing a penalty for its failure to provide timely discovery of documents. We disagree. The ALJ found that SAIF's failure to provide discovery within 15 days of the mailing of a discovery request, as required by OAR 438-007-0015(2), was unreasonable and warranted assessment of a penalty. The ALJ found, and SAIF does not dispute, that although claimant made a discovery request on October 30, 1996, SAIF did not provide some of the documents until January 1997. (Ex. 7a, Administrative Record; see also Ex. 10). Although SAIF explained the delay in producing some of the documents after mid-January 1997, it has provided **no** explanation for the delay prior to January 1997. (See Administrative Record). Therefore, we find that the ALJ did not err in assessing a penalty for SAIF's failure to timely provide discovery.

Finally, SAIF contends that the ALJ's award of a $4,000 attorney fee for claimant's counsel's services at hearing is excessive. Rather, SAIF asserts that a fee in the range of $2,500 to $3,000 would be reasonable. We affirm the ALJ's attorney fee award, based on the following reasoning.

Because claimant finally prevailed at hearing on a denied claim, claimant's attorney is entitled to an assessed fee for services at hearing. ORS 656.386(1). In determining whether an attorney fee is reasonable, we consider the factors set forth in OAR 438-015-0010(4), including: (1) time devoted to the case, (2) complexity of the issues, (3) value of the interest involved, (4) skill of the attorneys, (5) nature of the proceedings, (6) benefit secured for the represented party, (7) the risk that an attorney's efforts may go uncompensated, and (8) the assertion of frivolous issues or defenses.

Applying the above-listed factors to this case, we agree with the ALJ that $4,000 is a reasonable fee for claimant's attorney's services at hearing. In reaching this conclusion, we have considered that the time devoted to the compensability issue (as represented by the record), as well as the nature of the proceedings, which was of average difficulty. We find, however, that the complexity of the issues involved was above average, in light of the legal issues presented in this "course and scope" case, as well as the potential for a medical causation issue which claimant's attorney successfully removed from litigation. (See Administrative Record). The value of the interest involved and the benefit secured for claimant were significant, considering that the compensability of claimant's knee injury, for which she required surgery, was at issue. Claimant's counsel is a skilled workers' compensation attorney. There was a risk that claimant's counsel might go uncompensated. No frivolous issues or defenses were asserted. Considering all these factors, we conclude that $4,000 is a reasonable fee for claimant's counsel's services at hearing.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have also considered that claimant is not entitled to a fee for defending the ALJ's decision on the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 28, 1997 is affirmed. Claimant's attorney is awarded an $800 attorney fee for his services on review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
TAMMY J. COLLINS, Claimant
WCB Case No. 96-10084
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to set aside a Disputed Claim Settlement (DCS) regarding claimant's low back condition; and (2) did not assess penalties for allegedly unreasonable claims processing. On review, the issues are the validity of the DCS[1], compensability, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On review, claimant argues that the parties' October 10, 1996 DCS should be set aside. In support of her contention, she asserts that the insurer's failure to provide her with a copy of its denial prior to the execution of the DCS establishes extraordinary circumstances warranting the rescission of the settlement. See Pruitt Watson, 45 Van Natta 1633, on recon 45 Van Natta 2227 (1993).

Inasmuch as a denial involving a DCS between a carrier and an unrepresented worker must be issued separately, it logically follows that the worker must be provided the opportunity to review the denial and its contents. Any other rationale would be inconsistent with the 1990 adoption of former OAR 438-09-010(4) (now OAR 438-009-0010(5)), which requires the denial to issue separately from an unrepresented claimant's DCS. Such reasoning is also consistent with the "history" surrounding the adoption of this regulation, which establishes that it was intended to address concerns regarding denials that were contained in settlements involving workers and the need to allow workers an opportunity to consider the consequences of the denial and the resolution of the dispute by means of a DCS.

In light of such circumstances, we are inclined to agree with claimant's contention that her failure to physically receive and review the denial prior to the approval of the DCS invalidates the settlement. Such a determination is particularly appropriate where, as here, the DCS incorporated the denial by reference, but apparently the denial was not appended to the DCS.

In any event, we need not conclusively resolve the question of the validity of the DCS. In other words, even if the DCS was invalid and even assuming that claimant established "good cause" for her untimely hearing request from the denial, we would find the record insufficient to prove the compensability of the claim. We base our conclusion on the following reasoning.

Although Dr. Walch, the family doctor who initially treated claimant, reported that claimant's low back pain was "appropriate" as a workers' compensation case, he subsequently referred her for an MRI and an orthopedic consultation. Claimant eventually was examined by Dr. Miller, who found that the MRI demonstrated "mild-to-moderate congenital spinal stenosis." Dr. Miller opined that claimant's symptoms were "secondary to her spinal lateral stenosis with a bony disc at the L4-5 level." (Ex. 15-3).

Dr. Miller's opinion does not relate the stenosis or the disc condition to claimant's work activity or to a specific work incident. Accordingly, we do not find persuasive medical evidence of causation. We, therefore, would conclude that claimant has failed to establish compensability of her low back condition, whether analyzed under a material or major contributing cause standard. See ORS 656.005(7)(a); 656.266.

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[1] Claimant neither sought reconsideration of the prior ALJ's approval of the DCS nor filed a Request for Board review of the DCS. Instead, she requested a hearing, contending that the DCS was invalid.

ORDER

The ALJ's order dated February 28, 1997 is affirmed.

September 23, 1997 Cite as 49 Van Natta 1553 (1997)

In the Matter of the Compensation of
DANIEL D. LATHROP, Claimant
Own Motion No. 97-0194M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Shelley K. Edling, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 31, 1997 Notice of Closure which closed his claim with an award of temporary total disability (TTD) benefits from April 18, 1997 through May 6, 1997. SAIF declared claimant medically stationary as of July 22, 1997. Claimant does not contend that SAIF's closure was premature. Rather, claimant contends that he is entitled to additional temporary partial benefits from May 7, 1997 through June 20, 1997, as he was only released to work four hours per day. Furthermore, claimant contends that the rate of TTD paid by SAIF was incorrect. We modify SAIF's Notice of Closure.

Entitlement to Temporary Partial Disability Benefits

In a May 5, 1997 chart note, Dr. Peterson, claimant's treating physician, noted that:

> "We are going to send [claimant] back to no prolonged standing starting on Wednesday [May 7, 1997] and no lifting more than 20#. He will go 4 days a week for the next 2 weeks and then we will return him to full duty 2 weeks after that."

According to Dr. Peterson's May 5, 1997 chart note, it appears that he released claimant to fours days of work per week, with restrictions. However, in his May 23, 1997 chart note, Dr. Peterson apparently reconsidered his decision and approved half-time work, as he noted that "[claimant] will continue to work 4 hours a day and I will see him back in a month." Dr. Peterson noted that he fit claimant with a patellar Neoprene sleeve as claimant's leg became tired and painful during the day.

In a June 20, 1997 chart note, Dr. Peterson noted that claimant would be exercising on his own and "is returned to full duty now 8 hours a day."

We are persuaded that Dr. Peterson approved claimant's release to work for four hours per day after May 6, 1997. On this record, we find that claimant was temporarily partially disabled from May 7, 1997 through June 20, 1997, and that Dr. Peterson released claimant to full-time work after June 20, 1997. Therefore, we conclude that claimant was entitled to temporary partial disability compensation from May 7, 1997 through June 20, 1997.

Rate of Temporary Disability

Claimant contends that temporary total disability compensation was incorrectly paid. In a September 3, 1997 letter, claimant asserts that:

> "We further contend that temporary total disability should have been paid at a rate of $207.20 per week due to annual adjustments in effect since the date of injury. However, [time loss] was only paid at the rate of $64.38 per week."

In a July 16, 1997 Time Loss Payment Summary for claimant's claim, SAIF documented that it paid temporary total disability in the amounts of $73.34, $170.32, $117.34 and $272.51 for a total of $633.51 for 13 days of time loss. This amounts to a rate of $48.73 per day / $243.65 per week. Claimant does not indicate how he arrived at his calculation that SAIF paid TTD at a rate of $64.38 per week. Because the record indicates that SAIF paid temporary total disability at a rate commensurate with the rate claimant contended was due, we are persuaded that its calculation was proper.

Accordingly, we modify SAIF's July 31, 1997 Notice of Closure to award claimant temporary partial disability from May 7, 1997 through June 20, 1997.

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
DOROTHY M. HARRIS, Claimant
WCB Case No. 96-06362
ORDER ON RECONSIDERATION
Dierking & Schuster, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On August 26, 1997, we affirmed an Administrative Law Judge's (ALJ's) order that reduced claimant's scheduled permanent disability award for loss of use or function of the right forearm (wrist) from 11 percent (16.5 degrees) and for 3 percent (4.5 degrees) loss of use or function of the left right forearm (wrist), as awarded by an Order on Reconsideration, to 5 percent (7.5 degrees) for the right forearm (wrist) and 2 percent (3 degrees) for the left forearm (wrist). The parties have submitted a "Stipulation and Order," which is designed to resolve any and all issues raised or raisable between them. We treat this submission as a motion for reconsideration of our August 26, 1997 order. The motion is granted and prior order is withdrawn.

Pursuant to the stipulation, the parties agree that claimant's scheduled permanent disability award for her right forearm (wrist) shall be 10 degrees (6.66 percent) and her scheduled permanent disability award for her left forearm (wrist) shall be 4.7 degrees (3.13 percent). The stipulation further provides that the payment of these awards are subject to offset by the sums previously paid pursuant to a February 23, 1996 Notice of Closure. Finally, the parties stipulate that their agreement "resolves any and all issues, raised or raisable, with respect to claim processing and status to date."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CONSUELO TRUJILLO, Claimant
WCB Case No. 96-10056
ORDER ON REVIEW
Max Rae, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) pursuant to ORS 656.283(7), declined to admit claimant's testimony; and (2) increased claimant's unscheduled permanent disability for a neck, shoulder and chest condition from 16 percent (51.2 degrees), as awarded by an Order on Reconsideration, to 21 percent (67.2 degrees). On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

Relying on Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), the ALJ found that ORS 656.283(7)[1] prohibited the admission of claimant's testimony at hearing because it had not been part of the reconsideration record. The ALJ also found that such prohibition was not unconstitutional. Claimant disagrees that the statute is constitutional under the state and federal law and moves to remand to the ALJ for admission of the testimony.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, we agree with the ALJ's reasoning and conclusion concerning the admissibility of claimant's testimony and we adopt that portion of the order. Thus, we conclude that the record was not improperly or incompletely developed and we deny claimant's motion.

Extent of Unscheduled Permanent Disability

The parties dispute only the factor of adaptability. The Order on Reconsideration applied an adaptability value of 1. The ALJ found that claimant proved an adaptability factor of 2; in particular, the ALJ found that claimant's base functional capacity (BFC) was medium and the residual functional capacity (RFC) was light/medium. Claimant asserts that BFC is heavy and RFC is light/sedentary, resulting in an adaptability factor of 6 and a total unscheduled permanent disability award of 41 percent.

Adaptability is measured by comparing BFC to the worker's maximum RFC at the time of becoming medically stationary. Former OAR 436-035-310(2) (WCD Admin. Order 96-051). BFC is determined according to the highest strength category assigned in the DOT for the most physically demanding job that the worker successfully performed in the last 5 years prior to determination. Former OAR 436-035-0310(4)(a).

Here, the record shows that, along with his job at injury as a barricade assembler, claimant has worked as a cannery worker, fruit picker, vine pruner and Christmas tree farm worker. (Ex. 8). However, because there is no proof that the last three jobs were performed within the 5 years prior to determination, we consider only the job at the time of injury and the cannery job.

As noted by the ALJ, cannery worker has a strength category of light. DOT 529.686-014. Claimant contends that his job at the time of injury should fall under Lumber Handler, DOT 922.687-070, which has a strength category of heavy. We disagree. The description of that job pertains

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[1] 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[.]"

essentially to manually stacking lumber while claimant's job at injury was to assemble highway construction barricades, apply reflective tape to safety cones and barricade boards, and paint/seal the edges of plywood boards and finished signs. (Exs. 18, 21C).

The Order on Reconsideration applied the category for Production Assembler (any industry), DOT 706.687-010, which has a strength category of light. As discussed by the ALJ, however, there is evidence that claimant's job required more lifting than light capacity. See former OAR 436-035-0310(3)(f) (defining "light" as meaning that the worker has the ability to occasionally lift 20 pounds and can frequently lift or carry objects weighing up to 10 pounds). The record is not consistent concerning this issue. A job analysis provided that workers "[r]arely lift maximum of 40 pounds * * *; continually lift barricade boards weighing up to 5 pounds and occasionally assembled barricades weighing up to 15 pounds." (Ex. 18-2). In a written statement submitted during reconsideration, however, claimant indicated, in part, that rolls of netting material, weighing about 160 pounds, were carried between two persons and rolls of vinyl material, weighing from 160 to 200 pounds, were carried between three persons.

As discussed by the ALJ, the problem with basing BFC on claimant's statement is that it does not discuss whether the lifting ability is rare, occasional or frequent; such information is necessary to determine the appropriate strength category.[2] See former OAR 436-035-310(3)(c)-(k). Consequently, we rely on the job analysis. Based on this evidence, we find that claimant's BFC is medium. Former OAR 436-035-0310(3)(g).[3]

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 physical capacities evaluation. Former OAR 436-035-0310(5)(a), (b). Here, claimant's attending physician released claimant to work as a laborer in the sewing department. For the reasons discussed by the ALJ, we agree that this evidence is more persuasive than the PCE, and we adopt that portion of the order. This job requires occasionally lifting 15 pounds, (Ex. 17-2), which puts claimant in the sedentary/light category. See former OAR 436-035-0310(3)(e).

Comparing claimant's BFC of light to the RFC of sedentary/light, claimant's adaptability factor is 2. OAR 436-035-0310(6) (WCD Admin. Order 96-072).[4] Because this is the same value found by the ALJ, we agree with the ALJ that claimant is entitled to an award of 21 percent unscheduled permanent disability.

ORDER

The ALJ's order dated March 6, 1997 is affirmed.

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[2] Furthermore, we disagree with the dissent that claimant's statement establishes a BFC of "heavy." The heaviest loads described by claimant were carrying rolls of vinyl material weighing between 160 to 200 pounds between three people and carrying rolls of netting material weighing 160 pounds between two people. Dividing the entire load by the number of people carrying it results in between about 53 and 67 pounds for each person carrying the vinyl material and about 80 pounds for each person carrying the netting material, both of which are far less than the occasional lifting of 100 pounds required by "heavy" work under former OAR 436-035-0310(3)(j).

[3] We note that only the classifications of sedentary, light, medium, heavy, and very heavy apply to establish BFC. Former OAR 436-035-0310(4)(e).

[4] This rule, although not effective until February 15, 1997, applies to all claims closed on or after March 13, 1992 for workers medically stationary on or after June 1, 1990. OAR 436-035-0003(3).

Board Chair Hall dissenting.

I respectfully dissent to point out that the majority adds an element to claimant's burden of proof that is not contained in the subject rules. The applicable standards define "heavy" as meaning that the "worker has the ability to occasionally lift 100 pounds and the ability to frequently lift or carry objects weighing 50 pounds." Former OAR 436-035-0310(3)(j). The majority errs by requiring evidence

of how often claimant was actually required to lift or carry, rather than on this claimant's "ability" to lift or carry. That is, the subject administrative rule requires evidence of claimant's ability to lift/carry frequently, occasionally, or rarely, but does not require claimant to prove how often he actually lifted or carried. Claimant's statement would satisfy his burden, even if it lacks a description of how often he actually exercised his ability.

In the Matter of the Compensation of
ROY G. WELLS, Claimant
Own Motion No. 97-0432M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable bilateral leg amputation and bilateral arm fracture injury. Claimant's aggravation rights expired on September 26, 1989. The employer opposes reopening of the claim, contending that, although claimant underwent a "minor surgical procedure," claimant was not hospitalized, and, thus, is not entitled to temporary disability compensation.

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

On August 7, 1997, Dr. Tobin, consulting physician, performed an "I and D" (incision and drain) to a bursa over claimant's right (knee) stump. Although we have previously found that injections or diagnostic tests do not qualify as "surgery," Dr. Tobin describes these procedures as "incisions." See Tamera Frolander, 45 Van Natta 968 (1993) (the claimant did not qualify for temporary disability compensation where her sympathetic nerve block injections did not rise to the level of surgery or hospitalization); Everett G. Wells, 47 Van Natta 1634 (1995) (although hospitalized for a diagnostic procedure, the diagnostic nature of the procedure did not establish a worsening of the compensable injury). On August 8, 1997, Dr. Foglesong performed another I&D on claimant's right knee stump. On August 29, 1997, Dr. Boyd stated that claimant was "off work from 080797 through 082297 due to complications of [his] amputation [treatment]."

Here, claimant underwent several minor surgical procedures, on an outpatient basis. We conclude that, because they were invasive, and were provided to treat claimant's condition, the procedures qualify as invasive procedures, and, thus, as outpatient surgeries for a worsened compensable condition under ORS 656.278(1). See Fred E. Smith, 42 Van Natta 1538 (1990); Gary L. Dobbins, 49 Van Natta 88 (1997). Furthermore, according to Dr. Boyd, claimant missed work (was temporarily disabled from work) for nearly two weeks due to complications from the two surgical procedures. On this record, we are persuaded that claimant's compensable injury worsened requiring outpatient surgery.

The employer further recommends against reopening "as there is no hospitalization," and claimant underwent the procedures in a doctor's office. ORS 656.278(1) does not require that a claimant both undergo outpatient surgery and be hospitalized as an inpatient. Therefore, as we have concluded that, although provided on an outpatient basis, claimant's treatment qualifies as an invasive procedure (surgery), claimant does not have to establish that he was "hospitalized" as well. See ORS 656.278(1); Gary L. Dobbins, 49 Van Natta at 88.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning August 7, 1997, the date he underwent surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND D. CADY, Claimant
WCB Case No. 96-10538
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the self-insured employer's denial of claimant's bilateral carpel tunnel syndrome (CTS) and left ulnar neuropathy conditions; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction and supplementation. On November 7, 1996, Dr. Dordevich, rheumatologist, examined claimant on behalf of the employer. (Ex. 11).

On November 8, 1996, the claims examiner processing claimant's claim received a verbal report from Dr. Dordevich from which the claims examiner understood that claimant's claim was not compensable. (Tr. 38-39). A denial was issued on November 14, 1996. (Ex. 10).

On November 13, 1996, Dr. Kim, M.D., surgically repaired claimant's left ulnar nerve palsy and left CTS. (Ex. 8B). This surgery involved a left ulnar nerve neurolysis and transposition at the left elbow and a left carpal tunnel release. Id.

CONCLUSIONS OF LAW AND OPINION

In March 1993, claimant began working for the employer as a utility lineman. After a year, he was promoted to a lead lineman position and has worked in that position since. Claimant had no prior problem with his wrists or hands. Claimant's job duties require him to repetitively use his arms, wrists, and hands. In August 1995, claimant noticed that his hands would sometimes fall asleep. On August 13, 1996, while building a greenhouse for his wife, claimant first sought medical treatment regarding hand symptoms from Dr. Sims, treating family physician. (Ex. 1). His symptoms were greater on the left. Following conservative treatment and nerve testing, on November 13, 1996, claimant underwent surgical treatment of the left CTS and left ulnar nerve condition.

Applying ORS 656.802(2)(b),[1] the ALJ found that claimant failed to establish a compensable occupational disease claim. Specifically, the ALJ found that claimant had a preexisting condition (an anatomical predisposition to ulnar and median nerve entrapment) which combined with his work activities to cause CTS. The ALJ also found that claimant failed to prove that this preexisting condition was pathologically worsened, in major part, by his work activities. Based on the following reasoning, we find that claimant has established a compensable occupational disease claim regarding his left CTS condition.

We first determine which provisions of the Workers' Compensation Law are applicable. See Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995); Dibrito v. SAIF, 319 Or 244, 248 (1994) (it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim). ORS 656.802(2)(b) references ORS 656.005(7) in establishing the standard of proof in an occupational disease claim based on the worsening of a preexisting disease. We have previously determined that there must be evidence

[1] ORS 656.802(2)(b) provides: "If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

of a preexisting condition[2] combining with the work injury to cause or prolong disability or a need for treatment before compensability is analyzed under ORS 656.005(7)(a)(B). Tony D. Houck, 48 Van Natta 2443 (1996); Leon M. Haley, 47 Van Natta 2056, recon 47 Van Natta 2206 (1995).

On this record, we find no persuasive evidence that claimant had any preexisting disease or condition involving the ulnar and median nerves. Instead, the record contains little more than the unexplained suppositions of some physicians that claimant had an "anatomical predisposition/predilection" to develop entrapments of the ulnar and median nerves. Furthermore, even if we assume that such unexplained suppositions establish a preexisting condition, there is no evidence that claimant's work activity combined with this "preexisting condition" to cause or prolong disability or a need for treatment pursuant to ORS 656.005(7)(a)(B). Thus, neither ORS 656.005(7)(a)(B) nor ORS 656.802(2)(b) apply to this case. Therefore, in order to establish a compensable occupational disease claim for the bilateral CTS and left ulnar neuropathy conditions, claimant must prove that employment conditions were the major contributing cause of those conditions. 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).

Claimant has the burden of proving that his bilateral CTS and left ulnar nerve condition are 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).

Dr. Kim, claimant's treating surgeon, ultimately concluded that he was unable to determine whether the job activities were the major contributing cause of claimant's CTS or ulnar neuropathy. (Ex. 17-3). Dr. Dordevich, examining rheumatologist, opined that claimant's work activities were not the major contributing cause of claimant's CTS and left ulnar neuropathy based on his opinion that work activity, in general, does not cause CTS and his understanding that claimant did not perform repetitive work. (Ex. 11).

On the other hand, Dr. Sims, treating physician, opined that claimant performed repetitive job activities which were the major contributing cause of his CTS condition. (Ex. 16, 16A). However, although asked about the cause of both the bilateral CTS and left ulnar nerve conditions, Dr. Sims only responded regarding the CTS condition and rendered no opinion regarding the left ulnar nerve condition. (Exs. 15, 16, 16A). Thus, the record contains no persuasive medical evidence supporting compensability of the left ulnar nerve condition. Therefore, we find that claimant has failed to establish compensability of the left ulnar nerve condition.

We generally defer to the opinion of the treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to the opinion of Dr. Sims regarding the CTS condition. Dr. Sims' history of repetitive work activities more closely matches claimant's unrebutted testimony regarding his work activities as a lineman. (Tr. 12-16). Furthermore, claimant had no similar repetitious, hand intensive off-work activities, nor does any physician implicate off-work activities as a factor in claimant's development of CTS or left ulnar neuropathy. (Tr. 17-18).

Finally, there is no dispute that the left CTS is supported by objective medical findings. (Exs. 6, 7, 14). However, the insurer argues that the right CTS is not so supported. We agree.

None of the physicians note any objective findings for the right CTS. (Exs. 1, 2, 5, 6, 7, 8A-3, 11-3, -4, 14). Although Drs. Sims, Kim, and Dordevich diagnose bilateral CTS, their diagnoses regarding the right side appear to be based on claimant's subjective complaints because they do not record any right-sided objective findings. Nor do they record any right-sided subjective responses to clinical testing that could constitute objective medical findings. See Tony D. Houck, 48 Van Natta 2443 (1996) (subjective responses to clinical testing that are reproducible, measurable, or observable can constitute objective medical findings). Therefore, we find that claimant has failed to establish compensability of the right CTS condition. ORS 656.802(2)(d).

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[2] ORS 656.005(24) defines "preexisting condition," in relevant part, as "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease * * *."

However, based on Dr. Sims' persuasive medical opinion and the undisputed objective medical findings regarding the left CTS condition, we find that claimant has established compensability of his left CTS condition.

Claimant requests assessment of a penalty for the insurer's allegedly unreasonable denial. A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). Thus, if the carrier had a legitimate doubt about its liability, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, we have found that claimant failed to establish a compensable occupational disease claim regarding the left ulnar nerve condition and the right CTS condition. Therefore, it follows that the insurer's denial of those conditions was not unreasonable. We also do not find the insurer's denial regarding the left CTS condition to have been unreasonable. In this regard, the claims processing agent testified that she received a verbal report from Dr. Dordevich on November 8, 1996, the day after his examination of claimant. (Tr. 38). Her understanding from that conversation was that the claim was not compensable, although the claimant did have a problem and required surgery quickly. (Tr. 39). This testimony is unrebutted and is consistent with Dr. Dordevich's November 15, 1996 report, which states that claimant was seen and evaluated on November 7, 1996. (Ex. 11). Thus, we conclude that the insurer had "legitimate doubt" regarding its liability for claimant's bilateral CTS and left ulnar neuropathy conditions. Accordingly, we decline to award a penalty for unreasonable denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability of claimant's left carpal tunnel syndrome is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 14, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the self-insured employer's denial of claimant's left CTS condition is reversed. The employer's denial as it pertains to the left CTS condition is set aside and the claim is remanded to the employer for processing in accordance with law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by the insurer.

In the Matter of the Compensation of
CRYSTAL L. DOUGHERTY, Claimant
WCB Case No. 96-10249
CORRECTED ORDER ON REVIEW
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

It has come to our attention that our September 16, 1997 Order on Review contains a clerical error. Specifically, in modifying an Administrative Law Judge's (ALJ's) order to increase claimant's unscheduled permanent disability award to a total of 25 percent (80 degrees), we erroneously stated that the ALJ and the Order on Reconsideration had previously awarded a total of 8 percent (25.6 degrees). In fact, the ALJ's order had increased claimant's unscheduled permanent disability award from 2 percent (6.4 degrees), as awarded by the Order on Reconsideration, to 10 percent (32 degrees).

In light of such circumstances, our order should have stated that "In addition to the Order on Reconsideration and ALJ's awards totaling 10 percent (32 degrees) unscheduled permanent disability, claimant is awarded 15 percent (48 degrees), giving her a total award to date of 25 percent (80 degrees) unscheduled permanent disability for her back and jaw conditions." With the exception of these corrections, the remaining portions of our order require no further clarification.

To correct this oversight, we withdraw our September 16, 1997 order. As corrected herein, we republish our September 16, 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
CHARLES D. GREENOUGH, Claimant
WCB Case No. 96-10574
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On September 8, 1997, we abated our August 13, 1997 order that reduced claimant's scheduled permanent disability award for loss of use or function of the left arm to 2 percent (3 degrees). We took this action to consider claimant's motion for reconsideration. Having received the SAIF Corporation's response, we proceed with our reconsideration.

In our previous order, we relied on the arbiter panel's report that claimant's two point discrimination in the left hand was "less than 7 mm" (Ex. 24-3), and we concluded that the findings did not qualify for an award of permanent impairment for loss of sensation. On reconsideration, claimant contends that we misinterpreted the arbiter panel's finding of "less than" 7 millimeters.

Under OAR 436-035-0110(1) (WCD Admin. Order No. 96-051), loss of palmar sensation in the hand, fingers or thumb is rated according to the location and quality of the loss, and is measured by the two point discrimination method, as noted by the AMA Guides to the Evaluation of Permanent Impairment, 3rd edition, rev. (1990) (hereafter AMA Guides). OAR 436-035-0110(1)(a) provides:

"If enough sensitivity remains to distinguish two pin pricks applied at the same time (two point), the following shall apply:

Finding	Grade of Sensation
6 millimeters apart or less	normal
7-10 millimeters	less than normal
11-15 millimeters	protective sensation
Greater than 15 millimeters	total loss" (Emphasis added).

Thus, OAR 436-035-0110(1)(a) provides that, if a claimant is able to distinguish pin pricks that are less than 7 millimeters apart, he or she is not entitled to an award for loss of sensation.

Here, the arbiter panel was asked to describe sensation in the palmar surface of the hands and fingers based upon two point discrimination measured in millimeters. (Ex. 23A). The panel was instructed that only the methods described in the AMA Guides and Director's Bulletins 239 and 242 may be used to measure and report impairment. (Id.) The AMA Guides states:

"The minimum distance at which the individual can accurately discriminate between one and two-point applications in two out of three applications is recorded for each area tested." AMA Guides at 17 (emphasis added).

In the "physical examination" section of the arbiter panel's report, the panel determined that "[t]wo-point discrimination at tips of all digits of the right hand is less than 6 mm and all digits of the left hand is less than 7 mm." (Ex. 24-2; emphasis added). In the section of the report responding to specific questions, the panel reported that "[t]wo-point discrimination of the tips of all digits of the right hand is less than 6 mm and in the left hand, it is less than 7 mm." (Ex. 24-3; emphasis added). However, claimant refers to the diagram attached to the arbiter panel report, which shows a diagram of the left hand that indicated "7 mm all digits." (Ex. 24-5). In light of the two sections of the written report (one describing the "physical examination" and the other responding to specific questions), which stated that claimant's two point discrimination in the left hand was "less than 7 mm" (Ex. 24-2, -3), we are not persuaded by the notation on the diagram. Moreover, we note that the diagram was signed by only one member of the arbiter panel.

On reconsideration, we adhere to our conclusion that the arbiter panel's findings do not qualify for an award of permanent impairment for loss of sensation. See OAR 436-035-0110(1)(a). Therefore, we adhere to our conclusion that claimant's scheduled permanent disability award should be reduced to 2 percent.

On reconsideration, as supplemented herein, we adhere to and republish our August 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
THOMAS R. HELLINGSON, Claimant
WCB Case No. 96-06724
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Thomas B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock, and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order which determined that the SAIF Corporation properly recalculated claimant's temporary disability rate. On review, the issue is rate of temporary disability. We modify.

FINDINGS OF FACT

Claimant began work for the employer on December 7, 1995. On February 5, 1996, claimant received a wage increase from $7 to $8 an hour. On March 27, 1996, claimant compensably injured his left hand. The parties stipulated that, two weeks prior to his injury, claimant had taken a two-week leave of absence to attend a funeral. Although SAIF alleges that claimant earned $32 during this period, from our review of the payroll records, we find that claimant earned no wages for the two-week period from March 8, 1996 through March 22, 1996. (Ex. 3).

In May 1996, SAIF wrote claimant to inform him that his "biweekly" temporary disability rate had been reduced from $250 to $143.68. This rate was based on claimant's gross earnings from February 5, 1996 through March 27, 1996 ($1,092.00) being divided by the number of weeks during the relevant period (7.6), which equaled an average weekly wage of $143.68.[1] (Ex. 4). On June 6, 1996, claimant responded that he should be paid $214.94 every two weeks based on his gross earnings from December 7, 1995 through March 27, 1996 ($2,579.50). (Ex. 5). When SAIF failed to make the requested adjustment, claimant requested a hearing on July 19, 1996, contesting SAIF's calculation of his temporary disability rate.

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[1] Although SAIF described $143.68 as claimant's new "biweekly" compensation rate, SAIF was actually referring to claimant's average weekly wage on which his weekly temporary disability rate ($95.79) was based. (Ex. 4).

CONCLUSIONS OF LAW AND OPINION

At the hearing, claimant asserted that his two-week leave of absence, during which he earned no wages, should not be considered in calculating his temporary disability rate. The ALJ disagreed and held that, under former OAR 436-060-0025(5)(a),[2] SAIF correctly recalculated claimant's temporary disability rate based on the "actual weeks under the wage earning agreement at the time of injury." In reaching this conclusion, the ALJ rejected claimant's argument that, because his two week leave of absence constituted an "extended gap," only his actual weeks of employment should be used. The ALJ reasoned that, because there had been a change in the amount of the wage earning agreement on February 5, 1996, the portion of the administrative rule concerning "extended gaps" was inapplicable.

At the outset, we note that we have no disagreement with the portion of the ALJ's order that rejected claimant's argument that his two-week leave of absence should be considered an "extended gap" under the administrative rule. The ALJ correctly determined that this portion of former OAR 436-060-0025(5) did not apply because there had been a change in wage earning agreement on February 5, 1996. We do, however, disagree with the ALJ's interpretation of the phrase "actual weeks under the wage agreement..."

The ALJ interpreted this phrase as meaning the actual number of weeks (i.e., passage of time) since the wage agreement changed (7.6), regardless of whether wages were earned during claimant's leave of absence. Thus, the ALJ determined that the two-week leave of absence should be considered in calculating claimant's temporary disability rate.

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[2] The former administrative rule, which the parties agree applies, provides as follows:

"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 seasonally, 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 during the previous 52 week period, insurers shall use only 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 wage earning agreement during the previous 52 week period, the insurer shall use only the actual weeks under the wage agreement at the 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."

We note that, effective November 27, 1996, OAR 436-060-0025(5)(a) was amended. (WCD Admin Order 96-070). It now provides:

"For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

"(A) 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, insurers sll use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in written form.

"(B)(i) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due only to a pay increase or decrease, insurers shall use the worker's average weekly hours worked for the 52 week period, or lesser period as required in (5)(a)(A) of this subsection, multiplied by the wage at injury to determined the worker's current average weekly earnings.

"(ii) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, insurers shall average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A).

"(iii) For workers employed less than four weeks under a changed wage earning agreement as described in this subsection, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

In contrast to the ALJ's interpretation, we find that the last sentence of the administrative rule refers to the number of actual weeks worked under the new wage agreement. Because claimant did not work or earn wages while on leave of absence for two weeks, we conclude that those two weeks should not be included in calculating claimant's temporary disability rate.[3] This interpretation is both consistent with the administrative rule and with the statutory scheme, which is based on providing fair, adequate and reasonable income benefits to an injured worker. See ORS 656.012(2)(a).[4]

Accordingly, we find that SAIF improperly recalculated claimant's temporary disability rate and reduced his average weekly wage to $143.68. Instead of dividing claimant's gross earnings ($1,092) during the period from February 5, through March 28, 1996 by 7.6 weeks, we conclude that claimant's gross earnings should be divided by 5.6 weeks, which results in an average weekly wage of $195. This, in turn, results in a weekly temporary disability rate of $129.87 (two-thirds of $195).

Inasmuch as our finding results in increased temporary benefits, we conclude that claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); OAR 438-015-0055. Consequently, claimant's counsel is entitled to 25 percent of the increased temporary disability benefits resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

ORDER

The ALJ's order dated January 6, 1997 is modified. The SAIF Corporation is ordered to pay temporary disability benefits based on an average weekly wage of $195 for a weekly compensation rate of $129.87. Claimant's counsel is awarded 25 percent of the increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

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[3] The dissent contends that we have misconstrued OAR 436-060-0025(5)(a), first alleging that our interpretation of the rule renders its first sentence meaningless. The dissent's contention notwithstanding, we respectfully disagree. The rule states that the rate of compensation is computed "on the wages" determined by the rule. Because the majority is basing claimant's rate of compensation on his wages, our decision is consistent with the rule. Moreover, contrary to the dissent's interpretation, there is nothing in the first sentence of the rule that requires weeks in which a claimant has no earnings to be factored into a rate of compensation. The first sentence of the rule anticipates irregular or no earnings; so, too, does the majority's interpretation.

The dissent also argues that our interpretation of the rule would invalidate the "extended gaps" rule because even short, non-extended gaps would have to be excluded if no wages were earned. The dissent, however, does not sufficiently weigh the fact that the Department has chosen to deal with extended gaps separately, i.e., those instances where there has been a change in the amount or method of the wage earning agreement, and those where there has been no change. Under the circumstances presented in this case, the Department has determined that the compensation rate should be based on the actual wages earned, not the passage of time. The majority's interpretation of the rule is consistent with the policy behind the calculation of temporary disability that such computation fairly reflect wage replacement.

Finally, the dissent argues that our requirement that a worker earn wages would invalidate the calculation for volunteer workers in OAR 436-060-0025(5)(i). Once again, we respectfully disagree. The rule the dissent cites concerns an entirely separate and distinct class of workers (who earn no wages) different from those covered by OAR 436-060-0025(5), which anticipates that workers covered by this rule will have some periods of wages and some without. The dissent mixes "apples and oranges" in suggesting that the majority somehow transforms a claimant wage earner into a "volunteer" during a leave of absence by negating the separate rule for non-wage earners.

[4] Under ORS 656.012(2)(a), a primary objective of the Workers' Compensation Law is "[t]o provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents."

Board Member Haynes dissenting.

The majority inteprets the phrase "actual weeks under the wage agreement" in OAR 436-060-0025(5)(a) to refer to the number of actual weeks worked under the new wage agreement. Since claimant did not work or earn wages while on a leave of absence for two weeks, the majority concludes that those two weeks should not be included in calculating claimant's temporary disability rate. Because I believe that the majority has misconstrued the administrative rule, I respectfully dissent.

Former OAR 436-060-0025(5)(a) (WCD Admin. Order 96-053) 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 seasonally, 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 agreement at the time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker." (Emphasis added).

According to the majority, the phrase "actual weeks under the wage agreement" refers to the number of actual weeks worked under the new wage agreement. The majority interprets that phrase to require a worker to work or earn wages under the new wage agreement. That interpretation is inconsistent with OAR 436-060-0025(5)(a) and other department rules.

The majority ignores the first sentence of OAR 436-060-0025(5), which provides that the rule applies to "workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings[.]"

If, as the majority indicates, the "actual weeks under the wage agreement" requires a worker to earn wages, that interpretation renders the first section of former OAR 436-060-0025(5) meaningless.

Furthermore, if a worker is not employed when not receiving wages, any discussion of "extended gaps" in former OAR 436-060-0025(5)(a) would be meaningless. Based on the majority's interpretation, all gaps would have to be excluded from the wage averaging calculation because the worker would not be working or earning wages during those times. The majority's interpretation would invalidate the "extended gap" rule because even short non-extended gaps would have to be excluded if no wages were earned.

In addition, by interpreting former OAR 436-060-0025(5)(a) to require a worker to earn wages, the majority's interpretation apparently would invalidate former OAR 436-060-0025(5)(i), which provides that "[c]overed workers with no wage earnings such as volunteers, jail inmates, etc. shall have their benefits computed on the same assumed wage as that upon which the employer's premium is based." If a worker is required to earn wages, the calculation for volunteer workers would be invalid, because they do not earn wages.

I agree with the ALJ that SAIF properly included the two week leave of absence when it averaged claimant's earnings. Claimant continued to be employed during the leave of absence. Here, the "actual weeks under the wage earning agreement at the time of injury" are those weeks that claimant was employed between February 5, 1996 and the date of injury, or 7.6 weeks. I would adopt and affirm the ALJ's order.

In the Matter of the Compensation of
GUY A. LAWRENCE, Claimant
WCB Case No. 96-05226
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a cervical degenerative condition. On review, the issue is whether SAIF is responsible for claimant's condition. We vacate and remand.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant suffers from a cervical degenerative condition which was asymptomatic before he began working for SAIF's insured in 1991. He developed shoulder and neck pain in 1992, which worsened following numerous injuries while he was employed as a logger.

On March 25, 1996, Dr. Miller performed surgery on claimant's cervical spine at C5-7. SAIF denied claimant's cervical condition, contending that his work activity for its insured was not the major contributing cause.

The ALJ upheld SAIF's denial because claimant failed to prove that his work activities, with this employer, caused the condition or its worsening. The ALJ relied on Manuel Garibay, 48 Van Natta 1476 (1996).

In Garibay, the claimant had worked for 12 years as a tree planter and harvester. He worked for the sole employer against whom he filed a claim for only the last two years of that period. The medical evidence indicated that claimant's work over the entire 12 year employment period caused his carpal tunnel syndrome disease. The evidence did not indicate that the two year period of work for the employer in question caused or worsened the disease. We held that, where a claimant elects to pursue an occupational disease claim against only one employer (and does not invoke the last injurious exposure rule of proof), he must establish that work activities with that employer were the major contributing cause of the claimed condition. Accordingly, because the claimant filed a claim against only one employer and the medical evidence did not relate claimant's carpal tunnel condition to claimant's work with that employer, the Board concluded that claimant failed to prove compensability in Garibay.

Since the ALJ's decision in the present case, the court reversed our order in Garibay. Garibay v. Barrett Business Services, 148 Or App 496 (1997).[1] However, the Garibay court did not decide whether we erred in refusing to apply the rule of proof to determine compensability (because claimant did not invoke it) in that case.[2]

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[1] The court determined that resolution of the dispute was not dependent on whether claimant had "invoked" the "last injurious exposure rule." Rather, relying on former ORS 656.308(2), the court concluded that the carrier was obligated to disclaim responsibility when it learned that claimant's condition was work-related and potentially the responsibility of other carriers. Although the carrier had not "in the technical sense" raised responsibility as a defense, the court reasoned that was the practical effect of its contention that claimant had a "preexisting condition" which the record established was caused by his work activities for other employers. Because the carrier had failed to comply with former ORS 656.308(2), the court held that it was barred from making such an argument. Id.

[2] We note that the court previously affirmed our order in James H. Eisele, 48 Van Natta 1740 (1996), where we declined to consider the last injurious exposure rule of proof, because the claimant first raised the issue on review. Eisele v. Horizon Airlines, 148 Or App 70 (1997).

Here, claimant argues that his claim is compensable under the rule of proof, based on 23 years of heavy work activities and multiple injuries. SAIF responds that claimant should be foreclosed from relying on the rule, because he did not invoke it before closing arguments.

We generally decline to consider new issues raised for the first time during closing arguments. See Kenneth L. Devi, 49 Van Natta 108 (1997); Burton I. Thompson, 48 Van Natta 866, 868 (1996); see also Neely v. SAIF, 43 Or App 319, 323, rev den 288 Or 493 (1979) ("Fundamental fairness may dictate that the Board should not decide a claim on the basis of evidence not in the record,[], or on issues to which no evidence was presented.") (emphasis added, citation omitted). For example, in Curtis K. Joy, 49 Van Natta 260 (1997), we refused to consider the potential responsibility of non-joined carriers, because the defense theory was not raised until closing arguments. Inasmuch as a non-joined carrier cannot be held responsible for the claim, we reasoned that allowing such a defense would be fundamentally unfair and prejudicial to claimant. We reach the opposite result in the present case, based on the following reasoning.

We acknowledge that there is no indication that claimant specifically raised the rule of proof prior to closing arguments. On the other hand, it is understandable that claimant would not raise the rule of proof because no medical evidence in the record implicated work exposure other than that with SAIF's insured until after the hearing.

Following the hearing, in accordance with the parties' agreement and the ALJ's ruling, Dr. Miller's "post-hearing report" (*Exhibit 17*) was admitted into the record. (Tr. 1-2, 31). This report contained the first specific medical reference to claimant's 23 year history of heavy work activities (i.e., including about 18 years of exposure before claimant worked for SAIF's insured).

Relying on our decision in Garibay, the ALJ declined to analyze claimant's occupational disease claim by utilizing the "last injurious exposure rule." However, where, as here, the record was held open for a medical opinion and that opinion (for the first time) presents medical evidence supporting a causal relationship between claimant's claimed condition and his employment exposure with multiple employers, we conclude that claimant should not be prevented from relying on the rule of proof. See Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994); Mary A. Kelley, 47 Van Natta 822 (1995). On the other hand, considering our determination that it is permissible for claimant to invoke the rule of proof in this situation, we consider it appropriate to allow the parties the opportunity to further develop the record regarding this belatedly raised issue.

We may remand a case for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). For example, a compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court).

Here, for the reasons expressed above, we have found it appropriate to allow claimant to rely on the rule of proof. As previously noted, prior to this ruling, consideration of this "post-hearing" theory would not have been permitted. Under such circumstances, and because we consider the record sparsely developed on the "rule of proof" question, we find a compelling reason to remand this matter to the ALJ for further development of this insufficiently and inadequately developed record. On remand, the parties shall have the opportunity to present additional evidence on the "compensability/rule of proof" issue arising from the admission of Dr. Miller's "post-hearing" report. The proceedings to admit this additional evidence shall be conducted in any manner that the ALJ deems achieves substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

Accordingly, the ALJ's order dated October 31, 1996 is vacated. This matter is remanded to ALJ Marshall for further proceedings consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELISSA L. MERRICK, Claimant
WCB Case No. 96-09182
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Black's order that awarded an assessed attorney fee under ORS 656.382(2). On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." Additionally, we take administrative notice of our June 24, 1997 Order on Review that adopted and affirmed ALJ McWilliams' order setting aside the insurer's denial of claimant's C5-6 disc condition.[1] See Robert P. Roder, 49 Van Natta 755 (1997) (Board took administrative notice of Order on Review because it qualified as fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned").

CONCLUSIONS OF LAW AND OPINION

In 1995, the insurer accepted a claim for a cervical strain. In January 1996, the insurer denied claimant's C5-6 herniated disc condition. In June 1996, a Determination Order closed the cervical strain claim.

In August 1996, ALJ McWilliams set aside the insurer's denial of the C5-6 herniated disc. During the reconsideration proceeding, the Department was informed of the ALJ's order setting aside the denial. An Order on Reconsideration awarded 19 percent unscheduled permanent disability based on the cervical strain and C5-6 herniated disc.

The insurer requested a hearing; in doing so, it filed a form indicating that a hearing was requested concerning the Order on Reconsideration and the unscheduled permanent disability award. The hearing was on the record and the parties submitted written closing arguments. The ALJ affirmed the Order on Reconsideration, granted the insurer's request to stay payment of the unscheduled permanent disability award and awarded an assessed attorney fee of $750. As noted above, following the ALJ's order, we affirmed ALJ McWilliams' order setting aside the insurer's denial of the C5-6 herniated disc.

In requesting review in this proceeding, the insurer contests only the attorney fee award. In particular, it contends that claimant is not entitled to such an award because its hearing request was not "made to reduce or disallow the claimant's award of permanent disability" but rather it was "a protest of incorrect procedure and policy" by the Department in considering the C5-6 disc condition when deciding claimant's permanent disability award. The insurer further reasons that claimant is not entitled to an assessed attorney fee award under ORS 656.382(2), "because there was not a final determination on the compensability issue" and "because the merits of the compensability issue were not addressed" by ALJ Black.

In deciding this case, we emphasize that only entitlement to attorney fees is at issue. Consequently, our decision concerns only whether ORS 656.382(2) was satisfied and does not pertain to the unscheduled permanent disability awarded by the Order on Reconsideration.

ORS 656.382(2) provides:

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[1] Member Moller dissented in our June 24, 1997 Order on Review.

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

An award of attorney fees under the statute requires: (1) that a carrier initiate a request for a hearing to obtain a disallowance or reduction in a claimant's award of compensation; (2) that the claimant's attorney perform legal services in defending the compensation award; and (3) that the ALJ find on the merits that the claimant's award of compensation should not be disallowed or reduced. Deaton v. Hunt-Elder, 145 Or App 110, 114-15 (1996).

As discussed above, the insurer contends that its request for hearing was not initiated to obtain a disallowance or reduction of claimant's permanent disability award. We disagree. As previously noted, the insurer's request for hearing put at issue the Order on Reconsideration and the unscheduled permanent disability award. Its written closing argument stated that the ALJ needed to address two issues, including the Department's "improper consideration of the claimant's C5-6 disc herniated condition in the Order on Reconsideration" and whether it was entitled to stay payment of the compensation. In particular, the insurer argued that, because ALJ McWilliams' order was currently before the Board, it was procedurally improper for the Department to consider the C5-6 disc herniation in deciding the extent of claimant's unscheduled permanent disability.

We find that, in taking such a position, the insurer sought to reduce claimant's unscheduled permanent disability award. By arguing that the Department improperly considered the C5-6 herniated disc, in effect the insurer was contesting that portion of the award based on that condition. Moreover, because at least part of claimant's award was based on impairment from the C5-6 herniated disc (Exs. 69, 70), if the ALJ had agreed with the insurer, the result necessarily would have been to reduce the unscheduled permanent disability award. We reject the insurer's reasoning that no fee is due because the compensability issue was not final and was not addressed by the ALJ. That argument might be relevant under ORS 656.386(1), but it is not relevant to our analysis under ORS 656.382(2).

Consequently, we conclude that the insurer initiated a request for a hearing to obtain a disallowance or reduction in claimant's award of compensation. Furthermore, because claimant's attorney performed services in defending against the insurer's position that the Department's procedure was improper, we find that claimant's attorney performed legal services in defending the compensation award. Finally, in deciding that the Department's consideration of the C5-6 herniated disc was not improper, we conclude that the ALJ found on the merits that claimant's award of compensation should not be disallowed or reduced. Thus, the ALJ's assessed attorney fee award was proper under ORS 656.382(2). Deaton, 145 Or App at 114-15.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant's counsel is not entitled to a fee for services rendered on review. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 28, 1997 is affirmed.

In the Matter of the Compensation of
BARBARA J. NIXON, Claimant
WCB Case Nos. 97-00358 & 96-06425
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of brachial plexus compression, thoracic outlet syndrome, reflex symptom dystrophy, bilateral carpal tunnel syndrome and/or degenerative cervical disease. In her brief, claimant also requests an attorney fee for her counsel's efforts in obtaining clarification of an allegedly overbroad denial. On review, the issues are compensability and attorney fees.

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

On review, claimant asserts that even if SAIF's denials are upheld, she is entitled to an assessed attorney fee for her counsel's services at hearing based on the ALJ's determination that claimant's current symptoms remain related to her accepted 1993 shoulder injury. Citing Deanna L. Ross, 48 Van Natta 118 (1996), claimant argues that because her symptoms are compensable, she is entitled to a fee for clarifying SAIF's denials. We disagree.

ORS 656.386(1) allows an assessed fee for prevailing over a denied claim. In Deanna L. Ross, we held that where the scope of a carrier's partial denial was clarified at hearing so that the carrier was required to issue an amended acceptance, the claimant's counsel was entitled to an assessed attorney fee for her efforts in securing the acceptance. See also Ronald R. Willard, 45 Van Natta 937 (1993) (attorney fee appropriate for obtaining clarification of insurer's overbroad denial).

Unlike Ross or Willard, this case does not involve a clarification of an overbroad denial. Rather, as the ALJ found, SAIF's denials in this case were limited to the specific conditions that claimant asserted were related to her accepted injuries, and did not encompass her current left arm symptoms.[1] Thus, although the ALJ determined that claimant's continued left upper extremity symptoms were compensable, claimant has not prevailed over a denied claim nor has SAIF been directed to amend its acceptance to include any new medical conditions. Consequently, no attorney fee is authorized.

ORDER

The ALJ's order dated March 26, 1997 is affirmed.

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[1] In January 1997, SAIF issued a written denial of three conditions (left impingement syndrome, C5-6 and C6-7 disc degeneration and bilateral carpal tunnel syndrome), asserting that these conditions were unrelated to claimant's 1987 accepted strain injury. At the hearing, it was determined that claimant was actually making a claim for thoracic outlet syndrome and/or a brachial plexus condition related to her accepted injuries, but not for cervical disc degeneration or bilateral carpal tunnel syndrome. SAIF waived any procedural problems with claimant's claim and orally denied the compensability of the thoracic outlet syndrome and brachial plexus condition. (Tr. 5-8).

In the Matter of the Compensation of
JOSE L. VILLEGAS, Claimant
WCB Case No. 96-09207
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

On August 15, 1997, we abated our July 21, 1997 order that affirmed the Administrative Law Judge's (ALJ's) order finding that the Hearings Division had jurisdiction to determine the rate of claimant's temporary disability. We took this action to consider the SAIF Corporation's motion for reconsideration. Having received claimant's response, we now proceed with our reconsideration.

In requesting reconsideration of a closure notice (which did not recite his TTD rate), claimant disagreed with the duration of his TTD award. After the reconsideration order awarded two additional days of TTD, claimant requested a hearing, challenging the TTD rate paid by SAIF.

In determining that claimant could raise the rate issue for the first time at a hearing regarding the reconsideration order, we distinguished William Masters, 48 Van Natta 1788 (1996). We noted that, in Masters, the closure notice awarded TTD, and prior to the reconsideration proceeding, the carrier notified the claimant that the TTD rate had been based on incorrect wage information and that an overpayment would be deducted from future benefits.

In contrast to Masters, we observed that the present case involved no dispute regarding the rate issue before or during the reconsideration proceeding. Rather, we concluded that the dispute arose after the reconsideration order awarded claimant additional TTD, and SAIF had paid the TTD benefits based on a weekly wage of $163.66, which was subsequently challenged by claimant. In light of such circumstances, we held that claimant's failure to raise the rate issue during the reconsideration proceeding did not preclude him from raising the issue at hearing.

SAIF now contests our factual finding that it paid claimant two additional days of temporary disability based on a weekly wage of $163.66. SAIF asserts that there is no evidence in the record regarding whether or in what amount SAIF paid the TTD awarded in the reconsideration order. SAIF, therefore, argues that, without such evidence of payment, the TTD rate issue was not "ripe" for resolution.

We agree with claimant, however, that SAIF did not previously raise its "ripeness" argument. Therefore, we are not inclined to address the issue now. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Janice K. Gonzalez, 49 Van Natta 638, 639 (1997). Moreover, even if we were to consider the issue, we would reject SAIF's argument.

The ALJ specifically found that SAIF paid temporary disability based on a weekly wage of $163.66. (O&O p. 2). In its appellant's brief, SAIF stated that it generally accepted the ALJ's findings of fact. (Appellant's brief p. 2). At no point in its briefs did SAIF contest the ALJ's factual finding, nor did it contest the ALJ's statement in the opinion section of his order that SAIF paid two days of temporary disability based on the above weekly wage after the reconsideration order issued. To the contrary, SAIF conceded that it paid the same rate of temporary disability throughout the course of the claim. (Appellant's brief p. 4). Under these circumstances, we reject SAIF's belated "ripeness" argument.

Citing Drews v. EBI Companies, 310 Or 134 (1990) and Hammon Stage Line v. Stinson, 123 Or App 418 (1993), SAIF also contends that a TTD rate issue arises out of a Notice of Closure as a matter of law and must be raised in a request for reconsideration. However, neither Drews nor Stinson concerned closure orders subject to the mandatory reconsideration process of ORS 656.268. In addition, ORS 656.283(7) specifically allows an issue not raised by a party to the reconsideration to be raised at a hearing if the new issue "arises out of the reconsideration order itself." We have previously determined that, under the circumstances of this claim, the rate of claimant's temporary disability is such an issue.

Finally, SAIF argues that it was "irremediably prejudiced" by our holding that claimant could raise the rate issue at hearing without first raising the issue in the request for reconsideration. Asserting that evidence at a "post-reconsideration" hearing is limited to the reconsideration record pursuant to ORS 656.283(7), SAIF contends that, because it had no notice that it needed to submit evidence during the reconsideration proceedings to support its calculation of temporary disability, it was prejudiced by its inability to present evidence on the rate issue.

We are not persuaded by SAIF's "prejudice" argument. To begin, because SAIF made no attempt to present "non-reconsideration record" evidence at the hearing, we question whether the issue has been properly raised. This concern is further fortified by SAIF's failure to object to the ALJ's consideration of "post-reconsideration" facts. See Fister South Hills Care Center, 149 Or App 214, 218-19 (1997).

Moreover, as previously noted, ORS 656.283(7) allows a party to raise a new issue at hearing under certain circumstances. The TTD rate issue qualifies for the statutory exception to the general rule that prohibits the raising of issues not identified by a party during reconsideration proceedings. Although submission of new evidence on an issue arising out of a reconsideration order is not permitted under the statute, see Cathy M. Montgomery, 48 Van Natta 1170, 1171 (1996), this can also be said for any issue that "arises out of" the reconsideration order. While the evidentiary limitations of ORS 656.283(7) undoubtedly limit a parties' ability to respond to a new issue properly raised at a "post-reconsideration" hearing, SAIF's "prejudice" concerns are best addressed to the legislature, rather than to this forum.

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 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.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 21, 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
JAMES A. LINDEKUGEL, Claimant
WCB Case No. 96-07810
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
James Booth (Saif), Defense Attorney

On September 12, 1997, we withdrew our August 22, 1997 order that had affirmed an Administrative Law Judge's (ALJ's) order that awarded 35 percent (52.5 degrees) scheduled permanent disability for each hand, whereas an Order on Reconsideration awarded 63 percent (94.5 degrees) scheduled permanent disability for each hand. We took this action in response to the SAIF Corporation's announcement that the parties had entered into a Claim Disposition Agreement (CDA) which was designed to settle this matter.

On September 22, 1997, we approved the parties' CDA, in which claimant released his past, present, and future rights to workers' compensation benefits (including permanent disability), except medical services, related to his February 1996 claim. Pursuant to that agreement, the parties stipulated that the requests for hearing and review in this case "shall be dismissed."

In light of our approval of the parties' CDA, which contains the aforementioned provisions, we conclude that the parties' dispute in this case has been rendered moot. Accordingly, in lieu of our prior orders, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHARON K. FALSETTO, Claimant
WCB Case No. TP-97003
THIRD PARTY DISTRIBUTION ORDER ON RECONSIDERATION
Gaylord & Eyerman, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

On September 2, 1997, we withdrew our July 31, 1997 Third Party Distribution Order that determined that the insurer had not established its entitlement to the remaining balance of proceeds from claimant's third party settlement. We took this action to consider the insurer's contention that it is entitled to recover its lien for future medical expenses because it has proven that a projected surgery is "reasonably to be expected." Having receiving claimant's response and the insurer's reply, we proceed with our reconsideration.

Based on a longstanding principle expressed in cases such as David L. Whitlow, 41 Van Natta 1517 (1989), and Cynthia G. Lavelle, 41 Van Natta 1399 (1989), we previously held that it was not "reasonably certain" that the insurer would incur future expenses for fusion surgery arising from claimant's compensable injury. In reaching this conclusion, we found the opinion from Dr. Wilcox (claimant's attending physician, who reported that there was a risk for reinjury and exacerbation) insufficient to establish that a future fusion surgery was "reasonably certain." Although other medical opinions (Drs. Brett and Franks) had discussed the possibility of fusion surgery to alleviate claimants' pain, we observed that these physicians had not stated that such surgery was expected or necessary. Finally, we referred to Dr. Franks' report that claimant's desire to "avoid surgery at all costs" was reasonable because she did not harbor a fixed neurological deficit referable to her spinal cord and / or nerve roots.

Asserting that it should not be required to establish that its future expenses are "certain," the insurer contends that it is entitled to recover its lien for future medical expenses because it has proven that the surgery is "reasonably to be expected." After considering the insurer's argument and claimant's response, we adhere to our previous determination. We add the following comments.

To begin, in submitting its arguments prior to the issuance of our distribution order, the insurer expressed no concern with our longstanding "reasonably certain" standard. Considering the insurer's belated challenge to this standard, we are not inclined to address such an argument for the first time on reconsideration. In any event, whether phrased in terms of "reasonably certain" or "reasonable certainty," our standard has always been premised on the statutory requirement of whether a carrier has established that future medical expenses are "reasonably to be expected." See ORS 656.593(1)(c). Applying that standard, for the reasons set forth in our prior order, we continue to find that the insurer has not proven its entitlement to its projected lien for future claim costs.

Accordingly, we withdraw our July 31, 1997 order. On reconsideration, as supplemented herein, we republish our July 31, 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
STACY FRIERSON, Claimant
WCB Case No. 97-00637
ORDER ON REVIEW
Hollander, 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) Galton's order that set aside its denial of claimant's low back condition. On review, the issue is compensability.

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

This case turns on the credibility of the witnesses. The ALJ found, based on his observation of the demeanor of the witnesses at hearing, that claimant and his witness, Ms. Ison, were credible, while the employer's witnesses were not completely credible or reliable. We generally defer to an ALJ's demeanor-based credibility findings. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). However, we do not do so where inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. Id.; see also Terrance Nohrenberg, 47 Van Natta 2005, 2006 (1995).

Here, we find no basis for reversing the ALJ's credibility findings. After our review of the record, we find no material inconsistencies between claimant's testimony and the balance of the record such as would prevent us from concluding that claimant's testimony is credible. Therefore, we find no reason not to defer to the ALJ's credibility findings. Accordingly, the ALJ's order is affirmed.

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

ORDER

The ALJ's order dated April 25, 1997 is affirmed. Claimant is awarded an attorney fee of $1,500 for his counsel's services on review, payable by the self-insured employer.

In the Matter of the Compensation of
LINDA M. MENARD, Claimant
WCB Case No. C702130
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
John DeWenter, Claimant Attorney
Safeco Legal, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On August 20, 1997, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

As originally submitted, the CDA provided that both SAIF and SAFECO would pay a portion of the CDA proceeds to claimant and her attorney. However, the claim had been accepted by SAFECO and SAIF's compensability denial had been resolved by a disputed claim settlement.

On September 5, 1997, we wrote the parties seeking clarification of the CDA. We noted that the function of a claim disposition agreement is to dispose of an accepted claim. See Salvador Preciado, 48 Van Natta 1559 (1996); see also OAR 438-009-0001(1) (a claim disposition agreement is a written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations under ORS 656.001 to 656.794, except for medical services, in an accepted claim). Because SAIF did not have an accepted claim and was not a party to the CDA, we indicated that SAIF's payment under the CDA could not be considered proceeds of the CDA. We requested that the parties correct the CDA by submitting an addendum.

We have received an addendum to the CDA signed by counsel for SAFECO and counsel for claimant. The addendum revises the CDA to provide that SAFECO will pay the entire CDA proceeds in exchange for claimant's release of her rights to workers' compensation benefits, except medical services, in the claim.

Although it does not explicitly do so, we interpret the addendum as deleting that portion of the original CDA which provided that SAIF would pay a portion of the CDA proceeds to claimant and claimant's attorney.[1]

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

IT IS SO ORDERED.

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[1] Although we noted in our addendum letter that SAIF was not a party to the CDA and that its payment under the agreement could not constitute CDA proceeds, we also noted that there would appear to be no statutory prohibition against SAIF reimbursing SAFECO for all or a portion of its payment of the CDA proceeds on its accepted claim. Of course, because only SAFECO and claimant were parties to the accepted claim, only those parties could execute the CDA. Any reimbursement agreement between SAFECO and SAIF would constitute a private matter between them separate from this CDA.

In the Matter of the Compensation of
DAVID A. TOWNE, Claimant
Own Motion No. 96-0591M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Roger D. Wallingford, Claimant Attorney
Liberty Northwest, Insurance Carrier

Claimant requests review of the insurer's June 9, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from February 19, 1997 through May 30, 1997. The insurer declared claimant medically stationary as of May 30, 1997. 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 June 9, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980). Even though medical opinion established that claimant required ongoing care for an indefinite period of time, the ongoing care does not necessarily establish that claimant was not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

In a May 29, 1997 report, Dr. McNeill, claimant's treating physician, opined that claimant "is now medically stationary and ready for claim closure." Dr. McNeill noted that he had filled out the paper work for claimant's evaluation / work hardening program at Providence Medical Center, and noted to the insurer that "[o]nce [claimant] has been evaluated for [the] work hardening program I think you could use their evaluation, as well, for his claim closure." In a June 20, 1997 Work Conditioning Discharge Summary, Shelby Atwood, O.T.R, noted that claimant was discharged to a home physical therapy program. Ms. Atwood further asserted that:

> "It is the treatment team's opinion that [claimant's] work capacities have reached maximal level of improvement and that no further material improvement would reasonably be expected from the passage of time. Providing that the attending physician has no plans for additional medical interventions, it is suggested that the worker be declared medically stationary."

Here, although claimant was enrolled in a work hardening program, his physician had already declared him medically stationary. Dr. McNeill noted that the insurer could use the work hardening evaluation, as well as his own, to close the claim.

We further conclude that the "work hardening" program was not prescribed to medically improve claimant's compensable condition. The goals in claimant's work hardening program were projected as: (1) Increase lift/carry to 40 pounds occasionally, 20 pounds frequently; (2) increase overhead reaching to an occasional basis; and (3) increase tolerance for reaching at arm's length with both upper extremities to an occasional-to-frequent basis. Based on its goals, we do not find that the work hardening program provided medical improvement in claimant's medical condition. Rather, the program was designed to provide strengthening of and ongoing care to claimant's already-medically-stationary injury, and no material improvement in claimant's condition would be expected with further treatment or the passage of time. ORS 656.005(17); Maarefi v. SAIF, 69 Or App at 527; Lois Brimblecom, 49 Van Natta 721 (1997). Therefore, we conclude that claimant was medically stationary when his physician declared him so, and the insurer's closure was proper.

Accordingly, we affirm the insurer's June 9, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
WONDER WINDOM-HALL, Claimant
WCB Case No. 90-06799
SECOND ORDER ON REMAND
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al, Defense Attorneys

On July 25, 1997, we abated our June 26, 1997 order that, on remand from the Court of Appeals, reversed that portion of the Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's perilymph fistula condition and awarded an assessed fee of $5,000 to claimant's attorney for services concerning the compensability of the perilymph fistula. We abated our order to consider claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

Claimant seeks reconsideration of that portion of our order awarding an assessed attorney fee of $5,000, contending that a reasonable fee is $50,160. In reaching our $5,000 award, our order discussed the factors set forth in OAR 438-015-0010(4).[1] We first found that the time devoted to the case was "substantial"; in an accompanying statement of services from her counsel, claimant asserts that her attorney expended 209 hours. We further found that the complexity of the issue, value of the interest and benefit secured were "relatively average." In a footnote, we emphasized that claimant had finally prevailed over only the denial of the perilymph fistula and, thus, she was not entitled for services devoted to any other issue, including compensability of additional conditions previously litigated. Finally, we found that there was a risk claimant's attorney would go uncompensated and no assertion of a frivolous issue.

In response, claimant argues that the case was of high complexity, as shown by the number of experts who were deposed and testified at hearing and the issue of toxic exposure, as well as the numerous legal issues in contention. Claimant also maintains that we need to "recognize the 'value' of a case from the point of view of a claimant who has no medical coverage other than workers' compensation benefits, and who is caught in a web of litigation as complex, expensive and protracted as this has been." Moreover, claimant contends that her attorney's skill was high and the risk of going uncompensated was "enormous." Claimant additionally asserts that the "primary condition" for which she sought benefits was the perilymph fistula condition and her other conditions constituted a "minor component of this case." Finally, claimant notes that our first Order on Review awarded a fee of $8,000 and was before she expended additional services before the Court of Appeals and in petitioning for review by the Supreme Court. In sum, claimant requests that she be compensated for all of her attorney's time which, after applying a "multiplier" of 1.5, computes to $50,160.

The employer responds that claimant is entitled only for services related to the one condition found compensable. The employer further contends that we appropriately considered and assessed the factors for awarding an assessed fee and that we should deny claimant's request for additional fees.

As demonstrated by the numerous ALJ, Board, and court decisions, the procedural history of this case has been extremely lengthy. In August 1991, we reversed an ALJ's order that had dismissed claimant's hearing request and remanded the case for reconsideration. Wonder Windom-Hall, 43 Van Natta 1723, on recon 43 Van Natta 1886 (1991).

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[1] Those factors are:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

Thereafter, claimant retained her current attorney, who submitted medical reports from Drs. Black and Grimm, as well as participated in the deposition of Dr. Burton. Following remand, a "postponement" hearing was convened, which resulted in the scheduling of a hearing on the merits of the claim. The subsequent hearing regarding the claim's merits was convened in seven sessions. Following the closure of the record, the ALJ issued a July 1993 Opinion and Order on Remand. Pursuant to that order, the ALJ upheld the employer's denials of claimant's inner ear, neurological, and psychological conditions and declined to assess penalties for allegedly unreasonable claim processing.

Claimant requested Board review of the ALJ's decision, contending that the employer's prior acceptance of "toxic exposure to organic solvents on July 7, 1989" encompassed her current vestibular disorders, described as hydrops, benign paroxysmal positional nystagmus (BPPN), and bilateral perilymph fistulas. As an alternative argument to her "back-up" denial approach, claimant asserted that her vestibular disorders, (as well as encephalopathy, and dysthmia conditions) were either directly or indirectly caused by her occupational toxic exposure. Claimant also sought penalties and attorney fees for allegedly unreasonable claim processing. Finally, based on a "post-hearing" medical report, claimant sought remand for further development of the record.

In support of these contentions, her counsel filed appellate briefs and arguments totalling approximately 70 pages. Some 10 pages of their briefs addressed the "acceptance / back-up denial" theory, the compensability of the encephalopathy, and dysthmia conditions, and the penalty request.

In August 1994, we granted claimant's motion for remand. Wonder Windom-Hall, 46 Van Natta 1619 (1994). Consequently, the ALJ's order was vacated and the case was remanded for consideration of the additional evidence.

At the subsequent "remand" hearing, five additional exhibits were presented, 2 of which were generated by claimant's counsel. In addition, claimant's counsel participated in another deposition. In February 1995, following the hearing (which in combination with all of the previous hearings totalled 690 pages of hearing transcript) and closure of the record, the ALJ found that the employer's acceptance had not encompassed the denied vestibular conditions. In addition, although persuaded that claimant did have perilymph fistulas, the ALJ continued to conclude that neither the fistulas nor any of the claimed conditions were related to claimant's work or to her accepted claim.

Thereafter, claimant requested Board review of the ALJ's order. Her counsel submitted both an appellant's and reply briefs (totalling some 18 pages), which contended that: (1) the employer's denial was an impermissible "back-up" denial; (2) her vestibular disorder condition was compensable; (3) her encephalopathy was compensable; (4) her dysthmia was compensable; and (5) the employer's claim processing had been unreasonable. Most of these briefs addressed the compensability of claimant's vestibular conditions; approximately 2 pages pertained to claimant's "back-up denial" theory. Claimant also relied on her previous appellate briefs.

In June 1995, we found that the employer's acceptance had encompassed the denied vestibular conditions. Wonder Windom-Hall, 47 Van Natta 1007 (1995). Applying ORS 656.262(6), we concluded that the employer had established, by clear and convincing evidence, that claimant's vestibular conditions were not directly related to a work-related "toxic exposure." We next turned to the question of whether the employer had established (again by clear and convincing evidence) that claimant's perilymph fistulas were related to intractable vomiting caused by exposure to asphalt fumes at work. In doing so, we noted that, although Dr. Black supported such a relationship for claimant's fistulas, such a theory had not been extended to the remaining vestibular disorders of hydrops and BPPN. Based on Dr. Black's opinion, we concluded that the employer had not clearly and convincingly proven that the fistulas were not compensable. Consequently, we set aside that portion of the employer's denial. Finally, we affirmed those portions of the ALJ's order that had found claimant's encephalopathy and dysthmia not compensable and that had not assessed penalties for allegedly unreasonable claim processing.

Turning to claimant's counsel's attorney fee award for services at the hearing level and on Board review (including three hearings and two Board remands), we awarded $8,000. Claimant's counsel neither sought a specific attorney fee award nor filed a Request for an Assessed Fee under OAR 438-015-0029.

The employer petitioned for judicial review. Claimant filed a cross-petition for review. In support of claimant's position, her counsel submitted a 39-page respondent / cross-petitioner's brief, approximately 30 pages of which addressed the "back-up denial" theory, the compensability of the four conditions that the Board had found were not compensable, the Board's decision not to assess a penalty, and the Board's $8,000 attorney fee award (claimant sought a $23,000 award).

The Court of Appeals disagreed with our determination that the employer's acceptance included claimant's vestibular conditions. Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996). Nonetheless, because we had found only the perilymph fistulas to be compensable using the erroneous ORS 656.262(6) standard, the court determined that it was necessary only to remand for reconsideration regarding the compensability of that condition. The court affirmed those portions of our decision which had found the other vestibular conditions, the encephalopathy, and the dysthymia not compensable. The court did not address claimant's penalty and attorney fee contentions.

Claimant petitioned for Supreme Court review of the Court of Appeals' decision. Specifically, in a 7-page petition, she challenged the Court of Appeals opinion regarding the "back-up denial" issue. The Supreme Court denied the petition. Nordstrom, Inc. v. Windom-Hall, rev den 324 Or 513 (1997).

On remand, neither party sought permission for, nor did we invite, the filing of supplemental briefs. After further consideration, we found that claimant's perilymph fistula condition was compensable. In addition, without discussing claimant's previous $8,000 attorney fee award, we granted a $5,000 fee.

As previously noted, claimant seeks reconsideration of our attorney fee award, submitting her counsel's statement of services for $50,160 for efforts expended at the hearings, Board, and court levels over the nearly 6-year period she has been represented by her attorney. Claimant further asserts that the employer has taken the position that our $5,000 attorney fee award was granted in lieu of our prior $8,000 award.

In response, the employer argues that the $5,000 attorney fee award was reasonable. Noting that our order properly addressed the relevant factors recited in OAR 438-015-0010(4), the employer contends that $5,000 is an appropriate award for finally prevailing over the perilymph fistula portion of its denial.

After further consideration of this matter, including our review of claimant's submission and the employer's objections, we conclude that a reasonable attorney fee award for claimant's counsel's services throughout the hearing, Board, and court levels in finally prevailing over the employer's perilymph fistual condition is $17,000. We base this conclusion on the following reasoning.

To begin, claimant is statutorily entitled only for services directed at the perilymph fistula condition. Under ORS 656.386(1), an attorney fee is awarded when the claimant "finally prevails against" a denied claim. Thus, because claimant prevailed only against the denial of the perilymph fistula condition, an attorney fee can be awarded only for services concerning the compensability of that condition.

Furthermore, a portion of claimant's counsel's "pre-court appeal" services were devoted to eventually unsuccessful arguments regarding "acceptance / back-up denial" theories and the compensability of several denied conditions. In addition, the majority of her counsel's "post-court appeal" services were expended in unsuccessful attempts to either defend our previous "back-up denial" conclusion, reverse our noncompensability decisions on four denied conditions, or petition the Supreme Court for review of the Court of Appeals decision; e.g., some 36 of 46 pages of claimant's respondent's / cross-petitioner's brief and petition addressed these issues. Because these efforts were devoted to issues other than the merits of the compensability of claimant's perilymph fistula condition, her counsel is not entitled to an attorney fee award for such services. Finally, claimant is also not entitled to an attorney fee for her counsel's efforts in seeking an attorney fee. See Amador Mendez, 44 Van Natta 736 (1994).

In reaching our conclusions regarding a reasonable attorney fee award, we find that, in light of the protracted litigation regarding both procedural and substantive questions that claimant's counsel was required to successfully overcome surrounding the medically complex issue of toxic exposure, the compensability of the perilymph fistula issue was more complex than most issues that are presented to the Board for resolution. Although the value of the interest involved and benefit secured to claimant

was unquestionably personally significant to her, such factors are comparable to most cases reviewed by the Board. On the other hand, the nature of these proceedings were both lengthy and complex, involving numerous hearings, two ALJ orders on remand, several Board decisions, and court actions. Throughout these proceedings, claimant's counsel demonstrated a high level of skill in advocating claimant's position. Furthermore, considering the procedural and substantive complexities inherent in establishing the compensability of the fistula condition, there was a significant risk that claimant's attorney would go uncompensated for these efforts.[2] Finally, there were no assertions of frivolous issues.

Consequently, on reconsideration, we find that a reasonable attorney fee award for claimant's counsel's services at all levels regarding the perilymph fistula condition is $17,000, to be paid by the employer. This award is in lieu of all prior attorney fee awards. Accordingly, as supplemented and modified herein, we adhere to and republish our June 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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[2] Our conclusion does not rely on a contingency factor or "multiplier" as applied in a strict mathematical sense. Eg., Lois I. Schoch, 49 Van Natta 788, 790, n 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

In the Matter of the Compensation of
WILLIAM R. SHAPTON, Claimant
WCB Case Nos. 96-06273 & 96-04455
ORDER ON RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our August 27, 1997 Order on Review which assessed a penalty-related attorney fee for untimely discovery. The insurer contends that the attorney fee was not appropriate, as it had not been provided a copy of claimant's signed retainer agreement, and that it released the claim documents to claimant one day after it received the signed agreement. With its request for reconsideration, the insurer provided an affidavit from its claims examiner and relevant portions of the claims file. The insurer requests that we remand the case to the Administrative Law Judge (ALJ) for admission of this additional evidence regarding the discovery issue. We deny the insurer's request for remand.

Remand is appropriate if the record was improperly, incomplete 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 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). Here, at hearing, claimant contended that the insurer failed to timely provide discovery following a May 8, 1996 request. The evidence that the insurer seeks to have admitted on remand addresses whether the May 8, 1996 request was valid. We find no explanation why the proferred evidence was not obtainable with due diligence at the time of hearing. Consequently, remand is not appropriate.

Accordingly, we withdraw our August 27, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our August 27, 1997 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH D. LEGORE, Claimant
WCB Case No. TP-97005
THIRD PARTY ORDER
Nancy F.A. Chapman, Claimant Attorney
Scheminske, et al, Defense Attorneys

Self-Insured Management Services (SIMS), as paying agency, has petitioned the Board for an order resolving the parties' dispute regarding the distribution of proceeds from a third party settlement which arose from the assignment of claimant's cause of action to SIMS. Noting that our prior Third Party Distribution Order[1] did not expressly direct his counsel to endorse the settlement check, claimant asserts that his counsel is under no obligation to carry out our ultimate conclusion that SIMS is statutorily entitled to the entire proceeds of the third party settlement. Claimant further argues that his counsel has a separate, vested interest in a portion of the settlement proceeds for costs and attorney fees and that the Board lacks the authority to order his counsel to endorse the settlement check.

In accordance with ORS 656.591, we hold that we are authorized to resolve the "assignment" dispute, which arises from our prior order. Consistent with our previous determination, we further hold that the parties are required to take any and all actions necessary to achieve the ultimate conclusion reached by our prior final order, i.e., that SIMS is entitled to the entire proceeds of the third party settlement.

FINDINGS OF FACT

The factual background of this case is set out in detail in our prior third party distribution order. We briefly summarize and supplement those facts as follows:

Claimant, a truck driver, was compensably injured on November 27, 1993 when his truck was struck by another vehicle driven by Evelyn Martins. The paying agency (SIMS) accepted claimant's accident-related injuries and, as of November 26, 1996, had paid compensation of $27,505.

At some point in the Fall of 1995, claimant, through his attorney, initiated a civil action against Ms. Martins in the Wasco County Circuit Court, seeking $100,000 in non-economic damages and $24,658 in economic damages. In March 1996, claimant's counsel advised SIMS' counsel that claimant intended to "tender the [third party] claim back to SIMS to proceed to trial." SIMS interpreted claimant's action (the tendering of the claim back to SIMS) as an assignment of claimant's cause of action against the third party pursuant to ORS 656.591.

SIMS' counsel proceeded to pursue the third party action against Ms. Martins. On October 7, 1996, SIMS' counsel wrote to claimant's counsel advising that he had received a settlement offer from Ms. Martins' insurer that could be accepted if claimant would sign a release. SIMS' counsel also noted that the settlement proceeds would be distributed pursuant to ORS 656.591. Claimant's counsel did not respond to this letter, prompting SIMS' counsel to send another letter requesting, among other things, that claimant's counsel and claimant sign a formal assignment document.

SIMS' counsel continued his efforts to secure a settlement of the third party action through negotiations with counsel for the third party defendant. On November 25, 1996, SIMS' counsel wrote to claimant's attorney confirming an oral agreement the parties had reached a few days prior. This letter indicated, among other things, that the third party action would be settled upon payment by Ms. Martins' insurer of $10,000; that the check would be issued to claimant, his counsel and SIMS jointly; that claimant, his counsel and SIMS would sign a release; and that the proceeds of the settlement would be distributed in conformance with a final third party distribution order.

In December 1996, claimant signed a release, and Ms. Martins' insurer issued a check for $10,000, payable to claimant, his attorney and SIMS jointly. On January 31, 1997, the Wasco County Circuit Court entered the Stipulated Judgment of Dismissal in the third party action.

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[1] See Kenneth D. Legore, 49 Van Natta 736 (1997).

Claimant and SIMS then petitioned the Board for resolution of a third party dispute to resolve the following issues: (1) whether claimant assigned his third party cause of action to SIMS pursuant to ORS 656.591; (2) if so, whether the assignment was revoked or the cause of action "reassigned" to claimant by SIMS; and (3) whether the proceeds of the third party settlement should be distributed pursuant to the provisions of ORS 656.591(2) or the formula set forth in ORS 656.593.

On June 10, 1997, the Board issued a Third Party Distribution Order finding, among other things, that claimant had, in fact, assigned his third party cause of action to SIMS and that SIMS was authorized to distribute the proceeds of the third party recovery pursuant to ORS 656.591(2). The Board further found that SIMS' current, uncontested lien of $27,505 attached to the entire $10,000 settlement.[2] This order was not appealed, and became final by operation of law.

Claimant and SIMS have endorsed the settlement check. Claimant's counsel has refused to do so, despite the final distribution order.

CONCLUSIONS OF LAW AND OPINION

As noted above, claimant's counsel challenges our authority to direct her to endorse the settlement check. As a general rule, our authority is limited by statute to "matters concerning a claim." ORS 656.704(3). In the context of third-party issues, the courts have construed "matters concerning a claim" to include those matters that are derivative of a worker's rights or entitlements, such as a claimant's election to assign a third party claim, EBI Companies v. Cooper, 100 Or App 246 (1990), third party distribution, Schlecht v. SAIF, 60 Or App 449 (1982), and the determination of paying agent, SAIF v. Wright, 312 Or 132 (1991).

In this case, ORS 656.591 gives us jurisdiction over the parties and the subject matter of claimant's assignment of his third party claim to SIMS. See EBI Companies v. Cooper, 100 Or App at 249; see also Harvey v. Lou Surcamp Logging, 100 Or App 227 (1990). Because the parties continue to have a dispute regarding the distribution of third party settlement proceeds and because that conflict arises from a disagreement regarding our prior order addressing the assignment of claimant's cause of action under ORS 656.591, we conclude that we are authorized to resolve this matter. See Orman v. SAIF, 131 Or App 653(1994) (Under ORS 656.278, Board had authority to enforce its Own Motion Order); see also Chris A. Meirndorf, 42 Van Natta 2835 (1990) (Board held that a workers' compensation carrier's "post-third party distribution order" acceptance of a check from a claimant's attorney in an amount less than that ordered by the Board's prior appealed order was a partial payment of the carrier's share of the settlement proceeds and did not absolve the claimant's attorney from his obligations under the Board's previous order); Steven B. Lubitz, 40 Van Natta 450 (1988) (Board enforced Third Party Distribution Order by directing a claimant's attorney, who, in contravention of that prior order, had not fully distributed the workers' compensation carrier's share of a third party settlement to the carrier, to reimburse the carrier from the attorney's personal funds).

In our prior order, we held that claimant validly assigned his third party action to SIMS. We directed SIMS' counsel to forward the settlement check to SIMS, so that the proceeds could be distributed pursuant to ORS 656.591(2). Kenneth D. Legore, 49 Van Natta at 740. Although we did not expressly direct claimant's counsel to endorse the check, we did find, based on the record (which included the attorneys' correspondence concerning the third party settlement), that the parties agreed that the check would be issued to claimant, his counsel and SIMS jointly and that the settlement proceeds "would be distributed in conformance with a final third party distribution order." Id. at 737. Claimant neither challenged these findings, nor did he seek inclusion of the "condition" which he presently asserts, i.e., that his counsel would endorse the settlement check only if so directed by the Board. Because our prior order has become final, claimant is now precluded from asserting such a condition. Moreover, such actions are in contravention of both his counsel's prior agreement and the final third party distribution order.

Under ORS 656.591(2), the SIMS' lien applies to 'any sum recovered' by SIMS. See Dennis J. Harvey, 40 Van Natta 1940 (1988), aff'd Harvey v. Lou Surcamp Logging, 100 Or App 227 (1990). As found in our prior, unappealed order, because SIMS' lien ($27,505) exceeded the $10,000 settlement,

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[2] The order did not indicate that claimant's counsel would endorse the settlement check only if so instructed by the Board.

there is no "excess" to which claimant and/or his attorney would otherwise be entitled under the statute.[3] See id. Our prior order directed SIMS' counsel to forward the check to SIMS "as partial reimbursement for its third party lien." This statement, taken in the context of our findings, confirms our intention that SIMS receive the entire $10,000. Implicit in our prior order was the directive that the parties and their counsel take whatever actions were needed to achieve that result. The only way for SIMS to recover the entire $10,000 proceeds is for claimant's counsel to endorse the check.

Accordingly, consistent with our final June 10, 1997 order, the parties and their respective counsels are directed to take any and all actions necessary to carry out our determination that SIMS shall receive the entire $10,000 in settlement proceeds pursuant to ORS 656.591(2).

IT IS SO ORDERED.

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[3] In response to SIMS' request for relief, claimant's counsel asserts that she has a "vested right/interest" and a "contract right of action" to an attorney fee of one third of $10,000 plus costs of $2,050, and that her entitlement to these funds "remains outside the jurisdiction of the Board." While we have no authority to comment on matters outside of this third party dispute, we do have the authority to determine, as we already have in this case, that the paying agency's lien applies to the entire third party settlement under ORS 656.591.

In the Matter of the Compensation of
BRIAN L. SCHMITT, Claimant
WCB Case No. 96-06007
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) found that a letter from a Managed Care Organization (MCO) was part of the Director's reconsideration record under ORS 656.283(7); and (2) set aside an Order on Reconsideration that found claimant's right wrist claim to be prematurely closed. In his appellate briefs, claimant refers to a "post-hearing" letter from the Appellate Unit. We treat such reference as an objection to the ALJ's apparent refusal to consider the letter as a motion to remand for the taking of additional evidence. On review, the issues are evidence, remand, administrative notice, and premature closure. We deny the motion to remand and reverse.

FINDINGS OF FACT

On January 22, 1991, claimant sustained a compensable right wrist injury while lifting and stacking tires. In July 1991, Dr. Appleby, claimant's attending orthopedist, recommended right wrist surgery, consisting of an excisional arthroplasty of the distal ulna with tendon interposition, to relieve claimant's pain. (Ex.33). The insurer then issued a partial denial of the right wrist condition in September 1991 and closed the claim by Notice of Closure on September 30, 1991. An Order on Reconsideration of December 31, 1991 affirmed the closure notice.

In August 1992, a prior ALJ set aside the September 1991 partial denial. In December 1992, Dr. Appleby continued to recommend the same surgical procedure originally proposed for the right wrist condition. (Ex. 50-2). Dr. Appleby reiterated his surgical recommendation in May 1995. (Ex. 54-2).

By Opinion and Order of June 13, 1995, another ALJ set aside as premature the September 30, 1991 closure notice and the December 31, 1991 reconsideration order and remanded the claim for reopening and claim processing. The ALJ specifically found, based on Dr. Appleby's recommendation for surgery, that there was a reasonable expectation for further material improvement in claimant's right wrist condition. (Ex. 55-7). We affirmed the ALJ's order in February 1996. Brian L. Schmitt, 48 Van Natta 295, on recon 48 Van Natta 460 (1996).

In the meantime, on July 21, 1995, the insurer wrote Dr. Appleby and informed him that it had received a copy of a June 19, 1995 MCO notice of lack of medical necessity for the proposed surgery. (Ex. 57-1). The insurer asked Dr. Appleby whether he agreed that there was no alternative treatment for claimant now that the MCO had disapproved surgery and that there had been no appeal of the MCO's decision. Id. Dr. Appleby indicated he did not agree with the insurer. Id.

In a September 11, 1995 letter to the insurer, Dr. Appleby reiterated his surgical recommendation, but stated that the alternative was for claimant to accept his limitations. (Ex. 58).

On March 13, 1996, the insurer again closed the claim by Notice of Closure, as corrected on March 29, 1996. (Exs. 60, 61). However, on June 4, 1996, an Order on Reconsideration issued, rescinding the closure notice and finding that claimant was not medically stationary in light of Dr. Appleby's surgical recommendation. (Ex. 66-4).

The insurer requested abatement and reconsideration of the Order on Reconsideration on June 10, 1996. (Ex. 67). With its abatement request, the insurer enclosed a copy of the June 19, 1995 MCO notice disapproving Dr. Appleby's request for surgery (Ex. 67-3). On June 19, 1996, the Department advised the insurer that the reconsideration order would not be abated and withdrawn because disapproval of the proposed surgery did not alter the conclusion that claimant was not medically stationary. (Ex. 68). The insurer then requested a hearing on June 27, 1996 appealing the reconsideration order.

CONCLUSIONS OF LAW AND OPINION

At the hearing, claimant objected to the admission of the June 19, 1995 MCO surgery disapproval notice, contending that it was not admissible under ORS 656.283(7) because it was not submitted at the reconsideration proceedings that resulted in the June 4, 1996 Order on Reconsideration. The ALJ, however, admitted the document, finding that the surgery disapproval notice was submitted to the Department before filing of the June 27, 1996 hearing request. Reasoning that the Department retained jurisdiction over the matter until the filing of the request for hearing, the ALJ concluded that the disputed document was "submitted at the reconsideration" within the meaning of ORS 656.283(7).

Turning to the merits of the premature closure issue, the ALJ reasoned that, because the only treatment proposed for claimant had been disapproved, and because that decision had become final, he was bound by the determination that the proposed surgery was not necessary for claimant's condition. Based on that determination, the ALJ further concluded that no further material improvement would reasonably be expected from medical treatment. Accordingly, in the absence of proof that claimant's condition would improve with the passage of time, the ALJ found that claimant's wrist condition was medically stationary at claim closure. Therefore, the ALJ modified the reconsideration order to affirm the closure notice.

On review, claimant asserts that the ALJ incorrectly admitted the MCO surgery disapproval notice because it was not submitted at the reconsideration. To bolster his contention that the disputed document was not in the reconsideration record, claimant refers to a January 15, 1997 letter from the Department that confirms the surgery disapproval notice was not submitted until it was attached to the insurer's June 10, 1996 request for abatement of the reconsideration order. Arguing that the reconsideration occurred prior to June 4, 1996, the date the reconsideration order issued, claimant contends that the MCO surgery disapproval notice was not part of the reconsideration record and should not be considered on the issue of premature claim closure. Moreover, claimant asserts that, even if the MCO notice letter was a part of the reconsideration record, its determination that the proposed surgery was not necessary was not binding on claimant. Finally, addressing the merits of the premature claim closure issue, claimant argues that the reconsideration order correctly found that his wrist condition was not medically stationary at claim closure based on Dr. Appleby's recommendation that he undergo surgery.

In response to claimant's contentions, the insurer requests that we strike or disregard all references to the Department's January 15, 1997 letter because the document was not admitted into evidence. The insurer also urges us to affirm the ALJ's decision to admit the June 19, 1995 MCO surgery disapproval notice, arguing that we have the authority to take administrative notice of the document. Claimant also contends that the MCO order is not subject to the evidentiary limitations of ORS 656.283(7) because it is not medical evidence and because it is not relevant to a permanent disability evaluation. Moreover, the insurer argues that the treatment that Dr. Appleby proposes is palliative and cannot serve as the basis for a finding of premature claim closure.

We need not address the insurer's contentions regarding consideration of the Department's January 15, 1997 letter. That is, even if we did not consider the Department's letter, we would still find that the June 19, 1995 MCO surgery disapproval notice was not in the reconsideration record.[1] In addition, we conclude for the following reasons that claimant's wrist condition was not medically stationary at the time the claim was closed in March 1996.

Evidence

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, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), 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 that is not submitted at reconsideration is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. 48 Van Natta at 329. Thus, we concluded that the claimant's testimony at hearing was inadmissible.

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

Here the ALJ determined that the June 19, 1995 MCO surgery disapproval notice was evidence submitted at reconsideration because it was submitted to the Department while it had jurisdiction over the matter, i.e., before the insurer filed a hearing request. However, we are not persuaded that it was part of the reconsideration record given that the Department declined to abate its June 4, 1996 order in light of the MCO notice. (Ex. 68). Although the ALJ cited OAR 436-030-0008(1)(b) and Terry L. Maltbia, 48 Van Natta 1836, 1837 (1996), as support for his decision to admit the disputed MCO document, we find those authorities to be distinguishable.

The administrative rule only provides for abating, withdrawing or amending an Order on Reconsideration if a hearing has not been requested. However, the Department did not abate its reconsideration order. The rule, therefore, provides no authority for the admission of evidence that was not submitted in the reconsideration proceedings. Maltbia is distinguishable because that decision was based on a specific statue that allowed consideration of a "post-reconsideration" medical arbiter report. See ORS 656.268(6)(e); Terry L. Maltbia, 48 Van Natta at 1837. There is no such statutory exception to ORS 656.283(7) in this case that would allow submission of a "post-reconsideration" MCO surgery disapproval notice.

Accordingly, we conclude that the June 19, 1995 MCO document was not part of the reconsideration record and, thus, was not admissible at the hearing on premature claim closure. See ORS 656.283(7). The insurer argues, however, that we have the authority to take administrative notice of the MCO surgery disapproval notice. We disagree.

To begin, any consideration of this document would arguably violate the express prohibition of ORS 656.283(7) pertaining to the inadmissibility of "post-reconsideration" evidence. Nevertheless, we need not conclusively resolve this question because, even if administrative notice was possible in cases subject to the evidentiary limitations of ORS 656.283(7), such notice would not be warranted in this case. Our conclusion is based on the following reasoning.

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[1] Given this determination, we need not determine whether we should remand the case for admission of the January 15, 1997 letter. See ORS 656.295(5).

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." Rodney J. Thurman, 44 Van Natta 1572 (1992). This has been held to include agency orders and stipulations by the parties. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Jenetta L. Gans, 41 Van Natta 1791 (1989); Susan K. Teeters, 40 Van Natta 1115 (1988). However, because the MCO document is not an agency order or stipulation of the parties, we decline to take administrative notice of it.

We also reject the insurer's contention that ORS 656.283(7) is inapplicable because the MCO document is not "medical evidence" and because the statute only applies to permanent disability cases. As previously noted, we have held that the statutory limitations on evidence are applicable to cases involving premature claim closure. Arlie B. Tompkins, 48 Van Natta at 1665. In addition, as the insurer notes, ORS 656.283(7) refers generally to "evidence," not just the narrow category of "medical evidence."

In conclusion, we find that the June 19, 1995 MCO surgery disapproval letter was not submitted at the reconsideration proceeding. Therefore, ORS 656.283(7) prohibits its consideration with regard to the premature claim closure issue.[2] Having made this determination, we now proceed to the merits.

Premature Claim Closure

In June 1995, an ALJ set aside the September 1991 closure notice and subsequent December 1991 reconsideration order because Dr. Appleby's recommendation that claimant undergo surgery indicated that there was a reasonable expectation of further material improvement in claimant's wrist condition with surgery. (Ex. 55-7). The ALJ's determination was affirmed by the Board. Brian L. Schmitt, 48 Van Natta at 297. Although the insurer is correct that this determination was relevant to claimant's condition at the time of the claim closure in 1991, Dr. Appleby has consistently maintained that claimant should undergo the recommended surgery, as recently as March 1996. (Ex. 59). Moreover, the insurer concedes (insurer's brief page 3), and we find, that there has been no change in claimant's condition since 1991.

Thus, we conclude that there has been no material change in the operative facts of the claim. Therefore, consistent with our prior finding that the recommended surgery would be expected to materially improve claimant's right wrist condition, we again conclude that claimant is not medically stationary. See ORS 656.005(17). It follows that the Order on Reconsideration correctly determined that the March 29, 1996 Notice of Closure prematurely closed the claim. Therefore, we reverse the ALJ's decision and reinstate the June 4, 1996 reconsideration order.[3]

Attorney Fees

Claimant has requested Board review, which has resulted in a decision that may create additional compensation. In light of such circumstances, his counsel is entitled to an attorney fee payable from any increased temporary disability compensation created by this order. See ORS 656.386(2); OAR 438-015-0055; Trever McFadden, 47 Van Natta 790, 792 (1995); Dianne M. Bacon, 43 Van Natta 1930, 1931 (1991). That fee, which is payable directly to claimant's attorney, shall be equal to 25 percent of any increased temporary disability compensation created by this order, not to exceed $3,800.

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

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[2] We leave for resolution in another case the question of whether our decision regarding the merits of the premature claim closure issue would be different had the MCO surgery disapproval letter been part of the reconsideration record.

[3] Although concurring with the result in this case, Board Member Haynes notes that there is nothing to prevent the insurer from reclosing the claim and insuring that the MCO surgery disapproval letter is part of any future reconsideration record.

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

After consideration of the aforementioned factors and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $2,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the premature closure issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, the nature of the proceeding, and the risk that claimant's counsel might have gone uncompensated. Finally, we have not considered claimant's counsel's services rendered on Board review.

ORDER

The ALJ's order dated March 13, 1996 is reversed. The June 4, 1996 Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded 25 percent of any increased temporary disability compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. Claimant's attorney is also awarded an assessed fee of $2,800 for services at hearing, to be paid by the insurer.

In the Matter of the Compensation of
WALTER E. TAYLOR, Claimant
Own Motion No. 97-0443M
OWN MOTION ORDER DENYING CONSENT
TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, Moore, et al, Claimant Attorneys
Liberty Northwest, Insurance Carrier

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1988 injury claim with Liberty NW Insurance Corp expired June 2, 1992. 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.

On June 16, 1997, the Board issued an Own Motion Order denying claimant's request for own motion relief because the record submitted to us failed to demonstrate that claimant requires surgery or hospitalization now or in the near future (Own Motion case no. 97-0294M).

The record contains no request for surgery for claimant's compensable L-5 strain condition. Thus, the record fails to establish that there has been a worsening of the compensable injury which requires inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, based on this record, the Board may not authorize the payment of temporary disability compensation on its own motion.

Accordingly, the Board is without authority to consent to an order designating a paying agent for the purposes of temporary disability compensation. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-060-0180(13).

IT IS SO ORDERED.

In the Matter of the Compensation of
TAMITHA A. BARENDRECHT, Claimant
WCB Case No. 97-00034
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to award temporary disability from February 24, 1995 through December 24, 1995; and (2) did not assess penalties for allegedly unreasonable claim processing. Submitting a "post-hearing" medical report, claimant asks that the record be "reopened." We treat this submission as a motion to remand for the taking of additional evidence. On review, the issues are remand, temporary disability, and penalties.

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

Remand

Claimant has submitted a "post-hearing" medical report dated June 5, 1997 from physicians in Colorado and alleges that the report establishes that she has never been medically stationary. 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 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).

Here, we find that the submitted medical report is not reasonably likely to affect the outcome of the case because we conclude that it is not relevant to the issue of whether claimant was entitled to temporary disability from February 24, 1995 through December 24, 1995. Accordingly, we deny claimant's motion for remand and proceed to the merits of the temporary disability issue.

Temporary Disability

The ALJ denied claimant's request for procedural temporary disability, finding that claimant's treating physician, Dr. Malos, did not authorize temporary disability after February 8, 1995. See ORS 656.262(4)(f). On review, claimant contends that she is entitled to temporary disability during the disputed period because she did not need to comply with ORS 656.262(4)(f) because her claim was in denied status. Claimant's contention notwithstanding, we agree with the ALJ that claimant was not entitled to the requested temporary disability.

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

In this case, one of claimant's attending physicians, Dr. Young, authorized temporary disability on July 28, 1994. (Ex. 1). Eventually, Dr. Malos performed surgery on August 19, 1994. (Ex. 9). This record does not contain any authorizations of temporary disability after claimant's surgery. (Ex. 10). On January 11, 1995, an examining physician, Dr. Fuller, opined that claimant was medically stationary and able to perform medium work. (Ex. 11). Dr. Malos concurred with Dr. Fuller's report, except that he would restrict claimant's lifting to 25 pounds. (Ex. 12).

We agree with the ALJ that, under these circumstances, Dr. Malos had "cease[d] to authorize" temporary disability by the time the insurer terminated payment of temporary disability on February 25, 1995, shortly before its March 1, 1995 "back-up" denial.[1] Cf. Elizabeth Berntsen, 49 Van Natta 85 (1997) (attending physician "ceased" to authorize temporary disability when he stated that he assumed the claimant was doing well because the claimant had not sought further care); 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 authorize temporary disability). Accordingly, we find that the ALJ correctly denied claimant's request for temporary disability during the disputed period.[2] Therefore, we affirm.[3]

ORDER

The ALJ's order dated April 16, 1997 is affirmed.

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[1] The record does not disclose whether Dr. Malos ever authorized temporary disability. However, even assuming that he did, such authorization "ceased" by the time the insurer terminated payment of temporary disability on February 25, 1995.

[2] Claimant moved to Colorado on February 1, 1995, where she sought treatment from physicians in that state. Claimant does not contend that she was entitled to temporary disability based on their medical reports. In fact, claimant alleges that those physicians could not be "attending" physicians because her claim was in denied status when treatment was provided. (Appellant's brief page 5).

[3] Given our resolution of this dispute, it follows that the insurer's claim processing was not unreasonable.

In the Matter of the Compensation of
HABACUC R. DIAZ, Claimant
WCB Case Nos. 96-07263 & 96-04606
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its denial of claimant's occupational disease claim for right forearm extensor tendonitis; and (2) upheld AIG's denial of claimant's claim for the same condition. On review, the issue is responsibility.

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

Finding that claimant's employment at SAIF's insured actually caused claimant's tendinitis condition, the ALJ found that SAIF was responsible for claimant's claim. On review, SAIF argues that because the insurers have conceded compensability by requesting designation of a paying agent, compensability is not at issue and AIG may not argue actual causation as a responsibility defense. We disagree.

We have held that 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 in determining responsibility. Melvin A. Melton, 49 Van Natta 256, 257 (1997); Eva R. Billings, 45 Van Natta 2142 (1993). Moreover, a concession of compensability does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment. See Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992). Thus, we reject SAIF's argument that AIG may not argue that claimant's disability was actually caused by his employment at SAIF's insured.

We agree with the ALJ that the evidence supports a conclusion that claimant's employment at SAIF's insured actually caused claimant's condition. According to Dr. Arthur, the only medical expert to address causation, claimant's condition was caused by his work activities at SAIF's insured using scissors to trim trees and lifting heavy things. (Ex. 10-14). Although Dr. Arthur also indicated that claimant's general construction work at AIG's insured would exacerbate claimant's symptoms, she attributed claimant's tendinitis to claimant's work activities at SAIF's insured. Dr. Arthur based her conclusion on the history given to her by claimant at the time of his treatment.

SAIF argues that the ALJ should have relied on claimant's testimony at hearing regarding the onset of his symptoms rather than the history recorded by Dr. Arthur at the time of claimant's treatment. Claimant's hearing testimony, given through an interpreter, was contrary to the history taken by Dr. Arthur. At hearing, claimant testified that his symptoms began while he was working for AIG's insured rather than SAIF's insured.[1] By contrast, claimant had told Dr. Arthur at the time of his treatment that his symptoms began while employed by SAIF's insured and that his work activities trimming trees and lifting caused the symptoms.

Claimant is not fluent in English. Claimant indicated that Dr. Arthur knew a little Spanish and that someone in Dr. Arthur's office also knew some. The ALJ found that claimant's statements given at the time of the treatment and on the 827 form, which was filled out at that time, were likely to be more accurate than claimant's testimony which was given several months later at the hearing. Claimant's wife, who speaks Spanish and is fluent in English, filled out the 827 form based on what claimant told her. The history taken by Dr. Arthur at the time of claimant's treatment is consistent with the form 827.

We agree with the ALJ that the information on the form 827 is likely to be more accurate than what claimant recalled at hearing several months later. The 827 form was filled out at the time of claimant's treatment by his wife, who is fluent in Spanish, based on what claimant told her at the time. The form 827 indicates that the date of injury was March 5, 1996 while claimant was still working for SAIF's insured. Under such circumstances, we are persuaded that the history given to Dr. Arthur soon after the injury is more accurate than the hearing testimony given several months later.

ORDER

The ALJ's order dated April 8, 1997 is affirmed.

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[1] Claimant's hearing testimony is somewhat ambiguous. He first testified that he went to see a doctor because he developed a lump in his hand and that there were no other symptoms. (Tr.10). When asked at what point his hand first started to bother him, claimant replied: "When I didn't feel good." (Tr.11). He then testified that he was not working for SAIF's insured when he first noticed the knot in his hand. (Id.). However, the contemporaneous medical reports establish that claimant sought medical treatment for pain and tenderness in addition to localized swelling. (Exs. 2, 6).

In the Matter of the Compensation of
KAREN A. MABEN, Claimant
WCB Case No. 96-10887
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Moscato, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to admit "impeachment evidence" offered by claimant in response to an opinion presented by an insurer-arranged medical examiner; and (2) upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome. On review, the issues are evidence and compensability.

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

Evidence

Claimant argues that the ALJ erred by declining to admit Exhibits A and B as "impeachment evidence" against Dr. Radecki. The ALJ concluded that, even if he gave no weight to Dr. Radecki's opinion, claimant was unable to satisfy her burden of proof.

We need not address claimant's evidentiary argument because we agree with the ALJ that, even if we disregard Dr. Radecki's opinion in its entirety, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused his discretion by not admitting Exhibits A and B. See Jose L. Duran, 47 Van Natta 449 (1995); Larry D. Poor, 46 Van Natta 2451 (1994).

Compensability

We agree with the ALJ that the medical evidence is unanimous that claimant's carpal tunnel syndrome preexisted her work activities at the employer. Therefore, she must prove that her employment conditions were the major contributing cause of the combined condition and pathological worsening of her bilateral carpal tunnel syndrome. ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 2220 (1995).

Claimant relies on the opinion of Dr. Balkovich. Dr. Balkovich reported:

> "I think the cause of her carpal tunnel syndrome is multifactorial and that it pre-existed her position at [the employer]. However, I have had extensive discussions with [claimant] about her use of her hands at [the employer] and it was very intensive for long hours. Based on that, I feel that the major contributing cause of the worsening of her symptoms is due to the heavy use of her hands at her [employment] position." (Ex. 31).

We acknowledge that no incantation of "magic words" or statutory language is required, provided that the opinion otherwise meets the appropriate legal standard. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992). However, Dr. Balkovich's opinion indicates only that claimant's work activity caused a symptomatic worsening. There are no medical opinions that establish that her work activity at the employer was the major contributing cause of a pathological worsening of her preexisting carpal tunnel syndrome. Therefore, we agree with the ALJ that claimant has failed to satisfy her burden of proof.

ORDER

The ALJ's order dated April 1, 1997 is affirmed.

In the Matter of the Compensation of
RICHARD J. RIVERA, Claimant
WCB Case No. 95-04359
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a mental disorder; and (2) did not assess penalties for an allegedly unreasonable denial. Claimant also moves to strike the employer's respondent's brief as untimely filed. On review, the issues are claimant's procedural motion, compensability, and penalties. We grant claimant's motion and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike the employer's respondent's brief on the basis that it was not timely submitted. We grant claimant's motion based on the following reasoning.

The employer's respondents' brief was due on July 25, 1997. It was received by the Board on July 28, 1997. The employer asserts that it mailed its respondent's brief on July 23, 1997, but acknowledges that the brief was returned due to an inadvertent failure to provide postage. We do not consider the employer's failure to provide postage sufficient to constitute extraordinary circumstances beyond its control. See OAR 438-0011-0020(3); Curtis A. Miller, 48 Van Natta 2231 (1996) (calendaring error which caused untimely filing does not constitute extraordinary circumstances). Accordingly, claimant's motion to grant the employer's respondent's brief is granted and the brief has not been considered on review.

Compensability

We adopt the conclusions and reasoning as set forth in the ALJ's order with the exception of fourth, fifth, and sixth sentences of the first full paragraph on page 7 of the order. In addition, we add the following supplementation.

The ALJ found that claimant's testimony was not credible based on claimant's demeanor at hearing, as well as the record. For the reasons set forth in the ALJ's order, we agree with this finding. Consequently, the medical opinions which support claimant's claim are based on an inaccurate history and are therefore not persuasive. See Miller v. Granite Construction Co., 77 Or App 473, 476 (1977). Under these circumstances, claimant has not carried his burden of proving that his claim for a mental disorder is compensable.

Penalties

We adopt the conclusion and reasoning set forth in the ALJ's order with the following supplementation.

We have affirmed the ALJ's order upholding the employer's denial. Therefore, there has been no unreasonable resistance to the payment of compensation. James G. Harris, 47 Van Natta 2367 (1995). Under such circumstances, claimant is not entitled to a penalty. Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated March 21, 1997 is affirmed.

In the Matter of the Compensation of
FELICIANO R. VALDIVIA, Claimant
WCB Case No. 96-10338
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) found that claimant had established good cause for his untimely hearing request; and (2) set aside the insurer'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 affirm.

FINDINGS OF FACT

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

The second sentence of the fourth paragraph of the ALJ's findings of fact is corrected to read as follows: "His pain remained that way until he went to work that afternoon at 3 p.m."

The last sentence of the fifth paragraph of the ALJ's findings of fact is corrected to read as follows: "Claimant was next examined by Dr. Gasser, a chiropractor, on referral from Dr. Stringham. . ."

The second sentence of the sixth paragraph of the ALJ's findings of fact is corrected to read as follows: ". . . and he became medically stationary on August 19, 1996."

The eighth paragraph of the ALJ's findings of fact is replaced with the following paragraph.

Claimant first learned of the denial a few days before November 8, 1996, when an unidentified person called claimant and informed him that his claim had been denied. Claimant explained that he had never seen the denial letter, and the person promised to send claimant a copy of the letter in Spanish. (Tr. 18-19). Claimant never received another copy of the denial letter in the mail. (Tr. 19). Claimant first saw the denial letter when he went to Dr. Gasser's office on November 8, 1996, and Dr. Gasser's staff showed him the doctor's copy of the letter. (Ex. 15; Tr. 19).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established good cause for his untimely request for hearing, and set aside the insurer's denial of claimant's low back condition. We agree with the ALJ's reasoning and conclusions, but we write to address the insurer's arguments on review.

The ALJ found claimant to be a credible witness, based on the ALJ's observation of claimant's demeanor at the hearing. The ALJ also noted that claimant's testimony was consistent throughout the hearing. On review, the insurer argues that claimant is not credible. We defer to the ALJ's credibility findings based on his observation of claimant's demeanor. However, the ALJ is in no better position than we are to evaluate claimant's credibility based on the substance of his testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). After our review of the record, we are unable to find any material inconsistencies in the record that cause us to find claimant's testimony not credible. Accordingly, we agree with the ALJ's determination that claimant's testimony is credible.

The insurer also argues that claimant did not act with due diligence after he first learned of the denial. We disagree. Claimant credibly testified that he received a telephone call "a few days" before he first saw the denial letter at Dr. Gasser's office.[1] Claimant explained that the caller promised to send

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[1] The insurer contends that claimant received the telephone call two weeks before he saw the letter in Dr. Gasser's office. Consequently, the insurer contends that claimant did not act with due diligence upon first learning of the denial. In response to the insurer's counsel's question whether claimant waited "a couple of weeks" before inquiring at Dr. Gasser's office, claimant testified, "It may be possible, but --- because I don't remember how many days exactly." (Tr. 34). However, based on claimant's testimony as a whole, we find that the greater weight of evidence indicates that claimant inquired at Dr. Gasser's office no more than "a few days" after receiving the telephone call. (See Tr. 19, 33-34).

another copy of the denial letter to him, which he never received. Claimant acted promptly by inquiring at his doctor's office a few days after the telephone call, and by obtaining an attorney a few days after he actually saw the denial letter. Under such circumstances, we agree with the ALJ that claimant established good cause for his untimely hearing request.

Finally, the insurer contends that claimant failed to establish he actually sustained an injury at work. Again, we disagree. As noted above, we agree with the ALJ's determination that claimant's testimony is credible and consistent. Likewise, we find no basis for disturbing the ALJ's determination that Ms. Ventura's testimony was not credible. Claimant's credible testimony established that he sustained an injury at work when he turned quickly and went down a 12 to 18-inch step on July 29, 1997. (Tr. 11; see also Tr. 27, 30, 45). Moreover, claimant's testimony is not inconsistent with the description of the injury on the 827 form. (Ex. 5). Claimant testified that he turned quickly because one of his bean lines was very full, lowered his right foot down to the bottom of the step, and felt a "lump" in his lower back when he tried to move his other leg, so that he could not walk right. (Tr. 11). Claimant's testimony is not inconsistent with the incident description on the 827 form. (Ex. 5). Furthermore, we find that Dr. Stringham's report was based on an accurate history and is persuasive and sufficient to establish the compensability of claimant's low back condition.

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

ORDER

The ALJ's order dated March 11, 1997 is affirmed. For services on review, claimant's counsel is awarded a $1,000 attorney fee, to be paid by the insurer.

In the Matter of the Compensation of
SHERI L. EVANS, Claimant
WCB Case No. 96-08800
ORDER ON REVIEW
Max Rae, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller, Bock, and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that increased her unscheduled permanent disability award for a low back condition from 8 percent (25.6 degrees), as awarded by Order on Reconsideration, to 11 percent (35.2 degrees). In its respondent's brief, the self-insured employer challenges the portions of the ALJ's order that increased claimant's unscheduled permanent disability award and affirmed the Order on Reconsideration award of 5 percent (7.5 degrees) for loss of use or function of the right leg (knee). On review, the issues are extent of permanent disability, scheduled and unscheduled.

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

Scheduled Disability

On review, both claimant and the employer challenge the ALJ's affirmance of the Order on Reconsideration award of 5 percent scheduled permanent disability for the right knee condition. We find, however, that the employer waived its challenge to the scheduled disability award prior to the scheduled date of hearing.[1]

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[1] The hearing was scheduled for December 19, 1996, but the parties elected to submit this matter based on the documentary record and a hearing was not convened.

Waiver is the intentional relinquishment of a known right. Drews v. EBI Companies, 310 Or 134, 150 (1990); Wright Schuchart Harbor v. Johnson, 133 Or App 680, 685 (1995). Generally, the question of whether a waiver has occurred is resolved by examining the particular circumstances of each case. Johnson, 133 Or App at 686. Here, in response to claimant's hearing request, the employer cross-appealed the reconsideration order, contending "[t]hat the award of permanent disability is excessive." (Pleadings file). Subsequently, by letter dated October 23, 1996, the employer's counsel advised the ALJ that the employer was "dropping" its cross-appeal of the reconsideration order's permanent disability award. The letter further stated: "It is the employer's position that the permanent disability awarded by the September 23, 1996 Order on Reconsideration is correct and should be affirmed." (Pleadings file). The employer did not alter this position prior to issuance of the ALJ's order.

We conclude that the employer's October 23, 1996 letter was an explicit and intentional relinquishment of its cross-appeal of the permanent disability awarded by the reconsideration order. Having waived its cross-appeal at the hearings level, the employer may not revive its challenge on Board review.

We turn to claimant's challenge. She contends that the ALJ erred in using contralateral joint comparison to rate the loss of range of motion (ROM) in her right knee. Former OAR 436-035-0007(22)[2] provides that "[t]he range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease." Subparagraph (b) of the rule further provides: "When the contralateral joint has a history of injury or disease, the findings of the injured joint shall be valued based upon the values established under these rules."

Claimant argues that, because she has had surgery to her left knee, the right knee ROM should be rated based upon the values in the standards, rather than a contralateral joint comparison to the left knee. We disagree. As the ALJ observed, the only mention of left knee surgery in the record was claimant's report to the medical arbiter, Dr. Scheinberg, that she had left knee surgery at age 16 to "move the kneecap." (Ex. 88-2). There is no indication that the surgery to "move the kneecap" was the result of an injury or disease affecting the left knee.

Nor are we willing to interpret the surgery itself as an "injury or disease" to the knee joint. See Serafin C. Lopez, 49 Van Natta 874 (1997) (under OAR 436-035-0007(22), in the absence of persuasive medical evidence of a history of injury or disease to the noncompensable contralateral joint, it is appropriate to rate a worker's permanent disability for a compensable body part by comparing impairment findings for the injured joint with such findings for the contralateral joint). "Injury" is defined as "harm or hurt; a wound or maim. Usually applied to damage inflicted to the body by an external force." Dorland's Illustrated Medical Dictionary 668 (26th ed. 1981). There is no medical evidence in the record to support a finding that claimant's left knee joint was "hurt," "harmed," "wounded" or "maimed" by the surgery. So far as this record discloses, claimant's surgery could as easily have been directed toward increasing a congenitally reduced ROM in the knee joint as it could have resulted in more restrictive ROM than is normal for this worker. We are not permitted to speculate as to the cause or effect of claimant's surgery.[3]

Because claimant bears the burden of establishing the extent of her permanent disability, see ORS 656.266, we agree with the ALJ's conclusion that there is insufficient evidence in the record to prove the left knee has a history of injury or disease. Accordingly, claimant's right knee ROM was properly rated based upon comparison to the contralateral joint (left knee).

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[2] 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. OAR 436-035-0003(2).

[3] Our holding should not be interpreted as a ruling that a history of surgery to a contralateral joint can never be sufficient proof of an "injury" to the joint. We conclude, rather, that the record in this case is not sufficient to prove that the knee surgery resulted in "injury" to the knee joint.

Unscheduled Disability

The ALJ increased claimant's unscheduled permanent disability award from 8 percent, as awarded by Order on Reconsideration, to 11 percent. The increased award was based on the ALJ's finding that claimant's residual functional capacity (RFC) is medium/light. On review, claimant contends that her RFC should be rated as sedentary, while the employer contends that it should be medium.

RFC means the worker's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. Former OAR 436-035-0310(3)(b). RFC is the greatest capacity evidenced by: (1) the attending physician's release; or (2) a preponderance of medical opinion which includes, but is not limited to, a second-level PCE or WCE or any other medical evaluation which includes, but is not limited to, the worker's capability for lifting, carrying, pushing/pulling, standing, walking, sitting, climbing, balancing, stooping, kneeling, crouching, crawling and reaching. Former OAR 436-035-0310(5). Where a worker fails to cooperate or use maximal effort in the evaluation, the medical opinion of the evaluator may establish the worker's likely RFC had the worker cooperated and used maximal effort. Former OAR 436-035-0310(5)(b).

Claimant argues that her RFC is sedentary based on the results of the March 26, 1996 physical capacity evaluation (PCE) by physical therapist Colleen Guido. During the PCE, claimant demonstrated the ability to perform in the sedentary work range. (Ex. 71-5). However, the evaluator noted frequent verbal and non-verbal complaints of pain, and observed that claimant put forth less than full effort on the dynamometer. (Id.) The evaluator opined that claimant's PCE "performance was limited by her perceived pain and is not a valid measure of her current physical capacities." (Id.) Nevertheless, the evaluator recommended symptom management techniques to assist in maximizing claimant's physical abilities, and discussed the use of microbreaks and ice to mitigate symptoms during the work day. (Id.)

Claimant's attending physician, Dr. Donovan, reviewed the PCE report, declared claimant's condition medically stationary, and reported that she would change claimant's work restrictions to full-time, sedentary range with the ability to change positions frequently for comfort. (Ex. 72).

Claimant was then examined by a panel of medical arbiters, Drs. Ballard, Brown and Scheinberg. They found that claimant's spinal ROM did not meet the straight leg raising validity test. (Ex. 91-2). They diagnosed chronic pain complaints in the low back and right hip but opined "there is no reason to limit [RFC] due to the accepted condition." (Ex. 91-8).

After reviewing the medical evidence, we agree with the ALJ's assessment of claimant's RFC. Although the PCE evaluator observed claimant demonstrate the ability to perform in the sedentary work range, the evaluator noted that claimant's performance was not a valid measure of her current physical capacity. (Ex. 71-5). Dr. Donovan imposed sedentary work restrictions based on the PCE findings, (Ex. 72-2), but she did not offer any opinion about the validity of claimant's performance during the PCE. Given the PCE evaluator's reservation about claimant's performance, we conclude that the PCE findings, as well as Dr. Donovan's sedentary work restrictions based on those findings, are unreliable.

At the same time, however, we are persuaded that claimant has sustained some degree of limitation on her ability to lift and perform the medium work demands of her base functional capacity (BFC). In this regard, we rely on the PCE evaluator's recommendation that claimant use symptom management techniques to maximize her physical abilities and mitigate symptoms throughout the work day. (Ex. 71-5). The evaluator's recommendation for symptom management, despite claimant's invalid performance during the PCE, indicates some degree of functional limitation. The medical arbiter panel's opinion that claimant has no functional limitation is unpersuasive because it is unexplained and does not appear to be consistent with claimant's chronic low back pain. Based on our review of the record, we conclude that a preponderance of the medical evidence supports the finding that claimant's RFC is medium/light.[4] Accordingly, the ALJ's order shall be affirmed.

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[4] Given our finding that claimant's RFC is medium/light, we need not address claimant's contention that the employer lacked standing to argue that her RFC should be rated as medium.

Claimant's attorney is entitled to an assessed attorney fee for services on Board review in defending against the employer's request for reduction in claimant's award. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable attorney fee for claimant's attorney's services on review in defending against a reduced award is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the reduction issue (as represented by claimant's reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 9, 1997 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $500, payable by the self-insured employer.

Member Bock specially concurring.

Although I concur with the decision that the extent of claimant's permanent disability should be determined based on the "comparison rating method" of OAR 436-035-0007(22), I write separately to clarify my opinion.

Based on William L. Fishbach, 48 Van Natta 1233 (1996) and its progeny, I feel compelled to follow case precedent which effectively reads the word "medical" as a modifier for "history of injury or disease" as used in the rule. Nonetheless, I would note that such an interpretation of the rule causes us to essentially discard this injured worker's statements regarding her history of left knee surgery absent medical evidence that such surgery damaged the joint so as to preclude comparison.

Board Chair Hall dissenting in part.

While I recognize that the majority decision is limited to the specific facts in this case (see fn. 3), I nevertheless respectfully dissent from the majority's decision to not find that claimant's contralateral (left) knee joint has a "history of injury" within the meaning of OAR 436-035-0007(22).[1] Claimant reported to the medical arbiter, without contradiction, that she had left knee surgery to "move the kneecap" at age 16. The majority finds that uncontradicted report to be insufficient proof of an "injury" to the left knee; it relies on Dorland's Medical Dictionary to conclude that the prior surgery could just as easily have benefited claimant's knee, as it could have "injured" the knee.

To begin, OAR 436-035-0007(22) does not require proof of any resulting "restrictive ROM" or other lasting negative consequence. The OAR, on its face, requires only "a history" of injury or disease to the contralateral joint. While I agree with the majority that it is claimant's burden to establish permanent partial disability and that we cannot speculate, it is equally true that we cannot require claimant to prove more than "a history" of injury or disease. I submit that the majority is requiring claimant to prove some form of lasting injurious effect of the surgery, rather than accepting the surgery itself as injurious. Further, the majority is requiring claimant to establish more than "a history" of injury by requiring claimant to produce "persuasive medical evidence" of such a history.

Using the majority's own definition of "injury" (harm or hurt; a wound or maim), I would submit that knee surgery itself (to move the kneecap) was sufficiently invasive and wounding to qualify as an injury. It is immaterial whether the surgery ultimately had a lasting effect (good or bad). By definition, the prior surgery constituted an "injury." Claimant's uncontradicted report of the surgery constitutes "a history." Therefore, claimant's right knee ROM should not be rated by contralateral joint comparison. Rather, based on the standards for rating ROM in the right knee, I would conclude that claimant is entitled to an additional scheduled disability award for the right knee.

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[1] The majority's citation to Serafin C. Lopez, 49 Van Natta 874 (1997), does not assist in resolving the issue before us. Lopez addresses the lack of evidence of "a history of injury or disease" but does not define either "history" or the terms "injury or disease."

In the Matter of the Compensation of
JOAN L. KEARNS, Claimant
WCB Case No. 96-04693
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of claimant's occupational disease claim for a L5-S1 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer since 1992, first in Maine and then in Oregon beginning June 1995. While working in Maine, she had two work-related back injuries, one in 1992 and one in late July 1994. In March 1996, claimant was diagnosed with a herniated disc at L5-S1 and surgery was performed on April 24, 1996.

The ALJ found that claimant's low back/radiculopathy condition arose during her employment with the employer, but it predated her Oregon employment. The ALJ determined that claimant had previously accepted claims for the low back condition that formed the basis of the current Oregon claim. The ALJ reasoned that, because claimant had a preexisting condition, she must prove that her Oregon work exposure was the major contributing cause of the combined condition and pathological worsening of her condition under ORS 656.802(2)(b). The ALJ concluded that claimant did not sustain her burden of proof.

Citing Silveira v. Larch Enterprises, 133 Or App 297 (1995), and Charlene A. Dieringer, 48 Van Natta 20 (1996), claimant contends that her overall employment activities were the major contributing cause of the herniated disc at L5-S1.[1]

The insurer argues that, because claimant has a previous, accepted out-of-state claim for the same condition, ORS 656.802(2)(b) applies to this case. We disagree.

In Silveira, the court held that for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws. 133 Or App at 302-03. The court cited Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), which had held that, in determining whether a disease is work related, the rule of proof aspect of last injurious exposure rule allows consideration of all employments, even those that could not ultimately be held responsible for the claim. The court also relied on Progress Quarries v. Vaandering, 80 Or App 160 (1986), for the proposition that a claimant is not required to file a claim with other potentially causative out-of-state employers in order to receive compensation in Oregon.

Here, claimant seeks to establish compensability of a herniated disc at L5-S1. Claimant has worked for the employer since 1992. Although the medical reports indicate that claimant had back pain preceding her employment, the medical evidence does not establish that claimant's herniated disc

[1] We note that claimant also filed a claim in Maine. In January 1996, the claim was denied on the basis that her current problems were not related to the July 31, 1994 injury. (Ex. 19). Claimant did not challenge the denial. (Tr. 24-25).

condition preceded her work at the employer.[2] Based on Silveira v. Larch Enterprises, claimant may rely on all of her employments, even those not subject to Oregon's workers' compensation laws, for purposes of establishing that her L5-S1 disc condition is work related.

ORS 656.802(2)(b) applies only "[i]f the occupational disease claim is based on the worsening of a preexisting disease or condition * * *." Under ORS 656.005(24), a "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 * * *." (Emphasis added).

This is the initial claim for claimant's L5-S1 herniated disc. There is no evidence that claimant had a herniated disc condition at L5-S1 before she began working for the employer in 1992. Therefore, we conclude that there is no L5-S1 herniated disc condition that preexisted the initial onset of this claim. Because claimant's occupational disease claim is not based on the worsening or combining of a preexisting disease or condition, neither ORS 656.802(2)(b) nor ORS 656.005(7)(a)(B) apply to this case. See Thomas R. Smith, 48 Van Natta 2132 (1996); Dieringer, 48 Van Natta at 21.

To establish the compensability of her L5-S1 disc condition under ORS 656.802(2)(a), claimant must prove that her work activities for the employer, including her employment in Maine, was the major contributing cause of her herniated disc at L5-S1.

In June 1995, claimant transferred to Portland, Oregon. (Tr. 15-16). As we discussed earlier, claimant testified that after her recovery from the 1994 back injury, she did not have back pain again until early in fall 1995. (Tr. 9-10). In September 1995, claimant flew to Hawaii and was uncomfortable sitting for a prolonged time. (Tr. 17). She had pain down her right leg. (Id.)

On October 31, 1995, claimant was examined by Dr. Nicoski and she reported daily back pain for the last several months. (Ex. 12a). She had pain radiating down the back of her right leg to her calf and occasionally to her foot. Dr. Nicoski prescribed medication and physical therapy.

Claimant began working as a ticket counter agent on December 1, 1995. (Tr. 10). That position occasionally involved helping passengers lift luggage on a conveyor belt. (Tr. 11). She had some difficulty sitting at her work area due to back and leg pain. (Tr. 25-26).

In January 1996, claimant assisted a young woman in placing a large bag on the conveyor belt. Claimant estimated that the bag weighed over 50 pounds and by the end of the day, she was extremely uncomfortable. (Tr. 12-13). Claimant had the next two days off and rested. When she returned to work, however, she could not complete her shift due to back pain. (Tr. 13).

Claimant sought treatment from Dr. Nicoski on January 22, 1996, reporting that her low back pain was not getting any better. (Ex. 12a-1). She had pain radiating down the back of her right leg. Dr. Nicoski referred claimant to a neurosurgeon, Dr. Markham.

An MRI in March 1996 showed a substantial herniation at L5-S1. (Ex. 23). On April 26, 1996, Dr. Markham performed a right L5-S1 lumbar laminotomy with microdiscectomy. (Ex. 26A).

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[2] Moreover, regarding claimant's back injuries while working for the employer in Maine, we are not persuaded by the insurer's argument that those injuries were for the "same condition" as her current condition. Claimant sustained two back injuries while working for the employer in Maine. On November 21, 1992, claimant injured her back when she was lifting and moving a heavy bag. She was diagnosed with a low back strain and was released to regular duties on November 26, 1992. (Exs. 2, 3-2). In late July 1994, claimant sustained another back injury when she was removing baggage from a carousel. She was diagnosed with very acute, severe low back strain/sprain syndrome with somatic dysfunctions and severe D8 through L5 paravertebral myofascial tightness and spasms. (Ex. 5b-2). Claimant was told she had a "bulging disc" as a result of the 1994 injury. (Tr. 19). She was released to light duty on September 12, 1994 and to normal work without restrictions on October 12, 1994. (Exs. 8a, 11a). Claimant testified that she did not have back pain again until early in fall 1995, after she had moved to Oregon. (Tr. 9-10).

There are two medical opinions on causation. In a "check-the-box" letter from claimant's attorney, Dr. Nicoski agreed that claimant had a relatively minor lower back condition before she moved to Oregon. (Ex. 30-1). He agreed that the major contributing cause of her condition has been her work activities with the employer, including her 1994 injury in Maine and her work activities in Oregon. (Ex. 30-2). Dr. Nicoski agreed that claimant's recent worsened condition in spring 1996, which resulted in the need for surgery, was due in major part to her continued lifting activities for the employer. (Exs. 30-2, -3). In a deposition, Dr. Nicoski agreed that the major cause of claimant's condition was a combination of her work activities in Maine and Oregon. (Ex. 30-17).

Dr. Markham also agreed that the major contributing cause of claimant's condition was a combination of her work for the employer in Maine and in Oregon. (Ex. 27-2). In a later report, Dr. Markham determined that the major contributing cause of claimant's current condition and need for treatment was a combination of the 1992 and 1994 injury, which both weakened the L5-S1 disc. (Ex. 29-1). He said that claimant continued to perform work for the employer that was stressful to her back and the disc continued to degenerate. (Id.) Dr. Markham concluded that claimant's condition originally began in 1992, increased in severity in 1994 and, in 1996, it was severe enough to warrant surgery. (Id.)

Based on the opinions of Drs. Nicoski and Markham, we conclude that claimant's work activities with the employer, including her work activities in Maine, were the major contributing cause of her herniated disc at L5-S1. See ORS 656.802(2)(a); Silveira v. Larch Enterprises, 133 Or App at 302-03. There are no medical opinions attributing claimant's condition to any off-work activities. Consequently, we conclude that claimant's herniated disc at L5-S1 is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 16, 1997 is reversed. The insurer's denial of claimant's herniated disc at L5-S1 is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $5,000, payable by the insurer.

In the Matter of the Compensation of
GERI L. KERSHISNIK, Claimant
WCB Case No. 96-02568
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of her occupational disease claim for a herniated disc at C4-5. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. On page 2, we change the first sentence in the fourth paragraph to read: "On three separate occasions, Dr. Zimmerman, the surgeon, related claimant's herniated cervical disc to an on-the-job injury. (Exs. 29, 33, 36)."

Claimant contends that Dr. Zimmerman's reports establish that her herniated disc at C4-5 is compensable. We disagree.

In his April 1, 1996 report, Dr. Zimmerman indicated that claimant was injured on the job in approximately March 1994. (Ex. 29). Dr. Zimmerman reported that the injury "relates to [claimant's] entire condition." (Id.)

However, in a later report, Dr. Zimmerman said that claimant's neck and right arm pain came on gradually after starting work with the employer. (Ex. 30A). He indicated that claimant had been having neck pain for two years. Dr. Zimmerman acknowledged that claimant had a long history of rheumatoid arthritis, which could affect the cervical spine. Nevertheless, he concluded that the "onset and gradual worsening of her symptoms do seem to correlate with the commencement and subsequent performance of her job duties at the bakery." (Id.)

In his next report on causation, Dr. Zimmerman opined that "the issue as to etiology of her symptoms and complaints certainly surround an exacerbating injury while she was at work." (Ex. 33).

In a February 25, 1997 report, Dr. Zimmerman said that claimant's cervical spine complaints "had not been facilitated by [claimant] prior to an injury that she received while at work." (Ex. 36). He believed that claimant's preexisting condition was "significantly affected" by this industrial accident. (Id.)

Finally, in a "check-the-box" report from claimant's attorney, Dr. Zimmerman agreed that claimant had preexisting rheumatoid arthritis and spondylosis and there was a pathological worsening of her condition caused in major part by her work activities. (Ex. 37). He also agreed that claimant's on-the-job activities were the major contributing cause of her need for treatment and symptom complex. (Id.)

When medical opinions are divided, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Here, we are not persuaded by Dr. Zimmerman's opinion because it is not well-reasoned, nor is it based on complete information. Dr. Zimmerman's understanding of claimant's work history is, at best, confusing. In three of his reports, he referred to claimant's on-the-job injury as the cause of her condition. (Exs. 29, 33, 36). In another report, however, he indicated that claimant's neck and right arm pain came on gradually after starting work with the employer. (Ex. 30A).

Claimant testified that she did not have a specific job injury at work. (Tr. 11-12, 17-18). Rather, her symptoms came on gradually. (Tr. 12). We are not persuaded by Dr. Zimmerman's opinion because his history of claimant's symptoms is inconsistent and, in some instances, inaccurate. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977).

Furthermore, we are not persuaded by Dr. Zimmerman's reports because they are not well-reasoned. In his April 1, 1996 report, Dr. Zimmerman opined that claimant's work injury "relates to [her] entire condition." (Ex. 29). He did not refer to any of claimant's preexisting conditions in that report. In contrast, in his final opinion, Dr. Zimmerman agreed that claimant's work activities caused a pathological worsening of her preexisting rheumatoid arthritis and spondylosis. (Ex. 37). Dr. Zimmerman's inconsistent and conclusory opinions are insufficient to establish compensability. The other medical opinions do not support claimant's position. We agree with the ALJ that claimant has failed establish that her herniated disc at C4-5 is compensable.

ORDER

The ALJ's order dated May 2, 1997 is affirmed.

In the Matter of the Compensation of
LESLIE MOSSMAN, Deceased, Claimant
WCB Case No. 95-01237
ORDER ON REMAND
Peterson & Peterson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Mossman v. North Pacific Lumber Co., 146 Or App 180 (1997). The court has reversed our prior order, Leslie Mossman, 47 Van Natta 2401 (1995), which had upheld the SAIF Corporation's denial of the deceased worker's widow's claim for death benefits. Citing Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996), the court has remanded for reconsideration of our determination that SAIF was not precluded from contesting the compensability of the decedent's coronary disease by virtue of its failure to contest prior Determination Order awards of permanent disability which were allegedly partially based on coronary artery disease.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable myocardial infarction (MI) on May 23, 1969, for which a March 1971 Determination Order awarded unscheduled heart disability. In January 1972, claimant had another MI, as a result of which the claim was reopened and eventually closed with an additional unscheduled heart disability award.

In 1985, SAIF denied claimant's current coronary artery disease (CAD). By Stipulation and Order, SAIF agreed to pay for treatment and medication relating to claimant's compensable injury (MI).

On December 1, 1992, claimant died of cardiac arrest. Claimant's widow requested benefits pursuant to ORS 656.204. SAIF denied the claim and claimant's widow requested a hearing.

The ALJ found that the prior Determination Order awards were based, at least partially, on claimant's noncompensable CAD condition. The ALJ further found that claimant's death was due to progression of the noncompensable CAD condition. As a result, the ALJ determined that death benefits were due under ORS 656.204 because, pursuant to Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) (Messmer I), SAIF was precluded from denying compensability of the CAD condition because it had not appealed the prior Determination Orders.

On review, we reversed the ALJ's order, holding that SAIF was not precluded from denying claimant's CAD condition. Leslie Mossman, 47 Van Natta at 2402. In so doing, we relied on the 1995 amendments to ORS 656.262(10), which we believed had the effect of overruling the court's decision in Messmer I. See Or Laws 1995, ch 332, section 28 (SB 369, section 28) (amending former ORS 656.262(9)). On the merits, we found that claimant died due to the progression of his noncompensable CAD caused by risk factors unrelated to work. Therefore, we concluded that the compensable condition (MI) was neither a material nor the major contributing cause of claimant's death in 1992. Accordingly, we held that claimant's widow was not entitled to survivor benefits under ORS 656.204.

The court reversed our order, citing its opinion in Messmer, 140 Or App 548 (Messmer II). In Messmer II, the court concluded that ORS 656.262(10) did not overturn its prior decision in Messmer I. In Messmer I, the court held that an employer's failure to challenge a permanent disability award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that that condition was not part of the compensable claim. Therefore, the court reversed and remanded for reconsideration in light of its decision in Messmer II. Accordingly, we proceed with our reconsideration.

Subsequent to the court's decision in this case, the 1997 legislature enacted HB 2971, which amended ORS 656.262(10). As amended, the statute now provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Amendments to the statute are underlined).

In Keith Topits, 49 Van Natta 1538 (1997), we held that the 1997 amendments to ORS 656.262(10) legislatively overruled the Messmer decisions. In Topits, we concluded, based on the plain and unambiguous language of the statute, that a carrier's failure to appeal an Order on Reconsideration award does not preclude the carrier from denying a degenerative condition rated therein.

Here, permanent disability awards in prior Determination Orders rated claimant's CAD. While SAIF did not appeal those earlier Determination Orders, it also never formally accepted the CAD condition. Therefore, pursuant to amended ORS 656.262(10), we find that SAIF is not precluded from denying the CAD condition.

On remand, claimant contends that amended ORS 656.262(10) should not be applied retroactively to this case. We disagree.

In determining whether the amendments to ORS 656.262(10) should be applied to this case, we must construe the statutory provisions regarding applicability of the amendments. When interpreting a statute, our task is to discern the legislature's intent. This task begins with an examination of the text and context of the statutory provision. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11(1993).

Section 2 of HB 2971 provides:

> "Notwithstanding any other provision of law to the contrary, the amendments to ORS 656.262 by section 1 of this Act apply to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive."

The amendments to ORS 656.262(10) are in section 1 of the Act, which became effective July 25, 1997. This action was existing on the effective date of the Act because the Board's decision in this matter has not yet issued after remand from the court.

In Volk v. America West Airlines, 135 Or App 565 (1995), the court addressed a similar question regarding the retroactive application of the 1995 amendments to the Workers' Compensation Law. Construing a similar applicability clause in SB 369,[1] the court concluded that the legislature intended the Act to apply to matters for which the time to appeal the Board's decision had not yet expired or, if appealed, had not been finally resolved by the courts. 135 Or App at 573.[2]

Here, claimant appealed the Board's original order to the court. Thereafter, the court reversed our decision and remanded for reconsideration. Thus, the court's decision is not final until we have completed our reconsideration and issued an order. The matter was pending before the Board for reconsideration when HB 2971 became effective on July 25, 1997. Because no final order had issued, this

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[1] Section 66 of SB 369 provided, in part:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

[2] In reaching its conclusion, the court examined the statutory exceptions to the retroactive applicability of SB 369 and found only one potentially applicable exception, that pertaining to orders or decisions that had become final on or before the effective date of SB 369. 135 Or App at 568-69. Section 2 of HB 2971, however, contains no exceptions to its retroactive applicability.

case was "existing" on July 25, 1997. Therefore, pursuant to the plain language of the statute, since this case was existing on the effective date of HB 2971, we conclude that amended ORS 656.262(10) applies to this case. See Bay Area Hospital v. Landers, 150 Or App 154 (1997).

Claimant argues that retroactive application of HB 2971 will result in violation of Article 1, Section 20 of the Oregon Constitution[3] and the Fourteenth Amendment of the U.S. Constitution.[4] Specifically, claimant contends that retroactive application of HB 2971 will deny claimant equal protection of the laws by giving a privilege to insurers and self-insured employers that is denied to workers. We disagree.

The only basis for classification and differential treatment that claimant identifies is that based on the distinctions created by the statute itself. A classification created by the statute itself does not create a cognizable "class" within the meaning of Article I, section 20 of the Oregon Constitution. State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603, 608 (1990). Therefore, we find that the retroactive application of HB 2971 to this case does not violate the equal protection of the laws guaranteed by the Oregon and U.S. Constitutions.

Accordingly, we conclude that, pursuant to amended ORS 656.262(10), SAIF was not precluded from denying claimant's CAD condition.

Claimant's widow is entitled to survivor benefits under ORS 656.204 if claimant's death resulted from the compensable condition. Here, the ALJ determined, and claimant does not dispute, that death resulted from the CAD condition, not the compensable MIs of 1969 and 1972. SAIF denied compensability of the CAD condition. Since we have held that SAIF is not precluded from denying the CAD condition, we turn now to the merits of whether that condition is compensable.

In our previous order, we found, relying on Dr. DeMots' opinion, that claimant died as a result of another MI which was caused by the progression of his CAD condition. We further found that the progression of claimant's CAD condition was due not to his employment or compensable MIs, but due to non-work-related risk factors including smoking, diabetes and hypertension. Therefore, we concluded that claimant's CAD condition was not compensable. We further found that claimant's death was not caused in either major or material part by a compensable condition. Therefore, we concluded that claimant's widow was not entitled to survivor benefits under ORS 656.204.

We continue to adhere to our reasoning and conclusion as set forth in our original order. Accordingly, since we find that claimant's death was not caused by a compensable condition, his widow is not entitled to benefits under ORS 656.204.

On remand, claimant seeks, in the alternative, entitlement to widow benefits under ORS 656.208(1). We disagree. ORS 656.208(1) provides:

> "If the injured worker dies during the period of permanent total disability, whatever the cause of death, leaving a spouse or any dependents listed in ORS 656.204, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204."

Claimant raises this issue for the first time on remand. We are not inclined to consider issues that were not first raised and litigated at the hearing level. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991); Gunther H. Jacobi, 41 Van Natta 1031, 1032 (1989) (new issues or legal theories presented for the first time on review are not considered where prejudice would result to one of the parties); see also Fister v. South Hills Health Care, 149 Or App 214 (1997) (absent adequate reason,

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[3] Article I, Section 20 of the Oregon Constitution states:

"No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

[4] Section 1 of the Fourteenth Amendment of the U.S. Constitution provides, in material part:

"No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; *** nor deny to any person within its jurisdiction the equal protection of the laws."

Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing). Here, SAIF would be prejudiced were we to consider this issue because it has not had an opportunity to present or rebut evidence specifically related to the applicability of ORS 656.208 and the question of whether claimant was permanently and totally disabled at the time of his death. Therefore, we are not inclined to consider whether claimant's widow is entitled to benefits under ORS 656.208.

Moreover, were we to consider the issue, we would find that ORS 656.208 is not applicable in this case. The statute specifically applies only when the worker dies during the period of permanent total disability. Here, it is undisputed that, at the time of his death, claimant had not been granted permanent total disability benefits. Rather, claimant was only partially disabled due to his compensable condition at the time of his death. (Exs. 2d, 2m, 2n).

Finally, in any event, the evidence in the record fails to establish that claimant was in fact permanently and totally disabled due to his compensable injury at the time of his death.

ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." In order to establish permanent total disability, claimant must prove either that: (1) he was completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). In determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by the compensable injury. See Darlene E. Parks, 47 Van Natta 2404, 2408 (1995), recon den 48 Van Natta 190 (1996) (the claimant must prove that his or her permanent total disability is due to her compensable injury). Subsequent, noncompensable conditions are not considered. Elder v. Rosboro Lumber Co., 106 Or App 16 (1991); Emmons v. SAIF, 34 Or App 603 (1978).

On December 30, 1985, Dr. Freiermuth, claimant's treating physician, wrote that claimant was totally disabled. (Ex. 2q). However, Dr. Freiermuth indicated that claimant's total disability was due to his arteriosclerotic heart disease. (Id.). As discussed above, we have found that claimant's arteriosclerotic heart disease (CAD) is not a compensable condition. Therefore, even if we were to find that claimant was permanently and totally disabled at the time of his death, we would not find that his disability was due to his **compensable** condition. Therefore, claimant would not be entitled to permanent and total disability status under ORS 656.206 at the time of his death, and claimant's widow would not be entitled to benefits under ORS 656.208(1).

Accordingly, on reconsideration, as supplemented and modified herein, our December 27, 1995 order is republished.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM H. PAULEY, Claimant
WCB Case No. 96-10594
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
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) Brazeau's order that awarded 23 percent (73.6 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration awarded no permanent disability. In his respondent's brief, claimant argues that the ALJ erred in finding that his claim was not prematurely closed. On review, the issues are premature closure and extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Dr. Dinneen, orthopedist, served as the medical arbiter and examined claimant in that capacity on December 7, 1996. (Ex. 18). In his report, Dr. Dinneen erroneously listed the accepted condition as "[l]ow back and left leg pain." (Ex. 18-1). In addition, he did not mention or address claimant's noncompensable preexisting degenerative disc disease. (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

Premature Closure

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

Extent of Unscheduled Permanent Disability

Based on the medical arbiter's report, the ALJ awarded 23 percent unscheduled permanent disability for a low back injury. We reverse.

Claimant has the burden of proving the extent of any disability resulting from the compensable injury. ORS 656.266. The criteria for rating unscheduled disability is the permanent loss of earning capacity due to the compensable injury, as calculated using the standards. ORS 656.214(5); former OAR 436-035-0007(1). Claimant's claim was closed by Notice of Closure on June 25, 1996, as amended on July 5, 1996. Therefore, the standards found at WCD Admin. Order 96-051 apply to claimant's claim. OAR 436-035-0003(2).

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 436-035-0007(13); Orfan A. Babury, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Claimant's accepted condition is lumbar and sacroiliac sprain/strain. (Ex. 2). In addition, claimant has significant preexisting degenerative disc disease in his low back. (Exs. 1B, 3, 3AB, 3AC, 4). Furthermore, on June 26, 1996, the day after issuing the initial Notice of Closure, SAIF issued a denial of claimant's preexisting degenerative disc disease and his current low back condition. (Ex. 6). This denial was upheld by a November 4, 1996 Opinion and Order that has become final by operation of law. (Ex. 14). Thus, claimant's preexisting degenerative disc disease is not compensable.

On June 13, 1996, Dr. Pribnow agreed that claimant's preexisting degenerative disc disease was the major contributing cause of any permanent disability. (Ex. 4-1). He also agreed that any restrictions to claimant's returning to his regular work were due to his preexisting degenerative disc disease. (Ex. 4-2).

On December 7, 1996, Dr. Dinneen, medical arbiter, examined claimant. (Ex. 18). Dr. Dinneen had an incorrect history in that he identified claimant's accepted condition as "[l]ow back and left leg pain." (Ex. 18-1). In addition, he did not mention claimant's preexisting degenerative disc disease. Although he noted that claimant had a CT scan, he did not mention the results of this scan. Instead, Dr. Dinneen simply measured loss of range of motion, indicated the findings were valid, and noted "no unrelated cause." (Ex. 18-2).

Claimant contends that he is entitled to unscheduled permanent disability based on the arbiter's report, citing Kim Danboise, 47 Van Natta 2163, 2164, on recon 47 Van Natta 2281(1995), aff'd SAIF v. Danboise, 147 Or App 550 (1997). We disagree.

In agreeing with our holding in Danboise, the court concluded that "[t]he Board is correct that, when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as 'consistent with' the compensable injury supports a finding that the impairment is due to the compensable injury." Id. at 147 Or App 553. The record in the present case

does not meet that standard. Here, the record not only discloses other possible sources of impairment, Dr. Pribnow explicitly found that claimant's noncompensable preexisting degenerative disc disease was the source of his impairment.

In evaluating medical evidence, we rely on those opinions that are well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 263 (1986). Given the fact that Dr. Dinneen had incorrectly identified claimant's accepted condition and did not address claimant's noncompensable preexisting degenerative disc disease, we do not find his opinion persuasive. Instead, we rely on the opinion of the attending physician, Dr. Pribnow, who opined that any permanent impairment was caused by claimant's preexisting degenerative disc disease. Accordingly, we find that claimant has not established entitlement to any unscheduled permanent disability.

ORDER

The ALJ's order dated April 24, 1997 is reversed in part and affirmed in part. That portion of the order that awarded 23 percent (73.6 degrees) unscheduled permanent disability and an "out of compensation" attorney fee is reversed. The Order on Reconsideration that awarded no permanent disability is affirmed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JIM WHEELER, Claimant
WCB Case No. 97-00623
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's left knee injury claim. The insurer also moves to strike claimant's respondent's brief as untimely filed. On review, the issues are the insurer's motion and compensability. We grant the motion and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The insurer moves to strike claimant's respondent's brief on the ground that it was not timely filed. Claimant disagrees that his brief was untimely, asserting that it was not due until 21 days after the mailing date of the appellant's brief.[1]

Under OAR 438-011-0020(2), the respondent shall file its brief within 21 days after the date of mailing of the appellant's brief. According to its certificate of mailing, the insurer mailed its appellant's brief on June 24, 1997, See OAR 438-011-0020(2); 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). Thus, claimant had until July 15, 1997 to file his respondent's brief. Claimant's brief, however, was not filed until July 16, 1997, the date his brief was mailed to the Board. Consequently, the brief was not timely filed and we do not consider it on review.

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[1] Claimant also cites to ORCP 10A. Because we decide this issue pursuant to Board rules, ORCP 10A does not apply.

We further note, however, that our review is de novo. Thus, with or without claimant's respondent's brief, we perform a complete review of the record.

Compensability

Claimant testified that, in late June or early July 1996, he fell at work and injured his left knee. The ALJ also found that, in September 1996, claimant again fell at work. On October 10, 1996, claimant sought treatment for his left knee.

The ALJ first found that claimant proved legal causation. The ALJ further decided that, based on evidence from claimant's treating orthopedic surgeon, Dr. Morrison, claimant showed that his initial need for treatment was caused by sustaining a left knee strain in September 1996 and that there was no evidence that the strain combined with a preexisting condition. The insurer contests the ALJ's conclusions, arguing that Dr. Morrison established that claimant's need for treatment was in major part caused by a preexisting condition. We agree with the insurer.

When Dr. Morrison initially saw claimant, he found "some swelling along the lateral joint line of his left knee." (Ex. 3B-1). On October 30, 1996, Dr. Morrison performed an arthroscopy on the left knee, which revealed degenerative disease. (Ex. 8).

Dr. Morrison then concurred with a report written by the insurer's attorney stating that, based on evidence that claimant previously had experienced left knee symptoms, his "problems were apparently ongoing" and "claimant's pre-existing condition was the major cause (more than 51 percent) of his need for treatment when he saw you in October of 1996." (Ex. 11-1).

Dr. Morrison was then deposed. In response to claimant's counsel's inquiry whether claimant's initial symptoms "could [] be consistent with a sprain/strain," Dr. Morrison answered "I guess so, yeah." (Ex. 12-13). Dr. Morrison also answered "yes" to counsel's question whether the activity of mowing a lawn and slipping "could [] produce a sprain/strain." (Id.)

Dr. Morrison, however, continued to agree that "claimant had a preexisting condition that was the major cause for his need for treatment when he saw [Dr. Morrison]." (Id. at 15). Dr. Morrison also stated that he could not give a "good answer" as to whether claimant's swelling was the result of degenerative disease or "a more acute injury." (Id. at 17, 18-19). When asked if it was "probable that what brought [claimant] to seek treatment was the degenerative and plica condition," Dr. Morrison stated: "Again, yeah, considering the history that I've gotten, the findings at surgery, my best, my best guess is that, yeah, it's related to preexisting stuff." (Id. at 19).

Based on such evidence, we find that Dr. Morrison showed that claimant's entire need for treatment was caused by a preexisting condition. With regard to whether claimant sustained a compensable work injury, Dr. Morrison only indicated that claimant "could" have sustained a strain/sprain from the work event and that he could not provide an opinion as to whether the swelling was from a degenerative condition or acute injury. We find such evidence insufficient to prove that claimant sustained a compensable injury, much less that a compensable injury was the major contributing cause of claimant's need for treatment. See ORS 656.005(7)(a)(B). Inasmuch as the evidence shows only that claimant's preexisting condition was the major contributing cause of his need for treatment, we conclude that claimant failed to prove compensability. ORS 656.005(7)(a).

ORDER

The ALJ's order dated May 2, 1997 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

WORKERS' COMPENSATION CASES

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Cite as 325 Or 439 (1997) July 3, 1997

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of William A. Strametz, Deceased, Claimant.

THE BENEFICIARIES OF THE ESTATE OF WILLIAM A. STRAMETZ, *Respondents on Review*

v.

SPECTRUM MOTORWERKS, INC., *Respondent on Review,* and SPECTRUM MOTORWERKS, LTD., and SAIF Corporation, *Petitioners on Review.*

(WCB 91-17385, 91-10418; CA A80582; SC S43042)

On review from the Court of Appeals.*

Argued and submitted January 15, 1997.

Vera Langer, of Scheminske, Lyons & Bussman, Portland, argued the cause and filed the briefs for petitioners on review.

Kevin Keaney, of Pozzi, Wilson & Atchison, Portland, argued the cause and filed the brief for respondents on review The Beneficiaries of the Estate of William A. Strametz.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents on review Spectrum Motorwerks, Inc., and SAIF Corporation. With him on the briefs were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before, Carson, Chief Justice, and Gillette, Van Hoomissen, Fadeley, Graber, and Durham, Justices.**

325 Or 440> VAN HOOMISSEN, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is affirmed.

* Judicial review from the Workers' Compensation Board. 135 Or App 67,897 P2d 335, *adhered to as modified* 138 Or App 9, 906 P2d 825 (1995).

** Kulongoski, J., did not participate in the consideration or decision of this case.

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325 Or 442> The issue in this workers' compensation case is the application of the last injurious exposure rule in an initial claim context. Spectrum Motorwerks, Ltd. (SML), and SAIF Corporation seek review of a Court of Appeals' decision that reversed and remanded for reconsideration a final order of the Workers' Compensation Board (Board) affirming the denial of claimant's occupational disease claim. *Beneficiaries of the Estate of Strametz v. Spectrum Motorwerks,* Inc., 135 Or App 67, 897 P2d 335, *adhered to as modified* 138 Or App 9, 906 P2d 825 (1995).[1] The question is whether SML is responsible for compensating claimant. Because we conclude that claimant's exposure while working for SML could not have been the actual cause in fact of his occupational disease, we hold that SML is not responsible. Accordingly, we reverse the decision of the Court of Appeals and affirm the final order of the Board.

We take the following undisputed facts from the Court of Appeals' opinion:

> "At the time of the hearing in 1992, claimant was a 43-year-old auto mechanic suffering from mesothelioma, a cancer of the chest cavity. The only known cause of mesothelioma is asbestos. Claimant had served in the Navy from 1963 to 1968, where he was exposed to asbestos. After his discharge, he worked as an auto mechanic for 24 years but did not begin working in Oregon until 1984. There is evidence that claimant was exposed to asbestos as an auto mechanic. In 1990, while working for Spectrum Motorwerks, Ltd., claimant sought treatment for chest pains, which were later diagnosed as symptoms of his mesothelioma.
>
> "Claimant filed a claim against his Oregon employers, and settled with all of them except Spectrum Motorwerks, Inc. (SMI) and Spectrum Motorwerks, Ltd. (SML).[2]

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[1] William Strametz pursued the claim at issue through hearing and before the Board on review. He has since died. The beneficiaries of his estate have pursued the claim pursuant to ORS 656.218(3), and they are the actual claimants in this case. For ease of reference, we use the term "claimant" to refer to Strametz.

[2] SMI was an Oregon business formed by claimant and his wife in the mid-1980s. In 1988, SMI became insured by SAIF, but the insurance did not provide coverage to claimant because of his status as a partner in SMI. *See* ORS 656.027(8) (exclusion of partners from workers' compensation coverage). In 1989, claimant and his wife sold the business, and it was renamed SML. Claimant continued to work at SML as an employee. SML later was declared to be a noncomplying employer, and SAIF became SML's statutory claims processing agent pursuant to ORS 656.054.

> Both **<325 Or 442/443>** employers denied the claim and claimant requested a hearing. Dr. Dobrow, claimant's treating physician and the only medical witness to testify regarding causation, testified that mesothelioma has a minimum latency period of 10 years. The Board found that the asbestos exposure that caused the mesothelioma must have occurred before 1980. That led the Board to conclude that it was impossible for any Oregon employment to have caused claimant's mesothelioma and the Board affirmed employer's denial." *Strametz,* 135 Or App at 69-70.

Claimant sought judicial review of the denial.

The Court of Appeals noted on judicial review that both compensability and responsibility are at issue. The court concluded that "the evidence as to causation indicates that claimant's lifetime work-related exposure to asbestos caused his mesothelioma." *Id.* at 70. The court held:

> "[I]t is immaterial for purposes of establishing the compensability of the claim, that the employers here, because of the latency period of mesothelioma, were not the actual cause of claimant's disease. All claimant must show to establish a compensable claim is that conditions at the Oregon employer were of the type that could have caused the disease." *Id.* at 71.

With respect to the issue of responsibility, the Court of Appeals held that, under the last injurious exposure rule, SML would be liable for claimant's disability if it were found that the conditions at SML were of the type that could have caused the disease, even though, because of the latency period of mesothelioma, SML could not have been the qctual cause of the disease. *Id.* at 74. Thus, the court remanded the case to the Board to determine whether such conditions existed at SML. We allowed SML and SAIF's petition for review.

SML and SAIF argue that the Court of Appeals erred in applying the last injurious exposure rule to impose **<325 Or App 443/444>** responsibility on an Oregon employer for a disease caused solely by noncovered employment--that is, employment not subject to the Oregon Workers' Compensation Act. Moreover, they argue that the last injurious exposure rule was not intended to impose responsibility on an employer whose working conditions were capable of causing the type of disease sustained by a claimant but which, in fact, could not have been the actual cause of that claimant's disease.

In the evidentiary and procedural posture in which this case reaches us, we are required to address only one question: whether the last injurious exposure rule can place responsibility on an employer whose working conditions are capable of causing the claimant's disease, but who has proved that, in fact, those conditions did not cause the claimant's disease. We hold that the last injurious exposure rule cannot impose responsibility on an employer who has proved that it could not have been the cause of a claimant's occupational disease.[3]

> In *Roseburg Forest Products v. Long,* 325 Or 305, 313, 937 P2d 517 (1997), this court stated:
>
> "[U]nder this court's prior precedents, once compensability is established, an employer that otherwise would be responsible under the last injurious exposure rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case or (2) that the disease was caused solely by conditions at one or more previous employments."

The court held that the foregoing aspect of the last injurious exposure rule applies in the context of a dispute over responsibility between or among successive insurers of a single employer. *Id.* at 314.

That principle also applies in the context of an initial workers' compensation claim made against a single employer. Under the last injurious exposure rule, the **<325 Or 444/445>** employer that otherwise would be held responsible for a claimant's occupational disease may avoid responsibility by

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[3] Because of that ruling, the second question that is tendered to us, *viz.,* whether a claimant can be deemed to have suffered a compensable occupational disease when that disease was caused solely by "noncovered" employment, need not be addressed. Assuming, *arguendo,* that claimant's condition is "compensable," under *Roseburg Forest Products v. Long,* 325 Or 305, 937 P2d 517 (1997), SML cannot be held responsible for that condition.

proving that conditions of its employment could not have caused the disease or that previous employment was the sole cause of the disease. *See Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244-45, 675 P2d 1044 (1984) (last injurious exposure rule does not prevent an employer from proving that the claimant's disability was caused by another employment or was unrelated to employment).

In this case, the Board examined the medical evidence and found that it was impossible for any Oregon employer, which necessarily includes SML, to have contributed to the causation of claimant's condition. Thus, claimant's "exposure" at SML, while it may have been the "last," was not "injurious." Because the Board's finding to that effect was based on substantial evidence in the record, that finding is binding on this court on review. ORS 656.298(6); ORS 183.482(7) & (8); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). Under that finding, SML is not responsible.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is affirmed.

Cite as 325 Or 592 (1997) August 7, 1997

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Jody N. HAYES, Claimant.
FRED MEYER, INC., *Petitioner on Review,*
v.
Jody N. HAYES, *Respondent on Review.*
(WCB 94-07627; CA A89536; SC S43425)

In Banc
On review from the Court of Appeals.*
Argued and submitted March 5, 1997.
O.R. Skopil, III, of Moscato, Skopil & Hallock, Portland, argued the cause and filed the petition for petitioner on review.
Robert E. Nelson, Gresham, argued the cause and filed the response for respondent on review.
Michael O. Whitty, Salem, filed a brief on behalf of *amici curiae* SAIF Corporation and Coos County.
VAN HOOMISSEN, J.
The decision of the Court of Appeals and the order of the Workers' Compensation Board are affirmed.
Gillette, J., concurred and filed an opinion.
Graber, J., dissented and filed an opinion in which Carson, C.J., joined.
* Judicial review from the Workers' Compensation Board. 141 Or App 439, 917 P2d 1077 (1996).

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325 Or 594> The issue in this workers' compensation case is whether claimant's injury, which occurred when she was attacked in her employer's parking lot, arose "out of and in the course of (her] employment."[1] The Workers' Compensation Board (Board) held that it did and, therefore, that claimant's injury was compensable. The Court of Appeals affirmed without opinion. *Fred Meyer, Inc. v. Hayes*, 141 Or App 43 917 P2d 1077 (1996). We review pursuant to ORS 656.298(6) and 183.482(8)(a) and (e).[2] For the reasons that follow, we also affirm.

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[1] ORS 656.005(7)(a) provides in part:

"A 'compensable injury' is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death[.]"

[2] Substantial evidence exists to support a finding of fact when the record viewed as a whole, would permit a reasonable person to make that finding. ORS 183.482(8)(c). The court must evaluate evidence against the finding as well as the evidence supporting it to determine whether substantial evidence exists to support that finding. If a finding is reasonable in the light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. *See Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990) (applying "substantial evidence" standard of review).

On review, the facts are not contested. Claimant is retail department manager for Fred Meyer, Inc. (employer). At 8 p.m. on March 20, 1994, she completed her shift. For the next 15 to 20 minutes, claimant shopped in employer's grocery department and purchased items for her personal use.[3] After completing her shopping, she left the store through the grocery exit and walked directly toward her car, pushing a cart containing groceries. When claimant left the store, the parking lot was about half full of cars. Claimant's car was parked about 72 yards from the grocery exit in an area on the perimeter of employer's parking lot where employer had directed its employees park. That area of the parking lot was not well lit. As claimant approached her car, she was attacked by a man with a knife. The assailant stabbed her in the neck and right thumb. Claimant escaped and ran back **<325 Or 594/595>** into the store. Claimant's injuries required medical treatment and resulted in disability. Claimant did not know her assailant, and he was a stranger to her and to her employer.[4]

Employer denied claimant's workers' compensation claim, and an administrative law judge upheld that denial. On review, the Board reversed. Applying the "parking lot" exception to the "going and coming" rule, the Board concluded that claimant's injury was sufficiently work-related to be "in the course of" her employment and that her injury "arose out of" her employment, because a causal link existed between claimant's injury and a risk associated with her employment.[5] As noted, the Court of Appeals affirmed without opinion. We allowed employer's petition for review.

Employer contends that the Court of Appeals erred in affirming the Board's order on judicial review. Employer first argues that, because claimant did not go to her car immediately after work, as a matter of law she was not injured while "in the course of" her employment. Employer maintains that any hesitation in leaving an employer's premises or any deviation from proceeding immediately to one's car in an employer's parking lot removes a worker from the "in the course of" employment. Employer next argues that, because there is no evidence that the place where claimant's car was parked caused her to be exposed to risks or hazards greater than those to which employer's customers were exposed, there is no substantial evidence in the record to support a finding that claimant's injury "arose out of" her employment.

In interpreting a statute, this court's task is to discern the intent of the legislature. ORS 174.020; *see PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993) (explaining method of statutory analysis). In **<325 Or App 595/596>** attempting to discern the intent of the legislature, the first level of analysis is to examine the text and context of the statute. Text and context includes prior case law from this court interpreting the same statute. *See State v. King,* 316 Or 437, 445-46, 852 P2d 190 (1993) (when this court interprets a statute, that interpretation becomes part of the statute as if written into it at the time of its enactment). If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *PGE,* 317 Or at 611.

For an injury to be compensable under the workers' compensation law, it must "aris[el out of" and occur "in the course of employment." ORS 656.005(7)(a). The "arise out of" prong of the compensability test requires that a causal link exist between the worker's injury and his or her employment. *Krushwitz v. McDonald's Restaurants,* 323 Or 520, 525-26, 919 P2d 465 (1996);[6] *Norpac Foods,*

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[3] Claimant did not work in employer's grocery department. The record does not indicate whether employer had any company policy regarding employees shopping in the store. Employer does not argue that claimant violated any work rule by shopping before leaving employer's premises.

[4] The issue whether claimant's injury is compensable under the Act is a different question from the issue whether employer was negligent in failing to provide adequate security for its employees. We do not address any negligence issue in this opinion.

[5] One Board member dissented, concluding that claimant's grocery shopping errand after work amounted to a personal mission that removed her from the "course of" her employment and that, because the assault did not arise from any risk associated with claimant's employment, her injury did not arise "out of" her employment.

[6] In *Krushwitz,* 323 Or at 530, this court concluded that, although the "arising out of" prong of the compensability test was met, the "in the course of" prong was not. Therefore, the deceased worker did not suffer a compensable injury. ORS 656.005(7)(a).

Inc. v. Gilmore, 318 Or 363, 366, 867 P2d 1373 (1994).[7] The requirement that the injury occur "in the course of" the employment concerns the time, place, and circumstances of the injury. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366.

This court views the two prongs as two parts of a single "work-connection" inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366. *See* ORS 656.012(1)(c) (Legislative Assembly finds that "those injuries that bear a sufficient relationship to employment * * * merit incorporation of their costs into the stream of commerce"). Both prongs of the work-connection test must be satisfied to some degree; neither is dispositive. *Krushwitz*, 323 Or at 531; *Norpac*, 318 Or at 366. The work-connection test may be satisfied if the factors supporting one prong of the statutory test are minimal while the factors supporting the other prong are many. *Krushwitz*, 323 **<325 Or 596/597>** Or at 531 (citing *Phil A. Livesley Co. v. Russ*, 296 Or 25, 28, 672 P2d 337 (1983)).[8] Both prongs serve as analytical tools for determining whether, in the light of the policy for which that determination is to be made, the causal connection between the injury and the employment is sufficient to warrant compensation. *Andrews v. Tektronix, Inc.*, 323 Or 154, 161-62, 915 P2d 972 (1996).[9]

Ordinarily, an injury sustained while a worker is going to or coming from work is not considered to have occurred "in the course of" employment and, therefore, is not compensable. *Krushwitz*, 323 Or at 526 (citing *Cope v. West American Ins. Co.*, 309 Or 232, 237, 785 P2d 1050 (1990)); *Norpac*, 318 Or at 366. That general rule is called the "going and coming" rule. The reason for the "going and coming" rule is that the relationship of employer and worker ordinarily is suspended from the time the worker leaves work to go home until he or she resumes work because, while going to or coming from work, the worker is rendering no service for the employer. *Krushwitz*, 323 Or at 526-27 (citing *Heide/Parker v. T C.I. Incorporated*, 264 Or 535, 540, 506 P2d 486 (1973)).

However, there are some exceptions to the "going and coming" rule. One is the "parking lot" exception. Under that exception, injuries sustained on the employer's premises **<325 Or 597/598>** while the worker is going to or coming from work have a sufficient work-connection to be considered to have occurred "in the course of" employment. *Norpac*, 318 Or at 366-67 (citing *Cope*, 309 Or at 238).[10]

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[7] In *Norpac*, 318 Or at 369, this court concluded that, although the claimant's injury in the employer's parking lot occurred "in the course of" his employment, the Board had failed to examine the causal connection between the claimant's employment and his injury to determine whether he had shown a sufficient work-connection to justify compensability. The case was remanded to the Board for further consideration.

[8] Professor Larson states that, generally, the observation that each test must be independently applied and met does no harm. He cautions, however, that the basic concept of compensation coverage is unitary, not dual, and is best expressed in the term "work-connection." He warns that "an uncompromising insistence on independent application of the two portions of the test can, in certain cases, exclude clearly work-connected injuries." 1 *Larson's Workers' Compensation Law* § 6.10 at 3-3 (rebound ed 1997).

[9] In *Rogers v. SAIF*, 289 Or 633, 642-43, 616 P2d 485 (1980), this court concurred with the following statement found *Allen v. SAIF*, 29 Or App 631,633-34, 564 P2d 1086 (1977):

> "The statutory phrase 'arising out of and in the course of employment' must be applied in each case so as to best effectuate the socio-economic purpose of the Workers' Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. Various concepts have arisen from attempts to rationalize that purpose, *e.g.*, the going and coming rule, special errands, lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, etc. Each is helpful for conceptualization and indexing, but there is no formula for decision. Rather, in each case, every pertinent factor must be considered as a part of the whole. It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment." (Citations omitted.)

[10] The "parking lot" exception is a recognition that the parking lot over which an employer exercises control is a part of the worker's employment environment. *See Cope v. West American Ins. Co.*, 309 Or 232, 238, 785 P2d 1050 (1990) ("Employer control over the premises is the rationale supporting the parking-lot exception."). *See also* Alan Stephens, *Workers' Compensation: Coverage of Injury Occurring in Parking Lot Provided by Employer, While Employee Was Going To or Coming From Work*, 4 ALR5th 443 (1992 and Supp).

The mere fact that a worker is injured in the employer's parking lot does not, in and of itself, establish a compensable injury. *Norpac,* 318 Or at 367-69 (rejecting view that injury in employer's parking lot is *per se* compensable). In addition to establishing that an injury occurred in the course of employment, a claimant also must establish a causal connection between the injury and the employment--that is, that the injury arose "out of" the claimant's employment. *Krushwitz,* 323 Or at 531; *Norpac,* 318 Or at 368-69.

We first address the issue whether claimant's injury occurred "in the course of" her employment. That inquiry tests the time, place, and circumstance of the injury. During oral argument in this court, employer's counsel conceded that, if claimant had gone to her car immediately after work, she would have been "in the course of" her employment at the time that she was injured. Employer argues, however, that claimant was not coming from work at the time she was injured; rather, employer asserts, she was coming from a personal shopping errand and, thus, her work-connection had been terminated.

An injury occurs "in the course of" employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it. "In the course of" employment also includes a reasonable period of time after work for the worker to leave the employer's premises, including the employer's parking lot. By "reasonably incidental to" employment, we include activities that are personal in nature such as a telephone call home or a brief **<325 Or 598/599>** visit with a coworker--as long as the conduct bears some reasonable relationship to the employment and is expressly or impliedly allowed by the employer. *See generally 2 Larson's Workers' Compensation Law* §§ 21.60 to 21.64 (rebound ed 1997) (discussing cases involving preparatory or incidental acts before and after work). *Cf Clark v. U.S. Plywood,* 288 Or 255, 266, 605 P2d 265 (1980) (compensability of on-premises injuries sustained while engaged in activities for the personal comfort of the employee can best be determined by a test that asks: Was the conduct expressly or impliedly allowed by the employer?).

Professor Larson summarizes the foregoing principle as follows:

> "The course of employment, for employees having a fixed time and place of work, embraces a reasonable interval before and after official working hours while the employee is on the premises engaged in preparatory or incidental acts. The rule is not confined to activities that are necessary; it is sufficient if they can be said to be reasonably incidental to the work. What constitutes a reasonable interval depends not only on the length of time involved but also on the circumstances occasioning the interval and the nature of the employee's activity." 2 *Larson's Workers' Compensation Law* § 21.60(a) at 5-45 to 5-46 (footnotes omitted).,

In this case, the Board found that claimant's "brief grocery shopping after work" was insufficient to sever the connection with her employment. The Board concluded that claimant was in the "course of her employment" when she was injured on the parking lot."[11] We agree.

325 Or 600> Employer argues that this court has construed the "place" component of the "in the course of" prong of the workconnection test strictly, citing *Cope,* 309 Or at 239-40 (worker who was injured on a public sidewalk over which employer has no control, and on which there were no employer-created hazards, would be denied compensation). From that premise, employer urges this court to construe the "time" and "circumstances" components of the "in the course of" prong of the test

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[11] Other courts have held that an injury is compensable for workers' compensation purposes when it occurs during a brief personal deviation in the employer's store after work. *See, e.g., Briley v. Farm Fresh,* Inc., 240 Va 194, 396 SE2d 835 (1990) (workers' compensation exclusive remedy for worker who slipped on floor while shopping 15 minutes after the end of her shift); *Carter v. Lanzetta,* 249 La 1098, 193 So2d 259 (1966) (workers' compensation benefits ordered for worker who fell while leaving employer's premises after lingering at store 20-30 minutes talking to employer); *Carter v. Winn Dixie Louisiana, Inc.,* 517 So2d 504 (La App 1987) *writ den* 520 So2d 755 (1988) (workers' compensation was exclusive remedy for worker who slipped on floor while shopping several minutes after work); *but see Fowler v. Texas Employers' Ins. Ass'n,* 237 SW2d 373 (Tex Civ App 1951) (worker who remained on employer's premises 15 to 20 minutes to shop was not entitled to workers' compensation).

with the same degree of strictness. Employer cites no authority for such construction of the time and circumstances components and we know of none. We reject such a rigid application as contrary to the well-reasoned principle, expressed by Professor Larson and by courts in other jurisdictions, that "in the course of" employment includes a reasonable period of time after work to leave the employer's premises, including the employer's parking lot.

Employer also contends that the Board engaged in a "distinct departure" analysis in this case and, thereby, reached an erroneous conclusion regarding the "in the course of" prong of the compensability test. Employer argues that a "distinct departure" analysis traditionally has been limited to compensability determinations in "traveling employee" cases.[12]

This court has no occasion to address whether a "distinct departure" analysis would be appropriate on these facts. Contrary to employer's reading of the Board's opinion, the Board does not appear to have engaged in a "distinct departure" analysis. We read the Board's opinion to rest on its conclusion that claimant's shopping did not take her outside the "course of" her employment.[13] The Board did not mention the **<325 Or 600/601>** "distinct departure" test and cited no cases applying a "distinct departure" analysis.

We conclude that the Board applied the correct principles of law when it found that claimant's brief grocery shopping after work was insufficient to sever the connection with her employment. Moreover, we agree with the Board that claimant was "in the course of' her employment when she was injured in employer's parking lot.

We next address the issue whether claimant's injury "arose out of" her employment. That inquiry tests the causal connection between claimant's injury and a risk connected with her employment. *Krushwitz,* 323 Or at 525-26; *Norpac,* 318 Or at 366.

Employer's premise, that claimant's injury did not arise "out of" her work, because the place where her car was parked caused her to be exposed to no greater risk or hazard than those to which employer's customers were exposed, is unwarranted and we reject it. In *Livesley,* 296 Or at 31, this court specifically rejected "the largely obsolete 'peculiar-risk' and 'increased-risk' considerations" in assessing whether a worker's injury was linked to a risk connected with employment. Rather, a worker's injury is deemed to "arise out of' employment if the risk of the injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker.

The Board found a sufficient relationship between claimant's injury and a risk of her employment to conclude that her injury "arose out of" her employment:

> "Claimant was required by the employer to park in an area on the perimeter of the parking lot. The closest lights were halfway between the area where claimant parked and the store. Claimant indicated that the area where her car was parked and where the attack took place was not well lit. In addition, witnesses testified that 'transients' were sometimes a problem on the employer's parking lot and premises."

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[12] 2 *Larson's Workers'Compensation Law* § 25.00 at 5-275, states:

"Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown."

[13] The Board's opinion states in part:

"In this case, instead of leaving work immediately, claimant grocery shopped briefly before leaving the employer's store and going out to the parking lot to go home. We do not find that claimant's brief grocery shopping after work was sufficient to sever the connection with claimant's employment. * * * [W]e conclude that claimant was in the 'course of her employment' when she was injured on the parking lot[.]"

The Board further found that claimant's employment exposed her to a risk of assault, because her employer required her to park at the "fringes" of the parking lot in an <325 Or 602/603> area that was not well lit and that "[those] factors made claimant vulnerable to an attack" and created the risk that such an attack would occur. The Board concluded that claimant's injury arose out of a risk to which her employment exposed her. We agree with the Board that claimant's injury "arose out of her employment.[14]

Both prongs of the compensability test having been established, we conclude that the relationship between claimant's injury and her employment is sufficient and that her injury is compensable. Accordingly, we affirm the decision of the Court of Appeals and the order of the Board.

The decision of the Court of Appeals and the order of the Workers' Compensation Board are affirmed.

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[14] The dissent cites several cases in which courts have held that assaults were not sufficiently work-related, because the employer did nothing to create the risk of an assault occurring. Other courts, however, have allowed workers' compensation benefits on similar facts. *See, e.g., Roberson v. Whetsell,* 21 Va App 268, 463 SE2d 681 (1995) (award upheld where, as a condition of employment, claimant was required to make regular trips through dangerous neighborhood that increased risk of exposure to criminal activity); *S.E. Rykoff & Co. v. Industrial Comm'n,* 172 Ariz 22, 833 P2d 39 (1992) (claimant injured attempting to stop a thief who had broken into his truck which had been parked at night in an unsafe area); *Bear v. Honeywell, Inc.,* 468 NW2d 546 (Minn 1991) (assault by unknown person was assumed to have been caused by worker's late night presence in employer's parking garage and, thus, was incident to her employment); *Jenkins v. Wilson,* 397 So 2d 773 (Fla App 1981) (claimant assaulted in parking lot while leaving work later than usual). Moreover, Professor Larson's treatise cites several cases in which courts have allowed compensation where, arguably, the case was weak on both prongs of the compensability test. 2 *Larson's Worker's Compensation Law* § 29.10 at 5-476 *et seq.*

GILLETTE, J., concurring.

I agree with the majority that there was a sufficient connection between claimant's work and the circumstances of her injury to require an award of workers' compensation benefits. I agree with the dissent that this is a very close case. I write this brief separate opinion to speak only to a concern that arises out of this court's involvement in cases like the present one.

Regrettably, it turns out that this case was not review-worthy. As we finally decide it by a divided court, we turn out to be disagreeing only over the sufficiency of the agreed facts to meet a legal test which is not new and on <325 Or 602/603> which all agree. That is not an appropriate expenditure of this court's judicial time.

This case was affirmed without opinion by a panel of the Court of Appeals. *Fred Meyer, Inc. v. Hayes,* 141 Or App 439, 917 P2d 1077 (1996). In that posture, the case had no precedential significance or, indeed, any other kind of significance to anyone other than the parties. A review of the extensive (but nonexclusive) list of criteria for granting discretionary review found at Oregon Rule of Appellate Procedure 9.07 fails to produce a single substantive example from that list that the present case fairly can be said to meet. With respect, I submit that we erred in allowing review.

The foregoing error would be of no moment, were it not for the collateral consequences that seem to flow from decisions like the one that we announce today: A number of parties, disappointed with the outcome of their intensely fact-bound disputes in the Court of Appeals, will feel that it is worthwhile to take a flyer on petitioning for review to this court. "After all," they fairly may say, "the court took review in the *Hayes* case."

I wish we hadn't.

GRABER, J., dissenting.

I respectfully dissent. Although this is a close case, in my view claimant did not establish that her injury was compensable.

> "The burden of proving that an injury * * * is compensable * * * is upon the worker. The worker cannot carry the burden of proving that an injury * * * is compensable merely by disproving other possible explanations of how the injury * * * occurred." ORS 656.266.

On review, the facts are not contested. The Board accepted the parties' stipulated facts, adopted the "notice[d] facts" found by the administrative law judge, and made its own findings.

The parties stipulated to these facts:

> "[C]laimant was assaulted within a half hour of finishing her work shift on a parking lot owned and controlled by the **<325 Or 603/604>** employer. The assault caused injuries which required medical treatment and resulted in disability. At the time she was assaulted, claimant's vehicle was parked in an area of the lot where the employer had specified that employees could park."

Among the "notice[d] facts" that the Board adopted were that:

* the distance from the south side of the employer's building to the sidewalk is about 225 feet;

* light was provided to the parking lot by a publicly owned light at an intersection adjacent to the employer's premises, by five light fixtures in the parking lot, and by three larger light fixtures at a parking lot across the street from the area where claimant's car was parked;

* employer's light fixtures are located about 180 feet south of employer's building, in between parking spaces; and

* the nearest vehicular entrances and exits are about 160 feet to the west and 200 feet to the north of where claimant's car was parked at the time of the assault.

The Board made these additional findings, among others:

> "On March 20, 1994, claimant finished her shift working in the employer's apparel department at 8:00 PM. She did some personal grocery shopping in the employer's grocery department which took about 15 to 20 minutes. After completing her shopping, claimant left the store through the grocery exit and walked toward her car pushing a cart containing groceries. The parking lot was approximately half full of cars when claimant left the store. Claimant's car was parked approximately 72 yards from the grocery exit.
>
> "On the night of her injury, the upper parking lot was full and claimant parked in an area around the perimeter of the main lot in a space which the employer had designated for employees to park. The area where claimant parked on March 20, 1994 was not well lit. The closest lights were half way across the parking lot.
>
> "As claimant approached her car, she was attacked by a man with a knife who apparently attempted to force her into his vehicle. The man had apparently driven his vehicle **<325 Or 604/605>** onto the employer's lot. * * * Claimant did not know her attacker and the attacker was not known to have any connection with the employer or with claimant.
>
> "* * * * *
>
> "The employer required employees to park on the upper parking lot of the store where claimant worked, or if that lot was full, in areas specified by the employer around the perimeter of the main parking lot. Employees could be disciplined if they parked in areas other than those specified by the employer. On the night claimant was assaulted, there was no security guard in the parking lot. Transients occasionally came onto the employer's premises including the parking lot area. If transients or other individuals bothered employees or customers, the employer took steps to ask them to leave or called the police. The employer has a policy to escort employees who wished such an escort out to their cars."

For an injury to be compensable under the Workers' Compensation Law, it must "aris[e] out of" and occur "in the course of" employment. ORS 656.005(7)(a). To determine compensability, the court assesses the sufficiency of the relationship between the injury and the employment.[1] That unitary approach has two parts: the "in the course of" prong (time, place, and circumstances of the injury) and the "arising out of" prong (causal connection between the injury and the employment). *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994). Both prongs of the compensability test must be satisfied to some degree. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 531, 919 P2d 465 (1996).

In *Norpac Foods*, the court relied on *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29, 672 P2d 337 (1983), for the proposition that being injured on the employer's premises during work hours is not necessarily a sufficient work connection. 318 Or at 368-69. Rather, the court must "determine whether the injury had its origin in a risk connected with the employment or rationally and naturally incidental thereto." *Livesley*, 296 Or at 32. In *Livesley*, the court quoted with approval **<325 Or 605/606>** from Professor Larson's explanation of the two-pronged, but unitary work-connection approach:

> " 'One is almost tempted to formulate a sort of quantum theory of work-connection that a certain minimum quantum of work-connection must be shown, and if the "course" quantity is very small, but the "arising" quantity is large, the quantum will add up to the necessary minimum, as it will also when the "arising" quantity is very small but the "course" quantity is relatively large. But if both the "course" and "arising" quantities are small, the minimum quantum will not be met.' 1A Larson, Workmen's Compensation Law § 29.10 at 5-355." 296 Or at 28 (footnote omitted).

I turn first to the "course" prong of the test. In this case, claimant was injured after leaving work. Ordinarily, an employee who is going to or coming from work is not "in the course of" employment. *Norpac Foods*, 318 Or at 366. "The reason for the going and coming rule is that '[t]he relationship of employer and employee is ordinarily suspended from the time the employee leaves his work to go home until he resumes his work, since the employee, during the time that he is going to 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)." *Krushwitz*, 323 Or at 526-27. An exception to that general rule is recognized for employer-controlled parking lots. *Norpac*, 318 Or at 366-67. But, because the employee who comes within the parking-lot exception no longer is actually working (as recognized by the general rule against compensating injuries sustained while going to or coming from work), "the 'course' quantity is very small." *See Liuesley*, 296 Or at 28 (quoting Larson).

The "course" quantity is made even smaller in this particular case by the fact that, after her work shift ended, claimant spent more than a quarter of an hour engaged in the personal activity of grocery shopping, before going to the parking lot. Both the length of time and the nature of the activity are such as to be toward the outer edge of the course of employment. See 2 *Larson's Workers' Compensation Law* § 21.60 at 5-45 to 5-56 (rebound ed 1997) (collecting cases on "personal comfort doctrine"; "The course of employment, for employees having a fixed time and place of work, embraces a **<325 Or 606/607>** reasonable interval before and after official working hours while the employee is on the premises engaged in preparatory or incidental acts."). In all the circumstances of this case, the "course" quantity is so slight that the "arising" quantity must be weighty for claimant's injury to be compensable under the principles embraced in *Livesley*.

However, the "arising" quantity is not weighty. The court in *Livesley* noted that an attack on the job by an unknown person, whose motive may have been personal *or* related to the employment, is a "neutral" risk rather than a risk distinctly associated with the employment. 296 Or at 30 n 6.

The factors associated with claimant's employment on which the Board relied are: claimant's shift ended at 8:00 p.m. when it was dark outside; employer required claimant to park in an area on the perimeter of the parking lot if she drove a car to work and chose not to park on a public street; that area was not well lit, in that the closest lights were half way across the parking lot; and there had been an earlier problem with "transients" in the parking lot.

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[1] *See* ORS 656.012(1) (Legislative Assembly finds that "those injuries that bear a sufficient relationship to employment * * * merit incorporation of their costs into the stream of commerce").

Taking the last factor first, "transients" are not criminals. There is no finding and no evidence that a "transient" (or, indeed, anyone else) ever had attacked anyone in employer's parking lot. There is no finding and no evidence that claimant's attacker, who arrived by car, was a "transient." There is no finding and no evidence that the earlier presence of "transients" in the parking lot created a risk of assault. Indeed, as the Board found, "the attacker was not known to have any connection with the employer."[2]

That leaves time, location and lighting. The Board found that the assault occurred at about 8:30 p.m. and that it was dark outside. The Board further found that claimant's car was parked about 216 feet (72 yards) from the building, that the lot is adjacent to a public street, that the light fixtures were located about 80 feet from the building, and that the overall width of the parking lot was 225 feet. Accordingly, the Board's finding that the nearest light was "half way <325 Or 607/608> across the parking lot" translates into a finding that the nearest light was about 136 feet (216 feet minus 80 feet) from claimant's car. Her car was about 160 feet from the nearest vehicular entrance through which the attacker could have driven.

In order for claimant's injuries to be compensable, one must conclude that a requirement to work until 8:00 p.m. and to park near a public street at a point 216 feet from the employer's building and 136 feet from the nearest lamppost--without more--creates a risk of assault. As noted above, there is no finding and no evidence of prior assaults at that time or in that location. There also is no finding and no evidence that the neighboring street near which claimant parked was dangerous or that the area was deserted. In fact, although the Board did not make a finding one way or another with respect to the point, the undisputed evidence was that there were customers in the parking lot at the time of the attack. In other words, there is no evidence that the time, location and lighting (employment conditions) created a risk of assault. There is only the *post hoc* determination that this assault happened to occur under those conditions. *Post hoc* is not *propter hoc,* and fear is not causation.

As noted, under ORS 656.266, claimant bears the burden to prove compensability. Moreover, that statute specifies that a claimant cannot carry the burden of proving cornpensability "merely by disproving other possible explanations of how the injury * * * occurred." In general, a claimant can carry the burden to prove that injuries sustained in an assault arise out of employment in one of three ways.

In general, an assault arises out of employment if the *nature of the work* or the *setting of the work* creates a risk of assault, or if the *reason for the assault* was a quarrel having its origin in the work. *See* 1 *Larson's* § 11.00 at 3-22 (discussing concept). Here, the only possible basis, and the basis on which the majority relies, is that the time and the setting where employer required claimant to park (if she chose to drive to work and not to park on the public street) created a risk of assault. *See id.* at § 11.11(b) (assault may arise out of employment when employment required employee to work in or travel through a dangerous locality, or when employee is <325 Or 608/609> required to work late at night or in an isolated area) explained above claimant's evidence on this point is weak.

I am aware of no decided case that authorizes workers' compensation when the "arising" prong and the "course" prong are as tenuous as they are in this case. Even when the "course" prong is stronger than it is in this case, courts often have denied compensation to victims of unknown assailants when the "arising" prong is comparable to what exists here. For example, in *Hill City Trucking, Inc. v. Christian,* 238 Va 735, 385 SE2d 377 (1989), the Supreme Court of Virginia denied compensation to a truck driver who was assaulted on the road by robbers. The claimant did not show that he was targeted for assault as a truck driver, and anyone traveling at 3:00 a.m. was subject to the same risk. 385 SE2d at 380. The claimant thus failed to supply a causal link between risk and the employment and, accordingly, failed to show that his injuries arose out of his employment. Ibid.

Similarly, the court in *Walk v. S.C. Orbach Co.,* 393 P2d 847 (Okla 1964), held that the claimant's injuries from an assault in the employer's parking lot were not compensable, because they did not "arise out of" employment. There, the "course" prong was stronger than in this case, because the claimant left for the parking lot immediately after checking out from her work shift, which ended at 6:00 p.m. The court held that the injuries did not arise out of employment, however, because there was no evidence to show that the claimant's work environment created a risk of assault. The connections on which the

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[2] The majority appropriately does not rely on this factor.

claimant relied were that she was required to park in a specified part of the parking lot, where the assault took place, and that her regular work shift required her to frequent that area at the time the assault took place. *Id.* at 851. There was no showing, however, that assault was common at that location or time. *Ibid.* For injury to be compensable, "there must exist some causal connection between the injury and the employment," such as conditions under which the work is required to be performed. *Id.* at 849-50 (citing *Indian Territory Illumination Oil Co. v. Lewis*, 165 Okla 26, 24 P2d 647 (1933).

In *Gibberd by Gibberd v. Control Data Corp.*, 424 NW2d 776 (minn 1988), the claimant was working late and **<325 Or 609/610>** was shot and killed by an unknown assailant while returning to work from a meal break at a nearby restaurant. The court held that the claimant's death was not compensable, because the claimant was away from the premises on a meal break (making the "course" prong weak) and because there was no evidence to suggest that the assault bore any connection to employment (making the "arising" prong weak). *Id.* at 78184.

In *Williams v. Salem Yarns*, 23 NC App 346, 208 SE2d 855 (1974), the court denied compensation to an employee who was shot by a nearby resident while walking toward the mill's parking lot. The employee had left the mill after completing his shift, making the "course" prong stronger than in the present case. The court held that the "arising" prong was insufficient, because the assault had an insufficient connection with employment to make it logical to conclude that employment created the risk of the attack. 208 SE2d at 856. The court found, for example, that there was no evidence that the assailant held an animus toward all employees at the mill. *Ibid.*

In *Foster v. Johnson*, 264 Ark 894, 576 SW2d 187 (1979), the Supreme Court denied compensation to a claimant who was the victim of an unexplained shooting. The shooting took place on the employer's parking lot after the employee had left work. 576 SW2d at 188. Although the "course" prong was stronger than is true here, the "arising" prong was not met, because there was no evidence that the assault bore any connection to employment. *Id.* at 189. *See also* 1 *Larson's* § 11.33 n 5 (collecting cases in which courts have denied compensation for unexplained assaults by nonemployees).

To summarize, claimant failed to establish that her injuries are compensable, because the quantities of both the "course" and "arising" prongs of the work connection test are small. I dissent from the majority's contrary holding.

Carson, C. J., joins in this dissenting opinion.

Cite as 326 Or 32 (1997) August 21, 1997

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Perry A. Lang, Claimant.
REDMAN INDUSTRIES, INC., and AIG Claim Services, *Respondents on Review,*
v.
Perry A. LANG, *Petitioner on Review.*
(WCB 94-11757; CA A89422; SC S43586)

In Banc
On review from the Court of Appeals.*
Argued and submitted March 5, 1997.
David W. Hittle, of Burt, Swanson, Lathen, Alexander, McCann & Smith, Salem, argued the cause and filed the petition on behalf of petitioner on review.
Jerald P. Keene, of Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland, argued the cause and filed a response on behalf of respondents on review.
KULONGOSKI, J.
The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is affirmed.
* Judicial Review from Workers' Compensation Board, 142 Or App 404, 921 P2d 992 (1996).

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326 Or 34> The issue in this workers' compensation case is whether a claimant's injury is compensable when the injury was caused by an assault by a coemployee at the workplace. We hold that claimant's injury is compensable.

We take the following undisputed facts from the Court of Appeals' opinion.

> "Claimant, a Caucasian male, worked at employer's plant with [assailant], an African-American, male co-worker. Claimant installed windows on manufactured homes, and [assailant) installed doors. On August 3 or 4, 1994, claimant jokingly called [assailant] a 'watermelon,' which angered Assailant. On August 4, referring to that or a similar remark, [assailant] told claimant 'don't be playing with me like that.' The next morning, claimant referred to [assailant] as 'watermelon' and, less than an hour later, as 'buckwheat,' 'Kentucky Fried Chicken,' and 'watermelon eatin' fool.' Although [assailant] knew claimant was trying to joke with him, [assailant] became angry and called claimant 'cracker' and another name, possibly 'honkey.'
>
> "[Assailant] remained very upset by claimant's remarks. Within a few minutes, another worker called [assailant] a Spanish name that [assailant] believed was a racial slur. [Assailant] struck that worker. Moments later [assailant] saw claimant talking with an inspector. Assuming he would lose his job for striking the other employee, [assailant] struck claimant at least twice. [Assailant] asked claimant, 'Who's a Toby now?'" *Redman Industries, Inc. v. Lang,* 142 Or App 404, 406, 921 P2d 992 (1996).

Claimant received medical treatment and filed a workers' compensation claim. Employer denied that claim. An administrative law judge (ALJ) ruled that claimant's injury was compensable. The ALJ found that claimant's injuries arose out of and in the course of claimant's employment and that claimant was not an active participant in the assault. The Workers' Compensation Board (Board) adopted and affirmed the ALJ's order. On employer's petition for judicial review, the Court of Appeals reversed, concluding that **<326 Or 34/35>** claimant's injury did not "arise out of" his employment. *Redman Industries,* 142 Or App at 410. For the reasons that follow, we reverse the decision of the Court of Appeals.

For an injury to be compensable under the Oregon workers' compensation law, it must "aris[el out of and in the course of employment." ORS 656.005(7)(a). The phrases "arise out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Fred Meyer, Inc. v. Hayes,* 325 Or 592, 596, ___ P2d ___ (1997). This is called the "work-connection" test. *Id.* at 596.

Under that test, both elements must be satisfied to some degree. *Id.* at 596. However, the two elements need not be met to the same degree. When the factors supporting one element are many, the factors supporting the other may be minimal. *Ibid.* In this case, it is undisputed that claimant's injury occurred "in the course of" his employment. The question, therefore, is whether the injury "arose out of employment" and, if so, whether there is any other statutory bar to compensation.

We start with the phrase "arising out of" in ORS 656.005(7)(a). In interpreting a statute, this court's task is to discern the intent of the legislature. ORS 174.020; *see PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993) (explaining methodology). In attempting to discern legislative intent, the first level of analysis is to examine the text and context of the statute. *Ibid.* Text and context include prior case law from this court interpreting the same statutory terms. *See State v. King,* 316 Or 437, 446, 852 P2d 190 (1993) (explaining proposition). Context also includes other related statutes. *PGE,* 317 Or at 611. If the legislature's intent is clear from text and context, further inquiry is unnecessary. *Ibid.*

In prior cases interpreting ORS 656.005(7)(a), this court has held that the inquiry into whether an injury "arises out of employment" tests the causal connection between the injury and the employment. *Fred Meyer,* 325 Or at 596; *Norpac Foods v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994); *Clark v. U.S. Plywood,* 288 Or 255, 260, 605 P2d 265 (1980). A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. *Norpac Foods,* 318 Or at 368; *Phil A. Livesley Co. v.* **<326 Or 35/36>** *Russ,* 296 Or 25, 29, 672 P2d 337 (1983). A causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed claimant. *Fred Meyer,* 325 Or at 601.

In some jurisdictions, courts have required not only that an injury be linked to a risk connected with employment, but also that the risk be "peculiar to the employment" or that the employment "increase[] the risk of injury." *See, e.g., Sacks v. Industrial Commission,* 13 Ariz App 83, 474 P2d 442 (1970). However, this court has "rejected 'the largely obsolete "peculiar-risk" and "increased-risk" considerations' in assessing whether a worker's injury was linked to a risk connected with employment." *Fred Meyer,* 325 Or at 601 (quoting *Livesley,* 296 Or at 31).

In this case, the Court of Appeals formulated the test as being whether claimant's specific employment tasks " 'created or enhanced' the risk of assault by a coworker." *Redman,* 142 Or App at 408. In our view, that test, at least in part, simply reformulates the "peculiar-risk"/"increased-risk" inquiry rejected by this court in *Livesley* and *Fred Meyer,* and we reject it for that reason. Therefore, we are left to apply the proper test to the circumstances of this case: namely, whether the risk of claimant's injury either resulted from the nature of his work or whether the work environment exposed him to the risk of his injury.

In discussing "risks," this court in *Livesley* quoted with approval the following from 1 *Larson's Workers' Compensation Law* § 7.00 at 3-14 (rebound ed 1997):

> "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." *Livesley,* 296 Or at 29-30.

326 Or 37> In *Livesley,* this court then determined that unexplained injuries are a classic example of neutral risks. The court listed, as an example of such a neutral risk, an assault against an employee on the job by an unknown person, when the motive for the assault is unknown but may have been either personal or employment-related.[1] 296 Or at 30 n 6.

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[1] This court also noted that other examples of neutral risks would include an employee being hit by a stray bullet, bitten by a dog, struck by lightning, or injured by debris from a distant explosion. *Phil A. Livesley Co. v. Russ,* 296 Or 25, 30 n 6, 672 P2d 337 (1983).

In this case, however, both the identity of the assailant and the motive for the assault are known. The assailant was a coemployee. The motive for the assault was the assailant's anger over being called racially derogatory names, combined with the assailant's belief that he would be fired for having assaulted another coemployee moments earlier and, therefore, that he had nothing to lose by assaulting complainant. Because both the identity and the motive are known, the assault does not fall into the category of neutral risks. Instead, the question is whether an assault under the above-mentioned circumstances constitutes either a risk "associated with the employment"[2] which would be compensable, or a risk "personal to the claimant," which would not be compensable.

That specific question still is one of legislative intent. This court has not considered whether the legislature intended to treat an assault by a coemployee on a claimant/employee as one associated with employment or one personal to the claimant. The text of ORS 656.005(7)(a) does not provide an answer. However, ORS 656.005(7)(b)(A) provides context for the inquiry. That statute is an express statutory exclusion to what is compensable under ORS 656.005(7)(a). ORS 656.005(7)(b)(A) provides:

> " 'Compensable injury' does not include * * * [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[.]"

326 Or 38> By its terms, that statute excludes from compensability injuries from assaults (1) to an active participant in the assault and (2) when the assault is not connected to the job assignment and amounts to a deviation from customary duties. Unless both of those elements are met, the exclusion does not apply. Because the statute excludes only a subset of the types of injuries from assault that will not be deemed compensable, a logical inference is that the legislature intended other types of injuries from assault to be deemed compensable, so long as they arose out of and in the course of employment.

The parties agree that an injury caused by an assault in the workplace by a coemployee is compensable if the assault grew out of a quarrel whose subject matter is related *directly* to work. We also agree that the legislature intended such injuries to be compensable. However, the parties disagree concerning whether the same assault is compensable if it grew out of a quarrel whose subject matter is not related *directly* to work. In this case, employer argues that the racially derogatory statements that led to the assault had no direct reference to work-related matters. On that basis, employer argues that claimant's injury did not arise out of his work. We disagree.

The normal work environment necessitates that employees work together and exposes them to each other, based solely on their employment status. Professor Larson characterizes this variously as "proximity," "friction and strain," or "positional risk" work connection. 1 *Larson's Workers' Compensation Law* §§ 11.16(a) at 3-299 and 11.16(c) at 3-309. That doctrine was popularized in the germinal case of *Hartford Acc. & Indem. Co. v. Cardillo*, 112 F2d 11, *cert den* 60 S Ct 1100, 84 L Ed 1032 (1940). There, a claimant repeatedly had been called "shorty" by a coemployee. The claimant retaliated by calling the coemployee a vile name and thereafter was assaulted and injured. The court concluded that the injury arose out of employment and stated:

> "This view recognizes that work places men under strains and fatigue from human and mechanical impacts, creating frictions which explode in myriads of ways, only **<326 Or 38/39>** some of which are immediately relevant to their tasks. Personal animosities are created by working together on the assembly line or in traffic. Others initiated outside the job are magnified to the breaking point by its compelled contacts. No worker is immune to these pressures and impacts upon temperament. They accumulate and explode over incidents trivial and important, personal and official. But the explosion point is merely the culmination of the antecedent pressures. That it is not relevant to the immediate task, involves a lapse from duty, or contains an element of volition or illegality does not disconnect it from them nor nullify their causal effect in producing its injurious consequences." 112 F2d at 17.

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[2] In *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601, ___ P2d ___ (1997), we defined a risk "associated with the employment" to mean a risk "resulting from the nature of [the] work" or a risk "to which the work environment exposes the worker."

Since Hartford, numerous other jurisdictions have adopted the foregoing reasoning to various degrees. *See, e.g., Mullins v. Tanksleary*, 376 P2d 590, 592 (Okla 1962) (assault by coemployee that was unrelated to employment or personal animosity "lay within that range of work-connected peril which was inseparable from the risk incidental to employment"); *Crotty v. Driver Harris Co.*, 49 NJ Super 60, 139 A2d 126 (1958) (assault by coemployee was work-connected so long as the assault was not motivated by contact with the employee outside of the employment); *Nash-Kelvinator Corp. v. Industrial Commission*, 266 Wis 81, 62 NW2d 567 (1954) (assault by coemployee concerning homosexuality was compensable, because the work environment was a causative factor); *see also 1 Larson's Workers' Compensation Law* §11.16(a) (annotating holdings from other jurisdictions and noting that the trend is toward adopting this reasoning).

In our view, the reasoning in *Hartford* and its progeny is consistent with Oregon's test for assessing whether an injury arises out of employment. As mentioned, employer asserts, as did the Court of Appeals, that only those injuries from assaults that are directly precipitated by "work-related" factors--such as a coemployee's critique of another employee's job performance--are compensable. We conclude that that focus is too narrow. An injury arises out of employment if the risk of injury results from the nature of the claimant's work or from the work environment. That test does not require that the motivation for a coemployee's assault be an argument over job performance or some other work-related factor.

326 Or 40> Just as the workplace exposes an employee to a myriad of risks that inhere in the physical workplace environment--such as machines and office equipment that can malfunction--the workplace also exposes employees to the risk that a coemployee may lose control of his or her emotions and assault the employee. @ether the coemployee's loss of control is connected to a work-related comment is not dispositive. That difference does not, *ipso facto*, distinguish those cases that can be deemed to arise out of employment from those that cannot. Employee interactions cannot be so easily isolated and compartmentalized. The most direct cause of an assault by a coemployee may be a criticism of another employee's work, lack of hygiene or fashion sense. However, in any such case, the criticism may be but the last of many straws precipitating the assault. Based on the foregoing reasoning, we hold that the risk of an assault by a coemployee in the workplace is a risk to which the work environment exposes an employee.

This does not mean that an injury resulting from an assault by a coemployee arises out of employment *per se*. The rationale for the "proximity" test is that a workplace assault by a coemployee is caused by circumstances *associated with the work environment*. When the motivation for an assault by a coemployee is an event or circumstance pertaining to the assailant and the claimant that originated entirely separate from the workplace, and the only contribution made by the workplace is to provide a venue for the assault, then the rationale does not apply. Larson explains this limitation as follows:

> "When the animosity or dispute that culminates in an assault is imported into the employment from claimant's domestic or private life, and is not exacerbated by the employment, the assault does not arise out of the employment under any test." *1 Larson's Workers' Compensation Law* § 11.21(a) at 3-314.[3]

326 Or 41> An example would be where two employees had a romantic relationship outside of work and a workplace assault by one on the other was based on an event unique to that relationship and was not fueled, in part, by any workplace event.

Applying the foregoing analysis to this case, there is no evidence that claimant and his assailant had any relationship outside of work or that the motivation for the assault was fueled by an occurrence involving them outside of work. Rather, the undisputed motivation for the assault was the assailant's

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[3] A New Jersey court characterized the limitation in a similar fashion:

> "[A]ssaults by co-workers are compensable as long as they are not motivated by personal vengeance stemming from contact with the employee outside of the employment." *Crotty v. Driver Harris Co.*, 49 NJ Super 60, 139 A2d 126, 134 (1958).

anger over being called racially derogatory names, combined with the assailant's belief that he would be fired for having assaulted another coemployee moments earlier and, therefore, that he had nothing to lose by assaulting complainant, all of which occurred at the workplace. Under those circumstances, we conclude that claimant's injury arose out of his employment.[4]

The Board, having concluded that claimant's injury arose out of and in the course of his employment, concluded further that claimant was not an "active participant" in the assault and that compensability, therefore, was not excluded under ORS 656.005(7)(b)(A).[5] As noted above, 325 Or at 37, that statute provides that compensability does not include

> "[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[.]"

Employer argued below that claimant's derogatory racial comments angered assailant and thereby caused assailant to assault claimant. Consequently, employer argued that claimant's comments made claimant an active participant in the assault. The ALJ, however, made a contrary finding. He concluded that:

> **326 Or 42>** "Because of the intervening time period, the intervening provocation by another employee and the assault on that employee, and because claimant neither intended nor anticipated the assault that injured him, I conclude that claimant was not an 'active participant.' He did not voluntarily assume an active or aggressive role in the assault."

The Board adopted that finding. Under the circumstances of this case, we agree that the claimant was not an active participant. The statutory provision expressly requires that a claimant be an "active participant in assaults or combats." (Emphasis added.) Those terms require more than that a claimant anger an assailant in such a way that the assailant later assaults the claimant. Based on the text alone, we conclude that claimant was not an active participant in the assault that injured him. Therefore, claimant's injury is compensable under ORS 656.005(7).

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is affirmed.

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[4] The reasonableness or offensiveness of claimant's racially derogatory comments is irrelevant to this inquiry. *See Clark v. U.S. Plywood*, 288 Or 255, 265,605 P2d 265 (1980) (asserting that a "holding that compensability is determined by the reasonableness of the worker's conduct has no foundation in the workers' compensation statutes or in Oregon case law").

[5] The Court of Appeals did not reach that issue. Typically, in that situation, this court remands to the Court of Appeals to consider such an issue in the first instance. In this case, however, for efficiency's sake, and because the issue was decided by the Board and presented in the briefs, we decide the issue now.

Cite as 148 Or App 472 (1997) June 18, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Tracie L. Martin, Claimant.
Tracie L. MARTIN, *Petitioner,*
v.
HEWLETT-PACKARD CO., *Respondent.*
(WCB No. 94-12729; CA A92915)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 17, 1997.
Robert Wollheim argued the cause for petitioner. With him on the brief were Welch, Bruun, Green & Wollheim, J. David Kryger and Emmons, Kropp, Kryger, et al.
Ruth C. Rocker argued the cause for respondent. With her on the brief were Janet M. Schroer and Hoffman, Hart & Wagner.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Reversed and remanded.

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148 Or App 474> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in reversing an order of an administrative law judge (ALJ) and finding that claimant had failed to establish that she has permanent impairment. Because we conclude that the Board erred as a matter of law in concluding that there was no evidence of permanent impairment, we reverse the Board's order and remand the case for reconsideration.

While working for employer, claimant sustained a left wrist injury, diagnosed as carpal tunnel syndrome. Employer accepted the claim as disabling. Dr. Warren, claimant's attending physician, limited claimant to light duty, and her symptoms began to improve. After approximately six months of light duty work, claimant reported to Warren that her condition was better and asked to be released for regular work. Warren released her for regular work and, in a report dated February 2, 1994, which claimant characterizes as a closing examination report, indicated that claimant had become medically stationary and that there was no need for surgical intervention. Claimant returned to her regular work.

The claim was closed on July 28, 1994, with no award of permanent partial disability. Claimant sought reconsideration, contending that there was permanent disability. The Department of Consumer and Business Services affirmed the notice of closure, and claimant requested a hearing. An ALJ awarded claimant 14 percent scheduled permanent partial disability and attorney fees, and employer appealed to the Board. The Board reversed the ALJ's order, finding that claimant had failed to present any evidence that she had permanent impairment. The Board said:

> "To obtain a permanent scheduled disability award, claimant must establish a permanent loss of use or function of a body part due to an industrial injury. ORS 656.214(1)(b); OAR 436-35-010(2). If there is no medical evidence of permanent loss of such use or function, there is no basis for a permanent disability award. *E.g., Nancy P. Strande,* 46 Van Natta 400 (1994).
>
> **148 Or App 475>** "Here, Dr. Warren found numbness and tingling in the fingers of claimant's left hand and determined that claimant was 'obviously unable to perform repetitive heavy grasping activities with the left hand and forearm.' *Warren did not, however, state that those findings were permanent. Because there is no other medical evidence establishing the permanency of claimant's left hand findings, there is no basis for a permanent disability award.* Consequently, we reverse the ALJ's scheduled permanent disability award and reinstate the Order on Reconsideration." (First emphasis Board's; second emphasis supplied.)

Claimant asserts that the Board erred as a matter of law in finding that claimant had no permanent disability. Claimant notes that, pursuant to OAR 436-10-080(2), when the attending physician determines that a worker is medically stationary, the physician must state whether the worker's injury-related condition has resolved, returning the worker to pre-injury status. The rule further provides that

"[i]f there is a permanent loss of use or function, a closing examination as described in this rule shall be performed." Claimant asserts that OAR 436-10-080(2) permits a closing examination only after the claimant has become medically stationary, *i.e.*, when "no further material improvement would reasonably be expected from medical treatment, or the passage of time," ORS 656.005(17), and only if there is permanent residual loss of use or function. Accordingly, she reasons, if a closing examination is conducted, then any identified impairment must be permanent.

We disagree with claimant's first assumption that, because the rule requires a closing examination when the impairment is permanent, a closing examination is conducted only when there is permanent disability. Although the rule requires a closifig examination if there is permanent impairment, it does not prohibit a closing examination in other circumstances. Any final examination by an attending physician before claim closure might satisfy the criteria for a closing examination, whether or not the claimant has permanent impairment. Thus, the fact that Warren's last examination of claimant met the criteria for a closing examination does not necessarily mean that claimant has permanent disability.

148 Or App 476> Claimant further contends that the Board erred as a matter of law in finding that Warren's opinion could not support a finding of permanent impairment. In his February 2, 1994, report concerning claimant's condition, Warren found that claimant has a loss of sensation in her fingers and "is obviously unable to perform repetitive heavy grasping activities with the left hand and forearm." He did not say whether those conditions were permanent, but they are conditions that together have an impairment value of 14 percent. Warren recommended, in the same report, that the claim be closed and "be made medically stationary." When a person's condition is medically stationary, "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). In view of the simultaneous finding in Warren's report that claimant is medically stationary, at least one reasonable finding is that the impairment described in the report is not reasonably expected to improve from medical treatment or the passage of time. That is evidence of permanent impairment. Accordingly, the Board erred as a matter of law in concluding that claimant presented no evidence of permanent impairment. On remand, the Board should reconsider its order in the light of this opinion.

Reversed and remanded.

Cite as 148 Or App 484 (1997) June 18, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jon O. Norstadt, Claimant.
Jon O. NORSTADT, *Petitioner,*
v.
MURPHY PLYWOOD/LIBERTY NORTHWEST INSURANCE CORPORATION; Douglas County Forest Products/Liberty Northwest Insurance Corporation; Parkway Ford/Liberty Northwest Insurance Corporation; Huffman & Wright/Liberty Northwest Insurance Corporation; and Able Temporary/Health Future Enterprises, *Respondents.*
(94-10782, 94-10781, 94-10773, 94-10774, 94-05124; CA A93457)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 22, 1997.

Thomas Cary argued the cause for petitioner. With him on the brief was Coons, Cole, Cary & Wing, P.C.

Brian L. Pocock argued the cause and filed the brief for respondent Murphy Plywood/Liberty Northwest Insurance Corporation.

David O. Wilson argued the cause and filed the brief for respondents Douglas County Forest Products/Liberty Northwest Insurance Corporation and Parkway Ford/Liberty Northwest Insurance Corporation.

Patricia Nielsen argued the cause for Huffman & Wright/ Liberty Northwest Insurance Corporation. With her on the brief was Mannix, Nielsen & Crawford, P.C.

Adam Stamper filed the brief for respondent Able Temporary/Health Future Enterprises.

148 Or App 485> Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LEESON, J.

Reversed and remanded for reconsideration.

148 Or App 487> Claimant seeks review of an order of the Workers' Compensation Board determining that his bilateral hearing loss is compensable but that the loss is not the responsibility of any of the employers joined in this proceeding.[1] We reverse and remand.

Claimant has had multiple employers over the years, most of whom were in the forest products industry. Claimant worked for Huffman & Wright cutting lumber from December 1985 to January 1986. Claimant first sought treatment for his compensable hearing loss in October 1986, while he was working for Douglas County Forest Products (DCFP), then insured by Lumbermen's Underwriting Alliance (DCFP/ LUA). Claimant did not seek workers' compensation benefits for his condition at that time, however, because he was not aware that the condition was work related. In subsequent years, claimant worked for many employers, including all of those listed as respondents to this petition. He had a second period of employment with DCFP, from October 16, 1991, to March 16, 1992, when DCFP was insured by Liberty Northwest (DCFP/LN.) All of the employers remaining as parties to this petition, see note 1, were insured by Liberty Northwest as their insurer at the relevant times, and when we refer to them collectively, we refer to them as the "Liberty employers."

In 1993, claimant learned that his hearing loss was work related. He filed claims against each of his former employers. Substantial evidence supports the Board's findings that the hearing loss is work related and that, under the last injurious exposure rule, presumptive responsibility for claimant's hearing loss should rest with DCFP/LUA, because claimant first sought treatment for the condition while employed there in 1986. *Timm v. Maley,* 125 Or App 396, **<148 Or App 487/488>** 400-01, 865 P2d 1315 (1993). The Board found, however, that although claimant filed a claim against DCFP, "claimant apparently did not file a claim against [DCFP/LUA] and it was not a party to the hearing." Therefore, claimant's claim against DCFP related only to his second period of employment, when DCFP was insured by Liberty. The Board also found that claimant had waived his claim against DCFP/LUA and "chose to pursue his claim" against his earlier and subsequent employers and was entitled to compensation only if the evidence established that responsibility could be shifted to a subsequent or preceding period of employment. Substantial evidence supports the Board's findings that DCFP/LUA is not a party to this proceeding and that the earlier and later periods of employment with DCFP did not independently contribute to claimant's condition.

The essence of claimant's argument is that, having asserted his claim against DCFP, he has satisfied his statutory obligation with regard to his entire employment with that employer, including the period during which DCFP was insured by Lumbermen's. Consequently, the question of which insurer must pay his benefits, Liberty or Lumbermen's, is not his concern. The dissenting Board member agreed with claimant that the filing of a claim against DCFP satisfied claimant's obligation with respect to each *insurer* of DCFP. As the dissenting Board member said:

> "A claimant's claim is with the employer, not with any particular carrier. A claimant is required to give notice of the occupational disease claim to the employer. *See* ORS 656.265; ORS 656.807."

That view is consistent with the Supreme Court's decision in *Runft v. SAIF,* 303 Or 493, 739 P2d 12 (1987). Relying on administrative rules of the Department of Consumer and Business Services (Department), the court held that when an insurer discovers that its insured and another employer are involved in an occupational disease claim that could have resulted from exposure at either or both places of employment, the insurer must join the other employer by a procedure that is equivalent to a claim against that later employer. The failure of the insurer in *Runft* to do so prevented it from **<148 Or App 488/489>** using the last injurious exposure rule to avoid responsibility for payment of a claim. *Id.* at 504.

The Department responded immediately to the Supreme Court's opinion in *Runft* with new procedures and forms for insurers and employers to complete when other insurers or employers were believed to be involved in a claim. Then, in 1990, the legislature enacted what became codified as ORS 656.308(2), which provides:

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[1] The respondents involved in this petition, referred to collectively as the Liberty employers, are Murphy Plywood, Douglas County Forest Products/Liberty Northwest (DCFP/LN) and Parkway Ford. Claimant withdrew his request for hearing with respect to Able Temporary/Health Future Enterprises, Inc. Accordingly, although named as a respondent, Able Temporary is not a party to this petition. Claimant makes no contention on review with regard to employer Huffman & Wright, also insured by Liberty.

> "No employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer, or the employer or insurer has consented to the issuance of an order designating a paying agent under ORS 656.307. *Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named orjoined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."*

(Emphasis supplied.) ORS 656.308(2) (1990) was the legislature's response to the issue of joinder of multiple employers and insurers. It provides that, to join an "employer or insurer," the worker must file a claim against "that employer or insurer." The language of the statute makes it clear that claims must be filed against each employer and insurer and that the filing of a claim against an employer does not join each of the employer's insurers. The 1990 version of ORS 656.308(2) also requires that the employer or insurer who intends to argue that another employer or insurer is responsible issue a notice of disclaimer. That notice must contain a list of employers or insurers that the disclaiming party believes to be responsible for the claim and must be issued within 30 days of notice of the claim. The claimant then has **<148 Or App 489/490>** 60 days from the notice of disclaimer to file a claim against the named employers or insurers. The statute prohibits reliance on the lack of responsibility as a defense if the insurer or employer does not comply with the disclaimer process.

In 1995, the legislature made extensive amendments to ORS 656.308, including elimination of the requirement that an employer or insurer issue a responsibility disclaimer. ORS 656.308(2) (1995) now provides, as relevant:

> "(a) Any insurer or self-insured employer who disputes responsibility for a claim shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued *in the 90 days allowed for processing of the claim.* The denial shall advise the worker to file separate, timely claims against other potentially responsible insurers or self-insured employers, including other insurers for the same employer, in order to protect the right to obtain benefits on the claim. The denial may list the names and addresses of other insurers or self-insured employers. * * *
>
> "(b) No insurer or self-insured employer, including other insurers for the same employer, shall be joined to any workers' compensation hearing unless the worker has first filed a timely, written claim against that insurer or selfinsured employer, or the insurer or self-insured employer has consented to issuance of an order designating a paying agent pursuant to ORS 656.307. An insurer or self-insured employer against whom a claim is filed may contend that responsibility lies with another insurer or self-insured employer, including another insurer for the same employer, regardless of whether the worker has filed a claim against that insurer or self-insured employer."

(Emphasis supplied.) The amendments eliminate the requirement for the issuance of a disclaimer and also expressly provide that the period for denying responsibility is 90 days from the date of knowledge of the claim. The statute retains the requirement that a claim be filed against each employer or insurer before the employer or insurer can be joined in a hearing.

Claimant contends that the 1990 version of ORS 656.308(2) applies in this case and that the Liberty employers are precluded from asserting that another employer is responsible because they did not comply with the disclaimer **<148 Or App 490/491>** requirement. The Liberty employers reply that the 1995 version of the statute is to be applied retroactively, that a disclaimer is no longer required and, consequently, that their failure to disclaim responsibility does not prevent them from asserting their lack of responsibility for the claim.

We addressed the retroactivity of the 1995 amendments to ORS 656.308(2) in *Motel 6 v. McMasters*, 135 Or App 583, 899 P2d 1212 (1995). The claimant had worked for Motel 6 for a time during which the employer had had two different workers' compensation carriers. The claimant was compensably injured when Motel 6 was insured by CIGNA. Her claim was closed with an award of benefits. After the employer became insured by Alexsis, the claimant experienced another injury for which she filed a claim with Alexsis. Pursuant to ORS 656.308(2) (1990), Alexsis denied the claim and notified the claimant that it believed that her injury was the responsibility of CIGNA. The claimant requested a hearing on the denial, but did not file a claim against CIGNA until 85 days after Alexsis had denied the claim. A referee concluded that because the claimant had not filed her claim with CIGNA within 60 days of the notice from Alexsis, as required by the 1990 version of ORS 656.308(2), the claim was untimely. The Board reversed the referee and held that the claim was not time barred. On review, before considering the merits of CIGNA's petition for review, we first considered the effect of the 1995 amendments to ORS 656.308(2). Citing *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), we noted that, generally, changes made to the Workers' Compensation Law by Oregon Laws 1995, chapter 332, are applicable to all cases in which a final decision has not issued on the effective date of the act. Or Laws 1995, ch 332, § 66. We also noted an exception to that general requirement:

> "'The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act *do not extend or shorten the procedural time limitations with regard to any action* on a claim *taken prior to the effective date of this Act.'*
>
> "Because this case involves a procedural time limit, the changes made by SB 369 are not applicable here."

148 Or App 492> *McMasters*, 135 Or App at 587 (emphasis supplied). The retroactive elimination of the disclaimer requirement eliminated one procedural time limitation and altered the time limitation for the filing of a claim. Neither change affected the outcome in *McMasters*. Nonetheless, we held that the 1995 amendments to ORS 656.308(2) would not be applied retroactively because they "involve[] a procedural time limit." *Id.*

This case demonstrates our holding in *McMasters*. The amendments to ORS 656.308(2) eliminate procedural time deadlines for the filing of a disclaimer and alter time deadlines for the filing of a claim against an employer listed in a disclaimer, thereby subjecting a claimant who intends to file a claim with another employer to the different time frames set forth in ORS 656.807 with regard to occupational disease claims and ORS 656.265 with regard to injury claims. The amendments have the effect of shortening the time limitation period for the filing of a claim for injury fr6m 90 days from the date of the notice of disclaimer to 30 days from the date of injury. ORS 656.265(1) (1990).[2] Additionally, application of the 1995 version of ORS 656.308(2) here would give an employer who failed to disclaim responsibility under the 1990 version of the statute a second chance to deny responsibility. Neither the statute nor its legislative history manifests such an intention. The legislative history clarifies that the changes were not intended to provide new time frames for acts that should have been taken before passage of the amendments. Representative Mannix testified before the House Committee on Labor:

> "Sub. (6): The amendments to this chapter do not extend or shorten the procedural litigation time frames which began running before the date of passage of this Act. **<148 Or App 492/493>** 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 passage of this Act, if there's new time frames, those will apply, but not time frames from before the passage of this Act."

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[2] ORS 656.265(1) was likewise amended in 1995 to increase the time limitation for the filing of a claim from 30 to 90 days after the injury. It is clear that that amendment would not be applied retroactively. Or Laws 1995, ch 332, § 66(6). An injured claimant would therefore be subject to a 30-day limitation for the filing of a claim for which no disclaimer had been made. Because claimant's condition is an occupational disease, the amendments mean that claimant's claim would be subject to the general time limitation set forth in ORS 656.807(1), which requires the filing of a claim within one year from the date of discovery of the disease or from the date a claimant becomes disabled or is informed by a physician that there is an occupational disease.

Tape recording, House Committee on Labor, March 22, 1995, Tape 62, Side B at 466-79 (emphasis supplied). The 1995 amendments to ORS 656.308(2) eliminating the process for disclaimer also eliminate old time frames and substitute new time frames. Although the elimination of the disclaimer requirement itself neither shortens nor lengthens the requirement for disclaimer, the amendments touch on multiple time limitations. Consequently, ORS 656.308(2) (1995) does not apply retroactively.

Nonetheless, the Liberty employers contend that the 1990 version of ORS 656.308(2) does not apply because that subsection is applicable only if there is an accepted claim pursuant to ORS 656.308(1) (1990).[3] We disagree. The entire statute was enacted by the legislature in 1990. Or Laws 1990, ch 2, § 49. Although subsection (1) is limited to claims involving previously processed. claims, the language of subsection (2) unambiguously applies to all cases in which an employer or insurer intends to deny responsibility. The first sentence of subsection (2) refers to "any workers' compensation proceeding." The second sentence of subsection (2), which sets forth the requirements at issue in this case, refers to "any employer or insurer which intends to disclaim responsibility for a given injury or disease claim." Subsection (2), by its terms, is not limited to disclaimers of claims or injuries subject to subsection (1). We conclude that subsection (2) functions independently of subsection (1) and that it is applicable here.

148 Or App 494> Parkway Ford's disclaimer of responsibility in this case did not comply with ORS 656.308(2) (1990) because it was not issued for six months after Parkway Ford had been notified of the claim. DCFP/LN's disclaimer was defective in that it failed to list DCFP/LUA as a potentially responsible insurer. Murphy Plywood failed to deny the claim or disclaim responsibility at all.

Claimant cites several orders of the Board holding that an insurer's failure to comply with the requirements of ORS 656.308(2) (1990) relieves a claimant of the obligation of filing a claim against a prior employer and also precludes the disclaiming employer from arguing that a prior employer is responsible for the claim. In *Wayne D. Helgerson*, 45 Van Natta 1800 (1993), for example, the Board said:

> "ORS 656.308(2) provides that any carrier which intends to disclaim the responsibility on the basis of an exposure with another carrier must specify in its disclaimer of responsibility which carrier is allegedly responsible; and only then must the claimant file a claim with such other insurer."

See also Jon F. Wilson, 45 Van Natta 2362 (1993). In *Donald A. James*, 46 Van Natta 1898 (1994), the Board affirmed an assignment of responsibility for a hearing loss claim to an insurer that had failed to timely issue a disclaimer of responsibility. The claimant in that case chose to dismiss the other insurers because he knew that CIGNA, the improperly disclaiming insurer, would not be permitted to deny responsibility. The other insurers had denied responsibility. CIGNA argued that the claimant was not prejudiced by its untimely disclaimer of responsibility because all potentially responsible insurers had been joined as parties to the proceeding. The Board rejected CIGNA's argument:

> "The statutory language is clear. * * * [It] allows a responsibility defense if an insurer issues a timely disclaimer even if the claimant has not actually filed claims against other insurers. It follows that *an insurer which does not comply with the disclaimer requirements is precluded from asserting a responsibility defense.* Under ORS 656.308(2), prejudice to the claimant is not relevant to the analysis."

(Emphasis supplied.) The Board held that if an employer or insurer fails to comply with the disclaimer requirements, it **<148 Or App 494/495>** may not assert as a defense that actual responsibility for the claimant's disability lies with another insurer or employer. The Board noted that the claimant chose not to pursue a claim against another insurer, but that the claimant had no obligation to join any prior employers or insurers when the carrier with whom the claimant did file the claim had failed to meet the requirements of ORS 656.308(2) (1990). *See also Rachel J. Dressler-Iesalnieks*, 45 Van Natta 1792 (1993); *Byron E. Bayer*, 44 Van Natta 1686 (1992); *Rene C. Gonzalez*, 44 Van Natta 2483 (1992).

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[3] ORS 656.308(1) (1990) provided:

> "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 foregoing cases illustrate that, under the Board's interpretation of ORS 656.308(2) (1990), an insurer that does not comply with the disclaimer requirement loses the defense of responsibility. Although that analysis is correct, it was not applied by the Board in this case. Claimant's claim has been declared compensate and because they did not properly disclaim responsibility, each of the Liberty employers is precluded from asserting responsibility as a defense. The only question is which employer must pay. Claimant should not bear the burden of choosing which of his former employers should pay his benefits when each is potentially responsible for the claim. We remand to the Board to determine in the first instance how responsibility should be assigned in this case among Murphy Plywood, DCFP/LN and Parkway Ford.

Reversed and remanded for reconsideration.

Cite as 148 Or App 496 (1997) June 18, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Manuel Garibay, Claimant.
Manuel GARIBAY, *Petitioner,*
v.
BARRETT BUSINESS SERVICES, *Respondent.*
(94-14940; CA A94186)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 26, 1997.
Vance D. Day argued the cause and filed the brief for petitioner.
Travis Terrall argued the cause for respondent. With him on the brief was Terrall & Associates.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.

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148 Or App 498> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in affirming the administrative law judge (ALJ) and holding that his claim for carpal tunnel syndrome is not compensable. We agree with claimant that the Board erred and further hold that the claim is the responsibility of Barrett Business Services (Barrett). Accordingly, we reverse and remand the case for acceptance and processing of the claim by Barrett.

Claimant moved to Oregon from Mexico in 1981. His first language is Spanish, and the record shows that he does not read or write English. Claimant has been planting and harvesting trees since 1981. When he first came to Oregon, he worked for a company called Northwest Green Tree. Claimant testified that in 1983 or 1984 Green Tree changed its name to Chapparral. Barrett's last witness at the hearing, Caudillo, the owner of Chapparral, testified that Chapparral and Northwest Green Tree are related but separate corporations and that, although claimant continued to work at the same location, he became an employee of Chapparral in 1990. In 1991, Caudillo transferred claimant to Barrett, which leased claimant to Chapparral until 1994, when he stopped working. All of these changes took place without claimant's knowledge, as he continued to do the same work at the same location. Until the time of the hearing, claimant believed that he had worked for the same employer from 1981 until 1994.

Claimant first saw a doctor in 1993 when one of his supervisors took him to the emergency room for treatment of a finger that had been cut by a chain saw. In follow-up examinations, the doctor suspected that claimant also suffered from carpal tunnel syndrome (CTS) and referred claimant to a specialist, who ultimately diagnosed CTS. The medical evidence specifically related claimant's condition to his work as a tree planter and harvester "for this company, for 13 years." Claimant testified that his symptoms began in 1989. In his original order, the ALJ did not address the multiple employer situation and found that claimant's condition was related to his years of work as a planter/harvester and was compensable. The fact that the condition was caused by claimant's work over the 13 years is not disputed.

148 Or App 499> The ALJ's order was mailed on July 17, 1995. In a motion for reconsideration, Barrett asked the ALJ to consider the effect of a 1995 amendment to ORS 656.005 providing a definition of "preexisting condition." ORS 656.005(24).[1] In its motion for reconsideration, Barrett argued:

> "[W]hile you may find that claimant's work since 1981 was responsible for his bilateral carpal tunnel syndrome, *with regard to the claim filed with our employer, claimant has a 'pre-existing condition'* pursuant to ORS 656.005(24)." (Emphasis supplied.)

Claimant responded that Barrett's assertion was, in essence, a responsibility denial for which Barrett was required to issue a disclaimer pursuant to ORS 656.308(2) (1990).[2] Claimant contended that Barrett, having failed to disclaim responsibility, could not raise lack of responsibility as a defense.

In his order on reconsideration, the ALJ agreed with Barrett that claimant's prior work exposure had given rise to a preeidsting condition and that claimant had failed to show **<148 Or App 499/500>** that his work with Barrett had caused a worsening of his preexisting condition. On review, the Board found that "[t]he medical evidence shows that the major contributing cause of claimant's CTS is his 12-year work history as a tree planter and harvester." However, the Board did not specifically adopt the preexisting condition analysis. Instead, it held that by the time of the hearing claimant had sufficient information to know that he had had multiple employers but that he joined only Barrett and that claimant had not established that his employment with Barrett had either caused or worsened his CTS. The Board rejected the dissenting Board member's view that claimant had established the compensability of his condition under the last injurious exposure rule, reasoning that claimant's only theory of compensability before the ALJ and the Board had been actual causation of an occupational disease by a single employment. The Board reasoned that claimant had not chosen to "invoke" the last injurious exposure rule and refused to apply the rule *sua sponte.*

We agree with the Board that claimant did not technically "invoke" the last injurious exposure rule. He filed a claim only with Barrett, apparently because he believed that Barrett had always been his employer's legal name and that he had worked for the same employer since 1981. His medical evidence was directed at proof of causation over that entire period. As the dissenting Board member pointed out, because of claimant's mistaken belief that he had had the same employer for 13 years, it cannot be said that claimant elected to prove actual causation by his 2 1/2 years of employment with Barrett.

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

[2] ORS 656.308(2) (1990) provides:

> "No employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer, or the employer or insurer has consented to the issuance of an order designating a paying agent under ORS 656.307. Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."

As we held in *Norstadt v. Murphy Plywood,* 148 Or App 484, ___ P2d ___ (1997), the 1995 amendments to ORS 656.308(2) are not applicable to this case, because they alter time limitations with respect to actions that had been taken on the claim before the effective date of the Act. *Id.* at 492.

Resolution of this dispute does not depend on whether claimant is entitled to rely on the last injurious exposure rule to establish the compensability of his claim. The Board found that claimant's condition was caused in major part by his work as a tree planter and harvester between 1981 and 1994. That finding is supported by substantial evidence. Whether through misunderstanding or oversight, claimant did not join Green Tree or Chapparral, and they cannot be held responsible for his CTS because they have not been joined. ORS 656.308(2) (1990). Claimant did file a claim with Barrett. Barrett had a statutory obligation pursuant to ORS 656.308(2) (1990) to disclaim responsibility **<148 Or App 500/501>** for the claim when it learned that claimant's condition was work related and potentially was the responsibility of Green Tree or Chapparral. Barrett failed to do so. Claimant's confusion about who employed him is exactly the circumstance that ORS 656.308(2) (1990) was intended to remedy. Under the relevant version of ORS 656.308(2), claimant did not need to seek out every potentially responsible employer or insurer; it was Barrett's obligation to provide claimant with a list of potentially responsible employers or insurers, if Barrett intended to assert that a different employer was responsible for claimant's CTS.

We agree with claimant that this case is about responsibility. As indicated by the testimony of Caudillo, Barrett's witness, Barrett knew that claimant had been transferred to it by Chapparral and had been doing the same work for many years; the medical evidence showed that it was his work over the entire period of employment that had caused his condition. Although Barrett did not, in the technical sense, raise responsibility as a defense, that was the practical effect of its contention to the ALJ that claimant had a preexisting condition for which Barrett was not responsible. In the light of the record, which supports the Board's finding that claimant's condition was caused by his work, we treat Barrett's preexisting condition argument as a contention that another employer is responsible. Barrett is barred from making that argument, because it failed to disclaim responsibility for the claim as provided by ORS 656.308(2) (1990).

The Board's order is based in part on its view, enunciated in *Joyce A. Crump,* 47 Van Natta 466 (1995), that the obligation to disclaim responsibility does not exist if there is a dispute as to the compensability of the claim. We reject that contention. The requirement for issuance of a disclaimer in ORS 656.308(2) (1990) is not contingent on a concession of compensability by an employer. The statute does not distinguish between cases involving responsibility only and cases involving both responsibility and compensability. It requires the issuance of a disclaimer by "[a]ny employer * * * which intends to disclaim responsibility for a given injury or disease claim." Failing that, an employer may not assert as a defense that "responsibility lies with another employer or insurer." **<148 Or App 501/502>** An employer that fails to disclaim responsibility may continue to assert that the claim is not compensate but not for the reason that it was caused by a prior work exposure. In this case, Barrett's denial of compensability was based solely on its contention that claimant's CTS was a preeidsting condition brought on by an earlier employment, which is merely an assertion that another employer is responsible. Having failed to disclaim responsibility for the claim, Barrett is barred from asserting that claimant's CTS was caused by a different employer.

Reversed and remanded.

Cite as 149 Or App 44 (1997) July 2, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marianne L. Sheridan, Claimant.
Marianne L. SHERIDAN, *Petitioner*,
v.
JOHNSON CREEK MARKET and United Employers Insurance, *Respondents*.
(WCB No. 91-09220; CA A93251)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 22, 1997.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Karen O'Kasey argued the cause for respondents. With her on the brief was Schwabe, Williamson & Wyatt.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P.J.
Affirmed.

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149 Or App 46> Claimant seeks review of an order of the Workers' Compensation Board on remand upholding employer's July 2, 1991, denial of an elbow condition. For the following reasons, we affirm.

On July 9, 1990, claimant fell at work and struck her right elbow. An x-ray revealed a free body lying in the anterior and lateral aspect of claimant's elbow joint. She filed a workers' compensation claim for "chipped bone," and employer accepted the claim. In August 1990, claimant's attending physician, Dr. Wade, performed surgery to remove the free body from the elbow joint. On November 26, 1990, Dr. Wade examined claimant and determined that she had normal ranges of motion in her elbow and that the bony architecture of the elbow was normal. Dr. Wade determined that claimant was medically stationary and released her for work. Because claimant did not feel able to return to work, she consulted Dr. Berselli on November 28, 1990. In January 1991, Dr. Berselli ordered an MRI, which revealed an irregularity of the articular surface of the olecranon in an area that was the donor site of the free body that had been removed from claimant's elbow in August 1990. In March 1991, an arthroscopy of claimant's elbow revealed reactive synovitis in the elbow joint. Meanwhile insurer had issued a notice of claim closure, based on Dr. Wade's report that claimant was medically stationary.[1]

Claimant challenged the closure of her claim, arguing that she was not medically stationary and that the closure had been premature. Claimant asserted that her need for treatment after November 1990 was exclusively due to the July 1990 accident at work. Employer responded that the **<149 Or App 46/47>** closure was not premature because claimant had been determined to be medically stationary in November 1990, and that her subsequent need for medical treatment was due to a preexisting condition and not due to the July 1990 accident. The referee determined that the causation of claimant's need for treatment after November 1990 was a complex medical issue that must be proved by expert medical opinion. Thus, the referee turned to the medical evaluations of claimant by Dr. Wade and Dr. Berselli.

Dr. Wade was of the opinion that the free body that he removed from claimant's elbow joint was the result of an older injury but that the July 1990 accident had shifted it into the area from which it was later removed. His opinion was based on his observation of the free body and of claimant's elbow during surgery, as well as the later MRI results and arthroscopy. Dr. Wade also indicated that, during the August 1990 surgery, he had found no cartilage damage or arthritic conditions at the elbow joint. Dr. Berselli was of the opinion that the free body taken from the elbow joint was the result of a fracture that had occurred at the time of the July 1990 injury.

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[1] Claimant requested reconsideration of that closure, and the Appellate Review Unit (ARU) subsequently rescinded the notice of closure on the ground that the closure had been premature. The ARU later withdrew its order rescinding the notice of closure on the ground that it lacked jurisdiction. Those procedural matters were at issue in *Sheridan v. Johnson Creek Market*, 127 Or App 259, 873 P2d 328 (1994). Subsequently, the Board determined that the denial was procedurally proper due to legislative amendment of the relevant statutes. Those issues are not before this court on judicial review.

The referee determined that the free body preexisted the July 1990 work injury, but that the injury caused the free body to become symptomatic. The referee further found that the symptoms caused by the free body were resolved by November 1990, when Dr. Wade declared claimant to be medically stationary. The referee determined that claimant's subsequent need for medical treatment was due to cartilage damage or arthritic conditions that were caused in major part by her preexisting free body condition, not by the work injury. The referee gave more weight to Dr. Wade's medical opinion than to the opinion of Dr. Berselli; Dr. Wade had had the opportunity to examine the elbow nearer the time of the 1990 work injury and to examine the free body removed from the elbow, which did not appear to be the result of a recent injury. The referee determined that denial should be affirmed. The Board adopted the referee's factual findings and ultimately determined that claimant's compensable injury had combined with a preexisting condition--the free body that.had resulted from an earlier fracture--and that claimant therefore needed to demonstrate that the work **<149 Or App 47/48>** injury was the major contributing cause of her need for treatment of the combined condition. ORS 656.005(7)(a)(B). The Board therefore affirmed the referee's order.

On judicial review, claimant argues that, because employer originally accepted a condition that was described as "chipped bone," its subsequent denial was an impermissible denial of a claim that it previously had accepted. Employer points out that claimant did not make this argument to the referee or the Board. The record does not show that claimant made any argument before the referee or the Board that employer was impermissibly trying to limit its acceptance of her condition. On judicial review, claimant notes that the Board never examined the scope of the acceptance. That is true. However, given that the record does not indicate that claimant requested the Board to do so, the Board did not err. Claimant's arguments below were that her elbow condition, both before claim closure in November 1990 and after, were caused exclusively by the July 9, 1990, injury. She did not argue that employer was responsible because its acceptance had encompassed the preexisting condition; her argument was that there *was* no preexisting condition. Arguments not raised in an administrative forum will not be considered on judicial review unless they concern errors apparent on the face of the record. *Kessler v. Board of Parole,* 145 Or App 584, 590, 931 P2d 801 (1997). No error is apparent on the face of the record. Claimant's arguments concerning the scope of employer's acceptance are not preserved, and we therefore will not consider them on appeal. ORAP 5.45(2).

Claimant argues that the causation of her elbow condition "is irrelevant when the real issue is what the insurer in fact initially accepted." Thus, claimant does not question whether substantial evidence supports the Board's conclusion that claimant's July 1990 injury was not the major contributing cause for her need for treatment after November 1990, and we do not address that issue.

Affirmed.

Cite as 149 Or App 94 (1997) July 2, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Larry L. Ledin, Claimant.
SAIF CORPORATION and Leo Carignan, *Petitioners,*
v.
Larry L. LEDIN, *Respondent.*
(93-13841; CA A92669)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 16, 1996.

Julene M. Quinn argued the cause and filed the brief for petitioners.

Gordon S. Gannicott argued the cause for respondent. With him on the brief were David J. Hollander and Hollander, Lebenbaum & Gannicott.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Reversed and remanded for reconsideration.

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149 Or App 96> Employer seeks review of an order of the Workers' Compensation Board (Board) setting aside a denial of claimant's consequential condition claim. Employer assigns error to the Board's refusal to allow it to amend its denial. We reverse and remand for reconsideration.

Claimant suffered a compensable injury in 1976 when a saw kicked back and hit him in the face. Following treatment for the injury and closure, claimant developed vision problems, headaches and neck pain. A myelogram showed defects in claimant's cervical spine, which his physician diagnosed as secondary to the trauma and as either a herniated disc or a root avulsion. The parties then entered into a stipulation, reopening the claim for payment of temporary total disability. The parties agreed "that claimant be provided medical care and treatment as necessary for the treatment of his cervical condition and other sequelae arising out of his injury." After the stipulation and surgery, claimant's physician discovered that claimant's neck condition was not a herniated disc or root avulsion, but was a neurilemmoma. Claimant's physician indicated that the neurilemmoma was probably preexisting, but that the injury precipitated and aggravated the symptoms. Claimant's claim was closed with an award of disability for the cervical condition.

In 1993, claimant was diagnosed with a tear of the medial meniscus in his right knee. Insurer denied the claim on the following grounds:

> "You filed a claim for a work-related injury to your face which occurred on or about July 26, 1976 * * *. The claim has been accepted for facial laceration and hyperextension of the neck and benefits were provided according to law.
>
> "We have recently received information that you are seeking treatment for a tear of the right medial meniscus which you feel is related to your July 26, 1976 injury. After reviewing the information in your file, we are unable to pay for your current treatment because the July 26, 1976 injury is not the major contributing cause of your condition. Your **<149 Or App 96/97>** current condition is related to treatment for a neurilemmoma which preexisted the injury of 1976. Therefore, we must issue this partial denial."

Claimant requested a hearing challenging the "denial" and "compensability."

During opening statements at the hearing, claimant argued that, because both parties agreed that the knee condition was related to the neurilemmoma, the only issue to litigate was whether the neurilemmoma was related to the original facial injury and the subsequent surgeries. Insurer argued that its denial did not concede that the treatment for the neurilemmoma was the major contributing cause of the knee condition and that, if its denial did make such a concession, insurer moved to amend its denial. Claimant objected to the amendment. The administrative law judge (ALJ) sustained the objection on the ground that, under our opinion in *Tattoo v. Barrett Business Service,* 118 Or App 348, 847 P2d 872 (1993), employers are not allowed to amend their denials at hearing. The ALJ ultimately set aside employer's denial. The Board adopted the opinion of the ALJ and affirmed.

On review, employer argues that the Board erred in failing to allow it to amend its denial. According to employer, our decision in *Tattoo* addressed only whether an employer may offer oral testimony that contradicts the plain wording of a denial and did not address whether a denial itself may be amended. Employer points out that precluding amendments of denials makes no sense, because it would prevent employers from withdrawing denials and accepting a previously contested claim and, likewise, would prevent amendments that have the effect of narrowing the scope of the denial to a claimant's benefit. Claimant contends that the Board correctly read *Tattoo* to preclude employers from amending their denials and that we subsequently said as much in *SAIF v. Mize,* 129 Or App 636, 879 P2d 907 (1994).

We agree with employer that the Board read *Tattoo* too broadly. In *Tattoo,* the claimant challenged the validity of the employer's denial of chiropractic care as being impermissibly prospective. The Board disagreed, concluding that the denial, by its terms, was for current chiropractic care only. On review, the claimant relied on the testimony of one of the **<149 Or App 97/98>** employer's own claims examiners to demonstrate that the employer intended the denial to cover future treatment, as well as past treatment. We held that the claimant could not rely on the testimony of the claims examiner: "[E]mployers are bound by the express language of their denials *and the testimony of the claims examiner here is irrelevant.*" *Id.* at 351-52 (emphasis supplied). We did not hold that an insurer may not amend its denial at hearing.

In *Mize,* we held that an insurer could not assert that its notice of acceptance was contingent on the insurer's right to appeal when the acceptance did not specify any such contingency. Although we cited *Tattoo* in stating that "employers are bound by the express language of their denials," and we

found "no reason why that rule should not apply to an acceptance as well," *Mize*, 129 Or App at 639, we did not address the ability of an insurer to amend a denial at hearing, which is the issue before us in the present case. Moreover, amending an acceptance can involve substantially different considerations than amending a denial. Accordingly, our holding in *Mize* is not relevant to the case before us.

In short, neither *Tattoo* nor *Mize* addressed the ability of an insurer to amend its denial at hearing, and the Board's reliance on those cases for that proposition was in error.

Reversed and remanded for reconsideration.

Cite as 149 Or App 190 (1997) July 9, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marlie D. Bruce, Claimant.
Marlie D. BRUCE, *Petitioner,*
v.
SAIF CORPORATION and FJF Logging, Inc., *,qespondents.*
(93-07131; CA A93094)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 14,1997.
Kevin Keaney argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison.
Michael O. Whitty, Appellate Counsel, argued the cause and fildd the brief for respondents.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Reversed and remanded for further proceedings not inconsistent with this opinion.

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149 Or App 192> Claimant petitions for review of the Workers' Compensation Board's order on review, in which the Board found that claimant was not entitled to benefits for permanent total disability. ORS 656.206. We reverse and remand.

Claimant is a 42-year-old log truck driver, who has worked as a truck driver since he was 17 years old.[1] On May 23, 1988, while claimant was driving a log truck for his employer, FJF Logging, Inc., the truck rolled off a cliff. Claimant suffered facial injuries, a closed head injury, as well as injuries to his upper and lower back, right knee, and right arm, and partial loss of his vision.

As a result of his closed head injury, claimant now suffers from post-traumatic stress syndrome, depression, severe memory loss, and cognitive defects. These conditions have left him unable to return to his prior work activities. A vocational counselor identified claimant's post-injury transferable job skills as the ability to: (1) work in short cycle repetitive tasks; (2) work with things in a routine manner in a nonsocial environment; and (3) work with machines. The counselor concluded that there were some potential jobs that claimant could perform but found that, when he searched claimant's geographical area, Baker City, for such jobs, none was available.

Claimant was awarded, *inter alia,* 88 percent unscheduled disability[2] by a determination order. An order on reconsideration decreased the unscheduled disability award to 86 percent. Claimant appealed the order on reconsideration to an administrative law judge (ALJ), who concluded that

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[1] Claimant's formal education ended in the ninth grade. He has no high school diploma or general equivalency diploma (GED).

[2] Unscheduled disability is based on loss of earning capacity, determined by reference to such considerations as the claimant's age, education, and ability to adapt from his former work capabilities to his post-injury work capabilities. *See* ORS 656.214(5) and ORS 656.726(3)(f).

claimant's injury had left him permanently and totally disabled. ORS 656.206(1)(a).[3] SAIF appealed the **<149 Or App 192/193>** ALJ's order to the Board, and the Board reversed the ALJ's order, concluding that claimant had not proven that he was permanently and totally disabled. Consequently, the Board reinstated the award of 86 percent unscheduled permanent disability.

On review, claimant raises two assignments of error. He first challenges the Board's conclusion that he is capable of performing work in the light range.[4] He argues that the Board erred in disregarding the testimony of one of his vocational expert witnesses, Huckfeldt, who rendered the opinion that claimant was limited to work in the sedentary range.[5] The Board disregarded Huckfeldt's opinion:

> "The record does not support Huckfeldt's belief that claimant is limited to sedentary work. Instead, the record supports the conclusion that claimant can perform work in the light category. Because Mr. Huckfeldt's opinion is based on an incorrect belief that claimant was limited to sedentary work, we are not persuaded by his opinion regarding claimant's employability." (Exhibit numbers and footnote omitted.)

Substantial evidence supported the Board's determination that claimant could perform light work and its consequent rejection of Huckfeldt's opinion. ORS 183.482(8)(c). Accordingly, there was no error.

Claimant's second assignment of error challenges the Board's rejection of the testimony of his other vocational expert witness, Ross. Ross rendered an opinion that claimant was permanently and totally disabled, based on the "odd-lot" **<149 Or App 193/194>** doctrine. In *Welch v. Banister Pipeline,* 70 Or App 699, 701, 690 P2d 1080 (1984), we explained that doctrine:

> "[U]nder [the 'odd-lot' doctrine,] a disabled person may remain capable of performing work of some kind but still be permanently disabled due to a combination of medical and non-medical disabilities, which effectively foreclose him from gainful employment. Such non-medical considerations include age, education, adaptability to non-physical labor, mental capacity and emotional condition, as well as the conditions of the labor market."

Larson describes the "odd-lot" doctrine as

> "the probable dependability with which claimant can sell his services in a competitive labor market, undistorted by such factors as business booms, sympathy of a particular employer or friends, temporary good luck, or the superhuman efforts of the claimant to rise above his crippling handicaps." 2 Larson, Workmen's Compensation Law, § 57.51, 10-60 (1976) (cited with approval in *Harris v. SAIF,* 292 Or 683, 695, 642 P2d 1147 (1982)).

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[3] ORS 656.206(l)(a) provides:

"Notwithstanding ORS 656.225, 'permanent total disability' means the loss, including preexisting disability, of the use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, a gainful occupation is one that pays wages equal to or greater than the state mandated hourly minimum wage. As used in this section, a suitable occupation is one that the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation."

[4] OAR 436-035-0310(3)(f) provides:

" 'Light (L)' means the worker has the ability to occasionally lift 20 pounds and can frequently lift or carry objects weighing up to ten pounds[.]"

[5] OAR 436-035-0310(3)(d) provides:

" 'Sedentary (S)' means the worker has the ability to occasionally lift or carry dockets, ledgers, small tools and other items weighing ten pounds[.]"

In other words, in determining whether a person is permanently and totally disabled under the "odd-lot" doctrine, the question is whether the claimant is currently "able to sell his services on a regular basis in a hypothetically normal labor market." *Harris*, 292 Or at 695.

In concluding that claimant was permanently and totally disabled, Ross stated:

> "I think in part it has to do with the labor market that he resides in. It is, as others describe it, tight, and that's described even in the file material that I reviewed. It's comprised primarily of mill work, logging, driving, and there's a trailer manufacturer and small retail operations. Given the lack of skills and the nature and degree of both his physical and cognitive impairments, I don't think he can find employment on a regular and sustained basis within that labor market."

The Board said of this testimony:

> "Ross based his opinion largely on the state of the labor market where claimant resides. Ross indicated that his opinion that claimant was permanently and totally disabled 'has to do with the labor market that [claimant] resides **<149 Or App 194/195>** in. It is, as others describe it, tight [* * *.]' We have previously held that where a claimant has not found work because of the competitiveness of the labor market and the more limited labor market in the area where he lives and not because he is unable to perform work, the worker has not sustained his burden of proof to show that he is permanently and totally disabled. *Vivian F. Foltz*, 43 Van Natta 119 (1991);[6] *see also Mary J. Kamm*, 47 Van Natta 1443 (1995) (vocational opinion found unpersuasive where it was based on a lack ofjob openings in a claimant's geographical area rather than on whether the claimant was employable).[7]
>
> "Because vocational expert Ross' opinion is based, in part, on the 'tight' labor market where claimant lives, and not on whether he is currently able to sell his services on a regular basis in a hypothetically normal labor market, we do not find it persuasive."

Claimant argues that the Board erred in failing to consider the chronically depressed nature of his labor market:

> "The Board's rejection of Mr. Ross' opinion rests upon the idea that 'employability' should be determined abstractly and without reference to local conditions. This is absurd. This claimant cannot find work that accords with his work limitations within the geographic area in which he resides. * * *
>
> "Consequently, under a correct interpretation of the law--one accounting for local conditions under which a disabled worker must look for and find work--claimant is 'unemployable.' "

149 Or App 196> As support for that argument, claimant asserts that, under OAR 436-030-0055, the Board must consider the type of labor market in which the claimant lives. OAR 436-030-0055 provides, in part:

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[6] In *Vivian F Foltz*, the claimant was only able to work part-time, but was otherwise able to transfer all of her previous job skills as a receptionist/reservation clerk, grocery clerk, and salesperson. The claimant argued that, because she could only work part-time at minimum wages, she could not find "gainful" employment. The Board disagreed, concluding that "the ability to do regular part-time work precludes a status of permanent total disability."

[7] In *Mary J. Kamm*, the vocational expert found 182 potential employment opportunities, 66 of which had "no openings." The Board concluded:

> "The fact that over one-third of claimant's potential employers lacked openings, does not mean that claimant would not be competitive for an open position. Thus, counselor Nelson's implicit reasoning that claimant is not employable (*i.e.*, able to regularly sell her services) because she has not found a job, is unpersuasive."

"(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule:

"* * * * *

"(b) 'Suitable occupation' means those occupations that exist in a theoretically normal labor market, *within a reasonable geographic distance,* for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

"* * * * *

"(e) A 'reasonable geographic distance'as used in this rule means either of the following unless the worker is medically precluded from commuting:

"(A) The area within a 60-mile radius of claimant's place of residence at the time of:

"(i) the original injury; or

"(ii) claimant's last gainful employment[.]

"* * * * *

"(g) 'Theoretically normal labor market' as used in OAR 436-030-0055 and 436-030-0065 means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity or technology trends in the long-term labor market." (Emphasis supplied.)

As we understand OAR 436-030-0055, and particularly subsection (1)(g), that regulation requires a determination of whether, assuming "normal" conditions in the pertinent labor market (*i.e.*, within a 60-mile radius of claimant's residence), work that plaintiff could perform would ordinarily be available. Thus, cyclical "boom or bust" conditions are immaterial to the inquiry. If, however, ordinarily there is a lack of suitable work in the claimant's labor market, either because of chronically depressed conditions or a generic lack **<149 Or App 196/197>** of available suitable positions, that "tight" state is material to the "odd-lot" analysis prescribed by OAR 436-030-0055. Any broader reading of subsection (1)(g) would transform the "odd-lot" inquiry into a sterile, clinical exercise, unanchored to any actual labor market, and would effectively read subsection (1)(b) out of the regulation.

The difficulty here, however, is two-fold. First, Ross' reference to the "tight" market is ambiguous in that it could be reasonably understood to refer either to a cyclical condition or to an ordinary state. Second, it is impossible to determine from the Board's opinion how it understood Ross' "tight" market reference.

If the Board understood that reference to be to a periodic lack of suitable positions in the market, it properly rejected Ross' testimony. If, however, the Board (1) understood that reference to be to the state of the labor market in Baker City and the surrounding areas, which rendered suitable work normally unavailable, but (2) nevertheless rejected Ross' testimony because it did not address some abstract labor market that bore no relationship to normal conditions in the pertinent labor market, the Board erred.

Because we cannot tell if the Board applied the correct legal principle, we remand to the Board to clarify and, if necessary, to revise its conclusions. See *Tilden v. Board of Chiropractic Examiners,* 135 Or App 276, 282, 898 P2d 219 (1995) ("Without an adequate explanation by the Board as to its reasoning, we conclude that a meaningful review is impossible.").

Reversed and remanded for further proceedings not inconsistent with this opinion.

Cite as 149 Or App 214 (1997) July 16, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Linda K. Fister, Claimant.

Linda K. FISTER, *Petitioner,*
v.
SOUTH HILLS HEALTH CARE and SAIF Corporation, *Respondents.*
(WCB 95-05569; CA A93974)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 16, 1997.
Max Rae argued the cause and filed the brief for petitioner.
David L. Runner argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Reversed and remanded.

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149 Or App 216> Claimant seeks review of an order on remand of the Workers' Compensation Board, contending that the Board erred in refusing to consider her testimony at the hearing because that evidence had not been submitted to the Department of Consumer and Business Services (DCBS) in its proceeding on reconsideration. ORS 656.283(7). We conclude that, because no objection to the evidence was raised by employer before the hearing record closed, the evidence was properly considered by the administrative law judge (ALJ) and should have been considered by the Board. Accordingly, we reverse the Board and remand the case for reconsideration.

Claimant suffered a compensable back and cervical injury while working for employer as a certified nurse's assistant. Her claim ultimately went to hearing on the issue of the extent of her permanent disability. One of the issues in dispute concerned the "adaptability value," for the purpose of determining the extent of claimant's permanent disability, and involved a deten-nination of claimant's "base functional capacity" (BFC), which, for the purpose of this case, is the physical strength requirement of claimant's job at the time of the injury. In an order on reconsideration, an Appellate Reviewer for DCBS assigned a BFC of "medium" to claimant's work as a nurse's assistant. Claimant testified at the August 1, 1995, hearing that the work she did for employer was similar to that of an orderly, which has a BFC of "heavy," and that her BFC should also be "heavy." That testimony had not been offered by claimant as a part of the record on reconsideration, but at the time of the reconsideration process, it would nonetheless have been admissible at the hearing. *Safeway Stores v. Smith,* 122 Or App 160, 857 P2d 187 (1993).

Subsequent to the reconsideration process, but before the hearing, the legislature amended ORS 656.283(7), and that subsection now 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."

149 Or App 217> That amendment became effective June 7, 1995, and applies retroactively to pending cases. Or Laws 1995, ch 332, § 66(1); *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). It was applicable to this case, which had not yet come to hearing at the time the provision became effective.

In *Precision Castparts Corp. v. Plummer,* 140 Or App 227, 914 P2d 1140 (1996), we held that ORS 656.283(7) (1995) makes inadmissible at hearing evidence not previously offered on reconsideration. By the statute's terms, claimant's testimony, which would have been admissible before the amendment, became inadmissible by the time of the hearing. It was, nonetheless, admitted by the ALJ without objection by employer. In fact, employer cross-examined claimant concerning the nature of her work and its lifting requirements.

Employer first raised the question of the admissibility of the evidence in its appeal to the Board. In a footnote to its opinion, the Board relied on its order in *David J. Rowe,* 47 Van Natta 1295 (1995), and rejected claimant's contention that employer had waived its challenge to the evidence by not raising it at the hearing. The Board said that, in the light of the "express statutory limitation" on the admissibility of the evidence, it could consider employer's argument despite the absence of an objection at the hearing.

In her first assignment of error, claimant asserts that the Board erred in holding that it was statutorily barred from considering claimant's testimony at hearing. Claimant does not contend, as she did before the Board, that employer waived its challenge to the admissibility of the testimony. Her primary contention on review is that the retroactive application of ORS 656.283(7) (1995), violates federal and state concepts of procedural due process. The Supreme Court has frequently said, however, that constitutional issues should not be decided if there is an adequate statutory basis for a decision. *State v. Lowry,* 295 Or 337, 343, 667 P2d 996 (1983); *Douglas County v. Briggs,* 286 Or 151, 593 P2d 1115 (1979). The court has adhered to that approach even when the parties have not raised the nonconstitutional issue on which the court ultimately bases its decision, as is the case **<149 Or App 217/218>** here. *Planned Parenthood Assn. v. Dept. of Human Res.,* 297 Or 562, 687 P2d 785 (1984).

In *State v. Hovies,* 320 Or 414, 887 P2d 347 (1994), the defendant raised only constitutional challenges to the trial court's failure to give him an opportunity to cross-examine the witness against him. The Supreme Court said that it was required first to consider whether there were statutory provisions that gave the defendant the right to cross-examine the witness and concluded that there were. *Id.* at 419. *See also Meltebeke v. Bureau of Labor and Industries,* 322 Or 132, 903 P2d 351 (1995). In *Lloyd Corporation v. Whiffen,* 307 Or 674, 773 P2d 1294 (1989), the parties disputed whether a circuit court judge's refusal to enjoin signature gathering was a taking under the state and federal constitutions. The court said:

> "From the beginning, the parties have treated this as a constitutional case. * * * Judicial opinions elsewhere take up the constitutional debate, displaying deep divisions about the correct analysis. [Footnote omitted.] We will not join in that debate, however, without first examining the parties' rights on a subconstitutional level. Our practice is to refrain from constitutional holdings unless ordinary legal principles tannot resolve the dispute. *State v. Edgmand,* 306 Or 535, 538-39, 761 P2d 505 (1988); *Planned Parenthood Assn.* [297 Or 564]." *Lloyd Corporation,* 307 Or at 680.

In a footnote, the court said:

> "Avoiding needless constitutional rulings is not a technical nicety of judicial etiquette. If there is no duty to decide the constitutionality of a law, there is a duty not to decide it. This rule prevents premature foreclosure of opportunities for legislators who are better equipped to consider and choose among different policies." *Id.,* at 680 n 4.

Because we conclude that claimant's assignment is correct for nonconstitutional reasons, we do not reach claimant's constitutional contentions.

The Board's own precedent establishes the rule that it will consider only issues raised by the parties at the hearing. *See, e.g., Gunther H. Jacobi,* 41 Van Natta 1031 (1989). The Board has not set forth an adequate reason for deviating **<149 Or App 218/219>** from that well-established practice. Because employer did not object to claimant's testimony at hearing, the Board should not have entertained employer's argument first made to the Board, that the evidence is inadmissible.

Contrary to employer's contention, the Board's error was not hannless. Claimant's testimony provided some evidence from which the Board could have found that her work before the accident was "heavy." Accordingly, we remand the case to the Board for it to reconsider, once again, the extent of claimant's disability.

Reversed and remanded.

Cite as 149 Or App 234 (1997) July 16, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Terry PILGRIM, *Appellant*,
v.
CLATSKANIE PEOPLE'S UTILITY DISTRICT, *Respondent*.
(94-2121; CA A90883)

Appeal from Circuit Court, Columbia County.
Donald Kalberer, Judge.
Argued and submitted December 23, 1996.
Donald D. Dartt argued the cause and filed the brief for appellant.
Kenneth Eaton Bemis argued the cause for respondent. With him on the brief were Alan M. Lee and Bullard, Korshoj, Smith & Jernstedt.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded.
Riggs, P. J., dissenting.

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149 Or App 236> Plaintiff appeals a summary judgment entered in favor of defendant in this action for failure to reinstate employment following a compensable work injury. We reverse and remand.

The facts are not in dispute. In 1993, plaintiff was employed by defendant as a lineman. On March 29 of that year, plaintiff injured his knee on the job. He did not work for approximately nine months while recovering from knee surgery. Plaintiff was released by his attending physician to modified work with instructions to do limited lifting, squatting, kneeling and the like. In May 1994, defendant's workers' compensation carrier obtained a second opinion confirming that plaintiff probably could not return to work as a lineman. Defendant had no other available and suitable positions for plaintiff. On May 18, 1994, defendant terminated plaintiff. The following week, plaintiff's attending physician changed his opinion about plaintiff's medical status, concluding that plaintiff should be returned to his previous position without restrictions. Defendant sought an independent opinion from a third physician and, on the basis of that opinion, adhered to its termination decision.

Plaintiff initiated this action for reinstatement under ORS 659.415(1), which provides, in part:

> "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."

Defendant answered, denying that the statute afforded plaintiff a basis for relief.

Defendant moved for summary judgment, arguing that it is not subject to the reinstatement statute by virtue of ORS 659.415(3)(b)(D), which provides, in relevant part:

> "(3) Notwithstanding subsection (1) of this section:
>
> "* * * * *
>
> **149 Or App 237>** "(b) The right to reinstatement under this section does not apply to:
>
> "* * * * *
>
> "(D) A worker whose employer employs 20 or fewer workers at the time of the worker's injury and at the time of the worker's demand for reinstatement."

In support of the motion defendant offered evidence that, at the time of plaintiff's injury and at the time of his request for reinstatement, it employed 20 and 19 people, respectively, not counting its publicly elected board of five directors. According to defendant, because it employed no more than 20 workers, the reinstatement statute does not apply. Plaintiff opposed the motion on the ground that the five members of the board also count as workers; therefore, because defendant employed at least 24 workers at the relevant times, the reinstatement statute does apply. In support of his contentions, plaintiff relied on the administrative rule promulgated by the Bureau of Labor and Industiies defining the statutory term "worker" for the purpose of implementing ORS 659.415:

> " '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 any employer *and includes salaried, elected and appointed officials* of the state, state agencies, counties, cities, school districts and other public corporations * * *."

OAR 839-06-105(4)(a) (1996) (emphasis supplied). According to plaintiff, because the rule expressly defines the statutory term "worker" to include elected officials, the five board members must be added to the employee total. Defendant replied that, because the rule defines "worker" to mean one who works "subject to the direction and control" of an employer, the five board members do not count because they are not subject to the control of any employer. The trial court granted defendant's motion.

On appeal, plaintiff offers a single, brief argument:

> "The definition of 'worker' [in the administrative rule] specifically includes elected officials of public agencies and corporations. Defendant is a public utility district. Its Board of Directors is comprised of five elected officials. As **<149 Or App 237/238>** such, defendant's Board members are 'workers' under OAR 839-06-105, and as that term is used in determining reinstatement rights under ORS 659.415. Consequently, defendant did not have '20 or fewer workers' at the time of plaintiff's compensable injury, nor at the time of the reinstatement request."

Defendant's argument similarly is narrowly focused:

> "Even though the definition [in OAR 839-06-105] specifically includes salaried, elected and appointed public officials as potential workers, this reference is not mutually exclusive and such individuals still must be subject to the direction and control of an employer to be 'workers' of that employer under the law."

Thus, we observe at the outset the narrow focus of the issue before us. It is limited to whether the definition of "worker" in OAR 839-06-105(4)(a) includes "elected officials," regardless of whether they are supervised by an employer. The parties do not argue--and we have no proper occasion to address--other potential issues such as whether the rule applies only to salaried officials, whether defendant's board members actually are salaried within the meaning of the rule or whether defendant is a public corporation within the meaning of the rule.

In addressing the limited issue before us, we attempt to ascertain, if possible, the meaning of the rule that the promulgating agency intended. *Perlenfein and Perlenfein,* 316 Or 16, 20, 848 P2d 604 (1993). In so doing, we apply the same interpretive principles that apply to the construction of statutes. *See Dept. of Land Conservation v. Lincoln County,* 144 Or App 9, 14-15, 925 P2d 135 (1996), *rev den* 324 Or 560 (1997). That means that we first examine the text in its context, and, if that inquiry does not reveal the intended meaning of the rule, we examine extrinsic evidence and relevant rules of construction. *See PGE v. Bureau of Labor and Industries,* 317 Or 606, 610-12, 859 P2d 1143 (1993).

In this case, the rule defines "worker" both in terms of what the word *means* and what it *includes*. As we noted in *State v. Haynes,* 149 Or App 73, 76-77, ___ P2d ___ (1997), it is fairly common for the law to specify what a word definitely includes and then provide a more general definition of **<149 Or App 238/239>** what the word means apart from those things specifically enumerated. The statute at issue in that case illustrates the point. ORS 164.325 defines first-degree arson to mean intentionally setting afire "protected property," defined by ORS 164.305(2) to mean "any structure, place or thing customarily occupied by people," and defined to specifically include churches and forestland, without regard to whether they are customarily occupied. *Id.* at 78. We held that proof that a church was customarily occupied at the time it was burned down was not required under the statute.

The same interpretive problem is posed in this case. OAR 839-06-105(4)(a) provides that "worker" means, among other things, a person who works "subject to the direction and control of any employer." The rule does not stop there, however. It also provides that "worker" specifically includes "salaried, elected and appointed officials." The rule does not say that salaried, elected and appointed officials are workers only to the extent that they work subject to the direction and control of an employer. That only makes sense, at least so far as elected officials are concerned, given that elected officials are not subject to the direction and control of an employer. Indeed, to read the rule as defendant suggests would require us not only to read language into the rule that the promulgating agency--for whatever reason--chose not to include, but also to make the language that it did include entirely superfluous. Both consequences are inconsistent with basic principles of construction. ORS 174.010.

Examination of the broader context in which the rule was adopted confirms what the language of the rule itself strongly suggests. OAR 839-06-105(4)(a) defines the term "worker" for the purpose of implementing ORS 659.415, which applies to workers who have not been reinstated after sustaining compensable injuries under the terms of the Workers' Compensation Law. *See generally Shaw v. Doyle Milling Co.*, 297 Or 251, 255, 683 P2d 82 (1984) (describing purpose of ORS 659.415 "to guarantee that an employer shall not discriminate against a disabled worker for exercising the worker's rights under the Workers' Compensation Law"). The Workers' Compensation Law defines "worker" in terms identical to the BOLI administrative rule's definition of the same word:

> **149 Or App 240>** " '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 * * *."

ORS 656.005(30). That definition, in relevant part, was enacted to address precisely whether elected officials who are not subject to direction and control of an employer are "workers" for the purposes of determining workers' compensation coverage.

> An earlier version of the statute defined "workman" in the following terms:
>
> "[A]ny person who engages to furnish his services, subject to the direction and control of an employer * * *."

ORS 656.002(15) (1957). The Attorney General concluded that the law did not apply to elected county officials--specifically, clerks, judges, treasurers and commissioners--because, among other things, they were "not subject to the direction and control of the county, but only to the law." 24 Op Atty Gen 20, 21 (1948). In 1959, the State Accident Insurance Commission proposed an amendment to the statute, specifically to include elected officials. Minutes, Senate Labor and Industries Committee, April 24, 1959, pp 1-2. Thus, the language "and includes salaried elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations" was added to the statute.[1] *See* ORS 656.002(16) (1959). In the context of the **<149 Or App 240/241>** Attorney General's opinion, the legislature's intentions can, not be mistaken.

The dissent takes us to task for failing to speculate on the effect, if any, of the correct punctuation of the statute. According to the dissent, the errant comma must be ignored, and the statute must be read to apply only to elected officials who are salaried. On that basis, the dissent contends, we should affirm the trial court's decision to grant summary judgment in favor of defendants. In so arguing, the dissent concedes that the parties failed to raise that issue. It nevertheless insists that we *must* decide it, because to do otherwise results in "an advisory opinion" that gives an incomplete picture of the statute. 149 Or App at 242. We remain unpersuaded.

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[1] In its original form, the added phrase contained no comma between the words "salaried" and "elected." In 1973, a comma appeared when the legislature enacted other, unrelated amendments to the statute. Or Laws 1973, ch 620, § 1. We express no opinion on the effect, if any, of the appearance of the new punctuation, as it does not bear on the narrow issue properly before us.

The issue before us is whether the trial court erred in granting summary judgment, not describing what the statute means in the abstract. Simply because we are required to construe one aspect of a statute in disposing of an assignment of error does not mean that, because we happen to be in the statutory neighborhood, we must express our opinion as to other matters not argued by the parties. That would be to render an advisory opinion. *See, e.g., State ex rel Kane v. Goldschmidt,* 308 Or 573, 590, 783 P2d 988 (1989) ("If we attempted to anticipate and resolve all the variations possible under the statute at this time, we would stray into giving an advisory opinion."); *see also SAIF v. Mize,* 129 Or App 636, 640, 879 P2d 907 (1994); *Clark v. Schumacher,* 103 Or App 1, 7, 795 P2d 1093 (1990).

Even if the dissent were correct that we should address the significance of the inadvertently included comma, *see* 149 Or App at 243-44, and even if the dissent were correct as to the actual significance of the punctuation of the statute, the fact remains that the parties have not argued whether the elected officials in this case--who are paid a small stipend plus expenses--are "salaried." The dissent *simply assumes* the very matter at issue; indeed, nowhere in the dissenting opinion is there even a discussion of whether the officials in this case are salaried. That is precisely the sort of issue that the parties should be allowed to argue and the trial court should be allowed to decide. No one is well served by our rushing in where the parties have failed to tread.

We conclude that elected officials of the state, state agencies, counties, cities, school districts and other public corporations may be "workers" within the meaning of OAR 839-06-105(4)(a), even though they are not subject to the direction and control of a supervisor. The trial court therefore erred in allowing defendant's summary judgment motion. We emphasize the limited nature of our holding, in particular, that we do not hold that the elected officials in this case are, in fact, workers within the meaning of the rule. That determination depends on proof as to other factors enumerated in the rule, matters that, as we have noted, the parties do not argue in this appeal and may or may not choose to address on remand.

Reversed and remanded.

RIGGS, P. J., dissenting.

I agree with much of what the majority has said in its partial resolution of this appeal. Through a slightly different analysis, I too conclude that elected officials "may" be workers under OAR 839-06-105(4)(a). Because the right to reinstatement provided by ORS 659.415 applies only to a worker who has sustained a compensable injury under the **<149 Or App 241/242>** terms of the Workers' Compensation Law, ORS chapter 656, I too conclude that the statutory definition, the cases interpreting it, and its legislative history provide context for the BOLI administrative rule. Ultimately, I too conclude that the legislative history shows that in 1959 the legislature amended ORS 656.005(30), then numbered ORS 656.002(16), for the purpose of including elected officials, who would otherwise be excluded because they are not subject to the direction and control of an employer. Or Laws 1959, ch 448, § 1. Further, I would hold, as the majority implicitly does, that BOLI's intention in adopting the administrative rule was to adopt the statutory definition of worker.

As far as it goes, the majority is correct. However, the majority's opinion stops short of answering the only question that the parties seek to have resolved on appeal: whether the elected members of defendant's board of directors are workers. That is a legal question, and one that is put squarely to us. The parties ask us to decide whether *these* elected officials *in this case* are workers. The majority's chosen route is nothing more than an advisory opinion: The board members *can* be workers under the statute, but they *may* not be, depending on other potential questions of interpretation of the statute that the parties have not precisely raised.

The majority appears to be concerned with the parties' failure to argue the question of the effect of the word "salaried," as used in the rule and the statute. As the majority says in a footnote, in its original form, the statute did not contain a comma between the words "salaried" and "elected." The comma appeared in 1973, when the legislature enacted other, unrelated amendments to the statute. Or Laws 1973, ch 620, § 1. The majority is unwilling to address the effect of that change here, however, because the parties have so "narrowly focused" the issue. It is true that the parties have not expressly asked that the effect of the word "salaried" be considered, undoubtedly because they were not aware of the possibility that it could have any effect, having not discovered that in its 1959 form the statute

contained no comma between the words "salaried" and "elected." However, our discovery of the change obligates us to complete the statutory inquiry that the parties have initiated. Our responsibility to interpret the statute correctly and completely according to **<149 Or App 242/243>** the legislature's intent does not begin where *the parties* have framed the question for us or end at the point where the parties' analysis is no longer helpful. We have an independent obligation to interpret the statutes fully and completely. As the Supreme Court said in *State v. Hitz*, 307 Or 183, 766 P2d 373 (1988), efficient procedures requiring that issues be raised on appeal are instruments for, not obstacles to, deciding the merits of an appeal. When a question of statutory interpretation is involved, we may not let the parties' briefing of the issue restrict our ability to give a correct *and complete* interpretation. *PacifiCorp v. City of Ashland*, 89 Or App 366, 370, 749 P2d 1189, *rev den* 305 Or 594 (1988).

As it was amended in 1959, ORS 656.002(16) included "salaried elected and appointed officials." Or Laws 1959, ch 448, § 1. As I have noted, there was no comma between "salaried" and "elected." Thus, as it then read, the word "salaried" modified "elected" and "appointed." Only *salaried* elected officials were included as workers. That was consistent with another amendment to ORS 656.002 made in 1959 that required that persons work for "remuneration." Or Laws 1959, ch 448, § 1.

The comma between "salaried" and "elected" first appeared in 1973. In that session, the legislature amended ORS 656.002 twice. In Oregon Laws 1973, chapter 497, section 3, the legislature first amended the statute to add a new subsection (2) defining "average weekly wage," and it renumbered the remaining subsections. In did not touch the definition of the term "workman," then contained in subsection (21), and renumbered to subsection (22). In Oregon Laws 1973, chapter 620, section 1, the legislature again amended ORS 656.002, by adding two subparagraphs to subsection (7), which defined "compensable injury." It did not make any amendment to subsection (22). However, as enacted and later codified, a comma appeared in the bill between "salaried" and "elected," not as an amendment or as part of other amendments. The comma is significant: With its insertion, the meaning of the statute is changed, at least grammatically. "Salaried" no longer modifies "elected" or "appointed," but simply becomes its own category of "official," as the first in a series of three types of officials who are considered to be workers. It is difficult to conceive of a rationale for such a **<149 Or App 243/244>** change. There is no testimony with regard to the insertion of the comma and no indication that it was added pursuant to legislative action. In the absence of legislative history, it is unlikely that the comma was inserted deliberately for the purpose of creating a separate category of "salaried official," or to eliminate the requirement that "elected" and "appointed" officials be salaried. For that reason, I conclude that the insertion of the comma was a clerical error.

The statute has been amended many times over the years, and the comma remains. We are mindful of the view that, having withstood the test of time without being changed, the comma should be regarded as expressing the legislature's intent, no matter what the cause of its insertion. *See Coston v. Portland Trust Co. et al.*, 131 Or 71, 282 P2d 442 (1929). However, in the light of the patent nature of the clerical error that resulted in its insertion, I would conclude that the comma must be disregarded. As the Supreme Court said in *State v. Lermeny*, 213 Or 574, 580, 326 P2d 768 (1958), when a clerical error defeats the purpose of an act, the court will correct the error to conform to the intended meaning of the legislation. *See Bush v. Greyhound Lines, Inc.*, 295 Or 619, 669 P2d 324 (1983); *see also Zidell Marine Corp v. West Painting, Inc.*, 133 Or App 726,894 P2d 481, *affd* 322 Or 347, 906 P2d 809 (1995). Specifically, punctuation, although a proper guide to interpretation, will be disregarded if it defeats a clear legislative intent. *Fleishauer v. Bilstad*, 233 Or 578, 379 P2d 880 (1963). In my view, there is nothing in the Supreme Court's statutory construction template, *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993), that makes binding on the court's interpretation of a statute an obvious clerical error that changes the meaning of the statute so as to defeat the legislative purpose. As it was originally enacted in 1959, only *salaried* elected officials were considered to be workers under ORS 656.002. Nothing in the legislative history shows that the legislature intended the results of the clerical error inserting the comma. We should, accordingly, disregard the comma between "salaried" and "elected," and hold that only salaried elected officials are to be treated as workers under the Workers' Compensation Act and for purposes of the right to reinstatement under ORS chapter 659.

149 Or App 245> As the majority says, the issue before us is whether the trial court erred in granting summary judgment to defendant. Because the record on summary judgment shows conclusively that the members of defendant's elected Board of Directors are not "salaried," I would affirm the trial court's granting of summary judgment for defendant. Although the trial court did not

expressly consider the question of the effect of the comma or the significance of the word "salaried," it correctly granted summary judgment to defendant, and we should affirm that ruling for the reasons explained in this dissent, despite the fact that the parties and the trial court focused on a different question. *See e.g., Bevan v. Garrett,* 284 Or 293, 586 P2d 1119 (1978); *Baumann v. Wright,* 249 Or 212, 437 P2d 488 (1968); *Capital Investments v. Lofgren, 81* Or App 93, 97, 724 P2d 862 (1986). Because the majority reverses a correct decision of the trial court and sends the case back for the resolution of issues that are ours to decide, I dissent.

Cite as 149 Or App 298 (1997) July 23, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joseph R. Huff, Claimant.
FARMERS INSURANCE GROUP/ Sterling Griffiths, *Petitioners - Cross-Respondents,*
v.
Joseph R. HUFF, *Respondent - Cross-Respondent,* and Sterling GRIFFITHS, *Respondent,* and SAIF Corporation, *Respondent - Cross-Petitioner.*
(WCB 93-09144, 93-08632; CA A92755)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 12, 1996.
Jerald P. Keene argued the cause and filed the brief for petitioners - cross-respondents.
Richard D. Barber, Jr., argued the cause for respondent Sterling Griffiths and respondent - cross-petitioner SAIF Corporation. With him on the brief was Bostwick, Sheridan and Bronstein.
Robert Pardington waived appearance for respondent cross-respondent Joseph R. Huff.
Before Warren,]Presiding Judge, and Edmonds and Annstrong, Judges.
WARREN, P. J.
Affirmed on petition; reversed on cross-petition.

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149 Or App 300> Farmers Insurance Group (Farmers), as employer's insurer for the first of claimant's four shoulder incidents, petitions for review of an order of the Workers' Compensation Board setting aside its denial of responsibility for claimant's compensable left shoulder condition. It renews its arguments before the Board that SAIF, as processing agent for the noncomplying employer, should be responsible for claimant's condition. SAIF cross-petitions from the Board's assessment against it of a $2,800 attorney fee. We affirm on the petition and reverse on the cross-petition.

The issues in this case are (1) responsibility and (2) attorney fees. The only facts that are truly material to our discussion concerning responsibility are not disputed. Claimant, a mechanic at the employer's service station, experienced left shoulder symptoms in connection with four work incidents. Farmers was on the risk for the first incident on June 19, 1992, when a transmission claimant was installing fell on his left shoulder. Claimant informed his employer of the incident but neither sought medical treatment nor missed time from work, although he continued to experience pain.

The next three incidents occurred bvtween July 1, 1992, and May 10, 1993, while employer was not in compliance with Oregon's workers' compensation law. Claimant reported all three incidents to employer, but he did not seek medical attention until after the last incident. Before the June 1992 incident, claimant had had no left shoulder problems.

Both Farmers and SAIF, as statutory processing agent for employer during its period of noncompliance, issued responsibility denials/disclaimers. No insurer denied compensability of claimant's left shoulder condition as an accidental injury, but SAIF specifically denied a claim for an occupational disease.

Claimant sought a hearing, asserting that his left shoulder condition was compensable as an accidental injury or, in the alternative, as an occupational disease. Claimant **<149 Or App 300/301>** also sought penalties and attorney fees against SAIF as processing agent for the noncomplying employer for allegedly unreasonable denials.

At hearing, the administrative law judge (ALJ) concluded that claimant's condition constituted an accidental injury and not an occupational disease. The ALJ found that the June 1992 incident constituted the major contributing cause of claimant's shoulder condition and need for treatment. The ALJ held Farmers responsible for claimant's left shoulder condition on the grounds that Farmers was employer's workers' compensation carrier at that time and that there was no basis for shifting responsibility to SAIF. The ALJ also awarded claimant an assessed attorney fee of $3,800, payable by Farmers, on the ground that claimant's attorney had "actively and meaningfully participated within the meaning of the law."[1]

Farmers sought review before the Board, contending that (1) the claim should be analyzed as an occupational disease rather than an accidental injury, (2) SAIF waived its right to contest responsibility under former ORS 656.308(2) because it had issued an untimely denial of responsibility, and (3) under amended ORS 656.308(2)(d), claimant's fee should be reduced to $1,000. On review, the Board adopted the ALJ's findings of fact.

The Board rejected Farmers' contention that this claim involved "a series of traumatic events" that culminated in claimant's need for medical treatment and that, consequently, it should be treated as an occupational disease under ORS 656.802(1)(a)(C). The Board explained, pursuant to *Dickson v. Carolina Casualty*, 108 Or App 499, 814 P2d 567 (1991),[2] that the statutory phrase "series of traumatic **<149 Or App 301/302>** events or occurrences" referred to "micro-trauma" or "overuse" syndromes caused by repetitive physical trauma or activity of a body part such as a hip, elbow or wrist. Furthermore, the Board explained:

> "[A]s the court noted in *Crowe v. Jeld-Wen*, 77 Or App 81, 85-86 [, 712 P2d 1451 (1985) [,*rev den* 301 Or 76 (1986)], 'An occupational disease is stealthy and steals upon its victim when he is unaware of its presence and approach. Accordingly, he cannot later tell the day, month or possibly even the year when the insidious disease made its intrusion into his body.' In this case, claimant knew precisely when his left shoulder symptoms began: June 19, 1992, when a transmission fell on his shoulder. Claimant had never previously had left shoulder problems and has been plagued ever since. In light of this, we conclude that claimant's claim, in which his left shoulder condition developed suddenly and unexpectedly on a specific date, was properly characterized as an accidental injury claim." (Citation omitted.)

Next, the Board concluded that under *Motel 6 v. McMasters*, 135 Or App 583, 899 P2d 1212 (1995), the 1995 legislative amendments to ORS 656.308(2), made by the adoption of Senate Bill 369 were not applicable to the claim. The Board then rejected Farmers' contention that, because SAIF's denial of responsibility was untimely, it should be held responsible for claimant's condition:

> "Although a carrier's failure to comply with the disclaimer notice of *former* ORS 656.308(2) may preclude the carrier from attempting to shift responsibility to another carrier, the carrier's violation does not preclude the claimant from pursuing the claim with another carrier. *Penny L. Hamrick*, [46 Van Natta 14, *on recon* 46 Van Natta 410 (1994)]; *Jon F. Wilson* 45 Van Natta 2362 (1993). In this case, SAIF may be precluded from attempting to shift responsibility to Farmers by its failure to timely disclaim. However, claimant pursued his claim against Farmers. When the ALJ specifically asked claimant's counsel whether claimant was actively pursuing a claim against Farmers, counsel replied 'yes.'" (Emphasis in original.)

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[1] We understand the ALJ to have made the attorney fee award pursuant to ORS 656.308(2)(d):

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and *active and meaningful participation* by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances." (Emphasis supplied.)

[2] In *Dickson* we simply reaffirmed, per curiam, our decision in *Sibley v. City of Phoenix*, 107 Or App 606, 610, 813 P2d 69, *rev den* 312 Or 527 (1991). It is clear that the Board, in referring to *Dickson*, therefore, really meant *Sibley*.

Finally, the Board affirmed the attorney fee award but reapportioned it between Farmers and SAIF. Pursuant to *amended* ORS 656.308(2)(d), the Board reduced Farmers' **<149 Or App 302/303>** assessment to $1,000 and, under ORS 656.386(1), held SAIF responsible for an attorney fee of $2,800 on the ground that SAIF denied compensability of the left shoulder *claim* by refusing to concede compensability under an occupational disease *theory*.

We review the Board's legal conclusions for errors of law, ORS 183.482(8)(a), and look to see that its findings are supported by substantial evidence in the record, ORS 183.482(8)(c).

On review here, Farmers renews the two arguments that it made below, contending that SAIF should be held responsible for claimant's compensable left shoulder condition. First, Farmers assigns error to the Board's treatment of the claim as an injury claim as opposed to an occupational disease. The thrust of Farmers' argument seems to be that this claim should be analyzed as an occupational injury, and, thus, responsibility for claimant's condition lies with SAIF under the "last injurious exposure" rule. Farmers' theory turns on the proposition that the facts here establish that claimant suffered "a series of traumatic events or occurrences" that resulted in his need for treatment or disability. It then follows, Farmers maintains, that under the "plain meaning" of ORS 656.802(1)(a)(C)[3] the claim should have been treated as one for an occupational disease as a matter of law. Moreover, Farmers contends that the Board's reliance on the "sudden and unexpected onset" standard as the benchmark for characterizing an injury versus the "gradual and unexpected onset" standard for an occupational disease was error. "Contrary to the Board's opinion," Farmers contends, "the fact the series began with an identifiable event at an identifiable time" is unremarkable, because "[e]very 'series of traumatic events or occurrences' necessarily begins with the **<149 Or App 303/304>** first 'traumatic event or occurrence.'" The key, Farmers maintains, is that claimant's need for treatment or his disability arose from the cumulative nature of the series of events or occurrences. In response, SAIF argues that the Board, as a matter of fact, found that claimant suffered from an injury and not an occupational disease. We agree with SAIF that Farmers' arguments fail at the outset.

Farmers' argument is based on the fact that claimant did not seek medical treatment until after his fourth incident. The record, however, supports the conclusion that claimant needed treatment after his June 1992 incident but that he sought medical treatment for his shoulder condition only after he could no longer manage the pain at work. It is clear to us that the Board reached that conclusion, as a matter of fact, and then proceeded from it in assigning responsibility for claimant's condition. First, the Board[4] found that "[c]laimant's current left shoulder condition and need for treatment are the result of accidental injury and not occupational disease." Moreover, it found that "[claimant's] work injury to the shoulder in June 1992 is the major contributing cause of the current shoulder condition and need for treatment." Those findings are supported by substantial evidence in the record. Before making those findings, the Board restated the opinions of numerous physicians who examined claimant and who concluded that his shoulder condition did not, as a matter of fact,[5] arise from "a series of traumatic events or occurrences," ORS 656.802(1)(a)(C), and, therefore, was not the result of an occupational disease. The Board's findings of fact disclose that the record is replete with testimony from physicians who examined claimant and who concluded that claimant's subsequent episodes were merely

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[3] ORS 656.802 provides, in part:

"(1)(a) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"* * * * *

"(C) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death."

[4] On review, the Board adopted the ALJ's findings of fact, and we therefore refer to them throughout as the Board's findings of fact.

[5] In its brief, Farmers concedes:

"Admittedly, the question of whether the circumstances of a claim in fact constitute a 'series of traumatic events or occurrences' could present a question of fact upon which the Court must affirm if based on substantial evidence."

That is the case here.

"exacerbations or aggravations of the condition caused by the original injury in June 1992." The Board found that, after his first incident in June 1992, claimant's "pain never went **<149 Or App 304/305>** away." The Board explained that claimant knew precisely when his left shoulder symptoms began and that he had never previously had left shoulder problems but has been plagued with them ever since. In that light, the Board's factual finding that claimant needed treatment after his June 1992 incident and that he sought medical treatment for his shoulder condition only after he could no longer manage the pain at work is supported by substantial evidence in the record. We therefore need not address Farmers' other arguments.

Farmers next assigns error to the Board's determination that it is responsible for claimant's compensable shoulder condition. Farmers' argument, in essence, is that SAIF is responsible, as a matter of law, for claimant's left shoulder condition by virtue of its untimely denial/disclaimer of responsibility.[6] This result follows, Farmers argues, because former ORS 656.308(2)[7] provided that SAIF "was precluded from asserting 'actual responsibility lies with another employer or insurer.'" SAIF responds that, under the facts, the Board correctly found Farmers responsible for claimant's left shoulder condition, and that "Farmers confuses the preclusion issue against SAIF with a mandate that the finder of fact must find SAIF responsible." The statutory **<149 Or App 305/306>** preclusion, SAIF argues, "does not require the ALJ or the Board to find a certain way. It merely would have precluded SAIF from contesting a decision that it was responsible." On the present facts, we agree with SAIF.

The problem with Farmers' argument is that it would bar claimant from fully asserting his rights under ORS chapter 656. In reaching its decision, the Board relied on both *Penny L. Hamrick,* 46 Van Natta 14, *on recon* 46 Van Natta 410 (1994) and *Jon F. Wilson,* 45 Van Natta 2362 (1993). In those cases, the Board affirmed an assignment of responsibility to an insurer that had timely issued a disclaimer of responsibility in conformance with former ORS 656.308(2), when another insurer, one that had failed to comply with the statute, was also joined. In both instances, the Board held that the noncomplying disclaimer precluded the offending carrier from arguing that the other, complying carrier was responsible and that it did not preclude the claimant from otherwise asserting his or her rights under ORS chapter 656 and pursuing the compensability of a timely filed claim against the complying carrier. In each case, the Board concluded that the claimant had established a compensable claim against the complying carrier and imposed responsibility on it.[8] That is the case here, and Farmers offers no argument as to why the same result should not follow.[9]

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[6] *Former* ORS 656.262(6), since renumbered as ORS 656.262(6)(a) by Oregon Laws 1995, chapter 332, section 28, provides that claimant must receive written notice of denial of the claim from the insurer within 90 days after the employer has notice or knowledge of the claim.

[7] *Former* ORS 656.308(2) has since been significantly revised by the changes to the Workers' Compensation Law made by Senate Bill 369 in the 1995 legislative session. Or Laws 1995, ch 332, § 37. SAIF does not renew here the argument it made before the Board that amended ORS 656.308(2), which eliminated the responsibility disclaimer requirements of *former* ORS 656.308(2), is retroactively applicable. As we held in *Norstadt v. Murphy Plywood,* 148 Or App 484, ___ P2d ___ (1997), the 1995 amendments to ORS 656.308(2) are not applicable to this case because they alter time limitations with respect to actions that had been taken on the claim before the effective date of the Act. *Id.* at 491-93. *Former* ORS 656.308(2) provided, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. * * * Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection."

[8] Our holdings in *Norstadt* and *Garibay v. Barrett Business Services,* 148 Or App 496, ___ P2d ___ (1997), are readily distinguishable from our holding here. In those cases, the claimants pursued claims against employers whose attempted disclaimers of responsibility were ineffective under *former ORS* 656.308(2). Therefore, responsibility for claimant's compensable injury was not at issue and the question that we address here whether claimant could pursue the compensability of an injury or occupational disease claim against an insurer that issued a disclaimer of responsibility in accordance with the statute when another insurer that had failed to do so was also joined, was not before us.

[9] We also reject Farmers' argument that the "record contains no basis for ruling claimant took any position, let alone 'pursued' responsibility issues at the hearing." Farmers contends claimant simply "protected the record as to compensability, then retreated to a passive, indifferent position with regard to which employer was responsible." The Board found otherwise, and that finding is supported by substantial evidence in the record.

We hold that former ORS 656.308(2) does not operate to bar a claimant from proceeding to prove the compensability of an injury or occupational disease claim against an insurer that issued an effective disclaimer of responsibility **<149 Or App 306/307>** when another insurer that had failed to do so is also joined. It provides only that an insurer who fails properly to issue a denial or disclaimer of responsibility thereby loses the defense, if available, that another insurer is responsible. The Board did not err.

On cross-petition, SAIF maintains that the Board erred in awarding claimant a $2,800 attorney fee, payable by SAIF, on two grounds. First, SAIF argues that the Board erred because it addressed the issue of attorney fees under ORS 656.386(l) *sua sponte.* We reject that argument because we have consistently held that the Board's review is *de novo* and that it may reverse or modify the order of the referee or make any other disposition of the case that it determines to be appropriate. ORS 656.295(6); *see also McCrea v. Arriola Bros., Inc.,* 145 Or App 598, 599 n 1, 930 P2d 1180 (1997); *Gates v. Liberty Northwest Ins. Corp.,* 131 Or App 164, 167, 883 P2d 1339 (1994). Thus., the Board may award claimant attorney fees under ORS 656.386(1); the question is whether the Board was correct in doing so in this case.

SAIF contends that ORS 656.386(1) does not contemplate an award of an attorney fee where, as here, the Board affirmed SAIF's denial of the occupational disease theory of compensability. The Board applied a broad reading of the statute, looking simply at whether the insurer had denied, on any theory, compensability of claimant's claim for benefits. Of paramount significance, in the Board's analysis, is simply whether claimant successfully established entitlement to benefits. ORS 656.386(1)[10] provides, in part:

> "In * * * cases involving denied claims[11] where the claimant prevails finally in a hearing before an [ALJ] or in a review by [the board], then the [ALJ] or board shall allow a reasonable attorney fee. * * * For purposes of this section, a 'denied claim' is a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation **<149 Or App 307/308>** is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

A claimant is entitled to an insurer-paid attorney fee under ORS 656.386(1) only if the employer denies the claim for compensation. If the employer denies responsibility but not compensability, it has not denied a claim for compensation and the statute is inapplicable. *Multnomah County School Dist. v. Tigner,* 113 Or App 405, 408, 833 P2d 1294 (1992); *Mercer Industries v. Rose,* 103 Or App 96, 98, 795 P2d 615, *rev den* 311 Or 150 (1991). The Board awarded fees on the ground that SAIF had denied the claim under an occupational disease theory. However, SAIF prevailed on that denial, and claimant is not entitled to fees under it.

Affirmed on petition; reversed on the cross-petition.

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[10] In 1995, the legislature amended ORS 656.386(1). We apply amended ORS 656.386(1) here because the amendments apply retroactively. *Volk v. America West Airlines,* 135 Or App 565, 573, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

[11] ORS 656.005(6) defines "claim" as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."

Cite as 149 Or App 309 (1997) July 23, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael T. Nehl, Claimant.
SAIF CORPORATION, *Petitioner*, and DEPARTMENT OF CORRECTIONS, *Employer*,
v.
Michael T. NEHL, *Respondent*.
(95-03780; CA A92311)

Judicial Review from Workers' Compensation Board.

On petitioners' petition for reconsideration filed June 4, 1997. Opinion filed May 21, 1997, 148 Or App 101, ___ P2d ___.

Michael O. Whitty, Assistant Attorney General, Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General, for petition.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Reconsideration allowed; opinion modified and adhered to as modified.

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149 Or App 311> SAIF Corporation moves for reconsideration of our previous opinion, *SAIF v. Nehl*, 148 Or App 101, ___ P2d ___ (1997), contending, *inter alia*, that "some of the language of the court's opinion appears to apply [ORS 656.005(7)(a)(B)] in a manner inconsistent with the court's prior opinions." We allow the motion to clarify our opinion and to respond to SAIF's argument that our opinion in this case is inconsistent with our opinion in *Robinson v. SAIF*, 147 Or App 157, 935 P2d 454 (1997), which we decided after oral argument in this case and cited in our previous opinion. We adhere to our opinion as modified.

The facts in this case are set out in our previous opinion and do not need repeating here. In that opinion, we concluded that, "regardless of the extent of claimant's underlying condition, if the immediate cause of claimant's need for treatment is an on-the-job accident, the treatment is compensable." 148 Or App at 106. Pointing to this language, SAIF argues that we eliminated from consideration the weighing process contemplated by ORS 656.005(7)(a)(B) and discussed in *Robinson* of '"evaluating the relative contribution of different causes of an injury."' (Quoting *Robinson*, 147 Or App at 162.) SAIF maintains that, in that light, "the work injury will *always* be the immediate reason claimant goes to the doctor * * *." (Emphasis in original.) SAIF is correct that the last sentence of our previous opinion misstated the test contemplated by ORS 656.005(7)(a)(B).[1] That sentence should have read: "We conclude that, regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment, the combined condition is compensable." We therefore withdraw the last sentence of our opinion and adhere to our opinion as modified.

149 Or App 312> Our previous opinion demonstrates that we reviewed the Board's analysis for conformity with ORS 656.005(7)(a)(B) and concluded that it properly engaged in the weighing process contemplated by the statute, *i.e.*, evaluating the relative contribution of claimant's preexisting condition and his on-the-job injury and deciding which was the primary cause of his need for treatment of his combined condition. In our previous opinion, we explained:

> "The Board concluded that the focus of the statute was on claimant's specific need for treatment and thus that the treatment is compensable if the on-the-job injury causes, in major part, claimant's immediate need for treatment, even though claimant's entire condition may not have been caused in major part by the on-the-job injury." 148 Or App at 106.

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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."

We concluded that the Board correctly said that when the claimant has a combined condition, not caused in major part by the on-the-job injury, the condition is nevertheless compensable when the on-the-job incident is primarily responsible for claimant's need for treatment.

We turn now to SAIF's argument that our holding in this case conflicts with our holding in *Robinson*. Specifically, SAIF argues that our emphasis on the statutory language "need for treatment" in our previous opinion, 148 Or App at 106, is inconsistent with our holding in *Robinson*, in which we emphasized the "combined condition" language in the statute. 147 Or App at 162. In that light, SAIF renews its argument that claimant must show that his *entire combined condition*, not just his *specific need for treatment*, was caused in major part by his on-the-job injury. *See* 148 Or App at 105. SAIF misses the point, which is that the extent of claimant's preexisting condition is weighed against the extent of his on-the-job injury in determining which of the two is the primary cause of his need for treatment of the combined condition. The extent of claimant's preexisting condition is not weighed against the extent of his on-the-job injury to determine which of the two is the primary cause of his combined condition.

In *Robinson* and *Nehl*, we emphasized different statutory language in order to point out the error in the appellant's argument.[2] In *Robinson*, the uncontroverted medical **<149 Or App 312/313>** evidence established that claimant had a congenital groin weakness that predisposed him to hernias and that his work activities made his hernias symptomatic. The relevant issue on appeal was whether the Board had erred in finding that claimant had failed to carry his burden of proof in establishing the compensability of his combined condition. We emphasized the "combined condition" language in the statute to refute the claimant's argument that the Board erred because "it disregarded the [statutory] language * * * *need for treatment*." 147 Or App at 162 (emphasis in original). The point of our discussion there was the same point that SAIF urges us to recognize here: that under the statute, a claimant needs to establish more than the fact that a work injury precipitates a claimant's need for treatment in order to establish the compensability of his combined condition. *See id.*

In *Robinson*, we did not need to distinguish between the major cause of claimant's combined condition and the major cause of claimant's need for treatment, because they were the same. Here, we need to make that distinction, because this case turns on the fact that there is a difference between the primary cause of claimant's condition and the primary cause of his need for treatment. We recognized that distinction in *Robinson*, where we explained:

> "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." Id.* (emphasis supplied).

We therefore emphasized the statutory "need for treatment" language in our previous opinion in this case to refute SAIF's argument. That argument failed to draw the distinction between the primary cause of claimant's need for treatment and the primary cause of his combined condition. On reconsideration, SAIF renews its arguments, which again contain the same error.

149 Or App 314> In this case, SAIF does not challenge the extent of claimant's preexisting condition, the existence of his combined condition, or the Board's finding that claimant's on-the-job incident was the primary cause of his need for treatment. On reconsideration, SAIF argues that, in emphasizing the statutory language "need for treatment" in our previous opinion, we "ignored" the "combined condition" language in ORS 656.005(7)(a)(B). According to SAIF, the statute provides that "[w]hen the preexisting condition predisposes the claimant to a need for treatment, and that condition combines with a work incident to cause any need for treatment, the major contributing cause of the combined condition must be determined by weighing the relative contributions of the preexisting condition and the work incident."

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[2] We affirmed the Board's order both here and in *Robinson*. The question of whether claimant's on-the-job injury, when weighed against the extent of his preexisting condition, constitutes the primary cause of his need for treatment is inherently a factual one. Because the Board's finding on that point was supported by substantial evidence, we limit our inquiry to whether the Board evaluated claimant's claim under the correct legal standard.

SAIF argues that, under these facts, " [t]he appropriate weighing process is to put all of the contribution of claimant's prior surgeries, including the installation of the [prosthesis] and the subsequent pain claimant was experiencing on one side of the scales, and the loosening of the screws in the [prosthesis] caused by the work incident on the other side of the scales." The problem with SAIF's interpretation of the statute is, in essence, that it reads the language "need for treatment" out of the statute. What SAIF proposes is tantamount to understanding the pertinent portion of the statute to read: "[T]he combined condition is compensable only if * * * the otherwise compensable injury is * * * the major contributing cause ~~of the need for treatment~~ of the combined condition." Under ORS 174.010,[3] we may not take the course that SAIF urges, and we therefore reject that reading of ORS 656.005(7)(a)(B). It follows that what we said in our previous opinion, and again here, does not conflict with what we said in *Robinson* because the two cases are distinguishable: here, the primary cause of claimant's combined condition is different from the primary cause of his need for treatment.

149 Or App 315> Finally, SAIF complains that our reference to ORS 656.245(1) in our previous opinion is not necessary to our holding. We agree.

In summary, we understand SAIF's argument to be that we should read the statute to distinguish between the compensability of claimant's need for treatment and compensability of claimant's combined condition. However, the statute expressly refers to the compensability of the combined condition and says that the combined condition itself is compensable when the on-the-job injury is the major cause of claimant's disability *or need for treatment*. Accordingly, we hold that in this case, that the Board correctly applied ORS 656.005(7)(a)(B) in concluding that claimant's work injury, when weighed against the extent of his preexisting condition, is the major cause of his need for treatment. Therefore, claimant's combined condition is compensable.

Reconsideration allowed; opinion modified and adhered to as modified.

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[3] ORS 174.010 provides:

"In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or substance, contained therein, not to * * * omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as to give effect to all."

Cite as 149 Or App 323 (1997) July 23, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michelle Dibrito, Claimant.
Michelle DIBRITO, *Petitioner,*
v.
ADULT AND FAMILY SERVICES and SAIF Corporation, *Respondents.*
(91-13969; CA A89201)

Judicial Review from Workers' Compensation Division.
Argued and submitted January 26, 1996.
Robert F. Webber argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.
Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Affirmed.
Armstrong, J., dissenting.

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149 Or App 325> Claimant seeks review of a Workers' Compensation Board order that denied her injury claim. We review for substantial evidence, ORS 183.482(8)(c), and affirm.

This case has a lengthy history. We take our facts from the Supreme Court's description in *Dibrito v. SAIF,* 319 Or 244, 246-49, 876 P2d 749 (1994).

> "Claimant was a caseworker for Adult and Family Services. She suffered from preexisting colitis and a preexisting personality disorder. Because of health problems, claimant sought to reduce her daily work hours by half and to take the remaining half as leave without pay. Claimant became upset during a meeting with her supervisor on May 14, 1991, during which she was informed that she would not be able to retain her status as a full-time employee if her request to work part-time were granted. Claimant experienced an episode of colitis requiring medical treatment and experienced psychological symptoms.
>
> "Claimant filed a workers' compensation claim for her physical and mental conditions, which her employer's insurer, SAIF Corporation (SAIF), denied. After a hearing, the referee concluded that claimant had suffered a compensable accidental injury under ORS 656.702 * * *.
>
> "SAIF appealed to the Workers' Compensation Board (Board). * * * On review of the record, the Board determined that 'claimant's psychological condition was due, in major part, to factors other than work conditions' and that, 'accordingly neither claimant's mental condition nor her physical symptoms resulting from on-the-job stress are compensable.'
>
> "Claimant sought judicial review in' the Court of Appeals, which affirmed the Board's order without opinion. *DiBrito v. SAIF,* 124 Or App 680, 865 P2d 1341 (1993).
>
> "* * * * *
>
> "Claimant sought compensation for both her colitis and her personality disorder. She alleged that those disabilities were caused by the stress of the May 14, 1991, meeting at work. The Board found that claimant's preexisting personality disorder was 'unaffected by the stress at work' and **<149 Or App 325/326>** that 'the primary cause or major contributing cause of claimant's personality disorder, which [was] diagnosed in August

> 1991, was claimant's relationship with her mother and her inability to resolve her feelings after her mother died.' The Board concluded that 'claimant's psychological condition was due, in major part, to factors other than work conditions' and that claimant failed to prove 'that her psychological condition arose out of and in the course of her employment.' Substantial evidence supports the Board's findings relating to claimant's mental disorder. Given those findings, the Board was entitled to hold that claimant's mental disorder was not compensable under ORS 656.802.
>
> "The Board erred, however, in not analyzing separately, under ORS 656.005(7), claimant's episode of colitis, alleged to have been caused by the stress of the May 14, 1991, meeting at work. Claimant is entitled to the Board's review of that portion of her claim under the standards that apply to injuries." (Footnotes and citations omitted.)

On remand, the Board undertook to determine whether claimant's colitis condition, alleged to have been caused by the stress of the May 14 meeting, was a compensable injury under ORS 656.005(7)(a). The Board adopted the administrative law judge's (ALJ) findings that "claimant left the meeting sobbing uncontrollably, she lost control of her bowels, she went home, went to Dr. Marx and obtained a fulltime release from work and went home. She was eventually admitted to the hospital for recurrent colitis and dehydration." However, it rejected the ALJ's ultimate finding that the events during the May 14, 1991, meeting were not generally inherent in every work environment and were not connected with a reasonable, corrective on-job performance evaluation. In its analysis, the Board noted:

> "Here the medical evidence shows that prior to claimant's May 14, 1991, episode of colitis, claimant had a longstanding history of abdominal distress, 'including acute and chronic colitis.' Furthermore, claimant's treating physician, Dr. Marx, opined that the stress of the work meeting on that day made claimant's preexisting colitis symptomatic.
>
> "* * * * *
>
> "Because claimant has had an extensive history of abdominal disease and a preexisting colitis condition, we **<149 Or App 326/327>** find that causation of claimant's resultant condition is a complex medical question, the resolution of which turns on the medical evidence. [Citations omitted.] We rely on those medical opinions which are well reasoned and based on accurate and complete histories."

There are several medical reports that discuss claimant's resultant condition. Dr. Marx, claimant's treating physician, reported that the stress of the May 1991 work meeting made claimant's preexisting colitis symptomatic. He also concluded that claimant's need for treatment and disability was in major part caused by the stress she suffered at work.

Dr. Herbert, who reviewed the medical records on behalf of SAIF, was doubtful that claimant had experienced a recurrence of colitis. His opinion was based on a nonspecific gastritis revealed by a gastroscopy and a normal barium enema. Because no documentation regarding claimant's condition was obtained, Herbert supported a diagnosis of irritable bowel syndrome. He opined that the "usual cause" of worsening symptoms of irritable bowel syndrome was stress. However, whether the work environment was responsible for claimant's condition was a determination that Herbert believed would "perhaps be made by the psychiatrist who will be seeing [claimant]."

Dr. Thompson, the psychiatrist who examined claimant, stated that the cause of claimant's physical symptoms was in question. Thompson found that claimant had a preexisting "personality disorder mixed with dependent and compulsive traits" and "that the stress at work probably didn't have any particular effect on the personality disorder." When asked to assume that claimant had an irritable bowel syndrome and whether he felt that the May work incident was "the major cause of her problem" and the reason for her subsequent hospitalization, Thompson replied, "No." He explained that claimant's case was more complicated than merely making a temporal connection between the meeting and the onset of the condition. He suggested that claimant could have been stressed from her job but that her symptoms also could have come about because of either her faulty perceptions or as the result of preexisting "neurotic problems."[1]

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[1] Thompson's testimony is set out later in this opinion.

The Board concluded:

> "Claimant has failed to show that the May 1991 injury (the work meeting) is and remains the major cause of her resultant abdominal/colitis condition."

It explained:

> "Dr. Marx's opinion is not persuasive because, although he opined that the stress of a meeting made a preexisting condition symptomatic, there is no indication that Dr. Marx assessed the relative contribution of different causes of claimant's condition."

As to Herbert's report, it pointed out:

> "Although Dr. Herbert offered an opinion concerning causation of worsening symptoms of irritable bowel syndrome in general, he declined to comment on the causation of *this* claimant's condition and instead deferred to a psychiatrist for that determination." (Emphasis in original.)

The Board then turned to Thompson's report and subsequent deposition:

> "Additionally, Dr. Thompson, the only psychiatrist to examine claimant, did consider the contribution of different causes of claimant's condition, but he could not conclude that work was the major contributing cause of claimant's condition or the need for treatment following the May 1991 incident. We note that, at one point, Dr. Thompson was asked to assume that all of the stress claimant had at work was work related. As we discussed above, inasmuch as claimant had faulty perceptions and preexisting 'neurotic problems' which contributed to her stress, that assumption was incorrect."

Claimant sought reconsideration of the Board's order on remand. In part, she asserted that the Board had misinterpreted Thompson's opinion. In response, the Board said:

> "As we have previously explained, notwithstanding his hypothetical opinion, *we interpret Dr. Thompson's ultimate conclusion to be that the primary cause of claimant's current disability and need for medical treatment are non-work factors.* In any event, *assuming for the sake of argument that claimant's perceptions of all of her alleged work stress were real, Dr. Thompson also referred to claimant's preexisting* **<149 Or App 328/329>** *'neurotic problems'as a contributor to her stress.* In light of such considerations, we are unable to find that Dr. Thompson['s opinion] supported a conclusion that claimant's work stress was the major contributing cause of her current colitis condition." (Emphasis supplied.)

On review, claimant's assignment of error reads:

> "The Board's ultimate conclusion that Dr. Thompson's opinion was that the primary cause of claimant's disability and need for medical treatment was non-work factors is contrary to the Findings of Fact and not supported by substantial evidence."

"[S]ubstantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. * * * A court must 'evaluate the substantiality of supporting evidence by considering *all* the evidence in the record.'" *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990) (emphasis in original) (quoting in part from *Younger v. City of Portland*, 305 Or 346, 356, 752 P2d 262 (1988)). After reviewing all of the medical evidence on a complex medical question, the Board was not persuaded that claimant had carried her burden of persuasion that work-related stress was the major contributing cause of her colitis condition. We conclude that the Board's reasons for not being persuaded are reasons on which a reasonable factfinder could rely. In particular, the Board reasoned that the hypothetical questions asked of Thompson excluded the component of her preexisting condition, and therefore, that the answers that followed were not persuasive. In other words, Thompson's report and testimony could reasonably be understood to mean that he could not determine whether the May 1991 work incident was the major contributing cause of claimant's colitis/irritable bowel syndrome condition, when the preexisting condition was factored into the causal equation.

The dissent does not believe that the Board was unpersuaded by the evidence that the May 1991 meeting was the major contributing cause of the colitis condition. Rather, it focuses on a finding that the Board never made, *i.e.*, that the Board adopted the meaning of Dr. Thompson's opinion as the dissent interprets it. The dissent relies primarily on an excerpt from Thompson's deposition. The context of that **<149 Or App 329/330>** excerpt is as follows: Thompson testified that, "The cause of the symptoms is what is in question" and that "I think the physical symptoms were probably mostly due to the flare-up of the colitis. Again I was hoping that the gastroenterologist would clarify that point." Counsel then handed to Thompson a medical report from Herbert and asked Thompson to interpret what Herbert had determined as the cause of claimant's symptoms. Thompson answered:

> "Well, Dr. Herbert says that there was not enough evidence to make a diagnosis of colitis, and indicated that the correct diagnosis may be irritable bowel syndrome. If that is the correct diagnosis, then he states that the usual cause of worsening of symptoms is stress; and he said whether or not the work environment was responsible for that remains to be determined by the psychiatrist."

Then the following questions and answers ensued:

Q. "So he sort of handed the ball back to you?"

A. "Yes."

Q. "*And if you assume that she did have an irritable bowel syndrome,* then *would that support the conclusion* that based on the temporal relationship between the incident at work and the onset of this particular condition, *that the stress at work was the major cause of her problem?*"

A. "Well, I think we have to define what problem you're talking about."

Q. "Well, the irritable bowel, at that point in time."

A. "Following that meeting and why she went into the hospital and all of that?"

Q. "Correct."

A. "[Pause.] *No.* I explained in my report that I thought it was more complicated than simply connecting up those two things in point of time. And I'm still wondering about that because I noted on page 7 of my report in the last paragraph that I think it depends whether the conditions at work were out of the ordinary to decide whether or not the stress is related to the job. *Because she could have been stressed out about her job, but it might have been based on faulty perceptions on her part or some of her neurotic problems that she had had her whole life.* So I think we have to **<149 Or App 330/331>** get to the point of whether or not there was a legitimate stressful event that occurred at work.

Q. "If you assume that the conditions at work were conditions other than conditions generally inherent in every work situation or reasonable disciplinary corrective job performance evaluation action by the employer, and that they existed in a real and objective sense--which is something someone else would have to decide--but if you assumed those facts, would the situation at work in May of 1991 be the major cause of her stress?

A. "So you're asking me if the conditions are not generally inherent in every work situation, assume that?"

Q. "Right."

A. "Then I would say that the exacerbation of her symptoms, which may or may not be irritable bowel syndrome, that those were--the major cause of that was the work stress, *if that assumption is correct.*" (Emphasis supplied.)

In isolation, the testimony that the dissent relies on could reasonably be understood in the way in which the dissent asserts. However, there is other testimony from Thompson which would cause a reasonable person not to be persuaded of claimant's position. Finally, the dissent's focus on the Board's assumption of a fact in its opinion for the sake of argument when it did not make that finding underlines its error in conducting, in effect, a *de novo* review. In sum, there is substantial evidence to support the Board's decision.

Affirmed.

ARMSTRONG, J., dissenting

The majority affirms the denial of claimant's colitis claim on the ground that substantial evidence supports the board's interpretation of Thompson's opinion of the cause of claimant's condition. The majority is wrong. Thompson's opinion cannot be understood to mean what the board says it means. Because the board's rejection of the claim is premised on its interpretation of Thompson's opinion, the claim must be remanded to the board for reconsideration. *See, e.g., Liberty Northwest Ins. Corp. v. Verner,* 139 Or App 165, 168-69, 911 P2d 948 (1996).

149 Or App 332> Thompson examined claimant at employer's request. Because of the information available to him, he could not resolve whether the major cause of claimant's colitis condition was work-related stress. He explained in his report that the resolution of that issue depended on whether claimant's view of her May 14 meeting with her supervisor was correct:

> "However, I would wonder if the conditions of her job were out of the ordinary to the degree that would justify a stress claim. I believe it is [claimant's] opinion that [her supervisor] was out of order when he appeared to be forcing her into a job share position so that she would lose her permanent position, and she saw that as a retaliatory move on his part. *If her view is correct, then she probably does have a legitimate stress claim. On the other hand, if her view is wrong and she was primarily angry over his way of handling it, then the stress could be related more to the past history of losses of her father and mother, the job being of primary importance to her at this point in her life, and the fear of losing that."* (Emphasis supplied.)

It is not surprising that Thompson testified as he did. He had not been given information on which to evaluate whether claimant correctly perceived the May 14 events. Consequently, he could state only a conditional conclusion about whether the major cause of claimant's colitis condition was work-related stress.

Thompson expanded on those points at his deposition. In doing that, he pinned down the information that, if known, would lead him to conclude that claimant's condition was work related:

> "Q. And if you assume that [claimant] did have an irritable bowel syndrome, then would that support the conclusion that based on the *temporal relationship* between the incident at work and the onset of this particular condition, that the stress at work was the major contributing cause of her problem?
>
> "* * * * *
>
> "A. [Pause.] No. I explained in my report that I thought it was more complicated than simply connecting up those **<149 Or App 332/333>** two things in point in time. * * * *I think it depends whether the conditions at work were out of the ordinary to decide whether or not the stress is related to the job. Because she could have been stressed out about herjob, but it might have been based on faulty perception on her part or some of her neurotic problems that she had had her whole life. So I think we have to get to the point of whether or not there was a legitimate stressful event that occurred at work.*
>
> "Q. If you assume that the conditions at work were conditions other than conditions generally inherent in every work situation or reasonable disciplinary corrective job performance evaluation action by the employer, and that they existed in a real and objective sense--which is something someone else would have to decide--but if you assumed those facts, would the situation at work in May of 1991 be the major cause of her stress?

"* * * * *

"A. *Then I would say that the exacerbation of her symptoms, which may or may not be irritable bowl syndrome, that those were--the major cause of that was work stress, if that assumption is correct.*"

(Emphasis supplied.)

Thus, Thompson testified that claimant's stress could have been caused by her job, by her misperception of the situation or by her neurotic problems, depending on whether a legitimately stressful event had occurred. However, if claimant did not misperceive the May 14 events, and those events were beyond those generally inherent in every work setting, then the May 14 events were the major cause of claimant's condition.[1]

In its initial order, the board interpreted Thompson's testimony as follows:

149 Or App 334> "Dr. Thompson, the only psychiatrist to examine claimant, did consider the contribution of different causes of claimant's condition but he could not conclude that work was the major contributing cause of claimant's condition or the need for treatment following the May 1991 incident. We note at one point Dr. Thompson was asked to assume that all of the stress claimant had had at work was work related. As we discussed above, inasmuch as claimant had faulty perceptions and preexisting 'neurotic problems' which contributed to her stress, that assumption was incorrect."

That interpretation is simply wrong. Thompson was not asked to assume that "all of the stress claimant had had at work was work related." Instead, Thompson was asked to assume only that the conditions of the May 14 meeting were "conditions other than conditions generally inherent in every work situation * * * and that they existed in a real and objective sense." Thompson said that claimant's condition could have been caused by claimant's misperception of events and by her preexisting neurotic problems, but, if claimant's perception of the events *were* correct and the events were other than those generally inherent in every employment, then the major cause of claimant's condition was work-related stress.

On reconsideration, the Board again misconstrued Thompson's testimony:

"As we have previously explained, notwithstanding his hypothetical opinion, we interpret Dr. Thompson's ultimate conclusion to be that the primary cause of claimant's current disability and need for medical treatment are nonwork factors. In any event, assuming for the sake of argument that claimant's perceptions of all of her alleged work stress were real, Dr. Thompson also referred to claimant's preexisting 'neurotic problems' as a contributor of stress. In light of such considerations we are unable to find that Dr. Thompson supported a conclusion that claimant's work stress was the major contributing cause of her current colitis condition."

Contrary to the board's conclusion, Thompson's testimony cannot fairly be read to imply that "the primary cause of claimant's current disability and need for medical treatment are non-work factors." As previously explained, Thompson testified that, whatever contribution nonwork factors made **<149 Or App 334/335>** to claimant's condition, the major contributing cause of the condition was work-related stress if claimant correctly perceived the May 14 events. Thompson's testimony cannot be interpreted to say anything different.

---

[1] It is worth noting that a medical diagnosis ofthe cause of claimant's condition presumably did not depend on whether the conditions at work were other than those generally inherent in every work setting. The conditions at work could have caused the claimant's colitis episode even if they were conditions generally inherent in every work setting. The reason that the nature of the work conditions matters is that ORS 656.802(3)(b) permits recovery for the effects of work-related stress only if those effects are not the product of conditions that are generally inherent in every work setting or of reasonable disciplinary action.

The majority notes that the board did not find that the May 14 meeting was indeed a legitimately stressful event. 149 Or App at 329. That is beside the point. The board based its decision on the assumption that claimant had not misperceived the situation. Once the board made that assumption, it could not interpret Thompson's testimony to mean anything other than what it says, namely that "the major cause of [the exacerbation of claimant's symptoms] was work stress."

In summary, the board relied on its interpretation of Thompson's testimony to reject claimant's colitis claim. Because the board and the majority misconstrue that testimony, I respectfully dissent.

Cite as 149 Or App 392 (1997) July 23, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mary R. Marcum, Claimant.
Mary R. MARCUM, *Petitioner,*
v.
CITY OF HERMISTON, *Respondent.*
(WCB 95-02745; CA A92829)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 22, 1996.
Michael A. Gilbertson argued the cause and filed the brief for appellant.
Jonn Oswald argued the cause for respondent. On the brief were Marianne Bottini and Bottini, Bottini & Oswald, P.C.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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149 Or App 394> Claimant seeks review of an order of the Workers' Compensation Board upholding employer's denial of her claim for an aggravation of her compensable knee injury. We affirm.

The facts in this case are undisputed. In December 1991, claimant compensably injured her knee. Employer accepted the claim. In March 1994, after several surgeries and extensive physical therapy, claimant received a scheduled disability award for her knee of 45 percent. In July 1994, claimant attended a baseball game at which she slipped on some mud and fell. In August 1994, claimant met with her physician, Dr. Lantz. Lantz noted a decline in the range of motion in her knee since her last visit with him in September 1993. However, there was no change in her knee that was apparent on x-ray from the period before the fall. Claimant subsequently filed a claim for an aggravation of her compensable injury. Employer denied her aggravation claim and the Board affirmed that denial.

Claimant seeks review of that denial. ORS 656.298. Aggravation claims are governed by ORS 656.273(1), which provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

Under that provision, "claimant has a compensable aggravation if [she] proves that [her] compensable injury materially contributed to [her] worsened condition," unless the employer proves that an off-the-job injury was the major contributing cause of the worsened condition. *Fernandez v. M & M Reforestation,* 124 Or App 38, 42, 860 P2d 898 (1993).

149 Or App 395> Claimant argues that the Board erred in affirming employer's denial because it did not weigh the relative contributions between her compensable knee injury and her fall in the mud to determine the major contributing cause of her worsened condition. We agree with claimant that in assessing the major contributing cause of an injury the relative contribution of different causes needs to be considered to determine the primary cause. *See Dietz v. Ramuda*, 130 Or App 397, 401, 882 P2d 618 (1994), *rev dismissed* 321 Or 416 (1995). Claimant incorrectly assumes, however, that that standard comes into play in this case. Employer did not have to prove that the off-the-job injury was the major contributing cause of claimant's worsened condition because the Board concluded that claimant had not met her threshold burden of proving that she had suffered a "compensable aggravation."

An examination of the Board's analysis supports our conclusion. First, the Board noted the legal standard outlined in ORS 656.273(1) and the standards for evaluating whether the claimant had established an aggravation. It then stated:

> "Claimant did experience a loss in range of motion after her slip in the muddy grass in July 1994. Dr. Lantz has described the slipping as a 'new and discrete incident' that aggravated her problem.' He felt that her condition was materially worsened following that episode (Exhibit 27). * * * [In] the last paragraph of the doctor's most recent report, he attributes decline in the range of motion in the knee to the slip in the mud (Exhibit 27). That appears consistent with claimant's own representation to Dr. Lantz in late August 1994. The doctor indicated that claimant 'feels she has lost some motion since [the July muddy grass] episode'(Exhibit 20).
>
> "The slip in the mud occurred off the job. I do not find evidence in the record to the effect that the slip resulted from the compensable injury. It appears, therefore, that the major contributing cause of the worsened condition is an injury that is not job-related. Claimant has not proved a compensable aggravation. ORS 656.273(1)."

Although the Board stated that "the major contributing cause of the worsened condition is an injury that is not job-related," it is evident that the statement was made in the context of assessing whether claimant had met her burden of **<149 Or App 395/396>** showing that the worsened condition was related to the original injury. It concluded that she had not met that burden, based on its findings that the worsened condition was due to claimant's slip in the mud and that the original injury had not caused the slip.

Our task, then, is to determine whether substantial evidence supports the Board's findings that the worsened condition was not caused by her original knee injury. ORS 183.482(8). We conclude that it does support those findings. Claimant's condition was worse because the range of motion in her right knee had declined since her prior compensation award. In three separate exhibits, claimant's physician, Lantz, provided the only medical opinion of the cause of that worsened condition. In his report on her August 1994 visit, he stated that claimant felt that her fall in the mud had aggravated her knee injury, and his examination revealed that her range of motion was more limited then when he had examined her the year biefore. In a letter responding to a request for information from employer's representative, Lantz described claimant's slip in the mud as a "new and discrete incident" that "aggravate[d] her problem." Finally, in a letter written after a conversation with claimant's attorney, Lantz stated:

> "I saw [claimant] in September 1993. She then suffered a slip in the mud in July 1994 and I saw her again in follow up in August 1994. I have not seen her in follow up since that time. It is difficult for me to know exactly what her knee range of motion was prior to the slip in the mud, as it was approximately nine months after her last visit with me. When I saw her in August, her range of motion was less than her previous visit a year ago. Some of this loss of motion was due to her slipping in the mud. I am not sure if she is now improved since the visit in August, since I have not seen her since that visit.
>
> "Her underlying condition and pathology in the knee, the majority of this is pre-existing the slip in the mud. However, I do believe the slip in the mud caused further loss of motion in the knee."

Most of the medical evidence does not tie claimant's worsened condition to her original injury. In the final letter, Lantz states that her underlying condition and pathology were from **<149 Or App 396/397>** her original injury, but he does not directly connect her reduced range of motion to that injury. Instead, he merely expresses doubt about whether he could state absolutely that her worsened condition was entirely due to her slip in the mud. Viewing that evidence as a whole, we conclude that a reasonable person could find that claimant's original injury did not materially contribute to her worsened condition.

Claimant's own testimony supports the finding that the original injury did not cause her to slip in the mud. She stated that, because of her original injury, she does not have "good ground clearance" when she walks. As a result, she testified, "I'm always real careful about how I walk, where I walk, and the surfaces I walk on." She described her slip on the mud as follows:

> "I was walking across this grassy area at this park, and I usually walk--watch where I walk, but this time I happened to be looking up. And my foot slipped in this muddy grassy area, and I went to the ground. And once I hit the ground my knee had twisted, and I cau--and it caused some pretty bad pain[.]"

She said that the grass was "wet and muddy. It was just like ice. Ijust slipped and fell." Based on that testimony, a reasonable person could find that the slip did not result from claimant's original injury.

Thus, we conclude that the Board applied the proper legal standard in determining whether claimant had suffered a compensable aggravation. Further, substantial evidence supports the Board's findings that the worsened condition, was not caused by her original knee injury. Thus, claimant did not prove that she had a compensable aggravation.

Affirmed.

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