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(Pages 1751-End)

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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CONTENTS

CITE AS

49 Van Natta ____ (1997)

In the Matter of the Compensation of
WRAY A. RENFRO, Claimant
WCB Case No. 97-00888
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reveiwed by Board Members Moller and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that declined to award an assessed attorney fee pursuant to ORS 656.382(2). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ declined to award an assessed attorney fee under ORS 656.382(2) after the insurer was unsuccessful in reducing an Order on Reconsideration's award of permanent disability. The ALJ reasoned that, because claimant did not raise the issue of an assessed fee pursuant to that statute until after his order had issued, it would be an abuse of discretion to award a fee. See James D. Lollar, 47 Van Natta 740, on recon 47 Van Natta 878 (1995).

On review, claimant contends that an attorney fee should be automatically awarded pursuant to ORS 656.382(2) after a carrier fails to reduce compensation granted in a reconsideration order. We agree.

We look to our cases addressing another assessed fee statute -- ORS 656.386(1) -- for guidance. In light of a claimant's statutory entitlement to an assessed fee under ORS 656.386(1), we have reasoned that an attorney fee is a "natural derivative" from a compensability determination regarding a represented claimant. The fact that an ALJ may have neglected to award an attorney fee in his initial order does not preclude the ALJ from later making such an award on reconsideration. Frank P. Heaton, 44 Van Natta 2104, 2106 (1992); see also Terry R. Myers, 48 Van Natta 1039 (1996) (following Heaton).

Similarly, the Board itself routinely awards an attorney fee under ORS 656.382(2) on review without discussion of whether an attorney fee was expressly sought. E.g., Jose D. Rodriguez, 49 Van Natta 703, 704 (1997). Because an attorney fee pursuant to ORS 656.382(2) is also a "natural derivative" of an order that does not reduce or disallow a claimant's award of compensation, we conclude that the ALJ incorrectly declined to award an assessed fee pursuant to that statute.[1]

In reaching this conclusion, we distinguish James D. Lollar. There, the claimant obtained rescission of the compensability portion of the carrier's denial. We concluded, however, that the claimant was not entitled to an attorney fee award pursuant to ORS 656.386(1) where he did not seek attorney fees pursuant to that statute until after the hearing. We noted that the parties had characterized the denial as a responsibility denial, and that there was no contention at hearing that the denial raised compensability issues or that the claimant was entitled to a "386(1)" attorney fee. 47 Van Natta at 879.

Unlike Lollar, where, in the context of a responsibility denial, the claimant sought an attorney fee pursuant to ORS 656.386(1) after the hearing based on an allegation that the denial raised a compensability issue, claimant in this case did not raise a new issue as a basis for his request for an assessed fee under ORS 656.382(2). Under these circumstances, we do not find Lollar to be controlling.

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[1] ORS 656.382(2) provides, in relevant part, that "[i]f a request for hearing * * * is initiated by an employer or insurer, and the [ALJ] finds that compensation awarded to claimant should not be disallowed or reduced, the employer or insurer should be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee[.]" (Emphasis supplied).

Accordingly, because we find that claimant was entitled to an attorney fee under ORS 656.382(2), we reverse the ALJ's order and award an attorney fee pursuant to that statute.[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 regarding the extent of disability issue is $750, 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, and the value of the interest involved. Contrary to the ALJ's statement of the issues, we note that the insurer sought only a reduction in claimant's 6 percent scheduled permanent disability award. Specifically, the insurer sought a 2 percent reduction in the scheduled permanent disability award. Finally, we do not award an attorney fee for claimant's counsel's services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 24, 1997, as reconsidered on June 3, 1997, is reversed in part and affirmed in part. That portion that declined to award an assessed attorney fee is reversed. Claimant's attorney is awarded an assessed fee of $750 for services provided at hearing, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

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[2] We emphasize that we will still follow our customary practice of considering only issues raised by the parties at the hearing. See Fister v. South Hills Health Care, 149 Or App 214, 218-19 (1997) (Because the employer did not object to the claimant's testimony at hearing regarding the extent of her disability, the Board should not have entertained the employer's argument, first made to the Board, that the evidence was inadmissible under ORS 656.283(7)). However, we find that this kind of case, involving entitlement to attorney fees that naturally derive from other raised and litigated issues, represents a limited exception to the general rule.

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

Pursuant to our September 23, 1997 Order on Remand, this case was dismissed. This action was taken in response to our August 29, 1997 approval of the parties' Claim Disposition Agreement (CDA), in which claimant released rights to worker's compensation benefits (including temporary and permanent disability, as well as aggravation benefits), except medical services, related to her August 1993 claim.

Since the issuance of our September 23, 1997 order, we have received a letter from the insurer's counsel. Stating that the parties wish to have its partial denials reinstated, the insurer requests our assistance in resolving this matter. We treat this request as a motion for reconsideration and withdraw our September 23, 1997 order.

The Board is always ready, willing, and able to consider proposed agreements which resolve issues that are subject to its review. Inasmuch as the partial denials are issues present in this case and because our September 23, 1997 order has not become final, we are authorized to consider such matters. Under such circumstances, it is not necessary to remand this case to the Hearings Division as the insurer alternatively requests. Instead, the parties are asked to submit a proposed stipulation for our consideration which provides that, in lieu of all prior orders, the insurer's denials are reinstated. On our receipt of the parties' fully-executed agreement, we will expeditiously proceed with our reconsideration. In the meantime, the parties are requested to keep us fully apprised of any future developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA M. GREENHAW, Claimant
WCB Case No. 96-04113
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Mitchell Lang & Smith, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's partial denial of claimant's right carpal tunnel condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer as a cook in September 1995. On October 19, 1995, claimant caught her right hand between a door and the "crash bar" of the door. (Tr. Day 1 at 16-18). Claimant was gripping the "crash bar" handle of the door when she was injured. (Tr. Day 1 at 23). Her wrist was forced downward in a hyperflexed position. (Ex. 14B-1). She felt immediate pain in her hand, the entire hand swelled, and there was bruising of her hand and third (long) and fourth (ring) fingers. (Tr. Day 1 at 17-19, 21).

Claimant continued working until December 11, 1995, although her fingers were numb and she had reduced strength in her hand. (Tr. Day 1 at 20). She did not immediately seek medical treatment because she believed her symptoms would go away. (Id.). However, claimant's symptoms persisted. (Tr. Day 1 at 20-21).

On January 11, 1996, claimant sought medical treatment from Dr. Dahlin. (Ex. 2-1). Dr. Dahlin ordered nerve conduction tests which revealed bilateral carpal tunnel syndrome (CTS), slightly worse on the left. (Exs. 1a, 2-1, 9-2).

On March 20, 1996, Dr. Jewell examined claimant at the insurer's request. (Ex. 9). Dr. Jewell diagnosed chronic, bilateral CTS and a contusion of the right hand. (Ex. 9-2).

On April 4, 1996, the insurer accepted claimant's claim as a disabling right hand contusion. (Ex. 7). On April 18, 1996, the insurer issued a partial denial for bilateral CTS. (Ex. 10). Claimant subsequently limited her claim to right CTS. (Tr. Day 2 at 2).

When claimant's right hand symptoms did not improve with conservative treatment, Dr. Dahlin referred claimant to Dr. Thayer, an orthopedist with a subspecialty in hand surgery. (Exs. 13, 18-3).

Dr. Thayer examined claimant on July 29, 1996. Dr. Thayer diagnosed bilateral CTS with the right side being symptomatic, as well as a trigger finger condition. (Ex. 14B-2). Dr. Thayer also believed that claimant sustained a scapholunate ligament injury when she injured her right hand, based on an x-ray he ordered. (Exs. 14A-2, 14B-2).

Claimant's bilateral electrical abnormalities preexisted her work injury, but she had no clinical CTS symptoms prior to the work injury. Claimant's left hand remained essentially asymptomatic following the October 1995 injury to the right hand.

Claimant was a credible witness based on her demeanor and manner of testifying.

We adopt the ALJ's "stipulated facts."

CONCLUSIONS OF LAW AND OPINION

Claimant had electrical abnormalities indicative of carpal tunnel syndrome (CTS) prior to her work injury on October 19, 1995. Claimant's consulting physician, Dr. Thayer, believes that the work

injury caused the right CTS condition to become symptomatic. Therefore, it is appropriate to analyze this claim under ORS 656.005(7)(a)(B)[1] as a compensable injury combining with a preexisting condition.

In order to establish compensability under ORS 656.005(7)(a)(B), it is the claimant's burden to prove by a preponderance of the evidence that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.266;[2] Hutcheson v. Weyerhaeuser, 288 Or 51, 55-56 (1979); SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997); Gregory C. Noble, 49 Van Natta 764, 767 (1997). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta at 765-66.

Here, there are primarily two differing medical opinions regarding the cause of claimant's need for treatment of the combined condition. Dr. Thayer described claimant's "combined condition" as symptomatic CTS on the right side, for which he recommended steroid injections and a cast, as well as surgery if conservative treatment is unsuccessful. (Ex. 14B). Based on the history of the injury he obtained from claimant, x-rays, examination, and review of medical records, Dr. Thayer opined that the October 1995 work injury was the major contributing cause of claimant's need for treatment of her symptomatic right carpal tunnel condition. (Exs. 14A, 14B, 18 at 4-7 and 25-26). In support of his opinion, Dr. Thayer explained that claimant sustained a scapholunate ligament injury, which probably caused synovial bleeding into the carpal canal and pressure on the median nerve, causing claimant's right hand and wrist symptoms. (Ex. 14A).

Dr. Jewell rendered a different opinion. Dr. Jewell opined that claimant's chronic, bilateral CTS was not caused by a minor right hand contusion. (Ex. 9-3). He opined that claimant's bilateral CTS was most likely caused by factors outside her work, including her age, gender, and obese body habitus. (Id.). Dr. Jewell also opined that claimant's work activities as a cook did not contribute to the development of her bilateral CTS. (Ex. 14).

When medical opinions differ, we rely on those opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, we find Dr. Thayer's opinion to be more persuasive.

After our review of the record, including Dr. Thayer's videotaped deposition, we find that Dr. Thayer's opinion is based on a complete and accurate understanding of claimant's history and the mechanism of injury. We find nothing in claimant's description of her injury that is contrary to or inconsistent with Dr. Thayer's understanding of the mechanism of injury. (See Tr. 16-19, 21-23; Ex. 1821, 27-28). Although claimant did not specifically describe her wrist being in a flexed position, her description of the injury is not inconsistent with Dr. Thayer's understanding of the mechanism of injury. Indeed, it is reasonable to assume that Dr. Thayer obtained a more medically complete history when he questioned and examined claimant than claimant provided in response to the attorneys' questions at hearing. In this regard, we note that neither attorney asked claimant whether her wrist was bent or straight, while Dr. Thayer did ask that question. (See Ex. 18-9).

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[1] ORS 656.005(7)(a) provides in material 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 *** 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."

[2] ORS 656.266 provides, in material part, that "[t]he burden of proving that an injury or occupational disease is compensable *** is upon the worker."

We further find that Dr. Thayer's opinion is well-reasoned and clearly explained. Dr. Thayer relied on x-ray evidence of a scapholunate ligament injury, and he clearly explained how the ligament injury probably caused median nerve damage. Finally, Dr. Thayer's opinion addressed the relevant question; that is, he offered an opinion regarding the major contributing cause of claimant's need for treatment of the combined condition (symptomatic right CTS).

On the other hand, we find Dr. Jewell's opinion less persuasive for two reasons. Dr. Jewell did not have an opportunity to review the x-rays Dr. Thayer obtained. Therefore, his opinion is based on incomplete information. In addition, Dr. Jewell's report addressed the cause of the preexisting CTS, rather than the cause of the need for treatment of the combined condition. Thus, Dr. Jewell's opinion does not address the central issue in this case.

For the above-stated reasons, we rely on Dr. Thayer's opinion. Accordingly, we conclude that claimant's right CTS condition is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, 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), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 6, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer's April 18, 1996 partial denial of bilateral carpal tunnel syndrome is reversed in part. The insurer's April 18, 1996 partial denial is set aside with respect to the right carpal tunnel syndrome, 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 of $5,000 for her attorney's services at hearing and on review, to be paid by the insurer.

In the Matter of the Compensation of
BETTY J. JOHNSON, Claimant
WCB Case No. 96-05887
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's denial of claimant's occupational claim for left arm strain/sprain and tendonitis/trigger finger. 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 worked for the employer, a fast food restaurant, from November 1995 through February 1996; she primarily was assigned to the salad bar. In March 1996, she sought treatment from chiropractor Dr. Petty for neck and left arm/hand symptoms. Dr. Petty referred claimant to Dr. Young, hand surgeon. Claimant eventually also was examined by Dr. Grant, a specialist in electrodiagnostic medicine, and examining physician Dr. Cronin. Dr. Worland, hand surgeon, performed a records review at the insurer's request.

The ALJ found the opinions of Dr. Grant and Dr. Worland to be the most persuasive. Although acknowledging the various diagnoses of claimant's condition, the ALJ upheld the denial with regard to every diagnosis. Claimant asserts that she carried her burden of proof concerning the specific diagnoses of "sprain/strain" and "tendonitis/trigger finger." Claimant further contends that, thus, these conditions are compensable.

Dr. Petty diagnosed sprain/strain to the left hand, arm, shoulder and neck, as well as lateral epicondylitis. (Exs. 2, 6). She stated that the "cumulative trauma of filling a coffee pot with hot water by reaching up with her left hand strained not only the hand and arm but also the lower neck as well." (Ex. 6-2).

Dr. Young diagnosed trigger fingers of the left middle and ring fingers, carpal tunnel syndrome, and tendonitis. (Exs. 7A-3, 12A, 13A). Dr. Young concurred with a "check-the-box" report from claimant's attorney stating that the major contributing cause of claimant's "condition and need for treatment" was her employment conditions. (Ex. 16).

Dr. Cronin diagnosed trigger finger of the left middle finger, possible tendonitis, lateral epicondylitis, and resolved shoulder/neck sprain/strain. (Ex. 15-3). Dr. Cronin stated that, based on claimant's history, "any impairment present would be due to the current industrial injury." (Id. at 4). Dr. Cronin further found, however, that he did "not believe that any permanent impairment exists." (Id. at 5).

Dr. Worland agreed with Dr. Cronin's diagnoses. (Ex. 17-1). He also thought that claimant's condition was "most likely idiopathic" and that her work was not the major contributing cause. (Id., Ex. 19).

Finally, Dr. Grant diagnosed left carpal tunnel syndrome, left volar wrist flexor tendonitis, and irritation of the MCP joint areas in the left hand. (Ex. 8-2). Dr. Grant concurred with a "check-the-box" report from the insurer's counsel stating that, although work may have contributed to claimant's carpal tunnel syndrome, he could not determine the cause of such condition. (Ex. 18). Dr. Grant reiterated this opinion in a subsequent deposition. (Ex. 20-17). With regard to the diagnosis of trigger finger, Dr. Grant stated he would defer to Dr. Young and Dr. Worland on the basis that those physicians had greater expertise with such a condition. (Id. at 10, 13, 24-25).

When evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). Here, Dr. Young diagnosed trigger finger and tendonitis and indicated that such conditions were in major part caused by claimant's work. The only rebutting opinion is from Dr. Worland, whose report was conclusory concerning the cause of the trigger finger and tendonitis conditions. Thus, finding no persuasive reasons not to defer to Dr. Young, we conclude that claimant proved the compensability of her trigger finger and tendonitis conditions. ORS 656.802(2).

Deciding the sprain/strain condition is more complex. Only Dr. Petty and Dr. Cronin diagnosed claimant with that condition. For the following reasons, we find their opinions insufficient to carry claimant's burden of proof. First, although supporting causation, Dr. Petty, claimant's initial treating physician, did not provide an opinion with the benefit of claimant's subsequent treatment. Furthermore, although Dr. Cronin reported that claimant's "impairment" was caused by the "industrial injury," which could be interpreted as supporting a causal relationship, Dr. Cronin did not distinguish between any of the diagnosed conditions in discussing impairment. Consequently, we find no basis to construe Dr. Cronin's report as meaning that "impairment" necessarily included every diagnosis.

Finally, because claimant on review asserted only that the sprain/strain and trigger finger/tendonitis conditions are compensable, we consider any remaining diagnosis to be within that scope of the insurer's denial that was upheld by the ALJ.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing over the insurer's denial of trigger finger and tendonitis conditions. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for 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 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 April 15, 1997 is reversed in part and affirmed in part. That portion of the order finding the conditions of trigger finger and tendonitis not compensable is reversed. The insurer's denial of such conditions is set aside and the claim is remanded for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review concerning compensability of the trigger finger and tendonitis conditions, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the insurer.

In the Matter of the Compensation of
MARY MARRS-JOHNSTON, Claimant
WCB Case No. 96-02878
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) found that the self-insured employer did not accept any right shoulder or neck conditions as part of claimant's 1988 occupational disease claim; (2) found that the employer's partial denials denied only claimant's current right shoulder and neck conditions; and (3) upheld the employer's partial denials of claimant's current right shoulder and neck conditions. On review, the issues are scope of acceptance, scope of denial, and compensability.

We adopt and affirm the ALJ's order with the following correction and supplementation. As diagnosed by Dr. Latman, claimant's current treating physician, claimant's current right shoulder condition is right chronic rotator cuff tendonitis, not right chronic rotator cuff tear. (Ex. 20).

Scope of Acceptance

In footnote 1 the ALJ referred to the "September 1989 Notice of Acceptance." This document was a "Notice of Closure," not a "Notice of Acceptance." (Ex. 7). The employer did not issue a written notice of acceptance.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). When the acceptance does not identify the specific condition, we look to contemporaneous medical records to determine what condition was accepted. Timothy Hasty, 46 Van Natta 1209 (1994); Cecilia A. Wahl, 44 Van Natta 2505 (1992).

For the reasons explained by the ALJ, we agree that the carrier did not accept any right shoulder or neck condition. We also note that claimant did not present any right shoulder or neck complaints when she described her condition in the 827 and 801 forms. (Exs. 1, 2). On the 827 form, claimant listed "[w]orking long hrs too much strain on joints and hand[,] pain in both elbows and left hand." (Ex. 1). On the 801 form, claimant listed the body part as "left," stated the nature of the disease as "[p]ain in elbow/wrist," and described the "accident" as "[s]train in joints and hand - pain in both elbows and left hand from long hours." Id. Thus, neither the contemporaneous medical records nor claimant's report of the occupational disease support a finding that the employer accepted any right shoulder and neck conditions.

The employer does not dispute that it accepted claimant's claim for the 1988 occupational disease. Instead, the employer argues that its acceptance is limited to elbow and wrist conditions, without identifying those conditions. The employer contends that the medical records show that claimant was diagnosed and treated for only elbow and wrist conditions at the time the employer "accepted" the claim. We agree.

On November 11, 1988, claimant first sought treatment from Dr. Stanford, who continued to treat her through March 27, 1989. (Exs. 1, 1A, 2A, 3, 3A, 4, 4B). During the time he treated claimant, Dr. Stanford provided conservative treatment, including prescribing rest, medications, a right arm sling, applications of ice and heat, and physical therapy. He variously diagnosed bilateral wrist extensor

tendinitis, right lateral humeral epicondylitis, and right elbow tendinitis and related claimant's condition to her work activities. Id. Claimant reported no shoulder complaints to Dr. Stanford. Furthermore, Dr. Stanford's only mention of neck symptoms occurred in his March 27, 1989 chart note, which stated that claimant "possibly" had cervical myalgia secondary to right elbow tendonitis. (Ex. 4B).

Dr. Stanford referred claimant to Dr. Hazel, orthopedist, who examined claimant twice in May 1989. (Ex. 5). In her initial visit, claimant reported shoulder pain dating from her increased work activities in July 1988. However, given the fact that claimant did not report any shoulder symptoms to Dr. Stanford, we find that Dr. Hazel had an inaccurate history regarding any shoulder condition related to work activities. Furthermore, Dr. Hazel's examination found the shoulder "unremarkable," with full range of motion. Id. Therefore, we do not find Dr. Hazel's chart note provides persuasive contemporaneous medical evidence of any shoulder condition related to work. Instead, based on the contemporaneous medical reports of Dr. Stanford, we find that claimant's bilateral wrist extensor tendinitis, right lateral humeral epicondylitis, and right elbow tendinitis are the accepted conditions.

Scope of Denial

We adopt the ALJ's reasoning and conclusions regarding the scope of the employer's partial denials, finding that the employer denied only claimant's current right shoulder and neck conditions and not her entire current condition. However, the ALJ also found that the employer "effectively orally amended its denial at the hearing to make clear that it was *not* denying claimant's entire current condition" and upheld that oral amendment in his order language. Opinion and Order, page 2, 4 (emphasis in original). On review, both parties agree that the employer did not orally amend its denial at hearing. Appellant's Brief, page 7; Respondent's Brief, page 6. Given this agreement, we do not find that the discussion at hearing regarding the partial denials constituted an oral amendment.

Compensability

We adopt the ALJ's reasoning and conclusions regarding the compensability issue, with the following supplementation. In opining that claimant's current neck and right shoulder conditions are caused by her 1988 work activities, Dr. Latman appears to rely on claimant's history that she had neck and shoulder complaints at the onset. (Ex. 30). However, as discussed above, the contemporaneous medical records do not support that history. Therefore, we find that Dr. Latman's opinion is based on an inaccurate history.

ORDER

The ALJ's order dated April 10, 1997 is affirmed.

In the Matter of the Compensation of
DEBRA L. RIDENOUR, Claimant
WCB Case Nos. 95-01135, 95-00795 & 94-12518
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld Aetna's denial of claimant's current low back condition; and (2) set aside the SAIF Corporation's denial of claimant's claim for the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact as set forth in his February 5, 1997 order.

CONCLUSIONS OF LAW AND OPINION

Claimant had prior injuries to the low back in 1974 and 1979. On February 16, 1987, she compensably injured her low back. The claim was accepted by SAIF as a herniated nucleus pulposus at L4-5. In March 1987, claimant underwent an L4-5 discectomy as part of the 1987 SAIF claim.

On February 16, 1994, claimant suffered a compensable low back muscle strain which was accepted by Aetna. Dr. Henderson performed an L4-5 decompression and discectomy on August 20, 1994. Both Aetna and SAIF issued disclaimers of responsibility and denials of claimant's current low back condition and need for treatment. Claimant requested a hearing regarding the denials.

The ALJ initially found Aetna responsible for claimant's current low back condition under the Kearns presumption. On reconsideration, the ALJ found that SAIF was responsible on the basis that Aetna's accepted low back strain was not the major contributing cause of claimant's current low back condition. On this basis, the ALJ found that Aetna did not have an accepted claim for the condition and that, consequently, the Kearns presumption did not apply and SAIF remained responsible for the current low back condition.

On review, claimant contends that the ALJ should have assigned responsibility to Aetna under the Kearns presumption. We agree.

The medical evidence is unanimous that claimant's current low back condition is compensable.[1] The remaining question is which carrier is responsible for that condition.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the same condition as that previously processed as part of an accepted claim. See SAIF v. Yokum, 132 Or App 18 (1994). Responsibility is then assigned to the carrier with the most recent accepted claim for that condition. Smurfit Newsprint v. DeRosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or need for treatment involves a condition different than that which has already been processed as part of a compensable claim. See Armand J. DeRosset, 45 Van Natta at 1059.

We have held that, in the context of successive accepted injuries involving the same condition, ORS 656.308(1) governs the determination of responsibility for further compensable disability or need for treatment involving that condition. Bonni J. Mead, 46 Van Natta 1185 (1994). However, where a claimant has several accepted claims for injuries involving the same body part, but not the same condition as that for which the claimant currently seeks compensation, Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), is applicable. Raymond H. Timmel, 47 Van Natta 31 (1995).

Kearns created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "Kearns presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. 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.

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[1] The two medical experts who gave opinions regarding the cause of claimant's current condition disagree as to which compensable injury constitutes the major contributing cause of that condition. Dr. Henderson, an orthopedic surgeon who performed claimant's 1995 back surgery, opined that the major contributing cause of claimant's current low back condition was the February 16, 1987 accepted injury with SAIF. However, Dr. James, an examining orthopedist, opined that the major contributing cause of claimant's current low back condition was the February 16, 1994 accepted injury claim with Aetna. Both physicians indicate that claimant's current condition is compensable.

Here, SAIF accepted claimant's 1987 injury claim for "herniated nucleus pulposus, L4-5 level." (Ex. 17). Aetna accepted a claim for a February 16, 1994 injury as a "low back muscle strain." (Ex. 31). Thus, each insurer has accepted a claim involving the same body part (low back) but different conditions (a herniated lumbar disc versus a low back muscle strain).[2] Under the Kearns presumption, Aetna, as the last carrier with an accepted claim involving the same body part is presumptively responsible for claimant's current condition unless it can establish that there is no causal connection between claimant's current low back condition and its accepted injury.

The medical evidence in this case establishes that claimant's 1994 accepted strain injury independently contributed to claimant's condition, even if that injury was not the major cause of the current low back condition. In this regard, Dr. Henderson opined that the February 16, 1994 injury at Aetna's insured was a contributing factor, although he was unable to say that it was the major contributing factor. (Ex. 52-A). Dr. Henderson explained that the February 16, 1994 incident injured the nerve causing it to swell. (Ex. 55-14 to 16). Dr. James opined that the February 1994 injury was the major contributing cause of the low back condition. Under such circumstances, we conclude that Aetna has not established that there is no causal connection between claimant's current low back condition and its 1994 accepted injury. Accordingly, Aetna has failed to rebut the Kearns presumption and is responsible for claimant's current low back condition and need for treatment.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding Aetna's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, payable by Aetna. 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. This award is in lieu of the ALJ's attorney fee award.

ORDER

The ALJ's order dated February 5, 1997, as reconsidered on March 25, 1997, is reversed. The SAIF Corporation's denial is reinstated and upheld. Aetna's denial is set aside and the claim is remanded to Aetna for processing according to law. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $5,000, payable by Aetna, for claimant's counsel's services at hearing and on review.

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[2] We reject Aetna's arguments on review that the Kearns presumption does not apply because the claims accepted by the two insurers involve different body parts. We find that the herniated lumbar disc and the low back lumbar strain involved the same body part: the low back. We likewise reject Aetna's argument that only SAIF has an accepted claim. Although Aetna later denied claimant's current low back condition, it has an accepted claim for a lumbar strain stemming from the February 1994 compensable injury. (Ex. 31).

In the Matter of the Compensation of
BRIAN J. TASCHEREAU, Claimant
WCB Case No. 96-09754
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) upheld the self-insured employer's denial of his injury claim for a cervical strain; and (2) declined to assess penalties or attorney fees for the employer's allegedly unreasonable claims processing. 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.

CONCLUSIONS OF LAW AND OPINION

Claimant, a shipping and receiving clerk, was injured on April 23, 1996 when a gust of wind blew a 4 ft. x 8 ft. plywood sheet from a stack that struck him in the head and chest area, causing him to be thrown into a fork lift. Claimant was unconscious for 20 to 30 seconds. When he became conscious, he noticed a head contusion and abrasions and bruises of the chest area. He experienced right shoulder pain adjacent to the neck area and back pain in the area of the shoulder blades. The onset of neck pain came on approximately three days following the injury.

On May 3, 1996, the employer accepted a claim for nasal laceration. (Ex. 8). On September 23, 1996, claimant objected to the employer's acceptance, asserting that a right shoulder strain and cervical strain had been erroneously omitted. (Exs. 29, 29A & 29B). On September 27, 1996, the employer amended the acceptance to include a right chest contusion, right shoulder strain and facial lacerations. (Ex. 30). On October 24, 1996, claimant again objected to the acceptance, asserting that a closed head injury/post-concussion syndrome had been incorrectly omitted. (Ex. 31). On November 15, 1996, the employer accepted a "concussion condition." (Ex. 32).

Claimant requested a hearing on a "de facto" denial of a cervical strain and requested penalties and attorney fees. The employer denied the cervical strain condition at hearing. (Tr. 5-6). The ALJ concluded that claimant failed to prove a compensable claim for a cervical strain and, because there was no compensation "due and owed" claimant, the ALJ declined to assess penalties or a penalty-related attorney fee.

Compensability

Claimant testified that he had not suffered from any neck symptoms before the April 23, 1996 accident. (Tr. 19). Because there is no evidence that claimant had a preexisting neck condition, he need only prove that his April 23, 1996 accident was a material contributing cause of the cervical strain.

The employer argues that claimant did not establish the existence of a cervical strain to a medical probability. The employer also contends that there were no objective findings to support a discrete cervical strain. We disagree.

Claimant testified that he began noticing symptoms in the lower part of his neck approximately three days after the April 23, 1996 incident. (Tr. 14). A medical report dated May 1, 1996 indicated that claimant complained of a sore neck and neck numbness. (Ex. 5). On May 7, 1996, Dr. Hansen-Smith referred claimant to a physical therapist. (Ex. 11). On May 8, 1996, physical therapist Lameh reported that claimant complained of neck pain, upper back pain and headaches and he had decreased neck mobility. (Ex. 11C). The physical therapist indicated claimant had "poss C6 nerve involvement and cerv strain." (Id.) On June 6, 1996, physical therapist Lameh referred to "apparent" cervical involvement. (Ex. 20).

In previous cases, we have held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that examination findings do not constitute objective findings is irrelevant if those findings otherwise satisfy ORS 656.005(19). See, e.g., Patricia Hofstetter, 48 Van Natta 2302 (1996); Catherine Gross, 48 Van Natta 99 (1996). Under ORS 656.005(19), objective findings in support of medical evidence are "verifiable indications of injury or disease" that may include range of motion.

Here, Dr. Hansen-Smith reported that claimant had some decreased range of motion in the neck as well as a "fair amount" of tenderness to palpation. (Ex. 33-1). In addition, physical therapist Lameh indicated that claimant complained of neck pain and he had decreased neck mobility. (Ex. 11C). Dr. Hansen-Smith referred to notes from physical therapist Lameh that indicated claimant had some cervical strain with possible C6 nerve involvement and she concluded that "certainly the physical examination done by the physical therapist based on my knowledge of her abilities would be sufficient to make me suspect that he does indeed have such cervical strain injury." (Ex. 33-1).

Although Dr. Hansen-Smith and Dr. Johanson indicated that there were no "objective findings" of a cervical strain (Exs. 34, 35), we are not bound by their conclusions if the examination findings otherwise satisfy ORS 656.005(19). Based on the reports of decreased neck range of motion from Dr. Hansen-Smith, we find that claimant had reduced range of motion in his neck. Such a finding satisfies the legal definition of an "objective finding." ORS 656.005(19). See Constance A. Asbury (Shaffer), 48 Van Natta 1018 (1996); Naomi Whitman, 48 Van Natta 605, on recon 48 Van Natta 891 (1996), aff'd mem Eagle Crest Partners v. Whitman, 146 Or App 519 (1997).

Furthermore, we are persuaded by Dr. Johanson's opinion, as supported by the physical therapist reports, that claimant sustained a cervical strain as a result of the April 23, 1996 injury. Dr. Johanson examined claimant on three occasions, including the day of injury. She reported that it was "extremely probable" that claimant sustained a cervical strain solely from his April 23, 1996 injury. (Ex. 34). She explained that the mechanism of injury related from both his hyperextending his neck to pull away from the object that struck him, as well as the object itself hyperextending his neck. (Id.)

Dr. Hansen-Smith also treated claimant and reported that it was "certainly possible with the trauma to his head and shoulder that he did receive some cervical strain injury[.]" (Ex. 33-1). As we discussed earlier, she referred to the physical therapist's examination and indicated that, based on her knowledge of the therapist's abilities, she suspected that claimant did have a cervical strain injury. (Id.) In a later "concurrence letter," however, Dr. Hansen-Smith agreed that, although it was "possible" that claimant sustained a cervical strain, she could not say that he sustained a cervical strain on a more probable than not basis. (Ex. 35).

After reviewing the record, we are most persuaded by Dr. Johanson's opinion because it is well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). Furthermore, Dr. Johanson's report is persuasive because she examined claimant on the day of injury. We conclude that, based on Dr. Johanson's opinion, as supported by the physical therapist reports, claimant sustained a cervical strain as result of the April 23, 1996 injury.

Penalties

Claimant requests separate penalties and attorney fees for failure to accept or deny his claim in a timely manner.

Claimant does not dispute the ALJ's finding that he has been paid all compensation to which he was entitled arising out of the April 23, 1996 work incident. Because all compensation has been paid, there are no "amounts then due" on which to base a penalty under ORS 656.262(11) and no unreasonable resistance to the payment of compensation to support an award of an attorney fee under ORS 656.382(1). We agree with the ALJ that claimant is not entitled to a penalty or a penalty-related attorney fee.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,000, 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 April 10, 1997 is reversed in part and affirmed in part. The self-insured employer's denial of claimant's cervical strain is set aside and the claim is remanded to the employer 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 $3,000, payable by the self-insured employer.

In the Matter of the Compensation of
EFREN QUINTERO, Claimant
Own Motion No. 97-0288M
OWN MOTION ORDER
Robert E. Nelson, Claimant Attorney

The insurer has submitted claimant's request for temporary disability compensation for his compensable low back strain at L5-S1 injury. Claimant's aggravation rights expired on January 26, 1984. 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 May 1, 1997 report, Dr. Neuwelt, claimant's treating physician and surgeon, requested authorization to perform claimant's L5-S1 laminectomy. Claimant underwent that surgery on June 23, 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 insurer contends that claimant was not in the work force at the time of his current disability. Claimant contends that he was not working, but that he was willing to work and unable to work because his compensable injury has made such efforts futile. See Id. Claimant contends that his receipt of social security disability payments as a result of his compensable back condition further establishes that he was in the work force at the time of disability.

Claimant submitted medical reports from 1990 to present, in which various physicians opine that, historically, claimant was incapable of working due to his back condition. See Kenneth C. Felton, 48 Van Natta 725 (1996); Richard Wright, 46 Van Natta 437 (1994). In a March 27, 1990 report, Dr. Aversano, D.O., opined that "[a]s of January 3, 1990 I do not believe [claimant] would be capable of working." Dr. Aversano noted in his report that claimant "has not worked since approximately December 1, 1989." In a January 9, 1995 report, Dr. Aversano noted that claimant "is disabled and on social security because of his back which has HNP [herniated nucleus pulposis] at L5-S1 on the left." In a January 24, 1997 medical report, Dr. Aversano opined that "[claimant] is not able to work." In a February 10, 1997 contemporary medical report, Dr. Neuwelt noted that "[claimant] apparently was declared unable to work and has not worked since 1986 [sic] due to this intermittent left lower extremity pain."[1]

Claimant also contends that he is receiving social security benefits because his was unable to work due to his compensable low back strain condition. However, we have previously found that the receipt of social security benefits is not necessarily determinative when evaluating whether a claimant was in the work force at the time of disability. See Robert E. Carper, 48 Van Natta 1160 (1996). In other words, a claimant might be receiving social security benefits because he is unable to work due to one or more medical conditions, or due to other non-compensable conditions. Here, several physicians have noted that claimant was receiving social security benefits, and at least one physician (Dr. Aversano) reported that claimant's social security disability benefits were awarded as a result of his compensable back condition, specifically, claimant's "HNP at L5-S1 on the left" condition.

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[1] Although Dr. Neuwelt used the term "left lower extremity" when referring to the condition which rendered claimant unable to work, Dr. Neuwelt's report and surgery recommendation indicate that claimant's current condition and the disabling condition for which he needs surgical treatment is left L5-S1 disc herniation.

On this record, we are persuaded that claimant was unable to work due to the compensable injury at the time of disability.

Pursuant to the Dawkins rationale, if a claimant was not working at the time of disability, in order to be considered a member of the work force, the claimant must simultaneously establish that he was willing to work and unable to work at that time. See Arthur R. Morris, 42 Van Natta 2820 (1990); Stephen v. Oregon Shipyards, 115 Or App 521 (1992). The record does not contain any statement or affidavit (other than claimant's attorney's June 25, 1997 letter) which would persuade the Board that, but for his compensable injury, claimant would have willingly sought work at the time of disability. See also Martin L. Moynahan, 48 Van Natta 103 (1996); Judith R. King, 48 Van Natta 2303 (1996). Because the statements of claimant's attorney are insufficient proof in this matter, we are not persuaded that claimant has satisfied the "willingness" test set forth in Dawkins. See Janice Connell, 47 Van Natta 292 (1995).

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.

In the Matter of the Compensation of
HERBERT K. SHINN, Claimant
Own Motion No. 66-0117M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for medical services and temporary disability compensation for his August 8, 1955 compensable injury. SAIF agrees that claimant's right hip is a compensable part of his 1955 industrial injury, however it requests that the Board disallow the payment of medical services for claimant's current right hip dislocation. Contending that claimant's right hip dislocation occurred while claimant was skiing, SAIF asserts that it is not responsible for treatment associated with the dislocation. SAIF also recommends against authorizing temporary disability compensation for claimant's current condition and subsequent surgery.

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).

We recite a brief history of this claim. On August 5, 1955, claimant sustained an injury to his left tibia and fibula, his humerus and his right pelvis. The physician's records indicate that the treatment provided included open reduction and plating of fractures, closed reduction for his right hip dislocation, and a cast to his left leg. The left leg injury resulted in an "above-the-knee" amputation. On October 9, 1990 and February 5, 1991, the Board reopened claimant's claim for payment of prosthetic repairs and injury-related medical services. On January 10, 1992, the Board authorized payment for a new prosthesis. On October 1, 1992, the Board again reopened the claim for payment of prosthetic services for a modified socket.

On June 9, 1993 and July 8, 1993, the Board issued orders denying payment for medical services related to claimant's right hip dislocation because we lacked evidence that the right hip dislocation, which occurred during a January 1993 skiing accident, was a direct consequence of the 1955 work injury. In an August 6, 1993 reconsideration order, we authorized the payment of a diagnostic report.

On August 5, 1997, SAIF submitted claimant's request for medical services for his 1955 right hip and left "above-the-knee" amputation injury. SAIF recommended that the Board deny the provision of the requested medical services. Therefore, we requested the parties to submit their positions and any supporting medical evidence regarding the compensability of the requested medical services. Furthermore, because claimant's current condition required surgery, we requested that SAIF submit a recommendation regarding claimant's entitlement to temporary disability compensation. SAIF responded by sending copies of the February 13, 1997 operative report, as well as a recommendation to deny the authorization of temporary disability compensation for claimant's surgery. Those records do not contain any medical opinion as to whether claimant's current right hip dislocation is related to his compensable injury. No response was received from claimant.

On this record, we are unable to conclude that claimant has established a causal relationship between his current condition and his compensable injury. Furthermore, because we are unable to determine a causal relationship, we are likewise unable to find that claimant is entitled to temporary disability for surgery for his right hip dislocation condition. However, should the parties wish to supplement the record with medical evidence and opinion regarding whether claimant's current right hip dislocation was causally related to his original injury, they may do so provided that the additional evidence is filed within 30 days from the date of this order.

Accordingly, we decline to authorize payment for medical services and temporary disability compensation for claimant's current right hip dislocation condition. We will reconsider this order if further evidence is forthcoming within 30 days after the date of this order.

IT IS SO ORDERED.

In the Matter of the Complying Status of
ROBERT COLWELL, Employer
WCB Case No. 96-00792
And, In the Matter of the Compensation of
LONNIE B. DIRKS, Deceased, Claimant, and
RICKY V. BAUGHMAN, Claimant
WCB Case Nos. 96-02267 & 96-00793
ORDER ON REVIEW (REMANDING)
Mitchell & Associatess, Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Robert Colwell, an alleged noncomplying employer, pro se, requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) dismissed his requests for hearing pursuant to OAR 438-006-0071(1); and (2) affirmed the Department's order of noncompliance. On review, the issues are dismissal and, potentially, subjectivity and noncompliance. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Mr. Colwell, the alleged noncomplying employer, filed hearing requests contesting the Department's order declaring him to be a noncomplying employer and SAIF's acceptance of the injury claims for claimants Dirks and Baughman. The Baughman case was originally scheduled for hearing on April 2, 1996 and the Dirks matter was scheduled for hearing on May 21, 1996. The hearings were postponed and consolidated for hearing on September 9, 1996.

The scheduled hearing was postponed, however, and reset for February 25, 1997 after Mr. Colwell was unable to attend the September 1996 hearing due to a medical condition. The February 1997 hearing was also postponed due to Mr. Colwell's health problems. On February 27, 1997, an ALJ then wrote to Mr. Colwell to advise him that he could testify by telephone at the rescheduled hearing and that he should provide the Hearings Division with a telephone number. Mr. Colwell never provided a telephone number. Further attempts to contact Mr. Colwell were unsuccessful.

On the day of the rescheduled hearing (June 23, 1997), the Hearings Division received a prescription note from a physician stating that claimant was too ill to travel. Claimant did not appear in person or through an attorney when the hearing convened. The SAIF Corporation and counsel for claimant Baughman moved for dismissal of Mr. Colwell's hearing requests. The Department sought affirmance of its noncomplying employer order.

On June 30, 1997, the ALJ issued an order dismissing claimant's hearing request pursuant to OAR 438-006-0071(2), on the ground that claimant had abandoned his request for hearing. The ALJ also affirmed the Department's Proposed and Final Order Declaring Noncompliance.

Thereafter, Mr. Colwell requested Board review of the ALJ's order, indicating that he did not have access to a telephone for long distance calling. Furthermore, Mr. Colwell asserted that he had a mental disability.

CONCLUSIONS OF LAW AND OPINION

Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-006-0071(2). An ALJ shall dismiss a request for hearing if the party that waives appearance is the party that requested the hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. Id. OAR 438-006-0081 provides that a "scheduled hearing shall not be postponed except by order of a referee upon finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." It is well-settled that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. William E. Bent II, 48 Van Natta 1560 (1996); Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992).

Here, in response to the ALJ's June 30, 1997 dismissal order, Mr. Colwell submitted a letter requesting review of the ALJ's order, alleging that he did not have access to a telephone and that he had a "mental disability." In light of these circumstances, we interpret Mr. Colwell's correspondence as a motion for postponement of the scheduled hearing. See Randy L. Nott, 48 Van Natta 1 (1996).

Inasmuch as the ALJ did not have an opportunity to rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Mark Totaro, 49 Van Natta 69 (1997) (remand appropriate to consider "Motion to Postpone" when the claimant contended that ALJ's order was "erroneous" and that "injustice would result" if the ALJ's order was not reversed); compare Shirley J. Cooper, 49 Van Natta 259 (1997) (no compelling reason to remand when the claimant offers no explanation or argument concerning his failure to appear at hearing); James C. Crook, Sr., 49 Van Natta 65 (1997) (same).[1]

In determining that remand is appropriate, we emphasize, as we have in similar cases, that our decision should not be interpreted as a ruling on the substance of any of Mr. Colwell's representations or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have previously explained, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of Mr. Colwell's hearing request is justified. Jennie S. Debelloy, 49 Van Natta 134 (1997).[2]

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[1] A briefing schedule has not been implemented. However, because it is the Board's standard practice to remand to the ALJ in cases where a party provides some explanation for not appearing at a hearing, and because Mr. Colwell has provided an explanation for his failure to attend the hearing, substantial justice is achieved by immediately remanding to the ALJ for consideration of Mr. Colwell's motion. Cf. Robert K. Hedlund, 47 Van Natta 1041, 1043 n.1 (1995) (Board review conducted and case remanded even though standard briefing schedule no implemented). Moreover, we note that both Mr. Colwell and the other parties will have the opportunity to present their respective positions regarding the "postponement" motion to the ALJ on remand.

[2] Because it is not clear whether a copy of Mr. Colwell's request for review was served on all the parties, we have included a copy of that request with their copies of this order.

Accordingly, the ALJ's June 30, 1997 order is vacated. This matter is remanded to ALJ Podnar to determine whether postponement of Mr. Colwell's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

October 7, 1997 Cite as 49 Van Natta 1767 (1997)

In the Matter of the Compensation of
TIMOTHY A. GEHRIG, Claimant
WCB Case No. 96-04753
ORDER ON RECONSIDERATION
Neil Jackson & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

On August 21, 1997, in response to the insurer's motion, we abated our July 25, 1997 Order on Review that adopted and affirmed an Administrative Law Judge's (ALJ's) order that increased claimant's unscheduled permanent disability for a skin condition from 3 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 12 percent (38.4 degrees). Having received claimant's response, we proceed with our reconsideration.

Claimant worked as a machinist. In November 1994, claimant developed a skin condition after working with a new liquid coolant. The insurer subsequently accepted a claim for "dermatitis bilateral hands, central face." As indicated above, the ALJ ultimately decided that claimant was entitled to 12 percent unscheduled permanent disability under former OAR 436-035-0450.[1]

On review, the insurer in part argued that claimant had not proved impairment under former OAR 436-035-0450 because the accepted condition of "dermatitis bilateral hands, central face" did not qualify as "impairment of the immune system." As indicated above, we adopted and affirmed the ALJ's order.

In requesting reconsideration, the insurer again asserts that the accepted condition is limited to "include only dermatitis demonstrated by skin rash on certain parts of claimant's body." The insurer distinguishes this condition from claimant's other diagnosed skin condition of "allergic contact dermatitis," which it concedes is an immune system disorder. According to the insurer, however, because the medical evidence shows that the skin rash resolved and caused no permanent disability, claimant did not prove impairment due to his compensable injury.

Claimant initially was diagnosed with "contact dermatitis." (Exs. 1A, 4). In June 1995, two months before the insurer issued its Notice of Acceptance, claimant's treating dermatologist, Dr. Weiss, diagnosed claimant with "allergic contact dermatitis." (Ex. 5-2). Consulting and examining dermatologists also diagnosed claimant with "allergic contact dermatitis." (Exs. 9-2, 13-2). The medical arbiter characterized claimant's condition as "chemical hypersensitivity." (Ex. 37-2).

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[1] That rule provided:

"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 activities; OR

"(c) 13% when the reaction prevents most regular work related activities."

In short, the medical record does not support the insurer's argument that claimant's condition includes irritant contact dermatitis. Rather, the record shows that claimant's condition only is allergic contact dermatitis. Furthermore, the acceptance itself states only "dermatitis" without distinguishing between "irritant" and "allergic." For these reasons, we find no merit to the insurer's position that the acceptance is limited to "irritant contact dermatitis."

We also disagree with the insurer that its inclusion of "bilateral hands, central face" means that it limited its acceptance "to the temporary skin disorder on claimant's forearms and lateral neck [sic]." Instead, based on the most reasonable construction of the language, we find that the terms merely describe the areas affected by the dermatitis. Accord Jerry L. Bliss, 49 Van Natta 1133, 1134, on recon 49 Van Natta 1471 (1997).

Based on the record and the terms of the acceptance, we conclude that the insurer's acceptance included "allergic contact dermatitis" but not "irritant contact dermatitis." Because it concedes that such a condition comes under former OAR 436-035-0450, we continue to adhere to our conclusion concerning claimant's permanent disability.

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

On reconsideration, as supplemented and modified 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
WENDY M. SEALS, Claimant
WCB Case No. 96-10624
ORDER ON REVIEW
Cole, Cary & Wing PC, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) awarded claimant 29 percent (92.8 degrees) unscheduled permanent disability for her cervical, thoracic, and lumbar spine conditions, whereas an Order on Reconsideration had not awarded any permanent disability; and (2) declined to allow the insurer to offset a portion of claimant's permanent disability award paid by the insurer pursuant to a Determination Order. Noting that a copy of the insurer's request for review was not mailed to her, claimant moves to dismiss the employer's appeal. On review, the issues are dismissal, extent of unscheduled permanent disability and offset. We deny claimant's motion and affirm in part and modify in part.

FINDINGS OF FACT

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

The ALJ's Amended Opinion and Order issued on June 16, 1997. Copies of the order were mailed to claimant, the employer, the insurer, and their respective attorneys. On June 19, 1997, the insurer mailed to the Board, by certified mail, its request for review of the ALJ's order. The insurer's counsel's certificate of service, which was attached to the request for review, contained counsel's certification that a copy of the request had been mailed by certified mail to claimant's counsel on June 19, 1997. Claimant's counsel does not dispute this certification.

On June 23, 1997, the Board mailed a computer-generated acknowledgment of the insurer's request for review to claimant, claimant's counsel, the employer, its insurer and their respective attorneys. Claimant concedes that she received the Board's acknowledgment letter.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Contending that a copy of the insurer's request for review had not been timely served on claimant, claimant has moved to dismiss the insurer's request for Board review. Claimant does not contend that her counsel was not timely served with a copy of the insurer's request for review. Furthermore, she concedes that she received the Board's acknowledgment letter. Finally, claimant recognizes that court and Board precedent support a conclusion that a party's actual notice of a Board acknowledgment letter within 30 days of the appealed order is sufficient to vest jurisdiction with the Board. See Kelsey v. Drushella-Klohk NCE, 128 Or App 53 (1994); Argonaut Insurance Co. v. King, 63 Or App 847 (1983); Nancy C. Prevatt-Williams, 48 Van Natta 242 (1996). Nonetheless, asserting that the court's decisions have been "misdecided," claimant asks that we address her motion for purposes of preserving the issue on further appeal.

In response to claimant's request, we hold that we retain appellate jurisdiction to consider the insurer's request for Board review. We reach this conclusion based on the following reasoning.

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice received within the statutory period. Argonaut Insurance v. King, 63 Or App 847, 852 (1983).

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47, 51 (1985); Argonaut Insurance v. King, 63 Or App at 847.

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of prejudice to a party, timely service of a request for review on an employer's insurer or the attorney for the party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. King, 63 Or App at 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Daryl M. Britzius, 43 Van Natta 1269 (1991); Harold E. Smith, 47 Van Natta 703 (1995); Nancy C. Prevatt-Williams, 48 Van Natta at 242.

Here, the 30th day after the ALJ's amended order was July 16, 1997. Based on the insurer's counsel's unrebutted June 19, 1997 Certificate of Mailing, we are persuaded that claimant's attorney was copied with the request for Board review prior to the expiration of the aforementioned 30-day period. Inasmuch as no contention has been made that claimant has been prejudiced by not directly receiving a copy of the insurer's request for review, we hold that the insurer's timely service by mail upon claimant's counsel is adequate compliance with ORS 656.295(2). See King, 63 Or App at 847; Nollen, 23 Or App at 420; Harold E. Smith, 47 Van Natta at 703; Nancy C. Prevatt-Williams, 48 Van Natta at 242.

Alternatively, claimant's admitted actual notice of the Board's June 23, 1997 acknowledgment letter would be sufficient to vest appellate jurisdiction with this forum. See Nancy C. Prevatt-Williams, 48 Van Natta at 242; Patricia A. Voldbaek, 47 Van Natta 702 (1995); Wayne V. Pointer; 44 Van Natta 539 (1992); Denise M. Bowman, 40 Van Natta 363 (1988).

In conclusion, we are persuaded that either the insurer's counsel's mailing of a copy of the request for review to claimant's counsel or claimant's actual notice of the Board's acknowledgment letter provide sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with the Board. Consequently, claimant's motion to dismiss the insurer's appeal is denied. We turn to the substantive issues presented for review.

Extent of Unscheduled Permanent Disability

We adopt the conclusions and reasoning set forth in the ALJ's order.

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

Offset

At hearing, the insurer requested that it be allowed to offset the 1 percent awarded by the Determination Order (and paid to claimant), as the Order on Reconsideration had reduced claimant's award to zero. In the original Opinion and Order, the ALJ had declined to granted the insurer's request on the basis that claimant's award of permanent disability had been increased. In the Amended Opinion and Order, the ALJ did not change this conclusion.

Because of the procedural posture of this case, the insurer's request does not technically concern an overpayment of permanent disability benefits to which claimant was not entitled. Rather, the insurer seeks "credit" for the 1 percent (3.2 degrees) unscheduled permanent disability it has already paid to claimant pursuant to the Determination Order. This request is not contested by claimant. Inasmuch as the insurer has already paid 1 percent unscheduled permanent disability, it is now required to pay only 28 percent (89.6 degrees) to comply with the ALJ's award of 29 percent (92.8 degrees), as affirmed herein. In other words, the insurer is authorized to "offset" the 1 percent (3.2 degrees) unscheduled permanent disability that was previously paid to claimant against the ALJ's 29 percent award.

ORDER

The ALJ's order dated May 6, 1997, as amended June 16, 1997, is modified in part and affirmed in part. That portion of the ALJ's order which declined to grant the insurer's request for an offset is modified. The insurer is authorized to offset the previously paid award of 1 percent (3.2 degrees) unscheduled permanent disability against the ALJ's total award of 29 percent (92.8 degrees) unscheduled permanent disability. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $1,500, payable by the insurer.

In the Matter of the Compensation of
VICKI D. POLLOCK, Claimant
WCB Case No. 94-10269
SECOND ORDER ON REMAND (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our September 9, 1997 Order on Remand (Remanding) that: (1) concluded that claimant's June 1994 aggravation claim was not barred by the Stipulation and Order dated July 26, 1994; and (2) remanded the aggravation claim to the Hearings Division for the taking of additional evidence as to whether there was an "actual worsening" of her compensable right shoulder muscle strain. The employer contends that this matter should also be remanded for the taking of additional evidence regarding the parties' intent in entering the Stipulation and, alternatively, that the language of the Stipulation is not ambiguous.

The employer takes issue with our finding that under the terms of the oral settlement agreement, "the employer agreed to rescind its denials and accept claimant's conditions under one non-disabling injury claim. Those terms were eventually recorded in the written agreement that the parties executed in July 1994." The employer argues that this finding is speculative because the record contains no evidence regarding the terms of the parties' oral settlement agreement.

The employer's point is well taken; therefore, we modify our order to remove the above-quoted language. Nevertheless, our conclusion is unchanged. Because the June 1994 aggravation claim was not in existence when the parties orally agreed to settle (prior to the June 14, 1994 scheduled date of hearing), and the employer received no notice of the aggravation claim prior to the ALJ's approval of the Stipulation and Order on July 26, 1994, we remain persuaded that the aggravation claim was not among the "raised or raisable issues" that were settled under the terms of the settlement agreement. Therefore, the aggravation claim was not barred by the agreement.

The employer's remaining arguments are adequately addressed by our prior order. Accordingly, our September 9, 1997 order is withdrawn. On reconsideration, as modified herein, we adhere to and republish our September 9, 1997 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT D. AVERY, Claimant
WCB Case Nos. 96-01975 & 95-13779
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) found that claimant had established "good cause" under ORS 656.319(1) for his untimely request for hearing from its denial of claimant's memory loss/dementia conditions; and (2) set aside its denial of that condition. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to admit a "post-hearing" report from Dr. Oken; (2) found that claimant had withdrawn his aggravation claim for a right shoulder condition; and (3) awarded a $15,000 attorney fee under ORS 656.386(1).[1] On review, the issues are the ALJ's evidentiary ruling, "good cause," compensability, aggravation, interim compensation, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and offer the following summary.

Claimant worked as a treatment plant operator for the employer for over 17 years. His job involved loading sheets of fiberboard onto carts and directing the carts into and out of a dehumidifier oven, using overhead electrical switches.

On June 19, 1993, claimant was caught on the cart and dragged into the oven. Claimant was in the oven for some time (probably ten minutes, perhaps longer) before the accident was discovered. The temperature in the oven was between 170 and 200 degrees Fahrenheit.

Co-workers spent about thirty minutes extracting claimant from the oven. At one point during the rescue, claimant's head became wedged.

Claimant received emergency room treatment for multiple contusions, second degree burns, and prolonged steam inhalation. He was released from the hospital the next day.

SAIF accepted claimant's claim for burns as a disabling injury.

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[1] Claimant also argues that the ALJ should have addressed his contingent request for interim compensation. (Claimant's Respondent's/Cross-Appellant's Brief, p. 31). However, claimant only requested interim compensation under the mental condition claim if SAIF's denial is upheld. Because the denial is set aside and the claim is remanded for processing, we decline to address claimant's contingent request.

Shortly after the accident, claimant's wife noticed that claimant was unusually quiet and had difficulty communicating. In April 1995, Dr. Gray, family physician, reported claimant's symptoms of confusion and disorientation. Claimant's condition was eventually diagnosed as dementia.

In July 1995, SAIF issued a partial denial of claimant's claim for memory loss. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

"Good Cause"

We adopt the ALJ's reasoning and conclusion on this issue, with the following comment.

SAIF argues that claimant has not proven a lack of mental competency sufficient to excuse his untimely request for hearing. See ORS 656.319(2), (3).

Claimant responds that the stringent statutory requirements for mental incompetency set out in ORS 656.319[2] do not apply because his request for hearing was filed within 180 days after mailing of the denial. We agree.

Subsection (1) of the statute provides that no hearing will be held on a claimant's objection to a denial unless a request for hearing is filed not later than 60 days after the denial was mailed or not later than 180 days after the denial was mailed if the claimant establishes that he or she had good cause for failing to request a hearing within 60 days. Subsection 2 provides that, notwithstanding subsection 1, a hearing "shall be granted even if a request therefor is filed after the time specified in subsection (1) . . . if the claimant can show lack of mental competency to file the request within that time." (Emphasis added). Based on the plain language of the statute,[3] we find that subsection 2 (and the requirements for establishing mental incompetency in this context, as set out in subsection 3) is not applicable unless the request for hearing was filed more than 180 days after the denial (and the claimant seeks tolling of the time limitation based on mental incompetency). Accordingly, subsection (1) applies in the present case, because claimant requested a hearing within 180 days of the denial (and he seeks to establish "good cause," not a tolling of the statutory time period). See, e.g., Patricia J. Mayo, 44 Van Natta 2260, 2261 (1992) ("Notwithstanding the good cause excuse for late filing, the time limitation may be tolled under limited circumstances for periods when a claimant lacks mental competency." (citation omitted)).

In this case, we agree with the ALJ that claimant's condition and circumstances at and before the December 22, 1995 request for hearing indicate "mistake, inadvertence, surprise, or excusable neglect," and "good cause" for claimant's untimely request for hearing. Consequently, we adopt the ALJ's reasoning and conclusion in this regard. (See also Ex. 57).

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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 mailing of the denial to the claimant; or

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

"(2) Notwithstanding subsection (1) of this section, a hearing shall be granted even if a request therefor is filed after the time specified in subsection (1) of this section if the claimant can show lack of mental competency to file the request within that time. The period for filing under this subsection shall not be extended more than five years by lack of mental competency, nor shall it extend in any case longer than one year after the claimant regains mental competency.

"(3) With respect to subsection (2) of this section, lack of mental competency shall apply only to an individual suffering from such mental disorder, mental illness or nervous disorder as is required for commitment or voluntary admission to a treatment facility pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380 and the rules of the Mental Health and Developmental Disability Services Division." (emphasis added).

[3] We particularly note that subsection 1 refers to two possibilities, in the alternative: (1) a hearing requested within 60 days of the denial; or (2) a hearing requested within 180 days of the denial, where the claimant had good cause for failing to file it within 60 days.

Evidentiary Ruling

Claimant argues that the ALJ should have admitted Dr. Oken's "post-hearing" report, as part of the rebuttal evidence for which the record remained open after hearing.

SAIF responds that the ALJ properly excluded Dr. Oken's report because it exceeded the scope of rebuttal evidence for which the record had remained open. See February 14, 1997 Interim Order, p. 2.

We agree with SAIF that the record remained open for the specific purpose of allowing claimant to obtain a rebuttal report from Dr. Zimmerman and/or to allow SAIF to depose Dr. Zimmerman. (1Tr. 2-4; 3Tr. 191). Under these circumstances, we conclude that the ALJ did not abuse his discretion in excluding Dr. Oken's "post-hearing" report. See Clifford L. Conradi, 46 Van Natta 854 (1994); Darrel L. Hunt, 44 Van Natta 2582 (1992) (When an ALJ leaves the record open for a limited purpose, it is within the ALJ's discretion to exclude evidence that does not comport with that purpose). Finally, because consideration of Dr. Oken's report would not affect the outcome of this case, we further conclude that this case is not improperly, incompletely, or otherwise insufficiently developed without Dr. Oken's "post-hearing" report. See Lilia D. Parel, 42 Van Natta 2855, 2856 (1990).

Compensability

The ALJ analyzed claimant's claim for memory loss/dementia under ORS 656.005(7)(a) and concluded that claimant established that his June 19, 1993 compensable injury was a material cause of his memory loss/dementia condition.

Because claimant seeks compensation for a mental condition, the claim must be analyzed under ORS 656.802.[4] Fuls v. SAIF, 321 Or 151 (1995). Thus, claimant is subject to the "major contributing cause" standard under ORS 656.802(1)(a)(B). He must prove the existence of his condition with medical evidence supported by objective findings. ORS 656.802(2). Additionally, pursuant to ORS 656.802(3)(a) - (d), 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. Furthermore, there must be a diagnosis of a mental or emotional disorder which 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.

We conclude that the claim for a mental condition is compensable, based on the following reasoning. First, we find that claimant has a generally recognized diagnosis of a mental disorder (dementia) and the existence of his condition is established by medical evidence supported by objective findings; the employment conditions claimed to cause the disorder existed in a real and objective sense; and the conditions were other than those generally inherent in every working situation.[5] Second, we agree with the ALJ that the claimant's lay witnesses and Drs. Hills, Friedman, Zimmerman, and Camicioli are persuasive, and we adopt his reasoning in this regard. Third, based on claimant's persuasive evidence, which we find to be clear and convincing, we conclude that claimant has carried his burden of proving that his June 19, 1993 work injury was the major contributing cause of his memory loss/dementia condition. We offer the following supplementation regarding the latter conclusion.

SAIF contends that claimant's 22 month delay in reported or recorded cognitive difficulties suggests that claimant did not have such difficulties immediately after the injury. SAIF relies on medical opinions suggesting that claimant's condition is not injury-related, based on this delay and a perceived progressive cognitive decline thereafter. SAIF also argues that the opinions supporting the

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[4] Claimant argues that SAIF first raised an occupational disease "theory" on review and we should therefore not address it. However, because the claim for a mental condition must be analyzed under ORS 656.802, we would apply the statute sua sponte, i.e., even if the "theory" was not timely raised. See Fuls, 321 Or 151; see also DiBrito v. SAIF, 319 Or 244, 248 (1994); Daniel S. Field, 47 Van Natta 1457, 1458 (1995).

[5] The conditions were not 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.

claim are based on inaccurate histories (of immediate "post-injury" mental changes) and insufficient to carry claimant's burden because they are based solely on an assumed (but inaccurate) temporal relationship between claimant's work injury and his mental problems.

The experts agree that resolution of the causation question depends largely (but not entirely) on whether claimant's cognitive memory difficulties began with the injury and/or whether he experienced a progressive mental decline thereafter (beginning at or before the time of injury).

As a preliminary matter, we find that claimant had neither cognitive problems nor a mental condition before the June 1993 accident. (See Tr. 32-33, 1Tr. 151, 1Tr. 167, 1Tr. 188-89, 2Tr. 93, 2Tr. 146-47; cf. 2Tr. 177-79, 2Tr. 188-89). The lay evidence regarding claimant's post-injury mental functioning is conflicting. Claimant's co-workers generally did not notice immediate cognitive changes when claimant returned to work 2 months after the injury. However, they did notice such changes over time thereafter. (1Tr. 154-55, 1Tr. 168-71, 2Tr. 5-6, 2Tr. 8-10, 2Tr. 15-16, 2Tr. 75-76, 2Tr. 78-82, 2Tr. 97-98, 2Tr. 149-59, 2Tr. 181-83, 3Tr. 11-12). Claimant's family, on the other hand, observed dramatic personality and communication/memory changes right after the injury, without subsequent progression. (1Tr. 37-47, 1Tr. 86-91, 1Tr. 175-76, 1Tr. 190-92, 1Tr. 196-97, 1Tr. 202-04).

Considering claimant's co-workers' relatively limited contact with claimant, compared with claimant's family's regular long-time relationship with him (including family members' opportunity to observe claimant immediately after the injury), we agree with the ALJ that claimant's family was in the best position to observe claimant's communicated cognitive functioning. Accordingly, based on the credible, persuasive evidence indicating that claimant was a "different person" after his work injury, we find that the injury marked a personality change in claimant and the beginning of his cognitive problems. Based on claimant's family's observations of claimant's behavior between the injury and hearing (and the corroborative medical evidence), we are also persuaded that claimant's mental condition has not changed.

Moreover, we find that the delay in recognizing and acknowledging claimant's "post-injury" mental problems is convincingly explained in the record; that is, neither claimant nor his wife wanted to admit that claimant was mentally impaired. (See Ex. 60-1; 1Tr. 87, 1Tr. 112-13; see also 3Tr. 61). Considering claimant's wife's understandable concern that claimant might lose his job if the employer knew about his diminished mental abilities, we do not find the delay in reporting these difficulties (or seeking treatment for them) to be confusing or to suggest that the difficulties did not exist.[6] (See Exs. 43, 51-2, 51-6, 69A-21; compare Ex. 69B-29). When claimant's wife eventually acknowledged the severity of her husband's condition, she admitted that the problems began right after the injury and the persuasive doctors' histories were corrected in this regard. (Compare Exs. 42 & 60; Exs. 65 & 70, 81). The persuasive expert evidence also establishes that claimant's cognitive problems did not change or progress significantly thereafter. (See Exs. 60-4; 81-2).

In light of these important facts, the ultimate opinions of Drs. Hills, consulting neurologist, Friedman, neuropsychologist, Zimmerman, neurologist, and Camicioli, geriatric neurologist, persuade us the work injury was the major cause of claimant's mental condition. (Exs. 51, 60, 69-3, 70, 81). These doctors effectively ruled out non-injury related diseases (e.g., Alzheimer's and Creuzfeldt-Jakob diseases) based on the likely mechanism of injury, claimant's age, lack of family history of such disease, and apparently normal pre-injury mental functioning. Further considering the temporal relationship between the injury and claimant's cognitive problems, Drs. Hills, Friedman, Zimmerman, and Camicioli concluded that the injury caused the subsequent problems. These opinions are persuasive because they are well-reasoned and based on accurate histories. See Somers v. SAIF, 77 Or App 259 (1986); Randy S. Girard, 48 Van Natta 2167, 2169 n. 1 (1996) (Where the medical opinion addressed more than the temporal relationship between the work exposure and the condition, the opinion was not impermissibly based solely on that relationship). The countervailing medical opinions are unpersuasive because they are inconsistent with claimant's history.[7] Id. Accordingly, because the evidence supporting the claim is

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[6] Moreover, considering the mechanism of injury, we do not find claimant's or his doctors' initial focus on physical injuries to be unreasonable or confusing. (See Exs. 72, 81; 1Tr. 112).

[7] The opinions of Drs. Binder, Dickerman, and Gray are based largely on an mistaken belief that claimant did not have mental changes immediately after the injury and the similarly mistaken understanding that claimant's mental deterioration has progressed over time. (See Exs. 59, 63-6-7, 69A, 69B; see also 1Tr. 176-79, 1Tr. 193, 1Tr. 197).

clear and well-reasoned (and in the absence of persuasive rebuttal), we conclude that the claimant has established, by clear and convincing evidence, that his compensable injury caused his mental condition. See Riley Hill General Contractor, Inc. v. Tandy Corp., 303 or 390, 402 (1987) ("Clear and convincing evidence" is evidence sufficient to establishes that the truth of the facts asserted is highly probable.) Under these circumstances, claimant has established a compensable claim for a mental disorder under ORS 656.802.

Aggravation/Right Shoulder Claim

The ALJ found that claimant withdrew his aggravation claim for an allegedly worsened right shoulder condition (WCB Case No. 96-019785, DOI March 21, 1993). (See Ex. 46). The ALJ therefore declined to address the aggravation claim, reasoning that SAIF's subsequent denial had no effect because the claim had been withdrawn. Alternatively, the ALJ stated that, even if the claim and denial remained effective, claimant would not prevail on the merits of the claim, because there is no evidence that claimant's compensable right shoulder condition actually worsened since claim closure. We agree and adopt the ALJ's reasoning in this regard.

Attorney Fees

The ALJ awarded an assessed attorney fee of $15,000 under ORS 656.386(1) for claimant's counsel's services in prevailing over SAIF's denial of the claim for a mental condition.

Claimant asks us to increase the fee award to $20,000, considering the factors set out in OAR 438-015-0010(4), particularly the time devoted to the compensability issue, the complexity of the case (including the fact that claimant could not assist in case preparation), and its significant financial value. In support of this request, claimant submits an affidavit from his counsel detailing the services performed at the hearing level. SAIF does not respond.

On de novo review, 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 issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in dispute were the compensability of claimant's memory loss/dementia condition; timeliness of the hearing request ("good cause"); exclusion of Dr. Oken's "post hearing" report; and claimant's aggravation claim for a right shoulder condition. Approximately 88 exhibits were received into evidence, including three physicians' depositions and at least six exhibits generated by claimant's counsel. The hearing lasted 3 days (about 18 hours) and the transcript consists of approximately 589 pages. Thirteen witnesses, including claimant, testified on his behalf. Ten witnesses, including the one physician, testified for the employer. Claimant submitted 46 pages of written closing arguments and an affidavit from his counsel attesting to 108.7 hours of attorney services and 16 hours of legal assistance. The affidavit does not differentiate between services devoted to the various issues.

As compared to typical compensability/timeliness cases, the issues here were of above average complexity. The claim's value and the benefits secured are of above average proportions, consisting of substantial medical services and likely permanent disability. The hearing was lengthy (lasting 3 days). Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Finally, although there was a decided risk that claimant's counsel's efforts might have gone uncompensated, counsel's skill and time was well spent in reducing that risk through preparation. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)).

After considering the above factors and applying them to this case, we find that $15,000 is a reasonable fee for claimant's counsel's services at hearing regarding the compensability and timeliness/"good cause" issues. In particular, we have considered the complexity of the compensability and timeliness issues, 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. Finally, we note that claimant's counsel is not entitled to an attorney fee for services devoted to the aggravation claim and the ALJ's "post-hearing" evidentiary ruling.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability and timeliness issues is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to these issues (as represented by claimant's respondent's brief), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issues or for services directed toward the right shoulder aggravation claim or admission of Dr. Oken's "post hearing" report. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 24, 1997 is affirmed. For services on review., claimant is awarded an assessed attorney fee of $3,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
KIP D. BREITMEYER, Claimant
WCB Case No. 96-11267
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the insurer's denial of claimant's neck injury claim; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings" except for the second to last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant asserts that his neck and left shoulder were injured while working as a dump truck driver. Based on witness testimony and the documentary record, the ALJ found that, except for Marie Sayre, "it is not possible to state that the witnesses were not truthful in their testimony[.]" The ALJ further found, however, that the "aggregate evidence" did not carry claimant's burden of showing that he was injured as he alleged. We agree with claimant that he proved compensability.

Claimant testified that, on October 31, 1996, while hauling mud from a job site with a dump truck, mud caked onto the dump box. (Tr. 13). Claimant further stated that he then used a scraper tool to clean out the dump box. (Id. at 14). While using the scraper, he felt a "pop" in his left shoulder and neck, along with the onset of pain. (Id.)

Defense witnesses included claimant's employers, Marc and Marie Sayre, and Marc Sayre's father, Orville Sayre, who worked for the Sayre's company. Marie Sayre testified that she saw claimant on October 31, 1996, when she gave claimant a bag of Halloween candy for his son; on November 1, 1996, when she briefly saw claimant using a power washer on the dump truck; and on November 2, 1996, when claimant came to the office to pick up his pay check. (Tr. 102, 106, 108). According to Ms. Sayre, claimant exhibited no pain behavior during any of these incidents. (Id. at 106, 108, 111). She also testified that claimant did not report the injury until the morning of November 4, 1996. (Id. at 113-14).

Orville Sayre similarly testified that he saw claimant on October 31 and November 1; on the latter date, claimant called Mr. Sayre because of problems with his dump truck. (Id. at 125, 127, 129). Mr. Sayre stated that he went to the job site to look at the dump truck and then followed claimant

when claimant drove the dump truck back to the office shop. (Id. at 131). He then helped claimant with a power washer to clean the dump truck. (Id. at 132). Mr. Sayre testified that claimant exhibited no pain behavior on both days. (Id. at 126, 133). Furthermore, Mr. Sayre disputed claimant's testimony that claimant told him on November 1 about an injury the previous day. (Id. at 135).

Although not statutorily required, the Board generally defers to the ALJ's credibility determination. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). When the ALJ's credibility finding is based on the substance of the witness' testimony, rather than demeanor, we are equally capable of assessing credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). In this case, the ALJ only made one explicit credibility finding (concerning Marie Sayre) and it was based on the substance of the testimony and documentary evidence. Consequently, we proceed with our own assessment of credibility.

With regard to claimant, we first note that he not only consistently reported the mechanism of injury to medical providers, but such history was also consistent with his testimony at hearing. (See Exs. 3, 5, 8, 15-1, 17). Claimant's wife also provided some corroboration of the injury by testifying that, after returning home from work on October 31, 1996, he told her about the incident. (Tr. 188).

The insurer argues that claimant's credibility is undermined by his failure to report his injury to the employer until November 4 and the testimony by Marie and Orville Sayre that, when they saw claimant between October 31 and November 4, 1996, he displayed no pain behavior consistent with a neck injury.

With regard to the latter argument, we first note that claimant disputes Marie Sayre's testimony that she gave him Halloween candy and spoke with him on Thursday, October 31; claimant testified this event occurred on Wednesday, October 30. Notes written by Ms. Sayre on November 4 following claimant's report of the injury also are inconsistent with her testimony. (Ex. 19-, 19-6). Claimant also disputes that he was in the office on Saturday, November 2, to get his pay check. Claimant does agree that he saw and spoke with Orville on Friday, November 1, and briefly saw Marie on the same day.

Even assuming that Orville and Marie Sayre's testimonies are more reliable concerning their contact with claimant, we disagree with the insurer that such evidence necessarily shows that claimant was not injured on October 31. The only medical evidence indicating that claimant would have exhibited pain behavior following the injury is from Dr. Fuller, who did not examine claimant. (Ex. 18). Claimant's wife testified that, although claimant told her about the injury, he did not appear to be in much pain until the morning of Monday, November 4. (Tr. 188, 194). Given Dr. Fuller's lack of contact with claimant and claimant's wife's testimony concerning claimant's appearance, we are not persuaded that an absence of pain behavior between October 31 and November 4 was necessarily inconsistent with the occurrence of an injury on October 31.

Claimant's failure to report the injury until the following Monday morning, however, is troublesome. Claimant explained that he waited until that time because he could not afford to be off work and Marc Sayre had previously threatened to replace claimant if he lost any time from work. (Tr. 39). Marc Sayre denied such an incident, instead testifying that he had asked claimant to reduce his overtime hours. (Id. 88-90). Marie Sayre also denied that there had been any plan to terminate claimant for absenteeism, although she conceded that she and Marc had discussed firing claimant after claimant "yelled" at Marie. (Id. at 155-56).[1]

Although the delay in reporting the injury undermines the reliability of claimant's testimony that he was injured on Thursday, October 31, we find such evidence insufficient to conclude that claimant is not credible. As noted above, claimant consistently reported the injury to medical providers and his wife provided some corroboration of the incident. Also as discussed above, we find no effect on claimant's credibility by any evidence showing a lack of pain behavior. Looking at the record as a whole, we conclude that the reporting delay is not enough to overcome the evidence supporting the reliability of claimant's testimony. Consequently, we find claimant's testimony credible and, based on such evidence, conclude that claimant proved legal causation.

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[1] Claimant also testified that he "felt pretty good" on Monday morning and that he planned to work that day. (Tr. 41). Claimant further stated that, when Marie told him that no work was available for Monday, he then reported his injury to her. (Id.) Claimant does not explain why he decided to report the injury at that time, when the lack of work provided him with another day to see if his pain would resolve and avoid any time loss.

The record also establishes that such injury caused claimant's neck and left shoulder condition. (Exs. 17-4, 18-2). Thus, we also conclude that claimant proved medical causation. ORS 656.005(7)(a).

Penalties

Claimant also contends that a penalty should be assessed because the insurer's denial was unreasonable. Specifically, claimant argues that, in the absence of corroborating evidence, the insurer was not reasonable in relying upon information from Marie Sayre concerning the claim.

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, 06 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, when the insurer issued its denial, it had information from Orville and Marie Sayre that they both had seen claimant after October 31, 1996, and he had exhibited no pain behavior. The insurer also had information that claimant did not report the injury to his employers until November 4. We find such evidence sufficient to show that the insurer had a legitimate doubt concerning the occurrence of an injury. Consequently, we conclude that the insurer's denial was not unreasonable and claimant is not entitled to a penalty.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing over the denial of claimant's neck and left shoulder 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 $5,000, 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 March 31, 1997 is reversed in part and affirmed in part. That portion of the order upholding the insurer's denial is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $5,000, to be paid by the insurer.

In the Matter of the Compensation of
ROBERT W. COBURN, Claimant
WCB Case No. 96-10496
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that denied its request for authorization to recover allegedly overpaid permanent disability paid pursuant to a final Notice of Closure against a subsequent permanent disability award granted by a Determination Order issued after an authorized training plan (ATP). In his respondent's brief, claimant contends that the ALJ erred in affirming the "post-ATP" Determination Order that reduced claimant's unscheduled permanent disability from 42 percent (134.4 degrees), as awarded by the final Notice of Closure, to 19 percent (60.8 degrees). On review, the issues are offset and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A January 19, 1995 Notice of Closure awarded claimant 42 percent unscheduled permanent disability for his compensable low back injury. That Notice of Closure was not appealed and became final 180 days later. See former ORS 656.268(6)(b).

On August 14, 1995, claimant entered an ATP that ended on April 25, 1996. A Determination Order then issued on June 5, 1996, which reduced claimant's unscheduled permanent disability award to 19 percent, based on a reduction of the SVP value and of the value for permanent impairment.

On July 2, 1996, SAIF advised claimant of an overpayment based on the reduction of his permanent disability. Claimant requested a hearing, contesting SAIF's reduction of his unscheduled permanent disability, as well as its assertion of an overpayment. (Tr. 2).

The ALJ determined that a carrier can reevaluate and reduce a permanent disability award after a claimant participates in an ATP. Thus, the ALJ upheld SAIF's reduction of claimant's permanent disability award. However, citing Maria S. Chavez, 47 Van Natta 721, on recon 47 Van Natta 1971 (1995), the ALJ declined to allow SAIF an offset for previously paid permanent disability because the January 19, 1995 Notice of Closure had become final.

On review, SAIF contends that, while the ALJ correctly found that it could reduce claimant's prior unscheduled permanent disability award, the ALJ improperly denied it an offset for permanent disability paid pursuant to the January 1995 Notice of Closure. We need not decide the offset issue SAIF raises because we agree with claimant that the "post-ATP" Determination Order improperly reduced his unscheduled permanent disability. We reach this conclusion for the following reasons.

In SAIF v. Sweeney, 115 Or App 506 (1992), on recon 121 Or App 142 (1993), the initial Determination Order was issued on July 28, 1989. Neither the claimant nor the employer requested a hearing on the Determination Order, which eventually became final. The court found that, under former OAR 436-60-150(5), the employer had 30 days to begin paying the claimant's permanent partial disability award. 121 Or App at 145. On July 31, 1989, three days after issuance of the Determination Order, the claimant entered a vocational training program, thus suspending the employer's duty to pay the permanent partial disability award. The claimant completed the training program on April 13, 1990. The court held that the employer's obligation to pay the permanent partial disability award resumed. Id. However, the employer still had 27 days to begin paying, or until May 10, 1990. On April 30, 1990, the employer issued its notice of closure that reduced the permanent partial disability award to 17 percent. The court stated:

> "We conclude that, because the notice of closure was issued before employer was obligated to begin payment under the original determination order, employer's issuance of its notice of closure effectively reduced the award and excused employer from payment under the original award. Had payment under the original determination order come due, employer would have been obligated to make the lump sum payment required by that award." Id.

The first closure order in this case, as in Sweeney, became final before issuance of the "post-ATP" closure order. However, unlike Sweeney, where the claimant entered the ATP before expiration of the 30-day period for payment of the claimant's permanent disability award, claimant in this case did not begin the ATP until August 1995, some 7 months after the January 1995 Notice of Closure and well after SAIF became obligated to pay the permanent disability award. Therefore, because claimant's prior permanent disability award had become final, SAIF had no authority to suspend payment of those benefits. Unlike the employer in Sweeney, SAIF could not reduce claimant's permanent disability award in the final closure notice of January 19, 1995. Cf. Natalie M. Zambrano, 48 Van Natta 1812, 1915 (1996) (Because a "post-ATP" Determination Order issued before the insurer was obligated to continue the monthly payments of permanent partial disability, and because the Determination Order reduced the

permanent disability award, the insurer was effectively excused from the remaining payments of the original permanent partial disability award).[1]

Accordingly, we disagree with the ALJ's affirmation of the "post-ATP" Determination Order that reduced claimant's unscheduled permanent disability from 42 percent to 19 percent. We, therefore, modify the June 5, 1996 Determination Order and reinstate claimant's prior unscheduled permanent disablity award of 42 percent.

Because we have reinstated claimant's prior award of unscheduled permanent disability, 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 23 percent "increase" between the ALJ's order and our 42 percent award), not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1). In the event that all or any portion of this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

Finally, we find that claimant's attorney is not entitled to an assessed fee for prevailing on the offset issue. In Strazi v. SAIF, 109 Or App 105, 108 (1991), the court reasoned that an offset is a correction of an overpayment which neither reduces nor disallows any portion of a claimant's compensation award; therefore, a request for an offset is not a threat to the award of compensation. Consequently, the court found that a claimant was not entitled to an attorney fee award under ORS 656.382(2) for successfully defending against a carrier's offset request. Id. Under the reasoning in Strazi, claimant is not entitled to an attorney fee award under ORS 656.382(2) for prevailing on the offset issue. Compare Bowman v. Esam, Inc., 145 Or App 46 (1996) (where a notice of closure erroneously awarded TTD at a higher rate and that notice of closure had become final, the carrier's subsequent request for an offset represented a challenge to the correctness of the award of compensation; therefore, the claimant was entitled to attorney fees under ORS 656.382(2) for prevailing on the carrier's challenge to the award of compensation).

ORDER

The ALJ's order dated March 14, 1997, as reconsidered on April 17, 1997, is modified. Claimant's award of 19 percent (60.8 degrees) unscheduled permanent disability in the June 5, 1996 Determination Order is increased to 42 percent (134.4 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order (23 percent), not to exceed $3,800. In the event that all or any portion of this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk.

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[1] We recognize that the court in Sweeney stated:

"Although we agree with the Board's conclusion that employer must comply with the original determination order unless and until claimant's disability is re-evaluated, we do not agree that, in its re-evaluation, employer may not reduce the extent of disability. We find nothing in the statute or rules that provides that the re-evaluation permitted after vocational rehabilitation can only result in a claimant's receiving benefits for an equal or greater disability. In providing for re-evaluation in ORS 656.268(5), the legislature apparently recognized that the extent of a claimant's disability may change as a result of participation in a vocational rehabilitation program. In Leedy v. Knox, 34 Or App 911, 920, 581 P2d 530 (1978), (footnote omitted) it was recognized that, although an initial determination order must be based on the claimant's condition before training, the extent of disability can be reexamined after training:

'If a claimant is able to reduce the extent of his or her disability through participation in a rehabilitation program, provision has been made for re-evaluation and reduction of the permanent award.'" 115 Or App at 511.

On reconsideration, the court adhered to that portion of its opinion that held that an employer may reevaluate a permanent disability award after the completion of a vocational rehabilitation training program. 121 Or App at 145.

It is thus clear from Sweeney that a carrier may reevaluate and, if circumstances warrant, reduce a claimant's permanent disability award after completion of an ATP. Nevertheless, based on a close examination of the facts of Sweeney, we are persuaded that, before a "post-ATP" reevaluation can reduce a permanent disability award in a "pre-ATP" closure notice, the "pre-ATP" award must not have been paid and become final prior to commencement of the ATP.

In the Matter of the Compensation of
HERBERT GRAY, Claimant
WCB Case No. 95-13675
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order which: (1) adhered to the evidentiary ruling in his prior order that reopened the record for the admission of "post-hearing" medical evidence; and (2) republished his prior order setting aside the insurer's denial of claimant's right shoulder injury claim. On review, the issues are evidence and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

On November 3, 1995, claimant, a carpenter, allegedly injured his right shoulder when he slipped and the two-foot wide "form" he was carrying struck his shoulder. Claimant, however, did not report the injury at the time and continued to perform his regular job, including some overtime. (Ex. 8-1).

Claimant sought medical treatment for right shoulder pain from Dr. Berselli, an orthopedic surgeon, on November 9, 1995. (Ex. 1). Dr. Berselli reported that claimant complained of a two-year history of right shoulder pain after lifting a heavy Christmas tree in 1993 and feeling a "popping" in his shoulder. Id. There was no mention of the alleged November 3, 1995 incident. Dr. Berselli diagnosed a probable rotator cuff tear in the right shoulder, but an arthrogram did not confirm its presence. Id.

On November 17, 1995, claimant completed a form 827 which described the November 3, 1995 incident and also noted the 1993 Christmas-tree injury. (Ex. 2). Claimant stated that he was sore for only a couple of weeks after the Christmas-tree injury. Id.

The employer completed and signed a form 801 on November 29, 1995. In early December 1995, claimant was involved in a motor vehicle accident, but he did not injure his right shoulder.

On December 14, 1995, the insurer denied the right shoulder claim on the ground that claimant's condition was not a work-related injury or disease. (Ex. 4). Claimant requested a hearing.

Dr. Berselli performed diagnostic arthroscopy on February 19, 1996, which detected some "fraying," but no actual tearing, of claimant's right rotator cuff. (Ex. 7). While Dr. Berselli initially related claimant's right shoulder condition to the alleged November 1995 incident, he subsequently opined that the Christmas-tree incident in 1993 was the likely cause of claimant's need for treatment, given that surgery did not reveal findings of a new, acute injury. (Exs. 9, 10-8).

CONCLUSIONS OF LAW AND OPINION

In a May 17, 1996 Opinion and Order, the ALJ initially upheld the insurer's denial, relying on Dr. Berselli's opinion. In the meantime, after the March 12, 1996 hearing, claimant began treatment with another orthopedic surgeon, Dr. Switlyk, on April 17, 1996. Dr. Switlyk performed right shoulder surgery on May 10, 1996.

On June 7, 1996, claimant filed a motion for reconsideration of the ALJ's order and for reopening of the record for receipt of Dr. Switlyk's May 31, 1996 medical report, in which Dr. Switlyk reported that he had identified a rotator cuff tear during surgery. In that report, Dr. Switlyk opined that, based on claimant's history and his operative findings, the November 3, 1995 injury was the major contributing cause of claimant's need for treatment. (Ex. 11).

After argument by the parties, the ALJ granted claimant's motion on July 12, 1996 and admitted Dr. Switlyk's report over the insurer's objections. Allowing the insurer to depose Dr. Switlyk, the ALJ stated that he would explain the reasoning for his rulings in his Order on Reconsideration. Dr. Switlyk was deposed on September 19, 1996. (Ex. 13).

In his November 29, 1996 Opinion and Order on Reconsideration, the ALJ set aside the insurer's denial. In doing so, the ALJ relied on Dr. Switlyk's medical opinion, finding the history on which Dr. Switlyk relied was accurate, i.e., that claimant's right shoulder condition resulting from the 1993 Christmas-tree incident had resolved and that the November 1995 injury incident had occurred as claimant had testified. The ALJ, however, did not explain his reasoning for admitting the "post-hearing" medical evidence from Dr. Switlyk.

Noting that the ALJ's evidentiary ruling was "unreviewable" in the absence of any reasoning, the insurer contended on review that the ALJ abused his discretion in reopening the record for "post-hearing" medical evidence. We remanded to ALJ Mills with instructions to issue a final, appealable order on remand explaining his reasons for reopening the evidentiary record. Herbert Gray, 49 Van Natta 714 (1997).

On remand, the ALJ adhered to his prior decision to reopen the record for receipt of Dr. Switlyk's May 31, 1996 report. The ALJ reasoned that, because claimant could not have known before the record closed that Dr. Switlyk would conclude that his shoulder condition was new and work-related, the evidence was not obtainable with the exercise of due diligence prior to closure of the record. Finally, the ALJ adhered to his previous compensability decision. The insurer requested review.

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).

Pursuant to OAR 438-007-0025, the ALJ may reopen the record and reconsider his decision based upon newly-discovered evidence where the motion to reconsider states the nature of the new evidence and explains why it could not have been reasonably discovered and produced at hearing. Here, claimant did not seek treatment from Dr. Switlyk until April 17, 1996, over a month after the March 12, 1996 hearing. We agree with the ALJ that claimant could not reasonably have anticipated before the record closed on May 17, 1996 that Dr. Switlyk would conclude, based on his May 10, 1996 surgery, that claimant's shoulder condition was work-related. Thus, we conclude that the ALJ did not abuse his discretion in reopening the record for receipt of Dr. Switlyk's May 31, 1996 report. 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); Evelyn J. Howard, 49 Van Natta 144 (1997) (same). Having made this determination, we now proceed to our review of the compensability issue.

Claimant has the burden of proving that the alleged November 3, 1995 injury is a material contributing cause of his right shoulder condition by a preponderance of the medical evidence. ORS 656.266. Given the multiple possible causes of claimant's right shoulder condition, we find the compensability issue involves 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 that are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986).

Here, the medical evidence is divided between the opinions of Dr. Switlyk and Dr. Berselli, both of whom have treated and performed surgery on claimant's right shoulder. Dr. Berselli opined that his February 1996 surgical findings were consistent with the Christmas tree incident in 1993 being the cause of claimant's right shoulder condition. (Exs. 9, 10-9). Dr. Switlyk, on the other hand, opined, after performing the May 1996 surgery, that the alleged injury of November 3, 1995 was the major contributing cause of claimant's shoulder condition. This conclusion was based on a history of a "severe jerking injury" in November 1995, an immediate onset of "severe" pain, and discovery of a rotator cuff tear during surgery, a finding that Dr. Switlyk believed was consistent with an acute injury occurring on November 3, 1995. Dr. Switlyk also assumed a history that claimant's shoulder pain resulting from the 1993 Christmas tree injury resolved in a few weeks. (Ex. 11).

Although the ALJ found that claimant's right shoulder pain resolved after the 1993 Christmas tree incident and that claimant sustained a new right shoulder injury on November 3, 1995, the ALJ did not make an express credibility finding based on demeanor. Accordingly, we are in as good a position

as the ALJ to determine whether claimant is credible, based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

In this case, we have serious reservations regarding claimant's credibility in light of the history contained in Dr. Berselli's November 9, 1995 chart note. As previously noted, there is no mention of the alleged November 3, 1995 injury, nor is there any mention of the allegedly severe onset of pain that claimant reported subsequently to Dr. Switlyk. Moreover, Dr. Berselli's initial chart note contains a history of right shoulder pain beginning two years previously after claimant lifted a heavy Christmas tree. Although the ALJ determined that claimant's testimony and history regarding the resolution of the 1993 injury and the occurrence of the November 1995 injury were accurate, we find the history given in Dr. Berselli's contemporaneous November 9, 1995 chart note to be more reliable.[1] See Steve L. Nelson, 43 Van Natta 1053, 1054 (1991), aff'd mem 113 Or App 474 (1992) (claimant's testimony given little weight when inconsistent with the contemporaneous medical documentation); Accord Charles W. Inmon, 42 Van Natta 569, 570 (1990); Cf. Diana M. VanKerckhove, 42 Van Natta 1067 (1990) (where contemporaneous medical records supported the claimant's testimony, the claimant's testimony found credible).

Accordingly, we give little weight to Dr. Switlyk's opinion because it was based on an inaccurate history.[2] See Miller v. Granite Construction Co., 28 Or App 473, 476 (1997). Because the only other physician to address the causation issue, Dr. Berselli, has opined that claimant's right shoulder conditon is the result of the 1993 Christmas tree injury, we find that the medical evidence does not satisfy claimant's burden of proof.

Alternatively, even if we did not discount Dr. Switlyk's opinion for lack of an accurate history, it would still not carry claimant's burden of proof. Considering Dr. Switlyk's testimony that his surgical findings are consistent with either a recent acute injury or a remote injury in 1993, we would find that, at best, the medical evidence is in equipoise with regard to causation. (Ex. 13-13, 14). Consequently, we would conclude that claimant failed to prove by a preponderance of evidence that his right shoulder condition is compensable. ORS 656.266.

ORDER

The ALJ's order dated June 26, 1997 is reversed in part and affirmed in part. That portion which set aside the insurer's denial is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[1] Claimant testified that, while filling out an unspecified "form" in Dr. Berselli's office, he "freaked" and told Dr. Berselli that he did not want to file a workers' compensation claim because he was afraid of the ramifications of such an action. (Trs. 16, 17). Dr. Berselli testified, however, that he had no recollection of those events and that he records a history as a patient recounts it. (Ex. 10-6).

[2] We note that Dr. Switlyk testified that his surgical findings were also consistent with a two-year history of right shoulder pain as noted in Dr. Berselli's November 9, 1995 chart note. (Ex. 13-9).

In the Matter of the Compensation of
LLOYD A. HUMPAGE, Claimant
WCB Case No. 96-08264
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's claim for an annular bulge at L5-S1 with foraminal disc herniation; and (2) assessed penalties and attorney fees for the insurer's allegedly unreasonable and untimely denial. On review, the issues are compensability, 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 with the following changes. In the third full paragraph on page 2, we change the date to "July 30, 1996." We do not adopt the last paragraph of the findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the portion of the ALJ's order finding the claim for an annular bulge at L5-S1 with foraminal disc herniation compensable, with the following change. In the fifth full paragraph on page 3, we change the date in the first sentence to "January 9, 1997."

Penalties and Attorney Fees

On November 14, 1995, claimant filed a claim for a "herniated disc" that occurred October 31, 1995. (Ex. 3). On March 1, 1996, the insurer accepted a claim for an acute low back strain. (Ex. 7). The claim was closed by a Notice of Closure issued April 29, 1996. (Ex. 9). Following claim closure, claimant's attorney requested claim acceptance of the condition of annular disc bulge L5-S1 with right foraminal disc herniation. (Ex. 10). On July 26, 1996, the insurer denied the claim on the basis that there was insufficient evidence that claimant's disc bulge at L5-S1 was causally related to the October 31, 1995 injury or to his work at the employer. (Id.)

The ALJ found that, despite the fact that claimant made a claim for a disc condition in his initial report of injury and then again post-closure through his attorney, the insurer made no investigation prior to issuance of the denial. The ALJ determined that the denial was well past the 90 day period the insurer was allowed to investigate the claim. The ALJ concluded that the lack of claim processing was unreasonable and assessed a $500 penalty-related attorney fee against the insurer.

The insurer argues that its denial was reasonable because, at the time it issued the denial, there was not any arguable evidence that claimant had an additional compensable condition. The insurer also contends that the ALJ erred by concluding that its denial was untimely.

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).

Claimant indicated on the "801" form that he sustained a "herniated disc" on October 31, 1995. (Ex. 3). At the time the insurer issued the denial, however, the medical record indicated only that there was a possibility that claimant had a herniated disc. (Exs. 1, 2, 2A, 4, 5). The November 1, 1995 CT scan referred to a "possible right foraminal disk herniation." (Ex. 2). By November 14, 1995, Nurse Practitioner Jacobsen had determined that an MRI was not necessary because claimant was getting better and had only 30 percent of his original pain. (Ex. 4). On December 12, 1995, Dr. Little reported that

claimant had a good response to the work hardening program and had no neurologic or motor findings in his low back. (Ex. 6). On December 27, 1995, Dr. Little reported that claimant had a "[r]esolving low back strain" and he was released to full duty with no restrictions. (Ex. 6E). Dr. Little performed a closing examination on March 13, 1996 and reported that claimant had a normal back examination. (Ex. 7A).

Until Dr. Gritzka issued his opinion on November 12, 1996, after the insurer issued its denial, no physician had diagnosed a herniated disc and reported that it was caused by claimant's work activities. (Ex. 13). Furthermore, a letter from Dr. Little dated July 30, 1996, 4 days after the insurer's denial, stated, in part:

> "I am afraid that the letter you sent me somewhat overstates what I said to you earlier this month. What I meant to say, but perhaps stated poorly, was that it is not possible to relate the radiographic findings to [claimant's] clinical situation. * * * It is more likely than not that the findings noted on the CT scan did pre-exist his injury. This is impossible to prove with certainty." (Ex. 11).

Although Dr. Little's letter was sent 4 days after the insurer's denial, the letter indicated that the insurer had some discussion with Dr. Little before the denial was issued. Under these circumstances, we conclude that the insurer's denial was based on an investigation that indicated that claimant's "CT findings" more likely than not preexisted his injury. Moreover, at the time the insurer issued its denial, the medical reports indicated only a possibility that claimant had a herniated disc. Therefore, we conclude that the insurer had a legitimate doubt as to whether claimant had a herniated disc and whether it was caused, in major part, by his work activities. Consequently, we do not consider the insurer's denial to have been unreasonable.

The insurer also contends that the ALJ erred by concluding that its denial was untimely. The insurer argues that, because claimant's attorney's letter requesting acceptance of the herniated disc is not in the record, there is insufficient evidence to determine when its denial was due. The insurer asserts, however, that its denial was issued long before there was any evidence that claimant had a compensable disc condition. We disagree.

The insurer ignores the fact that claimant's "801" form signed on November 14, 1995 indicated that he had a "herniated disc" that occurred October 31, 1995. (Ex. 3). The insurer's denial, which was issued on July 26, 1996, was issued more than 90 days after the initial claim for a herniated disc was filed.

The insurer did not accept or deny the claim within 90 days as required by ORS 656.262(6). Despite the untimeliness of this denial, there is no basis for the assessment of either a penalty or attorney fee. Our conclusion is based on the following reasoning. A penalty may be assessed under ORS 656.262(11)(a) if there were amounts then due between the date when the acceptance or denial should have issued and the date of the denial. Jeffrey D. Dennis, 43 Van Natta 857 (1991). Here, claimant asserts that the insurer unreasonably delayed in not accepting or denying the claim within 90 days, but he notes that "no amounts then due were established." (Claimant's br. at 13). Because the record does not support a finding that there were amounts due at the time of the unreasonable delay, there is no basis for a penalty. See Wacker Siltronic v. Satcher, 103 Or App 513 (1990). Moreover, claimant is not entitled to an assessed attorney fee under ORS 656.382(1) because the insurer did not unreasonably resist the payment of compensation. SAIF v. Condon, 119 Or App 194 (1993), rev den 317 Or 162 (1993).

Consequently, we reverse the ALJ's "penalty-related" attorney fee of $500 and modify the ALJ's attorney fee award. Under ORS 656.386(1), claimant's attorney is entitled to an assessed fee for services at hearing concerning the compensability issue. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing 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), 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 concerning the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on

review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty issue. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated March 25, 1997 is reversed in part, modified in part, and affirmed in part. That portion of the ALJ's order that awarded a $500 "penalty-related" attorney fee is reversed. We modify the ALJ's attorney fee award to award a fee of $3,500 for services at hearing, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
FRANCES M. McLAUGHLIN, Claimant
WCB Case No. 96-03489
ORDER ON RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

On August 15, 1997, we abated our July 18, 1997 order that affirmed the Administrative Law Judge's (ALJ's) order which set aside the self-insured employer's denial of claimant's bilateral elbow condition. We took this action to consider the employer's motion for reconsideration. Having received claimant's response, we now proceed with our reconsideration.

In our prior order, we found that the parties had modified the express terms of the employer's denial (which had denied a left epicondylitis or left elbow overuse syndrome) to litigate a bilateral epicondylitis condition. We then determined that this condition was compensable. In doing so, we agreed for the reasons the ALJ cited that the most persuasive medical opinion was that of Dr. Daugherty, claimant's attending physician, who concluded that claimant's work activities were the major contributing cause of her bilateral epicondylitis condition. Accordingly, we affirmed the ALJ's decision to set aside the employer's denial.

The employer now contends that we have failed to set forth the facts of the case and to explain why those facts led to our decision to affirm the ALJ's order. Specifically, the employer contends that we failed to state the legal theory under which claimant satisfied her burden of proof. Moreover, the employer asserts that we neglected to set forth facts establishing that claimant has bilateral epicondylitis. After considering the employer's arguments, we adhere to our prior opinion that claimant has proved a compensable bilateral epicondylitis claim. We reason as follows.

The employer is correct that neither we nor the ALJ expressly stated the applicable legal standard in finding claimant's bilateral upper extremity condition compensable. However, relying upon the medical opinion of Dr. Daugherty, the ALJ found that claimant's work activities for the employer in 1995 were the major contributing cause of her bilateral upper extremity condition. Thus, it is evident that the ALJ found that claimant had proven a compensable occupational disease claim. Inasmuch as we agree with the ALJ's reasoning that Dr. Daugherty's medical opinion was the most persuasive on this record, and because Dr. Daugherty agreed that claimant's work activities were the major contributing cause of claimant's bilateral epicondylitis condition, we also find that claimant established a compensable occupational disease claim. (Ex. 42).[1]

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[1] In reaching this conclusion, we note that counsel for the employer prepared a concurrence letter for Dr. Daugherty in which alleged inconsistencies in claimant's history and symptomatology were outlined. (Ex. 41). Dr. Daugherty signed the letter indicating his agreement with the contents. However, even with this information, Dr. Daugherty subsequently agreed that claimant's work activities were the major contributing cause of her bilateral epicondylitis condition. (Ex. 42). Considering that Dr. Daugherty's opinion was based on accurate and complete information, we find no persuasive reason not to defer to it. See Welland v. SAIF, 64 Or App 810 (1983).

With regard to the employer's final contention, the ALJ considered the bilateral upper extremity condition at issue to be a bilateral elbow overuse condition, either tendonitis or epicondylitis. Noting the ALJ's statement that there was more to recommend the tendonitis diagnosis, the employer asserts that our finding that claimant has bilateral epicondylitis is inconsistent with the ALJ's finding that claimant has tendonitis or an overuse syndrome.

The employer's contentions notwithstanding, we do not perceive a significant contradiction between our finding and the ALJ's. Based on his order, the ALJ used the terms "overuse syndrome," "tendonitis," and "epicondylitis" interchangeably. More importantly, claimant need not establish a specific diagnosis in order to establish a compensable occupational disease claim. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). We again emphasize that the physician we have found most persuasive, Dr. Daugherty, has opined that claimant's work activities are the major contributing cause of a bilateral epicondylitis condition. Based on that opinion, we conclude that claimant proved a compensable occupational disease for bilateral epicondylitis.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to the employer's motion for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, as supplemented herein, we republish our July 18, 1997 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRANCE L. MOORE, Claimant
WCB Case No. 96-10830
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the right forearm (wrist) from 2 percent (3 degrees), as awarded by an Order on Reconsideration, to 12 percent (18 degrees); (2) awarded 11 percent (5.28 degrees) scheduled permanent disability for the loss of use or function of claimant's right thumb; and (3) reinstated an 8 percent (25.6 degrees) unscheduled permanent disability award for claimant's neck and low back condition as awarded by a Determination Order. Claimant cross-requests review of the ALJ's order, contending that he is entitled to 14 percent (26.88 degrees) scheduled permanent disability for loss of use or function of the right arm, in lieu of the awards for loss of use or function of the right thumb and right forearm. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury on October 26, 1995, which the employer accepted as a scalp contusion, cervical and thoracic strains, right wrist contusion, right jaw contusion, and right carpal

tunnel condition. On July 8, 1996, a Determination Order awarded claimant 10 percent scheduled permanent disability for loss of use or function of the right forearm, and 8 percent unscheduled permanent disability for residuals in the cervical and lumbar spine. Claimant requested reconsideration.

Dr. Dineen conducted a medical arbiter examination. Relying on Dr. Dineen's report, an Order on Reconsideration reduced claimant's awards to 2 percent scheduled permanent disability for the loss of use or function of the right forearm, and zero for the unscheduled permanent disability award. Claimant requested a hearing.

The ALJ increased claimant's scheduled permanent disability award for loss of use or function of the right forearm to 12 percent, awarded 11 percent scheduled permanent disability for loss of use or function of the right thumb, and reinstated the 8 percent unscheduled permanent disability award made by the Determination Order. However, the ALJ declined to convert the thumb and forearm impairment values to a value for the arm. The employer requested review, contending that the Order on Reconsideration should have been affirmed. Claimant cross-requested review, contending that the thumb and forearm values should be converted to a value for the arm.

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). It is claimant's burden to establish the extent of his disability. ORS 656.266.

Scheduled Permanent Disability

The employer contends that the ALJ erred in relying on the treating physician's closing examination instead of the medical arbiter's examination. OAR 436-035-0007(13) provides that when a medical arbiter is used, impairment is established by the medical arbiter, **except** when a preponderance of the evidence establishes a different level of impairment. Here, the ALJ found that the report of treating physician Wigle is entitled to greater weight than the medical arbiter's report. After our review of the record, we agree with the ALJ's reasoning and conclusion that Dr. Wigle's report is entitled to greater weight. Therefore, we rely on Dr. Wigle's report in evaluating the extent of claimant's disability.

Based on Dr. Wigle's examination and report, we find that claimant has sustained loss of range of motion in the right wrist, as follows:

palmar flexion	62 degrees	equal to	1.6 percent
dorsiflexion	50 degrees	equal to	2.0 percent
ulnar deviation	20 degrees	equal to	2.0 percent
pronation	75 degrees	equal to	1.0 percent
supination	75 degrees	equal to	1.0 percent

(Ex. 19 at 1-2); OAR 436-035-0080(1), (3), (7), (9). Adding the values results in 7.6 percent range of motion loss in the right wrist, which is rounded up to 8 percent. OAR 436-035-0007(14)(a); 436-035-0007(21)(a).

The ALJ found that claimant sustained 4.4 percent impairment due to loss of grip strength in the right wrist. The employer contends that an award for loss of grip strength is inappropriate because any loss of strength is not due to peripheral nerve injury. We agree.

Loss of grip strength in the forearm is governed by OAR 436-035-0007(18) and OAR 436-035-0110(8). A worker is entitled to an impairment value for loss of grip strength when there has been damage to a specific nerve that supplies the weakened muscle. OAR 436-035-0110(8). Furthermore, loss of strength must be measured by the international 0 to 5 grading system. OAR 436-035-0007(18). Here, Dr. Wigle found reduced grip strength on the right, as compared to the left. (Ex. 19-2). However, he did not measure the loss at that time in terms of the 0 to 5 grading system. Nor did he attribute the loss in strength to injury to a particular nerve. Rather, Dr. Wigle opined that claimant's grip strength loss was due to a loss of "mechanical advantage of the flexor tendons due to the carpal tunnel release." (Id.). Furthermore, Dr. Wigle subsequently graded claimant's grip strength as 5/5. (Ex. 22). Therefore, we find that claimant has not established entitlement to an impairment value for loss of grip strength in the right forearm.

The ALJ also awarded claimant 11 percent scheduled permanent disability for loss of use or function of the right thumb. The employer contends that claimant is not entitled to an award for the right thumb because that condition is unrelated to the accepted conditions. We disagree.

A worker is entitled to an award of scheduled permanent disability for the loss of use or function of a body part "due to a compensable, consequential, combined condition (pursuant to these rules) and any direct medical sequelae." OAR 436-035-0010(2). The ALJ found, and we agree, that claimant's reduced ability to oppose his right thumb to the base of his fifth finger is related to claimant's compensable injury and carpal tunnel surgery. Dr. Wigle noted in his closing examination that the only postoperative complaint claimant still had following his carpal tunnel release was "a little difficulty opposing the thumb to the base of the fifth finger[.]" (Ex. 19-1). The loss in opposition of the thumb is distinguished from the noncompensable "trigger" finger condition Drs. Wigle and Stewart found later. (See Exs. 21, 22). Therefore, we agree with the ALJ that claimant is entitled to a scheduled permanent disability award for loss of use or function of his right thumb.

On his cross-request for review, claimant contends that the scheduled permanent disability awards for the right thumb and right forearm (wrist) should be converted to 14 percent impairment for the right arm. We agree that it is appropriate to convert the thumb value to a hand value, before combining with the forearm (wrist) impairment value. However, we disagree that claimant is entitled to conversion to a value for the arm.

When there are impairment findings in two or more body parts in an extremity, the total impairment findings in the distal body part are to be converted to a value in the most proximal body part, before combining impairment values for the most proximal body part. OAR 436-035-0007(16). Here, claimant has impairment findings in two body parts in the upper extremity: the right thumb and the right forearm (wrist). Therefore, it is appropriate to convert the right thumb impairment to a value for the more proximal impaired body part, the right hand/forearm (wrist). Pursuant to OAR 436-035-0070(3), 11 percent impairment of the thumb equals 4 percent impairment of the hand. The 4 percent hand impairment is combined with the 8 percent forearm (wrist) impairment, for a total impairment of 12 percent for the right forearm.

Because claimant's most proximal injury is in the forearm (wrist), there is no basis for converting the forearm impairment value to an impairment value for the arm. Simply because claimant's pronation and supination losses in the wrist are rated under the standards for the elbow does not mean that claimant has actually sustained impairment in the arm (elbow). See OAR 436-035-0080(9); 436-035-0100(4).

Accordingly, based on the foregoing reasoning, we conclude that claimant is entitled to 12 percent scheduled permanent disability for the right forearm.

Unscheduled Permanent Disability

The ALJ reinstated the 8 percent unscheduled permanent disability awarded by a Determination Order for impairment in the cervical and lumbar spine. The employer contends that claimant is not entitled to an unscheduled permanent disability award. We disagree.

We have previously agreed with the ALJ that Dr. Wigle's report constitutes the preponderance of evidence regarding claimant's impairment. Therefore, based on Dr. Wigle's examination, we agree with the ALJ that claimant is entitled to 8 percent unscheduled permanent disability for range of motion losses in the cervical and lumbar spine, as originally awarded by the Determination Order. (Exs. 19-2, 20); OAR 436-035-0360.

In the alternative, the employer argues that claimant is not entitled to any impairment for the lumbar spine because the low back is not an accepted condition. Generally, a worker is entitled to a value under the disability standards for permanent impairment findings that "were caused by the compensable injury or disease including the compensable condition, a consequential condition and direct medical sequelae." OAR 436-035-0007(1). Here, the evidence clearly establishes that claimant's low back condition was caused by his compensable injury. Claimant originally complained of injury to his entire back, and his original diagnoses included lumbosacral strain. (Exs. 1, 2-2). In fact, the employer

accepted claimant's claim on the 801 form, on which claimant indicated that he had injured his neck and back, specifically his upper and **lower** middle back. (Ex. 1). During his treatment for the compensable injury, claimant consistently complained of and was treated for a lumbosacral strain, among other conditions.[1] (See e.g., Exs. 6, 11). The employer has never denied compensability of the low back condition as being unrelated to the compensable injury. Under such circumstances, we conclude that claimant is entitled to have the lumbar spine impairment (2 percent) included in his 8 percent unscheduled permanent disability award.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services on review regarding the unscheduled permanent disability award and the scheduled permanent disability award for the right forearm. 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 unscheduled permanent disability and right forearm issues is $800, payable by the self-insured employer. 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 values of the interest involved. We note that because claimant's scheduled permanent disability award for the right thumb was reduced on review, claimant is not entitled to an attorney fee for his attorney's services on review regarding that issue.

ORDER

The ALJ's order dated March 28, 1997 is reversed in part, modified in part, and affirmed in part. The ALJ's award of 11 percent (5.28 degrees) scheduled permanent disability for the right thumb is reversed. The out-of-compensation attorney fee awarded by the ALJ is modified accordingly. The remainder of the ALJ's order is affirmed. Claimant is awarded a $800 attorney fee for his attorney's services on review, payable by the self-insured employer.

[1] Although the employer accepted a thoracic spine strain (Ex. 8), that condition was never diagnosed. Instead, claimant was diagnosed and treated for a low back strain. (See Exs. 2, 4, 6, 11).

In the Matter of the Compensation of
GORDON K. YEATER, Claimant
WCB Case No. 96-05602
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) upheld the insurer's "back-up" denial of claimant's accepted left shoulder strain and left elbow strain conditions; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are the propriety of the insurer's "back-up" denial and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize in pertinent part as follows.

On January 24, 1996, claimant sought treatment for left shoulder, neck and elbow symptoms. Dr. Chan diagnosed acute strains of the left elbow and left upper back. (Ex. 6). On April 5, 1996, the insurer accepted nondisabling strains of the left elbow and left upper back. (Ex. 16). At the time of acceptance, the claims adjuster had received Dr. Chan's January 24 and February 9, 1996, chart notes (Exs. 6, 8). (Ex. 24-1, Tr. 14).

On April 30, 1996, the claims adjuster received the reports of Dr. Mandiberg, Dr. Rosenbaum, and Dr. Buehler (Exs. 9, 10, 11, 12, 15, 17, 18, 19). On May 14, 1996, the insurer revoked acceptance and formally denied the January 8, 1996 injury claim on the basis that "recently received medical information from [claimant's] attending physician indicates that [his] medical condition is not the result of [his] employment with [the employer]." (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

"Back-up" Denial

Applying ORS 656.262(6)(a),[1] the ALJ found that the insurer had accepted claimant's left elbow and back strain claim in good faith and that, relying on later obtained evidence, the insurer appropriately issued a "back-up" denial of the claim. On review, claimant contends that the later obtained medical evidence indicated only that claimant has a condition, bilateral ulnar nerve subluxation, which is different from the accepted conditions, is not compensable, and for which no claim has been made.[2] We agree with claimant, as we are not convinced on this record that the accepted conditions of "left upper back strain" and "left elbow strain" are the same conditions for which claimant was subsequently examined and evaluated and for which the insurer issued its "back-up" denial.

It is the insurer's burden to prove, by a preponderance of the later obtained evidence, that claimant's accepted strain conditions were not compensable from the outset. ORS 656.262(6)(a); Gordon W. Naylor, 48 Van Natta 2607 (1996).

Here, Dr. Chan diagnosed acute strains of the left elbow and left upper back on January 24, 1996, which he attributed to claimant's work. (Ex. 6). He prescribed medication, treatment, and restricted claimant's work activities. Claimant was subsequently examined by Drs. Mandiberg, Rosenbaum, Buehler and Gill. Dr. Mandiberg's February 28, 1996, report noted a several month history of shoulder discomfort that was "actually better," and that claimant's current complaints were primarily left elbow and hand discomfort and numbness, and similar but lesser complaints on the right. Dr. Mandiberg diagnosed claimant's hand and elbow symptoms as the result of bilateral subluxable ulnar nerves, probably unrelated to work, as there has been no injury that would cause the subluxation. Dr. Mandiberg referred claimant to Dr. Rosenbaum, neurologist, for evaluation. (Exs. 9, 12, 15) .

Dr. Rosenbaum reported that claimant previously "had a great deal of difficulty with his left shoulder but that claimant's left shoulder symptoms had since resolved." (Ex. 11). He did not discuss the previous elbow strain or the cause of that condition in any way. Dr. Rosenbaum concluded that he could not find a neurologic cause of claimant's bilateral arm (nerve) complaints, but opined that they were most likely related to claimant's prior carpal tunnel surgeries. (Exs. 10, 11).

Dr. Buehler reported that in December 1995 claimant had sustained right and left shoulder and elbow strains, and that "with this injury" he developed some pain in the arm and paresthesias in the ulnar nerve distribution of both hands. (Ex. 18). Dr. Buehler diagnosed bilateral ulnar nerve irritation at the elbow, possibly secondary to subluxation. Dr. Buehler did not provide any opinion on a causative relationship between the strains and the nerve condition.

Finally, Dr. Gill, who assessed claimant's condition on September 23, 1996, after the "back-up" denial had issued, found no evidence of "any significant residual upper back, neck, shoulder, or elbow strains." Dr. Gill diagnosed claimant's condition as bilateral ulnar nerve subluxation, and concluded that this condition was not work-related. (Ex. 23).

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[1] Under ORS 656.262(6)(a), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable or the carrier is not responsible, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on the "back-up" denial, the carrier has the burden of proving by a preponderance of the evidence that the claim is not compensable or that it is not responsible for the claim.

[2] Claimant does not challenge the ALJ's findings of good faith acceptance, the timeliness of the "back-up" denial, or that the denial was based upon "later obtained evidence."

These medical records indicate that claimant currently has a condition affecting both arms, bilateral ulnar nerve subluxation. We construe the physicians as indicating that with the passage of time claimant's bilateral nerve condition was being treated, rather than a musculoligamentous condition such as a strain. We are not persuaded that claimant did not experience the strain conditions that were initially accepted by the employer. Although those accepted conditions may now be resolved, because bilateral ulnar nerve subluxation is not the same as the accepted "left upper back strain" and "left elbow strain," we find that the employer's "back-up" denial related to a different condition than the one accepted. Accordingly, we conclude that the insurer issued an improper "back-up" denial.

Penalties

Claimant asserts entitlement to a penalty for unreasonable claims processing, contending that the insurer had no evidence at any time to support a "back-up" denial of claimant's accepted strain conditions.

A penalty is assessable when a carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988).

On May 14, 1996, the insurer revoked acceptance and formally denied the January 8, 1996 injury claim on the basis that claimant's medical condition was not the result of his employment. Although the insurer had Dr. Chan's reports stating that claimant's left shoulder and elbow strains were caused by his work injury, the insurer also had reports from Drs. Mandiberg, Rosenbaum and Buehler indicating that claimant's current bilateral arm condition was not due to an injury at work. Under such circumstances, we conclude that the employer had a legitimate doubt as to its liability for claimant's current bilateral arm conditions. Consequently, a penalty is not warranted.

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 concerning the "back-up" denial 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 13, 1997, is reversed in part and affirmed in part. The insurer's revocation of acceptance and denial of the January 8, 1996 injury 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 a fee of $3,500, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
ISRAEL ACEVEDO, Claimant
WCB Case No. 96-06156
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its partial denial of claimant's claim for a current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

Claimant has an accepted claim for 1991 lumbar strain. A 1992 CT scan revealed bilateral spondylolysis at L5 with second degree spondylolisthesis at L5-S1.

After claim closure in 1993, the parties stipulated that claimant had 12.5 percent unscheduled permanent partial disability. Claimant did not seek treatment for his low back for about 2 years. However, he did take medication for low back pain during that time.

In March 1996, Dr. Teal, treating physician, filed an aggravation claim on claimant's behalf. SAIF issued a denial of claimant's current condition, contending that the 1991 compensable injury is not the major cause of claimant's current combined condition. Claimant requested a hearing.

Based on Dr. Teal's opinion, the ALJ concluded that claimant's compensable injury remains the major cause of his current combined condition (a lumbar strain combined with spondylolysis and spondylolisthesis). See ORS 656.005(7)(a)(B). We disagree.

We generally defer to a treating physician's opinion regarding causation, unless there are persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find such reasons.

Dr. Teal offered the following opinions regarding the etiology of claimant's low back condition. In March 1996, Dr. Teal diagnosed "symptomatic recurrent spondylolysis with first degree spondylolisthesis." (Ex. 4-10). He stated, "we have been treating him symptomatically with his spondylolysis with spondylolisthesis." (Ex. 4-9).

On April 15, 1996, Dr. Teal opined that the "major contributing cause of the current condition or need for treatment is indeed [claimant's] ongoing spondylolysis with spondylolisthesis."[1] (Ex. 13).

On August 16, 1996, Dr. Mayhall reviewed claimant's records and examined him at SAIF's request. Dr. Mayhall opined, inter alia, that claimant's spondylolysis and spondylolisthesis (which likely preexisted the 1991 injury) were the major contributing cause of claimant's "present need for treatment and/or disability." (Ex. 17-4-5). On September 5, 1996, Dr. Teal checked a box indicating concurrence with Dr. Mayhall's opinions. (Ex. 18).

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[1] In the same letter, Dr. Teal also opined that claimant's 1991 lumbar strain would have resolved "much quicker than it did," if claimant did not have the underlying problems (ongoing spondylolysis with spondylolisthesis). (Ex. 13).

On September 16, 1996, Dr. Teal checked boxes indicating that claimant's 1991 injury combined with his preexisting conditions and worsened them and that the injury was more than 50 percent responsible for the pathological worsening of the preexisting conditions. (Ex. 19). Finally, on November 12, 1996, Dr. Teal responded to a letter from claimant's counsel, stating, "It is my belief, and has been all along, that the spondylolysis with spondylolisthesis more than likely pre-existed [claimant's] injury of September 5, 1991 and caused a worsening of his underlying condition of more than 51%." (Ex. 21).

We are unable to reconcile Dr. Teal's various opinions. He has stated that claimant's preexisting conditions are the major contributing cause of his current combined condition (and/or need for treatment) and also stated that the injury is the major contributing cause of the current combined condition (and/or need for treatment) without explaining the apparent and material inconsistency between those opinions. We find Dr. Teal's opinion "as a whole" unpersuasive because it lacks adequate explanation for these variations. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Yann You, 49 Van Natta 602 (1997). Accordingly, in the absence of persuasive evidence establishing causation, we conclude that the claim must fail.[2]

ORDER

The ALJ's order dated April 4, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] Claimant argues that SAIF's denial is an impermissible "back up" denial because it purports to deny the accepted condition. We find that the current condition denial is not a "back up" denial because the accepted condition is a lumbar strain only and claimant's current condition involves spondylolysis with spondylolisthesis, instead of or in addition to the accepted 1991 lumbar strain..

Claimant also argues that SAIF is precluded from contesting the compensability of the spondylolysis/spondylolisthesis conditions, based on the 1993 stipulated 12.5 percent permanent disability award. However, even assuming (without deciding) that the stipulated award included compensation for spondylolysis/spondylolisthesis conditions (as well as the accepted lumber strain), SAIF would not be precluded from contesting the compensability of the spondylolysis/spondylolisthesis conditions under current ORS 656.262(10). See Keith Topits, 49 Van Natta 1538 (1997).

In the Matter of the Compensation of
STEPHANIE A. FARRELL, Claimant
WCB Case No. 96-06356
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order which: (1) awarded a penalty for the employer's alleged untimely payment of medical bills; (2) set aside the causation portion of its denial of claimant's low back aggravation claim as "overbroad"; and (3) admitted a payment ledger (Ex. 47A) into evidence. Claimant cross-requests review of those portions of the ALJ's order which: (1) upheld the employer's denial of her aggravation claim; and (2) awarded a $350 attorney fee. On review, the issues are compensability, aggravation, evidence, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding the evidence, penalty and aggravation issues.

Evidence

At the November 27, 1996 hearing, claimant raised for the first time the issue of untimely payment of medical bills. (Tr. 3). In support of her request for a penalty, claimant submitted as evidence a payment ledger from the office of her attending physician, Dr. Dunn. (Ex. 47A). The ALJ

admitted the document with the condition that the record be held open for 14 days, during which time the employer was allowed to investigate the penalty issue and determine whether it needed to present testimony or documentary evidence. (Tr. 8). The employer's counsel did not specifically object to the ledger's admission into evidence at the time, but emphasized that he was not waiving future objections. (Trs. 8, 9).

On December 10, 1996, the employer's counsel advised the ALJ that it would not be supplementing the record, but that it did object to the admission of Exhibit 47A. The ALJ, however, admitted the payment ledger into evidence.

On review, the employer contends that the ALJ improperly admitted the payment ledger, asserting that there was no foundation for its admission, that the disputed evidence was irrelevant, and that the payment ledger was inadmissible hearsay. We review the ALJ's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

In this case, we find no abuse of discretion. Although the payment ledger contains hearsay evidence, such evidence is admissible in workers' compensation proceedings. See Armstrong v. SAIF, 67 Or App 498, 501 n.2 (1984). Moreover, the document does have probative value because it shows when Dr. Dunn's office billed the employer and when payment was received. Thus, we find that the payment ledger is relevant. Most importantly, the employer was given ample opportunity to attack the reliability of the document and develop rebuttal evidence. It declined to do so. Although the employer made an unspecified objection to the admission of the payment ledger in its December 10, 1996 letter to the ALJ, no objection was made on hearsay, relevancy or foundational grounds at the hearing or before the record closed. Under these circumstances, we conclude that the ALJ did not abuse his discretion in admitting Dr. Dunn's payment ledger into evidence.

Penalty

The ALJ awarded a penalty pursuant to ORS 656.262(11)(a) for untimely payment of medical bills. In doing so, the ALJ found that the employer unreasonably failed to pay medical bills within 45 days of their "probable" receipt.

On review, the employer asserts that the ALJ incorrectly assessed a penalty because Dr. Dunn's payment ledger does not indicate when or if bills were mailed to or received by the employer. In addition, the employer argues that claimant's aggravation claim "superseded" Dr. Dunn's request for palliative care, thereby entitling it to withhold payment pending resolution of litigation concerning the aggravation claim. Finally, the employer contends that, in any event, Dr. Dunn's bills were paid on time. For the following reasons, we disagree with the employer's assertions.

OAR 436-009-0030(2) requires that a carrier must pay bills for medical services on accepted claims within 45 days of receipt of a billing submitted in proper form and which clearly shows that the treatment is related to an accepted injury. As previously noted, Exhibit 47A is a payment ledger which purports to show when medical bills were submitted for payment and when payment was received. The document contains dates in the far left column. In the center column, it is indicated whether the date in the far left column is the date of payment or the date the billing was submitted for payment. Under these circumstances, we find that the payment ledger does accurately state the dates that billings were submitted to the employer for payment.

The employer correctly observes that the ledger does not establish when it received the billings. However, OAR 436-009-0010(2) requires that chart notes accompany billings. As claimant points out, the payment ledger shows that x-rays were billed to the employer on May 10, 1996. The interpretation of the x-rays was received on May 22, 1996, as evidenced by the employer's date stamp. (Ex. 38). The bill was not paid until July 24, 1996, more than 45 days later. (Ex. 47A-7).

Similarly, Dr. Dunn submitted a bill on May 17, 1996 for an epidural injection. (Ex. 47A-7). The accompanying chart note was received on May 30, 1996. (Ex. 41). Yet the bill was not paid until July 24, 1996, again more than 45 days after the employer's receipt. (Ex. 47A-7). Finally, Dr. Dunn's initial consultation on May 15, 1996 was billed on May 17, 1996. (Ex. 47A-7). The accompanying chart note was received on May 30, 1996. (Ex. 40). Payment, however, was not made until July 24, 1996. (Ex. 47A-7).

Based on our de novo review of the record, we conclude that the above medical bills were paid untimely.[1] Under the circumstances, we find that claimant sustained her burden of proving entitlement to a 25 percent penalty based on untimely paid medical bills pursuant to ORS 656.262(11).[2]

Aggravation

The ALJ upheld the employer's denial of claimant's aggravation claim, finding that claimant failed to prove an "actual worsening" under ORS 656.273(1). In reaching this conclusion, the ALJ determined that Dr. Dunn's medical opinion had not established a pathological worsening of claimant's low back condition. Although claimant contends otherwise, we agree with the ALJ's conclusion.

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

In this case, Dr. Dunn opined, after reviewing a May 1996 MRI scan, that there had been no significant pathological change in claimant's spine since her 1991 surgery. (Ex. 49-1). Dr. Dunn noted that claimant's exacerbation in 1996 was a flare-up of "symptoms" dating back to claimant's original 1990 compensable injury. Id.

Although in his deposition, Dr. Dunn testified that claimant's 1990 injury and subsequent surgery played a role in accelerating the rate of a degenerative condition (neuroforaminal stenosis) noted in the May 1996 MRI scan (Ex. 50-11, 12), we conclude, based on our de novo review, that this record as a whole does not support a finding of a pathological worsening of claimant's low back condition. Therefore, we agree with the ALJ that claimant's aggravation claim was not compensable.

Attorney Fees

Inasmuch as claimant has prevailed on the issue of the compensability of his current 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 regarding the compensability issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We do not award an attorney fee for claimant's counsel's services regarding the penalty and attorney fee issues. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

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[1] In reaching this conclusion, we distinguish our decisions in Carole M. Cote-Williams, 44 Van Natta 369 (1992) and Shari Hallberg, 42 Van Natta 2750 (1990). In both cases, we rejected the claimants' contentions that the carrier unreasonably resisted payment of compensation. In each case, we found no evidence from which we could determine when the carrier received billings, nor did the claimants establish when billings were mailed in order to take advantage of the presumption of receipt under ORS 40.135(1)(q). In contrast, in this case, we have found evidence in the record from which we can determine when the employer received medical billings and made payments. Finally, unlike Hallberg and Cote-Williams, the ALJ specifically provided the employer in this case with the opportunity to present documentary or testimonial evidence to refute claimant's prima facie case of unreasonable claim processing. It declined to do so. Accordingly, unlike the claimants in Hallberg and Cote-Williams, we conclude that claimant here has proved her entitlement to a penalty.

[2] We also reject the employer's argument that OAR 436-010-0290(2) gave it an additional 45 days within which to pay medical bills related to claimant's palliative care request. There is nothing in that rule which modifies the requirement that billings be paid within 45 days of receipt. Finally, we reject the employer's contention that its denial of aggravation suspended its obligation to pay medical bills pending resolution of litigation. The July 1, 1996 denial of aggravation was based exclusively on a "no-worsening" defense. (Ex. 47). No causation defense was asserted. In fact, the denial specifically stated that claimant's medical treatment had been processed as palliative care. The employer subsequently issued a denial on July 30, 1996, alleging a lack of causation. However, by that time, the 45 day period in which to pay medical bills at issue had passed. The supplemental July 30, 1996 causation denial was ultimately set aside as "overbroad."

ORDER

The ALJ's order dated February 14, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
JAMES M. HEDDINGER, Claimant
WCB Case No. 96-06422
ORDER ON REVIEW (REMANDING)
Bennett, Hartman, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that dismissed, pursuant to ORS 656.308(2)(c), his hearing request concerning the SAIF Corporation's responsibility denial for his claimed hearing loss. On review, the issue is the propriety of the ALJ's dismissal order. We vacate the dismissal order and remand.

FINDINGS OF FACT

In June 1996, claimant made a claim for hearing loss with his current employer and several former employers, including Barrett Business Services, Pacific Fabricators, Inc. and T-Plus Steel Fabricators.

By letters dated July 9, 1996 and August 8, 1996, SAIF, on behalf of employer T-Plus Steel Fabricators, denied responsibility for claimant's hearing loss condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ found the record did not contain substantial evidence to support a finding of responsibility against SAIF and dismissed claimant's request for hearing as to SAIF pursuant to ORS 656.308(2)(c).[1] We vacate the ALJ's order and remand.

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).

In this case, claimant has represented in his appellant's brief that the other carriers against whom he has asserted his hearing loss claim have denied both compensability of and responsibility for his condition.[2] However, the record before us establishes only that SAIF has denied responsibility and moved for dismissal. The record does not include the denials of the other potentially responsible employers or insurers, nor sufficient evidence to determine whether these other employers or insurers should have been joined in this proceeding pursuant to ORS 656.308(2)(a).[3] See also OAR 438-006-0065(1).

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[1] This section 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."

[2] It appears from the ALJ's notes regarding the telephone conference on SAIF's motion to dismiss that claimant sought to consolidate his request for hearing as to SAIF's denial with his other hearing requests.

[3] This provision provides, in pertinent part, that all requests for hearing on responsibility denials for a claim shall be consolidated into one proceeding.

Subsequent to the ALJ's order, we held that it is inappropriate for an ALJ to consider a carrier's motion for dismissal under ORS 656.308(2)(c) when the compensability of claimant's condition remains in dispute. In Jack W. Swinford, 49 Van Natta 1519 (1997), we determined that a carrier may not take advantage of the dismissal procedure until the compensability of the new injury or condition has been determined. We explained that as long as compensability remains in issue (where at least one of the carriers joined in the proceeding continues to dispute the compensability of the claimant's condition), the claimant has the burden of proving compensability as a threshold to any responsibility determination, even if the particular carrier seeking dismissal has conceded compensability. Id.

In this case, because the record is incomplete and insufficiently developed, we are unable to determine whether the ALJ had the authority to dismiss claimant's request for hearing against SAIF pursuant to ORS 656.308(2)(c). On remand, the ALJ is directed to determine whether the compensability of claimant's hearing loss condition has been conceded or determined.[4] Only then may a party be dismissed for lack of substantial evidence pursuant to ORS 656.308(2)(c). Jack W. Swinford, 49 Van Natta at 1523.

Consequently, we vacate ALJ Howell's order dated October 1, 1996 and remand this case to the ALJ with instructions to conduct further proceedings consistent with this order and our decision in Jack W. Swinford. These further 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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[4] We acknowledge that, at this point in time, claimant has settled with the other carriers against whom he asserts his hearing loss claim by way of Disputed Claim Settlements. However, the issue before us is whether the ALJ properly dismissed SAIF as a party to the proceeding pertaining to claimant's hearing loss claim. The fact that claimant has subsequently settled his dispute with the other potentially responsible carriers does not resolve the question of whether the ALJ was authorized to dismiss SAIF pursuant to ORS 656.308(2)(c) at the time he did so, without determining whether the compensability of claimant's hearing loss condition remained in dispute. See Jack W. Swinford, 49 Van Natta at 1519, n.1.

October 10, 1997 Cite as 49 Van Natta 1798 (1997)

In the Matter of the Compensation of
GENIE E. KREITLOW, Claimant
WCB Case No. 96-04974
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl, and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as an electronic assembler since 1974. Since 1994, claimant has performed such work for the employer. In January 1996, claimant sought treatment with Dr. Ash, neurologist, for bilateral hand symptoms, reporting that such difficulties began two years ago. (Ex. 2). Dr. Ash diagnosed bilateral carpal tunnel syndrome. (Id.)

The ALJ concluded that claimant did not prove compensability of her condition. The ALJ first decided that the record showed that claimant's condition preexisted her employment with the employer. The ALJ reasoned that, because claimant had elected to prove actual causation against the employer rather than relying on the last injurious exposure rule, work conditions with prior employers would not be considered. Manuel Garibay, 48 Van Natta 1476 (1996). Analyzing the claim as a "combined condition" under ORS 656.802(2)(b),[1] the ALJ concluded that the medical evidence was insufficient to carry claimant's burden of proving that employment conditions with the employer were the major contributing cause of her bilateral carpal tunnel syndrome.

Claimant then sought reconsideration of the ALJ's order, arguing that she had not intended to elect only to prove actual causation and asking the ALJ to reconsider her decision in light of the last injurious exposure rule. On reconsideration, the ALJ found that, because the last injurious exposure rule had not been raised at any previous point during the proceeding, the case was litigated based on actual causation and that it was inappropriate to now consider a new theory of compensability. Thus, the ALJ adhered to her prior decision.

On review, claimant continues to assert that she need not explicitly raise the last injurious exposure rule because its application depends on the facts of the case. In a supplemental memorandum, claimant also cites to Garibay v. Barrett Business Services, 148 Or App 496 (1997).

Subsequent to the ALJ's order, the court decided Garibay, which concerned the compensability of the claimant's carpal tunnel syndrome condition. Although the claimant had worked since 1981 as a tree planter and harvester, while a number of carriers provided coverage only the last carrier was joined in the workers' compensation proceeding. The medical evidence specifically related the claimant's condition to claimant's entire work history as a tree planter/harvester. The carrier argued that, because the claimant had proceeded only against it in proving compensability, the claimant's condition qualified as a "preexisting condition" and the claimant's burden was to prove that only work conditions during its period of employment was the major contributing cause.

Although agreeing with the Board that the claimant did not technically "invoke" the last injurious exposure rule, the court found that, by arguing that the claimant had a "preexisting condition," the carrier in effect raised responsibility as a defense. 148 Or App at 501. The court further found that the carrier was barred from such a defense because it did not disclaim responsibility as required by ORS 656.308(2) (1990). Id. Consequently, the court reversed the Board's order concluding that the claimant did not prove compensability.

We conclude that, whether or not Garibay applies to this case, claimant proved compensability. That is, whether we consider claimant's entire job history as an electronic assembler or only her work with the employer, claimant carried her burden of proof. As a rule of proof, the last injurious exposure rule allows a worker to prove the compensability of a disease by showing that employment-related exposure was the major contributing cause without having to establish the degree, if any, exposure with a particular employer actually caused the condition. E.g., Runft v. SAIF, 303 Or 493, 499 (1987). Under actual causation, claimant must show that work conditions at a particular employment was the major contributing cause of the occupational disease. ORS 656.802(2); Runft, 303 Or at 498-99.

Claimant's treating orthopedic surgeon, Dr. McWeeney, concurred with a report drafted by claimant's attorney first stating that the major contributing cause of claimant's condition was her work with the employer. (Ex. 9-1). The report further asked Dr. McWeeney to consider claimant's "preexisting conditions" as consisting of her sex, age, body habitus, and possible cardiac status, and to assume that such conditions combined with the carpal tunnel syndrome, resulting in a "new combined condition." Dr. McWeeney agreed that claimant's work at the employer, weighed against her "preexisting conditions," was the major contributing cause of her carpal tunnel syndrome. (Id.)

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[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."

Examining hand surgeon, Dr. Button, found that Dr. Ash's history of onset of symptoms before claimant's work with the employer showed that claimant's condition preexisted her work with the employer. (Ex. 7-3). According to Dr. Button, claimant's symptoms were the result of a "natural progression" of her condition "in addition to the fact of aging, body habitus, obesity, etc." (Id.)

In a supplemental report, based on a videotape of claimant's job, Dr. Button described claimant's work conditions and explained why they did not involve the carpal tunnel. (Ex. 10). Dr. Button found it "far more likely that this is an idiopathic condition in a middle-aged, hypertensive, obese female, with those factors far more likely being causative as well as a major contributing factor to the progression of the condition." (Id.)

Finally, after viewing the videotape of claimant's work, Dr. Ash reported that claimant's "work is manual and repetitive, but not overwhelmingly rapid." (Ex. 11). Although work was "contributory," Dr. Ash found that obesity was the major contributing cause of claimant's carpal tunnel syndrome. (Id.)

Because Dr. McWeeney was the only physician supporting causation, we must decide if his opinion is sufficiently persuasive to carry claimant's burden of proof. We first note that, as the treating physician, we defer to Dr. McWeeney's opinion absent persuasive reasons to the contrary. See Weiland v. SAIF, 64 Or App 810 (1983). After evaluating the medical opinions, we find no persuasive reasons for not deferring to Dr. McWeeney's opinion.

Dr. McWeeney showed that he was aware of claimant's job duties. Consequently, we disagree with the ALJ that Dr. Button and Dr. Ash had a more accurate understanding of claimant's employment because they viewed a videotape of her work. Furthermore, Dr. McWeeney considered those factors that Dr. Button thought were the causes of claimant's carpal tunnel syndrome and continued to attribute her condition in major part to employment conditions. Thus, because Dr. McWeeney provided a well-reasoned opinion based on an accurate history, we find it the most persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Thus, whether under the rule of proof of the last injurious exposure rule or actual causation, we conclude that claimant established compensability.

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 7, 1997, as reconsidered February 18, 1997, is reversed. SAIF'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 $4,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
RON L. MERWIN, Claimant
WCB Case No. 95-10139
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." In addition, we find that, in 1990, SAIF accepted claimant's low back degenerative disc disease. (Ex. 20-2).

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable 1984 lumbosacral strain. As noted above, claimant also has a compensable low back degenerative disc disease condition. In 1992, ALJ Stephen Brown modified an Order on Reconsideration to award 5 percent unscheduled permanent disability. Claimant continued to experience a waxing and waning of low back symptoms. (Ex. 22).

In May 1995, claimant sought treatment from Dr. Mavris, stating that he had the sudden onset of low back spasm after cleaning the bathroom at home. (Ex. 24). The ALJ found that claimant proved that the major contributing cause of claimant's low back condition "was his employment conditions including physical activities and prior injuries in this employment under this insurer" and, thus, his claim was compensable. SAIF challenges the ALJ's order, asserting that, because the medical evidence shows that claimant has a preexisting condition that combined with his current low back condition, the claim should be analyzed under ORS 656.802(2)(b).[1] Specifically, SAIF contends that the 1991 Determination Order "establishes the cut off date for proof of a subsequent new occupational disease" and we therefore "should look to work conditions subsequent to the 1991 closure of the initial claim to determine whether a new occupational disease claim has been established."

The record contains two opinions concerning causation. Dr. Donahoo, examining orthopedic surgeon, first stated that the "major contributing cause of the current need for treatment was the activities in the week preceding carrying the cleaner in the bathroom at home." (Ex. 25-7). The report further found that "no specific conditions other than the work conditions have appeared to play a significant role in his need for care." (Id.) Dr. Donahoo then provided the following:

> "As noted, I believe he does have some degenerative changes with a recurring pattern of symptoms from a strain pattern. I believe the individual strain patterns are the current major contributing cause for his treatment but it is superimposed on an ongoing, repetitious pattern which has persisted since 1984. For administrative purposes, I would feel that that still remains the major contributing cause since his symptoms have been unrelenting and, in his words, 'have changed my life' with respect to his tolerances and capacities." (Id. at 8).

Dr. Donahoo then indicated in a "check-the-box" report drafted by SAIF that claimant had a preexisting low back condition, such condition combined with the "May 1995 condition" and the preexisting condition was the major contributing cause of his current need for treatment and disability. (Ex. 26).

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[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."

Dr. Mavris reported that claimant's "original injury never really cleared." (Ex. 28). Dr. Mavris added that claimant's "physically demanding occupation as a consequence of which he has had frequent additional injuries contributes more to his current condition than the initial episode in 1984." (Id.)

In Dan D. Cone, 47 Van Natta 1097, on recon 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995), we considered the application of ORS 656.802(2)(b) in the context of the claimant's theory that work conditions worsened his 1985 compensable low back injury, resulting in a herniated disc. We found that the 1985 injury constituted a "preexisting condition" and, because the claimant's occupational disease claim was based on a worsening of a preexisting disease, the claimant was required to prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. 47 Van Natta at 2221.

Here, claimant's theory of compensability is not based on a worsening of the 1984 compensable injury. Rather, claimant contends that his current low back strain condition was in major part caused by employment conditions subsequent to the 1984 injury. Claimant's theory is consistent with Dr. Mavris' opinion, which, although indicating that the 1984 injury has some continued effect, stated that claimant's employment is the major contributing cause of his current need for treatment. (Ex. 25-7).

Part of Dr. Donahoo's report also supports this opinion. Dr. Donahoo also indicated, however, that the major contributing cause was a preexisting condition. (Ex. 26). We find Dr. Donahoo's opinion inconsistent in that he at one point stated that work conditions were the major contributing cause, followed by statements that a preexisting condition was the major contributing cause; thus, we find Dr. Donahoo's opinion unpersuasive. See Somers v. SAIF, 77 Or App 259 (1986). Furthermore, we find no persuasive reasons not to defer to Dr. Mavris' opinion and we rely on it in deciding compensability. See Weiland v. SAIF, 64 Or App 810 (1983).

Based on Dr. Mavris' opinion, we conclude that claimant proved that work conditions were the major contributing cause of his current need for treatment and disability for his low back strain condition. Thus, because compensability of this condition is not based on a worsened preexisting condition, we find this case distinguishable from Dan D. Cone and that ORS 656.802(2)(b) is not applicable. Rather, claimant must show only that work conditions were the major contributing cause of his occupational disease. ORS 656.802(2)(a). Because claimant carried such burden of proof with Dr. Mavris' opinion, he proved compensability. Id.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 5, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JOHN D. MOANING, Claimant
WCB Case No. 96-10649
ORDER ON RECONSIDERATION
Douglas S. Hess, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

On September 16, 1997, we abated our August 18, 1997 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's injury claim for a low back condition. We took this action to consider the employer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

In our original order, we affirmed the ALJ's order that held that claimant had established a compensable claim for a new injury to his low back, caused in major part by the injury he sustained at work on September 5, 1996. On reconsideration, the employer argues that by affirming the ALJ's order, we failed to make adequate findings of fact and generate a reasoned opinion based on those findings. The employer further argues that we failed to address expert evidence that supports its position, and that we failed to address its arguments on review. We continue to adhere to our previous decision that affirmed the ALJ's order, finding that the ALJ's order is supported by adequate findings of fact and reasoning. However, we supplement our prior decision in order to respond to the employer's arguments.

The employer argues that we failed to adequately consider the testimony of its expert mechanical engineer, Mr. Juhnke. We disagree.

Mr. Juhnke testified that the bus in which claimant was seated when it was struck from behind by another bus would have sustained very little force from the contact. Mr. Juhnke testified that claimant's bus probably sustained a change in velocity (Delta V) of less than 1 (one mile per hour), whereas a Delta V of at least 5 (5 miles per hour) is usually necessary to cause injury. (Tr. 88). Mr. Juhnke also testified that claimant probably moved about one-half inch as a result of the other bus striking claimant's bus. (Tr. 84). The ALJ found, and we agree, that little force was exerted on claimant's body when his bus was struck by another rolling bus. This finding is supported by Mr. Juhnke's testimony.

However, Mr. Juhnke also testified that claimant would have felt a "jolt," similar to "a good rap to the seat, just hard enough to move it just a fraction of an inch[.]" (Tr. 84-85). This is consistent with the initial history of the injury obtained by nurse practitioner Lynch, as well as claimant's testimony that he felt the impact. (Ex. 14-3; Tr. 15, 29-30). Thus, while we recognize that the incident was minor, we also recognize that there is no dispute that an incident did occur in which another bus rolled into the rear of claimant's bus, causing claimant to at least feel a "jolt" upon impact.

Mr. Juhnke also offered the opinion, based on his expertise as a mechanical engineer, that the force of impact was insufficient to cause injury. However, the record also contains contrary evidence that supports a finding that claimant did sustain an injury.

Claimant testified without contradiction that he felt the collision, that he began to feel pain and "muscle spasm" in his lower left back within 15-20 minutes of the incident, and that he sought medical treatment for his back pain on the same day. (Tr. 12, 16-17, 29-30). When nurse practitioner Lynch examined claimant approximately three hours after the incident, she made objective findings of injury (tenderness to palpation over the lumbar spine and left paralumbar area), diagnosed a left-sided lumbar strain without radiculopathy, prescribed medication, and released claimant from work. (Exs. 14-3, 15; Tr. 17). When chiropractor Hamburg treated claimant on September 16, 1996, he obtained a history of the incident and the development of claimant's pain. (Ex. 23-2). On examination, Dr. Hamburg also found tenderness, worse on the left side, and diagnosed a moderate lumbar facet sprain/strain. (Id.). Thus, we find that claimant's testimony and evidence from the medical practitioners who treated claimant establish that he sustained an injury within the meaning of ORS 656.005(7)(a).[1]

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[1] ORS 656.005(7)(a) provides:

"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[.]"

Therefore, in this case, there are both expert engineering and medical opinions on the question of whether claimant sustained an injury. We believe the question of whether a particular claimant sustained an injury is primarily a medical question. Therefore, we give greater weight to the medical evidence in determining whether claimant sustained an injury.

In this case, there is also a medical opinion contrary to the treating medical practitioners' opinions. Dr. Farris, who examined claimant on behalf of the employer, opined that claimant probably did not sustain an injury, in light of the mechanical engineer's findings. (Ex. 35 at 10-11, 31). However, Dr. Farris examined claimant two months after the incident, when he was returning to full-time bus driving work. (Ex. 28 at 1-2). Dr. Farris acknowledged that a medical examination closer to the time of the incident would be more likely to reveal how badly a person is injured. (Ex. 35-28).

Here, nurse practitioner Lynch examined claimant a few hours after the incident, and Dr. Hamburg first examined claimant 11 days after the incident. Because they examined and treated claimant closer in time to the alleged injury, we find their observations are more persuasive on the question of whether claimant sustained an injury than Dr. Farris' opinion. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). Accordingly, based on the reports of Lynch and Hamburg, as well as claimant's uncontradicted testimony, we find that claimant sustained a work-related injury on September 5, 1996. See ORS 656.005(7)(a).

The employer also objects that we failed to address the discrepancy between Mr. Juhnke's description of the mechanics of injury and claimant's description of the incident. Claimant described what occurred to his body upon impact: "I surged forward in the seat. Then I whiplashed backwards." (Tr. 15). The employer contends that claimant's description conflicts with Mr. Juhnke's description of the mechanics of a rear-end collision. Specifically, Mr. Juhnke explained that the body in the rear-ended vehicle would go back relative to the seat (which is moving forward) and then it may rebound forward from the seat. (Tr. 90-91).

We note that claimant also described the impact thus: "[M]y bus surged forward and pulled back," and "the bus was surged forward, and it'll go back. So it pulled me back. It whiplashed me backwards." (Tr. 10, 12). We consider these descriptions to be substantially consistent with Mr. Juhnke's description of the mechanics of a rear-end collision. We also note that claimant testified that he felt the collision. (Tr. 29-30). This is consistent with Mr. Juhnke's description of what claimant would be likely to feel upon impact. (Tr. 84). Thus, to the extent there is a discrepancy between claimant's description of the impact and Mr. Juhnke's explanation of the mechanics of impact, we do not find such discrepancy to be material. Instead, we find that claimant's and Mr. Juhnke's testimony regarding the effect of impact on claimant's body is substantially consistent. Accordingly, we find no basis here for discounting claimant's testimony.

The employer also objects that there is no evidence that claimant sustained a "blunt trauma" injury. The employer apparently believes that the ALJ's opinion rested on an inference that claimant sustained a "blunt trauma" injury. The employer misreads the ALJ's opinion. The ALJ simply found, based on claimant's credible testimony and the records of claimant's medical treatment, that claimant sustained an injury to his low back. We agree with that determination.

The employer also objects to the ALJ's analysis of Dr. Farris' opinion. Specifically, the employer contends that the ALJ wrongly relied on Dr. Farris' opinion to support compensability. Again, the employer misreads the ALJ's opinion. The ALJ relied on Dr. Hamburg's opinion to establish compensability. The ALJ discussed Dr. Farris' opinion, but did not rely on it to find the claim compensable. We agree with the ALJ's analysis, with the following supplementation.

Dr. Farris opined that claimant probably did not sustain an injury as a result of the September 5, 1996 incident. (Ex. 35 at 10, 31). He based this opinion on his examination of claimant, as well as information from the mechanical engineer, Mr. Juhnke. This is a modification, based on additional information, of his original opinion that any symptoms claimant developed as a result of the incident "would be most accurately described as a symptomatic worsening of his pre-existing condition rather than a new injury as a such." (Ex. 28-5). Thus, we understand Dr. Farris' ultimate opinion to be that claimant did not sustain an injury as a result of the incident.

As discussed above, we are persuaded that claimant did sustain an injury. Thus, because Dr. Farris' opinion is based on a premise that we have found to be incorrect, we do not find his opinion

persuasive. See Queener v. United Employers Ins., 113 Or App 364, 367 (1992) (citing Kuhn v. SAIF, 73 Or App 768, 772 (1985)). We further note that Dr. Farris acknowledged that a medical practitioner who examined claimant within days of the incident would be in a better position to evaluate the extent of claimant's injuries. (Ex. 35-28). In addition, we note that Dr. Farris acknowledged that claimant's preexisting lumbarization of S1 would probably make him more susceptible to developing pain after some sort of trauma. (Ex. 35 at 26-27). However, he failed to reconcile this view with his opinion that claimant did not sustain an injury. Based on these considerations, we find Dr. Farris' opinion unpersuasive.

On the other hand, Dr. Hamburg, a chiropractor who began treating claimant on September 16, 1996, opined that the bus incident of September 5, 1996 was the major contributing cause of claimant's symptoms and need for treatment. (Ex. 32). Dr. Hamburg obtained a substantially accurate history of the incident,[2] examined claimant and found objective evidence of injury, and successfully treated claimant over approximately a two-month period. (Exs. 23-2, 32). This formed the basis for his opinion regarding the cause of claimant's symptoms and need for treatment.

When medical opinions differ, we rely on those opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). In addition, 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 Dr. Hamburg's opinion to be better reasoned and based on more complete information than Dr. Farris' opinion. Dr. Hamburg had more complete information about claimant's injury because he examined claimant a few days after the incident, whereas Dr. Farris examined claimant about two months after the incident. In addition, as discussed above, we disagree with Dr. Farris' premise that claimant did not sustain an injury as a result of the September 5, 1996 incident. Therefore, we do not find Dr. Farris' opinion to be as well-reasoned as Dr. Hamburg's opinion. Furthermore, we find no persuasive reason in this case not to rely on the treating physician's opinion. Accordingly, we conclude, relying on Dr. Hamburg's opinion, that claimant's September 5, 1996 injury was the major contributing cause of his lumbar strain/sprain.

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

Accordingly, 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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[2] The employer argues that Dr. Hamburg mistakenly thought that claimant had "immediate onset" of low back pain following the incident. Claimant testified that he began to feel low back pain about 15-20 minutes after the incident. (Tr. 12, 35). We find that the onset of claimant's pain was sufficiently close in time to the incident to be fairly characterized as "immediate." Therefore, we conclude that Dr. Hamburg's history was accurate in this regard.

In addition, the employer argues that Dr. Hamburg had an incorrect description of what happened to claimant's body upon impact. Dr. Hamburg obtained a history that claimant's body "lurched forward and back" upon impact. (Ex. 23-2). As discussed above, we find that this history is substantially consistent with claimant's testimony regarding the incident, as well as Mr. Juhnke's description of what is likely to occur in a rear-end collision. Moreover, to the extent that Dr. Hamburg's understanding of the incident varies, we do not find that variance to be material. Therefore, we conclude that Dr. Hamburg's history is substantially accurate in this regard, as well.

In the Matter of the Compensation of
SAMUEL PRADO, Claimant
WCB Case No. 96-11508
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that affirmed an Order on Reconsideration which awarded 35 percent (112 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

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

Claimant argues that his adaptability factor should be 5, rather than 4, because his residual functional capacity is "light," rather than "medium/light." Specifically, claimant contends that his treating physician's advice "against repetitive bending and stooping" established "restrictions" under the applicable rules. (See Ex. 3B-2). We disagree, based on the following reasoning.

We apply the standards in effect on the date of the Determination Order, except that we apply current OAR 436-035-0310(6). See former OAR 436-035-0003(1) & (2) (WCD Admin. Order 96-051) (effective February 17, 1996) & current OAR 436-035-003(3) (WCD Admin. Order 96-072) (effective February 15, 1997).

Former OAR 436-035-0310(3)(l) (which was in effect on the date of the Determination Order) provides, in relevant part:

> "'Restrictions' means that, by a preponderance of medical opinion, the worker is permanently limited by:
>
> "* * * * *
>
> "(C) From performing at least two of the following activities: stooping/bending, crouching, crawling, kneeling, twisting, climbing, balancing, reaching, or pushing/pulling." (WCD Admin. Order 96-051) (emphasis added).

In this case, Dr. Danillaya, treating physician, advised claimant to avoid repetitive bending or stooping. This advice is insufficient to establish a "restriction" under the above-quoted rule because the rule refers to "stooping/bending" as one activity, but two activities are required for a "restriction" under the rule. See Ann K. Bias, 48 Van Natta 1130, 1131 (1996). Accordingly, claimant's base functional capacity was heavy, because his residual functional capacity is classified as "medium/light," without restrictions, we find that the ALJ properly assigned an adaptability value of 4. See OAR 436-035-0310(6).

ORDER

The ALJ's order dated May 12, 1997 is affirmed.

In the Matter of the Compensation of
RONALD D. SMITH, SR., Claimant
WCB Case Nos. 97-00613 & 96-10508
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order which: (1) upheld the SAIF Corporation's denial of his left knee chondromalacia condition; (2) affirmed an Order on Reconsideration which affirmed a Notice of Closure's award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's left knee; (3) determined that the left knee injury claim was not prematurely closed; (4) declined to remand the claim for "reopening" after SAIF's "post-reconsideration" acceptance of claimant's left medial meniscus condition; and (5) declined to award penalties for SAIF's allegedly unreasonable claim processing. SAIF has moved to strike claimant's reply brief. On review, the issues are motion to strike, compensability, premature claim closure, scheduled permanent disability, claim processing, and penalties. We grant the motion, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant did not file an appellant's brief. SAIF then declined to submit a respondent's brief. Thereafter, claimant submitted a letter, stating that it was relying on an attached transcribed closing argument. SAIF has moved that we strike claimant's "reply" brief and the transcribed closing argument.

We do not consider a "reply" brief when no respondent's brief has been submitted. See Alvin Woodruff, 39 Van Natta 1161 (1987); Harold C. Kimsey, 39 Van Natta 1166 (1987). Under these circumstances, we do not consider claimant's transcribed closing argument. We emphasize, however, the filing of briefs is not jurisdictional. OAR 438-011-0020(1). Our de novo review authority encompasses all issues raised or raisable on the entire record regardless of whether those issues were raised by the parties on review. See Destael v. Nicolai Co., 80 Or App 596, 600-601 (1986). Accordingly, we have reviewed the ALJ's order in accordance with our de novo review authority.

Compensability

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

Scheduled Permanent Disability

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

Premature Closure

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

Claim Processing/Penalties

Claimant compensably injured his left knee on July 18, 1995, an injury initially accepted on October 19, 1995 as a disabling contusion and patellar tendonitis. Dr. Utterback performed surgery to repair a torn medial meniscus in December 1995. After Dr. Utterback declared claimant's left knee condition medically stationary on July 8, 1996, SAIF closed the claim by Notice of Closure dated July 19, 1996. The closure notice awarded 5 percent scheduled permanent disability for loss of use or function of claimant's left knee due to the meniscus surgery. An Order on Reconsideration issued on October 31, 1996, affirming the Notice of Closure.

On January 3, 1997, SAIF formally accepted a medial meniscus tear of the left knee. (Ex. 47A). Claimant's attorney then requested closure of the newly accepted condition on February 3, 1997. (Ex. 50). On February 4, 1997, SAIF's counsel replied that there was no need to issue another Notice of

Closure because the meniscus injury had already been rated for permanent disability in the July 1996 closure notice and in the October 1996 reconsideration order. (Ex. 51). Thereafter, claimant requested a hearing.

At hearing, claimant contended that he was entitled to reopening of the claim for processing of the left medial meniscus condition and that SAIF's failure to do so was unreasonable. The ALJ disagreed, concluding that there was no reason to remand the claim to SAIF for further processing because Dr. Utterback had considered the meniscus condition to be medically stationary and the meniscus condition had already been considered in the disability rating process.

In Anthony J. Telesmanich, 49 Van Natta 49 (1997), on recon 49 Van Natta 166 (1997), we held that where the carrier has accepted additional conditions after issuance of an Order on Reconsideration, the proper procedure at hearing on the Order on Reconsideration is to rate the conditions accepted at the time of the Order on Reconsideration and remand the later accepted conditions to the carrier for processing according to law. See also Bernard G. Hunt, 49 Van Natta 223 (1997). We further concluded that, depending on the circumstances and the medical evidence, the processing of these "post-reconsideration" accepted conditions may, or may not, involve the "reopening" of the claim and a redetermination of extent of permanent disability. We noted that, if the claimant objected to the carrier's subsequent processing of the claim, he may request a hearing at the appropriate time. Telesmanich, 49 Van Natta at 166; See also Patricia A. Dropinski, 49 Van Natta 206, 212 (1997).

Here, SAIF accepted claimant's left medial meniscus condition after issuance of the reconsideration order. In accordance with the rationale expressed in Telesmanich, the medial meniscus condition must be processed by SAIF according to law. While we have previously determined that this "processing" may or may not involve the "reopening" and "re-rating" of the claim, the legislature has recently amended ORS 656.262(7)(c) to provide that "If a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." HB 2971, 69th Leg., Reg. Sess., § (July 25, 1997) (emphasis added). The amendment applies to "all claims or causes of action existing 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." HB 2971, § 2. Because this claim existed on the effective date of HB 2971, and because that Act is intended to be fully retroactive, we apply amended ORS 656.262(7)(c) to this case. See Bay Area Hospital v. Landers, 150 Or App 154 (1997).

Accordingly, consistent with amended ORS 656.262(7)(c), SAIF must "reopen" the claim for processing of the meniscus condition.[1] If claimant is dissatisfied with SAIF's claim processing, he may request a hearing at the appropriate time. Patricia Dropinski, 49 Van Natta 212.

Finally, we decline to assess a Finally, we decline to assess a penalty against SAIF for its claim processing. Claimant's February 3, 1997 request for reopening preceded our February 19, 1997 decision in Telesmanich, which addressed a carrier's claim processing obligations with respect to "post-reconsideration" accepted conditions. Inasmuch as Board precedent was unclear as to SAIF's claim processing obligations when claimant requested "reopening," and because the closure notice had already apparently considered the meniscus condition in rating permanent disability, we do not find that SAIF's claim processing was unreasonable. Accordingly, we affirm the ALJ's decision not to assess a penalty.

ORDER

The ALJ's order dated May 7, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that declined to remand the claim to SAIF for processing is reversed. The left medial meniscus condition claim is remanded to SAIF for reopening and processing according to law. Claimant's attorney is awarded 25 percent of any increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's counsel. The remainder of the ALJ's order is affirmed.

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[1] In reaching this conclusion, we perceive no distinction between the situation where, as here, a carrier voluntarily finds a condition to be compensable after issuance of a reconsideration order and that in which a "post-reconsideration order" condition is found compensable via a litigation order. Our review of the legislative history surrounding the adoption of HB 2791 does not reveal that the legislature intended to draw such a distinction. In the absence of such intent, we decline to do so.

In the Matter of the Compensation of
TONYA A. RONCELLI, Claimant
WCB Case No. 96-10864
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that reduced an Order on Reconsideration's award of 3 percent (9.6 degrees) unscheduled permanent disability for a left shoulder injury to zero. 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

Claimant's claim was accepted for left trapezius muscle strain. (Ex. 5). This claim was closed by an August 5, 1996 Notice of Closure, which awarded no permanent disability and found claimant medically stationary as of July 25, 1996. Claimant requested reconsideration and the appointment of a medical arbiter. On November 12, 1996, an Order on Reconsideration awarded claimant 3 percent unscheduled permanent disability. Claimant appealed the unscheduled permanent disability award, and the ALJ reduced the award to zero.[1]

Based on the August 5, 1996 issuance date of the Notice of Closure in this case, we conclude the applicable standards for rating claimant's permanent disability are set forth in WCD Admin. Order 96-051, as amended by WCD Admin. Orders 96-068 and 96-072. See OAR 436-035-0003(2), (3).

For the purpose of making impairment findings to rate disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter, if any, may be considered. See ORS 656.245(2)(b)(B), 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442, 445 (1994); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). Furthermore, on reconsideration, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Former OAR 436-035-0007(13).

Dr. Bufton, attending physician at claim closure, reported that claimant had no impairment. (Exs. 8, 9). However, Dr. Bufton's closing report is conclusory and her closing examination is not as thorough as that of Dr. Smith, the medical arbiter. In this regard, although the accepted condition is left trapezius muscle strain, Dr. Bufton provided no range of motion findings regarding the left shoulder; instead, she noted that claimant had full range of motion of the neck. (Ex. 9). Furthermore, Dr. Bufton only treated claimant twice before performing the closing examination. Therefore, she does not have a long treatment history with claimant that might provide a basis for deferring to her opinion. (Exs. 4, 6, 9). Weiland v. SAIF, 64 Or App 810 (1983) (Absent persuasive reasons to the contrary, generally we defer to the opinion of the treating physician). Given Dr. Bufton's conclusory closing report and the more thorough examination and report provided by Dr. Smith, we find persuasive reasons in this case not to defer to Dr. Bufton's opinion. Therefore, we rely on Dr. Smith's persuasive opinion in determining claimant's impairment. Former OAR 436-035-0007(13).

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[1] We note that claimant contends that, because the SAIF Corporation did not contest the Order on Reconsideration's award of 3 percent unscheduled permanent disability, the ALJ erred in reducing that award to zero. We agree. Daniel M. Alire, 41 Van Natta 752, 759 (1989) (we will not reduce or increase an award of permanent disability in the absence of a request to do so by one of the parties); Jesus Mejia, 44 Van Natta 32, 33 (1992) (same). However, given our decision as explained below that claimant is entitled to an award of 10 percent unscheduled permanent disability, the issue of the 3 percent baseline award is moot.

SAIF argues that we should not rely on Dr. Smith's opinion because it is based on claimant's subjective pain complaints. We disagree. Former OAR 436-035-0320(3) provides, in relevant part: "Pain is considered in the impairment values in these rules to the extent that it results in measurable impairment. If there is no measurable impairment, no award of unscheduled permanent partial disability shall be allowed." Here, Dr. Smith found measurable impairment in claimant's reduced active ranges of motion of the left shoulder. Furthermore, although Dr. Smith found claimant's passive range of motion of the left shoulder "full," it is the active ranges of motion that are used in rating impairment. See former OAR 436-035-0007(21). Moreover, Dr. Smith was directed to provide the active ranges of motion of claimant's shoulders. (Ex. 11A-2)

In addition, former OAR 436-035-0320(5) provides that 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. In order to read former OAR 436-035-0320(5) consistent with former OAR 436-035-0320(3), "measurable impairment" under former OAR 436-035-0320(3) must include "chronic condition impairment" under former OAR 436-035-0320(5). As explained below, we find that Dr. Smith determined that claimant had chronic condition impairment due to the compensable injury. Accordingly, we conclude that Dr. Smith's findings of reduced active ranges of motion and chronic condition impairment in the left shoulder constitute measurable impairment under former OAR 436-035-0320(3).

Dr. Smith measured reduced ranges of motion in the left shoulder compared to the uninjured right shoulder. (Ex. 12-3). Although Dr. Smith reported that claimant's grip strength measurements were invalid, he made no such report regarding claimant's range of motion measurements. Therefore, we consider those measurements valid and ratable. See former OAR 436-035-0007(27) (Impairment that is ratable under these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion explaining why the findings are invalid).

Where, as here, there is no history of injury or disease in the contralateral joint, loss of range of motion of the injured joint is compared to and valued proportionately to the contralateral joint. Former OAR 436-035-0007(22). On the other hand, where the range of motion of the injured or contralateral joint exceeds the values for ranges of motion established under the rules, the values established under the rules are used to establish lost range of motion. Former OAR 436-035-0007(22)(a). Applying these rules to Dr. Smith's measurements of reduced ranges of motion (right/left) of flexion (145/130), abduction (180/135), and adduction (35/25) results in ratings of 1 percent, 1 percent, and .5 percent, respectively. Former OAR 436-035-0330(1), (5), (7). These values are added and rounded up for an impairment value due to lost range of motion of 3 percent. Former OAR 436-035-0007(14); 436-035-0330(17).

Dr. Smith also found that claimant has "some partial loss of ability to repetitively use the left shoulder for lifting activities or for prolonged use of the arms in an overhead position" and is "permanently precluded from activities requiring frequent and prolonged reaching." (Ex. 12-3). We find that these findings entitle claimant to unscheduled chronic condition impairment under former OAR 436-035-0320(5). However, where a worker has less than 5 percent total unscheduled ratable impairment in a body area, the worker is entitled to 5 percent unscheduled chronic condition impairment in lieu of all other unscheduled impairment in that body area. Former OAR 436-035-0320(5)(b).

Here, prior to considering chronic condition impairment, claimant has 3 percent total unscheduled impairment in the left shoulder. Therefore, claimant is entitled to a total of 5 percent unscheduled impairment. Id.

SAIF argues that, pursuant to ORS 656.726(3)(f)(D)(iii),[2] claimant is not entitled to any social/vocational factors in determining her unscheduled permanent disability award because she had been released to regular work and she quit her job for reasons unrelated to her injury. We disagree.

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[2] ORS 656.726(3)(f)(D)(iii) provides:

"Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if:

"* * * * *

"(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."

Although Dr. Buckingham, claimant's former treating physician, checked a box on an 828 form indicating that claimant had been released to regular work on November 30, 1995, claimant was not medically stationary at that time and Dr. Buckingham had referred her to another physician for evaluation and management. (Ex. 5A). As a result, Dr. Bufton became claimant's attending physician. (Exs. 4, 5A, 6). Subsequent to becoming claimant's attending physician, Dr. Bufton stated that she had not determined claimant's work status but that claimant was on "light duty" and had quit her job. (Ex. 7). She also stated that claimant "appeared ready for full duty 2/28/96." Id. Finally, Dr. Bufton performed a closing examination on July 25, 1996; however, she made no mention of claimant's work status other than to state that claimant was not working and had chosen to stay home with her children. (Ex. 9).

On this record, we do not find that claimant was released to regular work by her attending physician. Dr. Bufton's last explicit statement regarding claimant's work status was that she was on "light duty," although she also stated that claimant "appeared ready for full duty 2/28/96." (Ex. 7). However, pursuant to former OAR 436-035-0005(17)(b), a "physician's release" is defined as a written notification, provided by the attending physician to the worker and the worker's employer or insurer, releasing the worker to work and describing any limitations. We do not find that Dr. Bufton's statement that claimant "appeared ready for full duty" meets that definition. Furthermore, even if we considered this statement to be more than speculation, there is no indication the attending physician provided claimant with written notification of this alleged "release" to "regular" work. Therefore, ORS 656.726(3)(f)(D) does not apply to limit claimant's disability to the impairment factor.

Accordingly, we proceed to determine the non-impairment factors. Adaptability is measured by comparing Base Functional Capacity (BFC) to claimant's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. Former OAR 436-035-0310(2). Claimant's at-injury job was a motel maid in the housekeeping department, which corresponds to the DOT title "Cleaner, Housekeeping" and has a strength of light. DOT 323.687-014. Therefore, claimant's BFC is light. Former OAR 436-035-0310(4). For the same reasons that we relied on Dr. Smith's opinion regarding impairment, we rely on his opinion regarding RFC. Dr. Smith determined that claimant could lift and carry 15-20 pounds on a frequent basis and 30 pounds on an occasional basis, with restrictions on reaching, pushing and pulling. (Ex. 12-3). Therefore, claimant has a RFC of medium/light with restrictions, which translates to a RFC of light. Former OAR 436-035-0310(5)(b), (7). Comparing the BFC with the RFC results in an adaptability factor of 1. OAR 436-035-0310(6).

Claimant has not earned a high school diploma or GED, which results in a formal education factor of 1. Former OAR 436-035-0300(2)(b). The highest SVP of any job met by claimant in the five years prior to closure is her at-injury job of motel maid, which has an SVP value of 2, resulting in a SVP factor of 4. Former OAR 436-035-0300(3), (4); DOT 323.687-014. The formal education factor (1) is added to the SVP factor (4), for a total education factor of 5. Former OAR 436-035-0300(6). Claimant is under 40; therefore, her age factor is zero. Former OAR 436-035-0290(2). The age (0) and education (5) factors are added for a value of 5, which is multiplied by the adaptability factor (1), for a total non-impairment factor of 5. When this value is added to the value of 5 percent for impairment, the result is 10. Former OAR 436-035-0280. Therefore, claimant's unscheduled permanent disability is 10 percent.

Thus, claimant's unscheduled permanent disability is increased from zero, as awarded by the ALJ, to a total award to date of 10 percent. Claimant's attorney is entitled to 25 percent of this 10 percent increase, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055.

ORDER

The ALJ's order dated April 30, 1997 is modified. In lieu of the ALJ's award of zero unscheduled permanent disability, and in addition to the Order on Reconsideration award of 3 percent (9.6 degrees) unscheduled permanent disability, claimant is awarded 7 percent (22.4 degrees) unscheduled permanent disability, for a total award of 10 percent (32 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the additional compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

In the Matter of the Compensation of
JERRY E. BISHOP, Claimant
WCB Case No. 94-14311
ORDER ON RECONSIDERATION
David C. Force, Claimant Attorney
Thomas A. Andersen, Defense Attorney

Claimant requests reconsideration of our September 17, 1997 Order on Review which modified the Administrative Law Judge's (ALJ's) award of interim compensation from May 1, 1992 through June 20, 1995. In lieu of the ALJ's award, we awarded interim compensation from May 1, 1992 through December 15, 1993, the date claimant discovered the insurer's October 19, 1992 denial.

Claimant requests that we reinstate the ALJ's award of interim compensation, contending that he was never effectively served with a denial of his claim. Noting that he only learned of the insurer's denial by happenstance on December 15, 1993 while reviewing his legal file, claimant alleges that we improperly inserted a "subjective element" to the termination of interim compensation. Claimant asserts that accidental discovery of a denial cannot constitute valid service of a denial sufficient to terminate interim compensation. See Roger C. Prusak, 40 Van Natta 2037 (1988) (A carrier is required to pay interim compensation until it actually fulfills its duty to issue a formal denial).

In our original order, we terminated interim compensation on December 15, 1993 because we found that claimant "received actual knowledge" of the denial on that date. In Jones v. Emanuel Hospital, 280 Or 147, 152 (1977), the Court held that a worker cannot appeal until he or she "receives the notice of denial." Thus, under Jones, the focus is on actual receipt of the denial by a claimant.

In this case, claimant stipulated that he actually received the denial on or about December 15, 1993 after he obtained his legal file from the Gildea law firm. (App B-3, C-1). Thus, applying the objective standard of Jones, we find that claimant received the notice of denial on December 15, 1993. We, therefore, reiterate our prior holding that claimant's right to interim compensation ceased on that date.

Claimant alleges, however, that he could not have requested a hearing to contest the October 19, 1992 denial in December 1993. Once again, we disagree with claimant's contention.

In 1992, when the denial was issued, and in 1993, when claimant actually received the denial, the statutory 60-day period within which to request a hearing from a denial did not commence until there was actual or constructive receipt of the denial. SAIF v. Edison, 117 Or App 455, 458 (1992).[1] Here, claimant did not actually receive the October 19, 1992 denial until December 15, 1993. Thus, the 60-day period in which to request a hearing from the insurer's denial did not commence until December 15, 1993. Former ORS 656.319(1)(a). In any event, because claimant did not seek to establish the compensability of his claim, such timeliness questions are not properly before us for determination.

In conclusion, we continue to conclude that claimant's right to interim compensation ceased on December 15, 1993, when claimant received actual notice of the October 19, 1993 denial.[2] Accordingly, we withdraw our September 17, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our prior 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] In 1995, ORS 656.319 was amended to provide that the 60-day period runs from the date of mailing of the denial.

[2] Claimant requests that we release him from his stipulation that his claim was not compensable should we adhere to prior holding. However, for whatever reason, claimant chose not to pursue his psychological claim. Regardless of his intentions in making such a decision, it would be inappropriate for us to set aside his express waiver of the compensability issue at this late date to allow him the opportunity to litigate a matter that he voluntarily and intentionally relinquished at hearing. Consequently, we decline claimant's belated request to alter the parties' stipulation.

In the Matter of the Compensation of
OLIVER BROWN, Claimant
Own Motion No. 97-0427M
OWN MOTION ORDER
Pozzi, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable torn cartilage, right knee, and right knee chondromalacia injury/occupational disease. Claimant's aggravations rights expired on May 4, 1997. SAIF recommends against reopening the claim for the payment of time loss, contending that claimant was not in the work force at the time of disability.[1]

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

On June 30, 1997, the managed care organization (MCO) certified Dr. Manley's request for claimant's right knee arthroscopic surgery. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

Claimant contends that he was willing to work, but unable to work because of the compensable injury for the period in question. Claimant submitted an October 3, 1997 affidavit, in which he attests that he has attempted self-paced vocational retraining in the area of computer graphics. We are persuaded by claimant's sworn statement that he has attempted retraining and thus, has satisfied the "willingness" portion of the Dawkins criteria above.

Claimant submitted a September 29, 1997 statement from Dr. Manley, in which his attending physician opined that "it has been my contention that the initial problem [claimant] had that kept him out of the work force was his right knee problem." Dr. Manley further opined that:

> "If it had not been for this [knee] problem and the continuing difficulty with his knee, I have no doubt that [claimant] would have returned to work."

Even if [claimant] had tried to return to work prior to the most recent surgery, there is no way that he would have been accepted for his customary type of work because of his severe knee problems and the propensity for them to only worsen with any type of work situation."

We are persuaded by Dr. Manley's opinion, and we conclude that claimant was unable to work at the time of disability because of his compensable condition. On this record, we find that claimant has carried his burden of proving that he was in the work force at the time of disability.

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

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[1] In his September 12, 1997 letter, claimant advised that it was his position that "SAIF has failed to properly investigate this matter and has failed to pay [claimant] time loss since the date of surgery." SAIF submitted its recommendation to the Board on September 12, 1997. In its recommendation, SAIF noted that it received claimant's request for Own Motion relief on June 26, 1997. SAIF had 90 days from the date of receipt of claimant's request to process that request. OAR 438-012-0030(1). Claimant has not further argued that SAIF submitted an untimely recommendation. Therefore, for purposes of our order, we do not address that issue.

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
GENEVIEVE K. HANKEL, Claimant
Own Motion No. 96-0601M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin L. Alvey, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 5, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from September 5, 1996 through October 11, 1996. SAIF declared claimant medically stationary as of November 25, 1996. Claimant does not contend that SAIF's closure was premature. Rather, claimant contends that she was not medically stationary on November 25, 1996, and that she is entitled to additional temporary disability compensation until she became medically stationary.

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). The use of "magic words" or statutory language is not required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992), as cited in U-Haul of Oregon v. Burtis, 120 Or App 353 (1993); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986.

Claimant is substantively entitled to temporary disability benefits if the record establishes 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).

Claimant underwent C5-6 anterior cervical discectomy and interbody fusion surgery on September 5, 1996 for her compensable injury. In a September 26, 1996 letter, Dr. Rohrer, claimant's treating physician, opined that claimant was "still having some minimal neck pain but overall is feeling fairly well with no radicular pain." Dr. Rohrer reported that claimant planned to return to work on a part-time basis that next week. In a September 26, 1996 work restriction report, Dr. Rohrer noted that claimant was restricted to:

> "No lifting greater than 15-20 pounds. [From] 10/4[/96] - 10/11[/96 claimant is] restricted to 4 hours, more hours if tolerated. Then full time [work] beginning 10/12/96 as tolerated."

SAIF terminated temporary disability benefits on October 11, 1996.

In an October 24, 1996 letter, Dr. Rohrer opined that claimant was doing very well and had no neck pain or radiating arm pain. Dr. Rohrer further advised that he had "increased [claimant's] lifting tolerance to 25 pounds with a full time work schedule." In his October 24, 1996 work restriction report, Dr. Rohrer noted that claimant had been disabled until that date, that she was released to work as of October 24, 1996, and that she was to lift no more than 25 pounds.

In his November 25, 1996 report, Dr. Rohrer opined that "[a]t this point, [claimant] may resume full activities as tolerated." Dr. Rohrer noted that he would "see [claimant] back on an as needed basis only." In his November 25, 1996 work restriction report, Dr. Rohrer noted that claimant had been disabled and was released to return to work as of that date, but that she was to lift no more than 25 pounds until January 5, 1997.

In a July 11, 1997 Supplemental Medical Report, Dr. Rohrer opined that claimant was medically stationary as of November 25, 1996, and that modified work had been authorized beginning November 25, 1996.

Here, although Dr. Rohrer initially released claimant to part-time work on October 4, 1996, he noted that she could return to full time work beginning October 12, 1996 if she could tolerate full time work. On October 24, 1996, Dr. Rohrer had modified his work release to indicate that claimant was released to return to work as of October 24, 1996. However, on November 25, 1996, Dr. Rohrer again modified claimant's release to work to begin on November 25, 1996, and indicated that she had been disabled until that date. In his July 11, 1997 report, Dr. Rohrer affirms his November 25, 1996 opinion that claimant was released to work on November 25, 1996 and opined that claimant was medically stationary on November 25, 1996.[1]

On this record, we are persuaded that claimant was medically stationary on November 25, 1996 as SAIF declared. However, we are also persuaded that claimant has established that she was disabled due to her compensable injury until November 25, 1996, and, thus, entitled to temporary disability benefits until that time. See Frank L Bush, 48 Van Natta 1748 (1996). Therefore, we modify SAIF's Notice of Closure to award claimant temporary disability compensation, less time worked, from October 12, 1996 through November 25, 1996.

Accordingly, we modify SAIF's August 5, 1997 Notice of Closure to award claimant additional temporary disability compensation from October 12, 1996 through November 25, 1996 (less time worked) when she became medically stationary. The August 5, 1997 Notice of Closure is affirmed in all other respects.

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

IT IS SO ORDERED.

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[1] Claimant contends that Dr. Rohrer did not specifically use the term "medically stationary" in his September 26, 1996, October 24, 1996 and November 25, 1996 reports, and that she was not medically stationary until January 5, 1997 when Dr. Rohrer removed the 25-pound lifting work restriction. Although Dr. Rohrer does not specifically use the term "medically stationary" until July 11, 1997, the medical record supports that conclusion, and Dr. Rohrer's July 11, 1997 opinion that claimant was medically stationary on November 25, 1996 is unrebutted. Liberty Northwest Ins. Corp. v. Cross, 109 Or App at 109.

In the Matter of the Compensation of
RICKEY A. STEVENS, Claimant
WCB Case No. 96-00962
ORDER OF ABATEMENT
Emmons, Kropp, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

On September 11, 1997, we issued an Order on Review that set aside an Administrative Law Judge's (ALJ's) order that dismissed claimant's hearing request on the SAIF Corporation's denial of his injury claim. In our order, we denied claimant's request for remand and upheld SAIF's denial. Asserting that our order contains factual errors and erred in denying remand for a hearing on the merits, including the ALJ's assessment of credibility and the taking of additional evidence, claimant seeks reconsideration.

In order to further consider this matter, we withdraw our September 11, 1997 order. SAIF 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 shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DURWOOD McDOWELL, Claimant
Own Motion No. 95-0527M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Kirby & Johnson, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's May 27, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from May 20, 1995 through May 18, 1997. SAIF declared claimant medically stationary as of May 19, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary "as defined by workers' compensation law" when his claim was closed because he was dependent on prescription pain medication.

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 27, 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 recite a brief history of this claim. Claimant sustained a low back injury on December 4, 1981. Claimant's aggravation rights expired on January 26, 1988. On November 5, 1995, we authorized the reopening of claimant's claim for the payment of temporary disability benefits, commencing the date he was hospitalized for treatment of his worsened low back condition. SAIF requested reconsideration of our order, and, in an order issued on December 14, 1995, we republished our prior order.

Claimant was enrolled in a pain center rehabilitation program from April 1, 1997 through April 18, 1997. Dr. Murphy, pain center physician, opined that claimant was medically stationary as of April 18, 1997, and released claimant to full-time sedentary work. Dr. Murphy noted that claimant did not cooperate with the pain center program and would not agree to "an outlined medication taper." Dr. Murphy further reported that claimant was discharged from the pain center program because of non-compliance with the program, and recommended that further physical therapy, biofeedback or counseling was contraindicated.

Dr. Murphy discontinued claimant's Soma and Trazodone medications, instructed claimant to wean from Paxil over 10 days (as well as from Hydrocodone), and recommended that claimant follow up with Dr. Euhus, his attending physician, within two weeks. In his April 30, 1997 discharge report, Dr. Murphy opined that claimant was medically stationary "due to lack of objective quantifiable findings."

No closing examination report from Dr. Euhus is in the record. However, in a May 19, 1997 response to SAIF, Dr. Euhus concurred with the medically stationary date as opined by Dr. Murphy in his report.

On May 27, 1997, SAIF closed claimant's claim, declaring him medically stationary on May 19, 1997.

On July 14, 1997, SAIF issued a denial of claimant's current condition. That denial did not define the current condition which was denied. Claimant requested a hearing to contest the denial, as well as Director's review of denied medical services. On July 25, 1997, we requested the parties' positions with respect to whether the July 14, 1997 denial and pending litigation had any effect on claimant's request for review of SAIF's closure. In a September 18, 1997 brief, claimant stated that "the July 14, 1997 denial should not affect Board's Own Motion jurisdiction claim closure." In light of claimant's response, we have proceeded with our review.

Here, both Drs. Murphy and Euhus declared claimant medically stationary with respect to his compensable low back condition. Although Dr. Murphy recommended that SAIF declare claimant medically stationary on April 18, 1997, SAIF declared claimant medically stationary on May 19, 1997, the date his treating physician concurred with Dr. Murphy's opinion. These opinions are unrebutted. The record does not establish that a "pain condition" is a compensable component of claimant's 1981 injury claim. In any event, Dr. Sturges, consulting psychiatrist, opined that claimant had "no psychiatric condition," and recommended that claimant manage his daily medication dosage and taper program "in the framework of palliative care for a stationary condition." Thus, in spite of the fact that claimant was still taking pain medication from which he was advised to "wean" himself, three physicians opined that his compensable back condition was medically stationary. On this record, we conclude that claimant was medically stationary when SAIF closed his claim.

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's May 27, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
THERESA L. MESPLAY, Claimant
Own Motion No. 96-0566M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 24, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from October 30, 1996 through April 7, 1997. SAIF declared claimant medically stationary as of October 23, 1995. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her 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 she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 24, 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 recite a brief history of this claim. Claimant sustained a right medial meniscus tear and ACL disruption injury on July 1, 1989. Claimant's aggravation rights on her 1989 claim expired on March 14, 1996. On January 30, 1997, as reconsidered on February 3, 1997, we authorized the reopening of claimant's claim for the payment of temporary disability compensation for her October 30, 1996 right ACL reconstruction surgery. On July 24, 1997, SAIF closed claimant's claim, declaring her medically stationary as of October 23, 1995.

To support its position that claimant was medically stationary when it closed claimant's claim, SAIF submitted a copy of an October 23, 1995 "check-the-box" response to its questionnaire, in which Dr. Baum, claimant's treating physician, opined that claimant was released to modified work on August 21, 1995. Dr. Baum further reported that time loss was no longer authorized as of October 23, 1995. However, claimant's 1989 injury claim was reopened for her October 30, 1996 right anterior cruciate ligament reconstruction, and temporary disability compensation in this claim was paid by SAIF from October 30, 1996 through April 7, 1997. Therefore, the October 23, 1995 "check-the-box" response from Dr. Baum is not relevant to claimant's condition during this reopening, and, most significantly, it is not relevant to her condition at the time of SAIF's July 24, 1997 claim closure.

Claimant submitted an April 7, 1997 chart note, in which Dr. Baum opined that she needed to have her "lennox hill" knee brace refitted as it irritated her anterior tibial area. In an April 30, 1997 Supplemental Medical Report, Dr. Baum released claimant to modified work as of April 7, 1997, but indicated that claimant was not medically stationary. Rather, Dr. Baum "anticipated" that claimant might become medically stationary in two months. No closing examination report is in the record, therefore, the record contains no medical evidence to establish that claimant was medically stationary on July 24, 1997, when SAIF closed the claim.

Furthermore, SAIF apparently used an October 23, 1995 report to close this claim, and it declared claimant medically stationary on October 23, 1995. The October 23, 1995 report is not relevant to claimant's condition on July 24, 1997. By the same token, the fact that claimant may have been medically stationary on October 23, 1995 has no bearing on this issue, because time loss was not commenced in this reopening until October 30, 1996. Thus, we are unable to find that SAIF's closure was proper.

Accordingly, we set aside the July 24, 1997 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
ERNEST E. CODER, Claimant
WCB Case Nos. 96-07160 & 96-06455
ORDER ON REVIEW
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Black's order that: (1) dismissed as untimely filed claimant's hearing request from the SAIF Corporation's denial of his aggravation claim for a lower extremity condition; and (2) upheld SAIF's denial of an occupational disease claim for a lower extremity condition. On review, the issues are the propriety of the ALJ's dismissal and compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding that portion of the ALJ's decision which addresses the compensability of the occupational disease claim for claimant's bilateral chronic lower extremity venous insufficiency and stasis dermatitis conditions.

Claimant, 45 years of age at hearing, has a preexisting chronic venous insufficiency condition involving his lower extremities, having been diagnosed with deep vein thrombosis (DVT) at the age of 17. (Ex. 25). Chart notes from claimant's family physicians, Dr. Gurney, M.D., and Dr. Counts, M.D., record past problems in both lower extremities due to the chronic venous insufficiency condition. (Ex. 13). In addition, Dr. Counts noted that claimant has had coagulopathy since age 17. (Ex. 28).

In 1989, while under the care of Dr. Maeyens, dermatologist, claimant underwent an ultrasonography which documented his lower extremity venous insufficiency and valvular incompetence. (Exs. 15, 16, 17, 44). Dr. Maeyens last treated claimant in August 1989. (Ex. 19).

On September 6, 1996, Dr. Maeyens reviewed claimant's medical records and examined claimant on behalf of SAIF. (Ex. 44). Dr. Maeyens opined that claimant's bilateral lower extremity condition was intrinsic, not extrinsic and the cutaneous changes were consistent with venous vessel and valvular disease. He also opined that claimant's venous and valvular insufficiency condition was idiopathic, i.e., peculiar to the individual and not caused by external events or activities or claimant's employment. (Ex.

46). Finally, Dr. Maeyens concurred with the opinion of Dr. Taylor, professor of vascular surgery at OHSU, who examined claimant on behalf of SAIF and opined that the major contributing cause of claimant's need for treatment is his chronic venous insufficiency condition, with neither the 1988 work incident nor current work exposure being a contributing factor. (Exs. 37, 46).

Dr. Morrison, one of claimant's treating physicians, initially opined that claimant's "job as a custodian required him to stand 8 - 10 hours per day which aggravated his edema and worsened his condition despite appropriate medical care." (ex. 48-2). However, after reviewing additional records, Dr. Morrison concurred with the opinions of Drs. Maeyens and Taylor. (Ex. 51).

Thus, Dr. Counts provides the only medical opinion that might support claimant's occupational disease claim. However, like the ALJ, we find that Dr. Counts' opinion does not meet claimant's burden of proving that his work exposure was the major contributing cause of a pathological worsening of his preexisting chronic venous insufficiency condition and the major contributing cause of the combined condition involving the preexisting disease and the work activity. ORS 656.802(2)(a), (b), (e).

In this regard, 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). Although clearly aware of claimant's preexisting chronic venous insufficiency condition, Dr. Counts did not weigh the contribution of that condition in rendering his opinion regarding the cause of claimant's "increasingly severe venous stasis disease [with] ulcers/clots[;]" instead, he merely stated that claimant's condition was "caused by or worsened" due to his work activities. (Ex. 47). Furthermore, Dr. Counts' opinion regarding claimant's bilateral stasis dermatitis condition has the same problem. Dr. Counts simply stated that the stasis dermatitis condition had "worsened over time and [is] obviously caused and aggravated by [claimant's] work[,]" without weighing the contribution of the preexisting venous insufficiency condition. (Ex. 30-1).

On this record, we agree with the ALJ that claimant has failed to establish a compensable occupational disease.

ORDER

The ALJ's order dated May 2, 1997 is affirmed.

October 15, 1997 Cite as 49 Van Natta 1819 (1997)

In the Matter of the Compensation of
GAY COLLINS, Claimant
WCB Case No. 96-04356
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) held that the ALJ lacked jurisdiction to address the employer's objection to the Order on Reconsideration award; (2) affirmed the award of 5 percent (16 degrees) unscheduled permanent disability for claimant's low back condition made by an Order on Reconsideration; and (3) set aside the employer's partial denial of claimant's degenerative low back condition. Claimant cross-requests review of that portion of the ALJ's order that declined to award additional unscheduled permanent disability for claimant's low back condition. On review, the issues are jurisdiction, extent of unscheduled permanent disability, and compensability. We modify in part and affirm in part.

EVIDENCE

We adopt the ALJ's statement regarding the exhibits admitted at hearing, with the following supplementation. Exhibits 59, 60 and 61 were received as evidence for the purpose of determining compensability of the denied condition. (Tr. II[1] at 1-2).

[1] "Tr. II" refers to the transcript of the second day of hearing on January 28, 1997.

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

Jurisdiction

The ALJ determined that the Hearings Division lacked jurisdiction to consider the employer's request for reduction of the permanent disability award made by the Order on Reconsideration because the employer failed to request a hearing on the Order on Reconsideration. The employer contends that the ALJ had jurisdiction to address its objection to the Order on Reconsideration award. We agree.

The Board and ALJ have jurisdiction to address issues concerning a reconsideration order where at least one party has requested a hearing on the reconsideration order. Duncan v. Liberty Northwest Ins. Corp., 133 Or App 605, 608 (1995) (citing Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983)). Thus, where a claimant has requested a hearing on a reconsideration order, it is unnecessary for the employer to cross-request review of the reconsideration order in order to raise issues concerning the award made by the reconsideration order. Duncan, 133 Or App at 608-09.

Here, claimant requested a hearing on the Order on Reconsideration. At hearing, the employer objected to the award made by the Order on Reconsideration, arguing that it should be reduced to zero, consistent with the Determination Order. Since claimant had requested a hearing on the Order on Reconsideration, the employer was entitled to raise that issue at hearing. Duncan, 133 Or App at 611. The ALJ had jurisdiction to decide the permanent disability issue raised by the employer. Accordingly, we proceed to the merits of determining the extent of claimant's permanent disability.

Unscheduled Permanent Disability

Claimant sustained an injury to her low back on June 25, 1995, which the employer accepted as a disabling lumbosacral strain. On December 4, 1995, a Notice of Closure closed the claim with no award of permanent disability. Claimant requested reconsideration.

A medical arbiter, Dr. Dinneen, examined claimant on March 4, 1996. On April 12, 1996, an Order on Reconsideration issued, awarding claimant 5 percent unscheduled permanent disability for her low back condition. Claimant requested a hearing.

At hearing, the employer argued that the disability award should be reduced to zero, while claimant argued that the disability award should be increased. The ALJ affirmed the 5 percent disability award made by the Order on Reconsideration. The employer requested review, and claimant cross-requested review on the issue of the extent of unscheduled permanent disability.

Claimant's claim was closed on December 4, 1995. Therefore, the rating of permanent disability in this case is governed by the disability standards set forth in WCD Admin. Order 6-1992 (effective March 13, 1992), as amended by permanent rules set forth in WCD Admin. Order 93-056 (effective December 14, 1993) and WCD Admin. Order 96-072 (effective February 15, 1997) and temporary rules set forth in WCD Admin. Order No. 95-060 (effective August 23, 1995) and WCD Admin. Order 95-063 (effective September 21, 1995).

The dispute in this case concerns whether claimant's disability, as rated by the medical arbiter, is "due to" her compensable condition. See ORS 656.726(3)(f)(A);[2] 656.214(5).[3] The disability standards in effect at the time of claim closure provided, in material part:

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[2] ORS 656.726(3)(f)(A) provides:

"The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job."

[3] ORS 656.214(5) provides, in material part:

"In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section [pertaining to scheduled disability] , the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f)."

> Except for sections (3) and (4) of this rule, a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted injury and/or its accepted conditions. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules." Former OAR 436-35-007(1) (temp.).[4]

In determining the extent of disability where a medical arbiter has been used, "impairment is determined by the medical. arbiter, except where a preponderance of medical opinion establishes a different level of impairment." Former OAR 436-35-007(11) (temp.).

Here, only the medical arbiter measured claimant's impairment. (Ex. 55). Although claimant's treating physician, Dr. Kayser, found claimant to be medically stationary on December 4, 1995, he did not perform any range of motion measurements either at that time or later. (Ex. 44). He simply stated that he felt that claimant did not have any permanent impairment as a result of her employment. (Id.). By contrast, the medical arbiter examined claimant, measured impairment, and responded to the Department's questions on reconsideration regarding the extent of claimant's disability. Under such circumstances, we do not find that the preponderance of the evidence establishes a different level of impairment than that found by the medical arbiter. Accordingly, we rely on the medical arbiter's report in determining the extent of permanent disability.

The medical arbiter found there was evidence of "a slight limited ability to repetitively use the spinal area which can be attributed to the incident." (Ex. 55-3). We find that this is sufficient to establish that claimant's limited ability to repetitively use her spinal area is "due to" the compensable injury. Therefore, we agree that claimant is entitled to a 5 percent "chronic condition" award for her low back condition, as awarded by the Order on Reconsideration and affirmed by the ALJ. Former OAR 436-35-320(5).

Claimant contends that she is entitled to additional impairment based on the medical arbiter's range of motion measurements. We disagree.

The medical arbiter diagnosed claimant's condition as a lumbar sprain "superimposed on pre-existing degenerative changes," based on his review of medical records that revealed mild degenerative changes at L4-5. (Ex. 55-2, 55-1). Although the medical arbiter failed to respond to the Department's question whether claimant's findings were due to the injury and other unrelated causes (see Ex. 54-3, question 9), he did indicate that he believed that the major contributing cause of claimant's overall impairment was "pre-existent." (Ex. 55-3). The medical arbiter did not, however, apportion a specific percentage of impairment to the injury, as compared to the pre-existing condition. Thus, while it is clear that some portion of claimant's impairment is due to an unrelated cause, we are unable to determine on this record what proportion of the impairment must be excluded from rating. Under such circumstances, we conclude that claimant failed to carry her burden of establishing that her permanent disability due to the compensable condition exceeds 5 percent. ORS 656.266; former OAR 436-35-007(1) (temp.).

Claimant also contends that she is entitled to an additional disability value based on social and vocational factors. We agree.[5]

Pursuant to OAR 436-035-0270(4),[6] the adaptability factor has a value of 1 when a worker's residual functional capacity is equal to or greater than the base functional capacity, or when the worker

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[4] Subsections 3 and 4, which pertain to rating disability caused solely by a preexisting condition and when a "combined" condition has been accepted, do not apply in this case.

[5] Upon claim closure, the employer found that claimant had been released to modified work. (Ex. 45). Claimant did not contend otherwise in her request for reconsideration. (See Ex. 47). Accordingly, we accept the employer's determination that claimant was not released to regular work. Therefore, claimant's disability is not limited to impairment only. ORS 656.726(3)(f)(D).

[6] Pursuant to OAR 436-035-0003(3), found in WCD Admin. Order 96-072, effective February 15, 1997, the provisions of OAR 436-035-0270(4) "apply to all claims closed on or after March 13, 1992, for workers medically stationary on or after June 1, 1990, where the rating for permanent disability is not final by operation of law." Since this claim was closed after March 13, 1992, claimant became medically stationary after June 1, 1990, and the rating of permanent disability is not yet final, the current version of OAR 436-035-0270(4) applies in this case.

has ratable impairment of one through nine percent. The Order on Reconsideration found that claimant's residual functional capacity equalled or exceeded her base functional capacity. (Ex. 56 at 4-5). We agree with that determination.[7] We also note that claimant has ratable impairment equal to 5 percent. Therefore, claimant is entitled to an adaptability factor of 1.

The parties agree that claimant is entitled to a value of 1 for age and an SVP value of 3. Adding 1 plus 3, and multiplying by the adaptability value of 1, results in a value of 4 for social and vocational factors. Adding the value of 4 to claimant's impairment value of 5 percent results in an unscheduled permanent disability award of 9 percent (28.8 degrees). Former OAR 436-35-280. The Order on Reconsideration is modified accordingly.

Compensability

On July 26, 1996, the employer issued a partial denial of "osteophytes and degenerative changes." (Ex. 59). Claimant contends that the employer's partial denial is premature because she never made a claim for those conditions. We agree.

Pursuant to ORS 656.262(7)(a), after claim acceptance, a worker must clearly request formal, written acceptance of any new condition. Absent such a claim by the worker, the carrier's denial is a nullity and has no legal effect. Vicki L. Davis, 49 Van Natta 603, 604-05 (1997); Ramona E. Hamilton, 48 Van Natta 2438 (1996).

Here, claimant never made a "clear request" for acceptance of osteophytes and degenerative changes in her low back. Since claimant never made a claim for those conditions, the employer's partial denial is a nullity and has no legal effect. Therefore, the employer's July 26, 1996 denial is set aside as a nullity.

Because we have found that the employer's denial was a nullity, it is unnecessary to address the parties' arguments regarding the merits of whether the osteophytes and degenerative changes are compensable.

Attorney Fees

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

Claimant's attorney is also entitled to an out-of-compensation fee equal to 25 percent of the additional compensation created by this order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055(1).

Claimant's attorney is not entitled to an assessed fee for services related to the compensability issue. ORS 656.386(1); Stephenson v. Meyer, 150 Or App 300 (1997); Vicki L. Davis, 49 Van Natta at 606.

ORDER

The ALJ's order dated is affirmed in part and modified in part. In addition to the 5 percent (16 degrees) unscheduled permanent disability awarded by the Order on Reconsideration, claimant is awarded 4 percent (12.8 degrees), for a total award of 9 percent (28.8 degrees) unscheduled permanent disability for a low back condition. The remainder of the ALJ's order is affirmed. Claimant's counsel is

[7] Claimant contends, based on evidence that was not in the record on reconsideration, that her job at injury required strength in the "heavy" category. Pursuant to ORS 656.283(7), we do not consider evidence that was not in the reconsideration record when rating the extent of a worker's disability. Based on the record at reconsideration, we agree with the Department's determination that claimant's base functional capacity was "light," compared with a residual functional capacity of "medium-light." (Ex. 56 at 4-5). Therefore, claimant's residual functional capacity equalled or exceeded her base functional capacity, and claimant was entitled to an adaptability value of 1. See OAR 436-035-310(6).

awarded an "out-of-compensation" fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, to be paid directly to claimant's counsel. Claimant is awarded an assessed attorney fee of $500 for her counsel's services on review regarding the extent of permanent disability issue, payable by the self-insured employer.

In the Matter of the Compensation of
GEORGE FINCH, Claimant
WCB Case No. 96-07462
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock, and Moller.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's cervical conditions at C4-5, C5-6 and C6-7. 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 issue, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 2, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the self-insured employer.

Board Member Moller dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant has established the compensability of his cervical conditions at C4-5, C5-6 and C6-7. Unlike the majority, I do not find a preponderance of the medical evidence persuasively supports the "major contributing cause" standard which it is claimant's burden to meet. Therefore, I respectfully dissent.

Claimant was injured in a motor vehicle accident on January 2, 1996, when he was driving in the course of his work duties. Claimant subsequently began having radicular symptoms into his right arm. He was referred to Dr. Brett, a neurosurgeon. On March 25, 1996, Dr. Brett performed keyhole laminectomies and foraminotomies at C4-5, C5-6, C6-7 and C7-T1. (Ex. 15).

The employer accepted claimant's injury at right C7-T1 with right C8 nerve root involvement. (Ex. 26). However, the employer contends that the need for surgical treatment for the C4-5, C5-6 and C6-7 conditions was caused by claimant's preexisting cervical spondylosis and degenerative disease, not the accident.

Drs. Zivin and White did not believe that surgical treatment of C4-5, C5-6 and C6-7 was required as result of claimant's accident. Dr. Zivin reported that the only surgical correlation was C7-T1 on the right. (Ex. 17-5, -6). In a later report, Dr. Zivin opined that there was no objective finding or clinical evidence that C4-5, C5-6 and C6-7 were disrupted or brought to impinge nerve roots to account for symptoms as a result of the accident. (Ex. 25-3). He found that claimant did not present with any radicular pattern to suggest that any of his symptoms emanated from nerve root levels above C7-T1 to require treatment or disability. (Id.) Moreover, Dr. Zivin did not believe surgical treatment at levels above C7-T1 were necessary to treat the C8 nerve impingement at C7-T1. (Id.)

Dr. White similarly reported that claimant was not made symptomatic at disc levels above C7-T1. (Ex. 28-7). In a later report, he wrote:

> "[N]one of the pathology present at any other level [other than C7-T1] looks like it was changed or worsened by this accident. It is all chronic, and long preexisted the accident. While I do not disagree that it was wise to address it, also, at the time of surgery, its presence alone certainly would not have demanded surgical treatment." (Ex. 29).

Dr. Young examined several imaging studies performed on claimant. He reviewed the March 14, 1996 cervical MRI and cervical myelogram and found no compression at C4-5, C5-6 or C6-7. (Ex. 20-3, -4).

The employer correctly argues that Dr. Brett's opinion is not persuasive. Initially, Dr. Brett's focus was almost entirely at the C7-T1 level. Post-operatively, Dr. Brett acknowledged that "it is certainly clear that most of [claimant's] pathology" as a result of the accident was at the C7-T1 area. (Ex. 30-1). He further reported that claimant's "nerve root impingement was mainly a result of spondylotic change[.]" (Ex. 30-1). Dr. Brett acknowledged that claimant had preexisting degenerative change at the other levels, but he reasoned that treatment at these additional levels was the result of the injury because if "only the C7-T1 level had been treated, we would not have had as good a chance of the excellent post-operative that [claimant] has obtained." (Id.)

Dr. Brett's opinion does not properly evaluate the relative contribution of each cause of claimant's C4-5, C5-6 and C6-7 conditions, including the precipitating cause, to establish which is the primary cause. See Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). Although acknowledging preexisting degenerative changes, Dr. Brett did not weigh these competing causes nor explain why claimant's work injury was the primary cause. Dr. Brett simply employed a "but for" analysis in concluding that claimant's work incident was the major cause, which is legally insufficient. See Alec E. Snyder, 47 Van Natta 838 (1995).

Accordingly, in light of the persuasive evidence to the contrary, I find that claimant has failed to establish the compensability of his C4-5, C5-6 and C6-7 conditions and would uphold the employer's partial denial. The employer properly accepted the compensability of claimant's condition at C7-T1. Claimant's multiple, preexisting degenerative problems at C4-5, C5-6 and C6-7 are not properly part of his compensable claim. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
EDWARD M. JANUARY, Claimant
WCB Case No. 96-08893
ORDER OF ABATEMENT
Carney, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our September 15, 1997 Order on Review that set aside SAIF's denial of claimant's aggravation claim. In its motion for reconsideration, SAIF contends that the record lacks medical evidence that supports claimant's aggravation claim.

In order to allow us sufficient time to consider SAIF's motion, the September 15, 1997 order is withdrawn. Claimant is granted an opportunity to file a response to the motion. To be considered, claimant'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
DAVID D. KRONER, Claimant
WCB Case No. 96-09641
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that awarded no permanent disability for a right shoulder condition. On review, the issue is extent of unscheduled permanent disability.[1]

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

If there is no measurable permanent impairment under the standards caused by the compensable injury, no award of unscheduled permanent disability is allowed. Former OAR 436-035-0007(1); 436-035-0270(2); Robin W. Spivey, 48 Van Natta 2363 (1996) (disability attributable to preexisting degenerative disc disease eliminated from permanent disability award when not "due to" compensable injury).

Here, the insurer did not accept any combined condition involving claimant's preexisting right acromioclavicular arthritis condition. In fact, prior to issuance of the October 15, 1996 Order on Reconsideration, the parties entered into a Stipulation that upheld the insurer's denial of the right acromioclavicular arthritis condition, stating that "that condition shall remain denied and no benefits paid thereon." (Ex. 28-2). The Stipulation also stated that the parties agreed to "settle all issues raised or raisable" as of the date the Stipulation was approved. Id. Thus, the accepted conditions are right acromioclavicular strain and right rotator cuff tendinitis. (Exs. 13, 28, 29).

For the purpose of rating disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter's, findings if any, may be considered. See ORS 656.245(2)(b)(B), 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442, 445 (1994); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994). Neither are we required to accept the opinion of an attending physician in making our evaluation of a claimant's disability. Agripac, Inc. v. Beem, 130 Or App 170 (1994); Libbett v. Roseburg Forest Products, 130 Or App 50 (1994). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993).

Dr. Rand, orthopedist, served as the medical arbiter. (Ex. 31). Claimant argues that the ALJ erred in relying on Dr. Rand's opinion. Specifically, claimant contends that Dr. Rand's opinion is inconsistent in that he finds no impairment due to the accepted conditions but indicates that the work injury, when combined with the preexisting arthritis, worsened the underlying condition and that claimant's injury limits him for overhead work. We disagree with claimant's reading of Dr. Rand's opinion. Although Dr. Rand stated that the injury worsened the right AC joint arthritis, he indicated that claimant's residual, mechanical complaints are due to the arthritis and limit claimant from overhead work. (Ex. 31-6). More importantly, Dr. Rand opined that the accepted conditions had resolved and indicated no impairment due to the accepted conditions. (Ex. 31-5, -6).

Claimant urges that we rely on the opinion of Dr. Puziss, claimant's attending physician. However, we find that Dr. Puziss's opinion does not provide persuasive evidence of permanent impairment due to the compensable conditions. In this regard, in his closing exam, Dr. Puziss diagnoses only "chronic right acromial clavicular strain, essentially healed" and "underlying right acromial clavicular arthritis." (Ex. 16-1). In addition, Dr. Puziss opined that claimant has Grade II - III arthritic changes in his right shoulder, although the arthritis was not previously symptomatic. (Ex. 19).

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[1] Board review was initially suspended in response to the parties' announcement of a possible settlement. On August 6, 1997, when no evidence of a settlement was forthcoming, the parties were notified by the Board's staff counsel that, unless otherwise advised within 14 days, the Board would proceed with its review. Since no such response was received, the Board now proceeds with its review.

He also stated that the injury "aggravated" claimant's arthritis. (Exs. 16, 19). Although finding that claimant had impairment due to mild loss of internal rotation, Dr. Puziss did not indicate that the impairment was due to the compensable injury rather than the arthritis condition. Moreover, because the arthritis condition remains denied and is not part of the compensable condition, it cannot be the basis of an award of permanent disability. Former OAR 436-035-0007(1); 436-035-0270(2).

In conclusion, we find that the medical arbiter provided the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. Thus, we rely on his report in assessing claimant's unscheduled permanent disability. For the reasons discussed above, we find that the medical arbiter found no impairment due to the compensable injury. In any event, as discussed above, even considering Dr. Puziss's opinion, the preponderance of the medical evidence does not establish any impairment due to the compensable injury.

ORDER

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

October 15, 1997 Cite as 49 Van Natta 1826 (1997)

In the Matter of the Compensation of
COREY A. LEAVITT, Claimant
WCB Case No. 96-10006
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's current condition claim for chronic right rotator cuff tendinitis - impingement, chronic cervical strain, headaches and right cubital tunnel syndrome. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's reasoning and conclusions regarding claimant's chronic right rotator cuff tendinitis - impingement condition, his right cubital tunnel syndrome and the C3-4 disc bulge.

Chronic Cervical Strain and Headaches

Claimant suffered a compensable injury on February 22, 1996. On April 22, 1996, the insurer accepted a right shoulder contusion, right lateral and medial elbow contusion and cervical muscle strain. (Ex. 101). On October 30, 1996, the insurer issued a partial denial of several current conditions, including claimant's chronic cervical strain and headaches. (Ex. 121).

The insurer contends that claimant's preexisting cervical conditions combined with the industrial injury and the preexisting conditions constitute the major contributing cause of claimant's current neck condition. Claimant does not dispute that the major contributing cause standard applies. He argues, however, that Dr. Puziss' opinion establishes that his current cervical condition and related headaches are compensable.

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons to do otherwise.

Dr. Puziss examined claimant on February 22, 1996 and diagnosed severe contusion right shoulder, moderately severe contusion right lateral and medial elbow with strain, and acute cervical strain with spasm. (Ex. 91). On March 21, 1996, his diagnosis included chronic right rotator cuff tendinitis and impingement post contusion. (Ex. 97). On May 23, 1996, Dr. Puziss reported that claimant still had headaches and shoulder pain, as well as right shoulder and elbow pain. (Ex. 106). Dr. Puziss reported that claimant's headaches were "suggestive of intrinsic neck pathology" and he ordered a cervical MRI. (Id.)

In a June 27, 1996 report, Dr. Puziss reported that the cervical MRI showed some hypertrophic changes at C3-4, but no evidence of disc herniation. (Ex. 109). Dr. Puziss diagnosed, among other things, "[c]hronic right cervical strain and facet syndrome, probably secondary to abnormal biomechanics of the right shoulder." (Id.)

On August 19, 1996, Dr. Puziss suggested that claimant see a chiropractor for some adjustments to his neck to relieve his headaches. (Ex. 114-3). In a September 13, 1996 report, Dr. Puziss indicated that claimant had discontinued chiropractic treatment because it had increased his headaches. (Ex. 116-2). In the same report, Dr. Puziss opined that claimant required a right shoulder arthroscopic decompression and a right anterior ulnar nerve transposition by performing a medial epicondylectomy or subcutaneous transposition. (Id.) Dr. Puziss performed right shoulder and right elbow surgery on January 3, 1997. (Ex. 128).

In a January 30, 1997 report, Dr. Puziss reported that he had primarily been treating claimant for his right shoulder and right elbow problems. (Ex. 130-1). He explained:

> "With respect to the cervical spine, the patient does have some arthritis, but cervical problems are not his main complaint at this time. I think he did sustain a form of cervical sprain at the time of his injury. He does not require any significant treatment there, and improvement of the shoulder condition doubtless will help some of his right neck pain." (Ex. 130-3).

In the same report, Dr. Puziss concluded that the February 22, 1996 injury was the "major cause of the current conditions and need for treatment, and the treatment has been successful thus far." (Id.)

We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided that the opinion otherwise meets the appropriate legal standard. See Freightliner Corp. v. Arnold, 142 Or App 98 (1996); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). However, Dr. Puziss' opinion does not meet that standard with regard to claimant's chronic cervical strain and headaches.

Dr. Puziss implicated claimant's cervical arthritis as contributing to his continuing neck problems. (Ex. 130-3). Furthermore, in an earlier report, Dr. Puziss indicated that claimant's noncompensable C3-4 disc bulge also contributed to his neck and headache problems. (Ex. 114-2). Dr. Puziss did not specifically explain whether or not claimant's work injury was the major contributing cause of his current chronic cervical strain and headaches. Moreover, Dr. Puziss did not weigh the relative contributions from the preexisting neck condition and the work injury to claimant's current cervical strain and headaches. See Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). We conclude that Dr. Puziss' conclusory opinion regarding claimant's cervical strain and headaches is not sufficient to establish compensability.

There are no other medical opinions that establish compensability of claimant's current chronic cervical strain and headaches. Dr. Bald opined that claimant's preexisting cervical condition was the major contributing cause of his continued complaints. (Ex. 122-4). Dr. Gambee testified that in 1988 claimant had significant upper neck degenerative changes. (Tr. 27). By the time Dr. Gambee examined claimant on September 23, 1996, the work injury was no longer the cause of his neck complaints and associated headaches. (Tr. 29-32). Rather, he felt that claimant's preexisting cervical condition was the major cause of his current neck problems and headaches. (Id.) Because there is no persuasive medical opinion that establishes compensability, we conclude that claimant has failed to meet his burden of proving that his current chronic cervical strain and headaches are compensable.

Accordingly, we modify the ALJ's attorney fee award. Claimant's attorney is entitled to an assessed fee for services at hearing concerning claimant's chronic right rotator cuff tendinitis - impingement condition and his right cubital tunnel syndrome. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

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 concerning claimant's chronic right rotator cuff tendinitis - impingement condition and his right cubital tunnel syndrome is $900, 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, claimant's attorney's statement of services and the insurer's objections to that statement), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 24, 1997 is reversed in part and affirmed in part. The insurer's denial of claimant's chronic cervical strain and headaches is reinstated and upheld. The ALJ's attorney fee award at hearing is modified to award claimant's attorney $3,000, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $900, payable by the insurer.

In the Matter of the Compensation of
GEORGINA F. LUBY, Claimant
WCB Case No. 96-11313
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order which affirmed an Order on Reconsideration's award of 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of her right leg. On review, the issue is scheduled permanent disability.

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

The ALJ affirmed the reconsideration order's 11 percent award of scheduled permanent disability, rejecting claimant's contention that her impairment findings should be based on Dr. Gritzka's medical arbiter's examination. Noting Dr. Gritzka's opinion that claimant was not medically stationary on the date of the medical arbiter's examination, the ALJ instead determined that the arbiter's findings should not be used for rating permanent disability. Inasmuch as claimant had conceded that her 11 percent award was correct if the medical arbiter's report was not considered, the ALJ declined to award additional scheduled permanent disability.

On review, claimant contends that the ALJ erred in concluding that her condition had changed since August 12, 1996, the date Dr. Brenneke, her attending physician, had declared her medically stationary. Claimant asserts that merely because Dr. Gritzka's findings were different from those obtained during Dr. Brenneke's closing examination does not mean her condition had changed and that she was not medically stationary. We disagree with claimant's contention.

Dr. Gritzka's report reflected far more than a mere difference in examination findings. To the contrary, Dr. Gritzka stated that claimant was not medically stationary, should have additional

diagnostic studies, and had not reached maximum medical improvement. (Ex. 28-5). Under these circumstances, we conclude that the ALJ properly declined to rate claimant's permanent impairment based on Dr. Gritzka's findings. See Phyllis G. Nease, 49 Van Natta 195, on recon 49 Van Natta 301, on recon 49 Van Natta 494 (1997) (rejecting impairment findings of medical arbiter who believed that the claimant was not medically stationary and was in need of further medical treatment).

ORDER

The ALJ's order dated April 2, 1997 is affirmed.

October 15, 1997 Cite as 49 Van Natta 1829 (1997)

In the Matter of the Compensation of
CHARLENE NEWMAN, Claimant
WCB Case No. 95-08935
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a heart condition. On review, the issue is aggravation.

We adopt and affirm the ALJ's order except for the ALJ's statement on page 6 that claimant's sinus ventricular tachycardia (SVT) condition, because it was "a new heart irregularity," "probably should be considered an actual/pathological worsening of claimant's overall condition." Furthermore, based on the ALJ's order and the following supplementation, we find that claimant did not prove a compensable relationship between her SVT condition and the accepted condition and, thus, we need not address the issue of actual worsening.

Along with the reasons expressed by the ALJ, we find additional factors for deferring to the opinion of examining psychiatrist Dr. Wittkop. Claimant's accepted condition is for a "stress related heart condition," which included the diagnosis of "panic disorder without agoraphobia." (Exs. 6A, 21-3,). In 1995, claimant's treating physician, Dr. Donkle, a general practitioner, diagnosed the SVT condition. Dr. Donkle and Dr. Wittkop agree that the SVT condition is "new" in that it developed after the accepted condition.

Dr. Donkle thought that claimant's SVT condition was "precipitated by job stress." (Ex. 39-12). He based his opinion that the SVT condition was a compensable aggravation on the assumption that claimant's prior condition was found to be job-related and, because claimant had the "same work, same job, more stress," that her present condition also should be considered to be job-related. (Id. at 44, 50). He also indicated that the SVT "maybe" was a "part of the panic disorder." (Id. at 37).

Because Dr. Donkle indicated only that the SVT condition was caused by stress from current employment conditions without showing that the SVT condition was related to her accepted stress related heart condition, we agree with the ALJ that his opinion is not enough to establish that the SVT condition is compensably related to the accepted condition. Furthermore, as explained by the ALJ, Dr. Wittkop persuasively explained why the major contributing cause of claimant's heart symptoms was an underlying cardiac pathology combined with off-work stressors. (Ex. 32-16).

Consequently, having found that claimant failed to show a compensable relationship between the SVT condition and the previously accepted condition, we agree with the ALJ that she did not prove a compensable aggravation. ORS 656.273(1).

ORDER

The ALJ's order dated March 28, 1997 is affirmed.

In the Matter of the Compensation of
JUAN OJEDA, Claimant
WCB Case No. 96-07400
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the SAIF Corporation's denial of his injury/occupational disease claim for low back, neck and left shoulder conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 60 at the time of hearing, has worked for the employer as a nursery worker for nine or ten years. He is from Mexico and speaks very little English.

In 1993, claimant tried to grab a trailer filled with gravel and he injured his back. (Tr. 10). He told his supervisor about the pain, but he did not seek medical treatment and he kept on working at his regular duties. (Tr. 11). After the 1993 incident, claimant's back was better and only bothered him "a little bit." (Tr. 15, 16). Claimant saw a doctor in Mexico in December 1995 for a physical examination. (Tr. 11, 13).

In March 1996, claimant was injured when he was lifting and moving tree root balls weighing approximately 70 to 80 pounds. (Tr. 11-13). The weight of the root balls varied, with some weighing between 100 to 300 pounds. (Tr. 11-12). Claimant was working about 130 hours every two weeks. (Tr. 12). On March 21, 1996, claimant sought treatment from Dr. Reynolds for his left shoulder and low back pain. (Ex. 2). Dr. Reynolds' chart note referred to an injury about 3 years ago, noting that claimant had been "working at some new duties at work and it has been flaring up and hurting more than in the past." (Id.) Claimant was also treated by Dr. Holmes for his lower back and shoulder pain. (Ex. 4).

On June 6, 1996, claimant was examined by Dr. James on behalf of SAIF. On June 13, 1996, SAIF denied the claim on the basis that claimant's work activity was not the major contributing cause of the development of his condition diagnosed as low back strain, cervical strain and left shoulder tendinitis. (Ex. 8).

Claimant began treating with Dr. Fellin on August 6, 1996. Dr. Fellin referred to a "Workers' Comp injury on 3/20/96." (Ex. 9). Dr. Fellin diagnosed lumbar strain, and pectoralis muscle strain and tendinitis.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his claim should be found compensable under either an injury or occupational disease theory. He argues, however, that the weight of the evidence establishes that he suffered a lifting injury on March 20, 1996, when he was moving 70 to 80 pound tree root balls.

SAIF contends that the case should be analyzed as an occupational disease. In determining the appropriate standard for analyzing compensability, we focus on whether claimant's low back, neck and left shoulder conditions occurred as 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).

Claimant testified that after the 1993 "gravel trailer" back injury, his back got better and only bothered him "a little bit" after that injury. (Tr. 15, 16). On or about March 20, 1996, claimant was injured when he was lifting and moving tree root balls weighing approximately 70 to 80 pounds. (Tr.

11-13). Claimant's symptoms occurred after the March 20, 1996 work incident and he continued to have symptoms thereafter. Because claimant's symptoms were sudden in onset and occurred over a discrete, identifiable period of time, we conclude that the claim should be analyzed as one for an accidental injury.

SAIF contends that, if an injury theory applies, the case should be analyzed as a combined condition under ORS 656.005(7)(a)(B). We conclude that it is not necessary to determine whether claimant had a "combined condition," because even if the major contributing cause standard of ORS 656.005(7)(a)(B) applies, we find that the medical evidence satisfies that legal standard.

When medical opinions are divided, 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). Here, there is no persuasive reason in this case not to defer to claimant's treating physician, Dr. Fellin, who treated claimant on several occasions.

Dr. Fellin examined claimant on August 6, 1996 and referred to a "Workers' Comp injury on 3/20/96." (Ex. 9). Dr. Fellin diagnosed lumbar strain, and pectoralis muscle strain and tendinitis. In an "827" form signed by Dr. Fellin, claimant's injury was described as follows: "While was carrying dirt balls wrapped on twigs (each ball contains a planted tree and weighs approx. 150 lbs) towards the loading area (a distance of approx 25 to 40 feet) I felt a sharp pain on my left shoulder area and lower back." (Ex. 10).[1] Dr. Fellin continued to treat claimant on several occasions. He prescribed medication and physical therapy and placed claimant on light duty. On September 16, 1996, Dr. Fellin took claimant off work with no lifting, bending or driving. (Exs. 13, 14).

On November 4, 1996, Dr. Fellin reported that he had treated claimant for recurrent back and neck strain as well as left shoulder tendinitis. (Ex. 19). He opined that claimant had ongoing problems with the initial injury because of continued work and heavy lifting at his job site. Dr. Fellin found that claimant's pain had never completely resolved because of continued work and heavy lifting and bending. Although Dr. Fellin noted that claimant had some mild degenerative changes of the spine, neck and shoulders, he felt those changes were "not to the point that would be contributory[.]" Dr. Fellin had no evidence of any preexisting conditions or any contributing outside activities. He felt that claimant's condition was mainly exacerbated by lifting activities at work. Because claimant had been on modified work without bending and lifting, his back was much better and he had symptomatic relief. (Id.)

Although Dr. Fellin did not expressly state that claimant's work with the employer was the "major contributing cause" of his low back, neck and left shoulder conditions, it is well settled that "magic words" are not necessary to establish medical causation. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992). Dr. Fellin opined that claimant's conditions were attributable to the initial injury and his symptoms continued because of his heavy lifting and bending activities at work. Dr. Fellin did not believe that claimant's degenerative conditions were contributing and he found no contributing activities outside work. Although Dr. Fellin did not specifically discuss claimant's 1993 injury, he had reviewed Dr. James' report that referred to the earlier "gravel trailer" incident. (Exs. 7, 17). Based on Dr. Fellin's opinion, we conclude that claimant's March 1996 work incident was the major contributing cause of his low back, neck and left shoulder conditions.

SAIF relies on the opinion of Dr. James to argue that the claim is not compensable. Dr. James opined that it was not possible to clearly define any specific work activities that caused claimant's conditions. (Ex. 7-6). However, Dr. James focused on claimant's "gravel trailer" incident three years ago and he opined that claimant's condition had "gradually gotten worse." (Ex. 7-2). Although Dr. James reported that claimant's pain "became worse" in March 1996 when he was moving balled and burlap-wrapped materials, his report is inconsistent with claimant's testimony that his earlier injury had resolved and his back only bothered him "a little bit" after that injury. (Tr. 15, 16). We are not persuaded by Dr. James' report because he did not have an accurate history of claimant's symptoms.

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[1] Although claimant apparently signed the "827" form, it is not clear whether he filled out the description portion of the form.

Moreover, although Dr. James opined that he could not clearly differentiate between claimant's work activities and the natural progression of degenerative changes in the spine and shoulder (Ex. 7-6), his reports of claimant's degenerative changes were quite minimal. Dr. James did not review any of claimant's x-rays and relied instead on a verbal report from Dr. Wearn. Dr. Wearn reported no significant findings in the cervical spine. (Ex. 7-5). The disk spaces in the lumbar spine were well-maintained, although claimant had some zygopophyseal joint hypertrophy. Dr. Wearn opined that there "may have been" a small spur on the acromion, but he was not certain. (Id.) Dr. James opined that claimant did not have any significant degenerative conditions present, but he "may well have" some degenerative change in the rotator cuff, although he did not have any clear-cut evidence of such. (Ex. 7-7).

Because Dr. James did not examine claimant's x-rays and in light of his minimal findings of degenerative conditions, we are not persuaded by his focus on the "natural progression of degenerative changes" or by his conclusion that claimant's work was not the major contributing cause of his conditions. Because we are not persuaded by Dr. James' report, we are not persuaded by Drs. Reynolds' and Holmes' concurrences with his report. (Exs. 15, 16).

In sum, we are most persuaded by Dr. Fellin's opinion and we conclude that claimant's March 1996 work incident was the major contributing cause of his low back, neck and left shoulder conditions.

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 SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 24, 1997 is reversed. The SAIF Corporation's denial of claimant's low back, neck and left shoulder conditions 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 $4,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
JOSE E. SOLIS, Claimant
WCB Case No. 97-01908
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

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

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

Under amended ORS 656.386(1), which is applicable in this case, a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation." Id.

Here, there is no contention that any benefits for claimant's thoracic parascapular and anterior chest wall strain conditions have been unpaid. Moreover, the record does not establish that the SAIF Corporation refused to pay compensation on the express ground that these strain conditions were not compensable or did not give rise to an entitlement to compensation. Therefore, under these circumstances, no "denied claim" has been established and no attorney fee is warranted under amended ORS 656.386(1). See Joseph S. Orlow, 49 Van Natta 642 (1997) (whether alleged "de facto" denial arose from employer's knowledge of the claim or from carrier's failure to timely accept or deny, the claimant was not entitled to an attorney fee under ORS 656.386(1) because there was no "denied claim" since carrier paid all benefits for the compensable condition and did not expressly contend the condition was not compensable); Michael Galbraith, 48 Van Natta 351 (1996) (no "denied claim" where carrier paid all benefits for the compensable condition and did not expressly contend the condition was not compensable); Jerome M. Baldock, 48 Van Natta 355 (1996) (no attorney fee authorized where carrier did not "refuse to pay" compensation).

ORDER

The ALJ's order dated June 11, 1997 is affirmed.

October 16, 1997 Cite as 49 Van Natta 1833 (1997)

In the Matter of the Compensation of
CHARLES BERTUCCI, Claimant
WCB Case No. 96-03524
ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

On August 5, 1997, on our own motion, we withdrew our prior order that affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the self-insured employer's partial denial of claimant's "post-retirement" hearing loss; and (2) vacated that portion of the ALJ's order that addressed claimant's medical services claim for hearing aids. We withdrew our order for further consideration of the jurisdictional issue posed by the court's holding in SAIF v. Shipley, 147 Or App 26 (1997). Having received the employer's brief on this issue, we now proceed with our reconsideration.[1]

In our prior order, we found that although the employer had accepted claimant's claim for "pre-retirement" industrial hearing loss, claimant did not establish the compensability of the additional hearing loss he sustained after retiring in 1984. We did not, however, address the cause of claimant's current need for hearing aids because we found, based on Shipley, that exclusive jurisdiction over the medical services dispute rested with the Director.

In Shipley, the court held that pursuant to ORS 656.246(6), the Board lacks jurisdiction to consider disputes that concern only the compensability of medical services.[2] There, the claimant received medical treatment for an off-the-job injury to his knee five years after closure of his compensable knee injury claim. The carrier denied that the claimant experienced a worsening of his compensable condition and declined to reopen the claim. The Hearings Division and Board assumed jurisdiction over the matter and determined that the claimant's medical services were compensably related to his accepted injury. On appeal, the carrier argued that the Board lacked jurisdiction because the case involved only a claim for medical benefits on a previously accepted claim. The claimant contended that, because the carrier denied the compensability of his current condition and need for treatment, it also denied the compensability of the "underlying claim" as described in ORS 656.245(6).

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[1] Claimant has not submitted a supplemental brief.

[2] 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."

The court rejected the claimant's contention and agreed with the carrier that the Board lacked jurisdiction over the dispute. The court noted that the claimant never sought benefits for an aggravation of his accepted injury, nor did he seek to establish the compensability of a "new consequential condition." Rather, the court reasoned that the claimant sought only treatment of his current condition, contending that the treatment was compensable because it was materially related to his accepted injury. The court concluded that because the dispute concerned only the compensability of medical services under ORS 656.245, the case was subject to the exclusive jurisdiction of the Director under ORS 656.245(6).

Unlike the claimant in Shipley, who sought only treatment and did not seek to establish the compensability of a new condition, claimant here sought to establish the compensability of a new condition, specifically his "post-retirement" hearing loss, as an occupational disease related to his employment exposure. Therefore, the dispute in this case goes beyond medical services for a compensable condition. Although part of the benefits potentially flowing from a resolution of the dispute (if it were to be resolved in claimant's favor) would include medical services (hearing aids) for his current condition, the claim in this case is not as limited as the claimant's medical benefits claim in Shipley.

Consequently, contrary to our prior order, we conclude that the Director does not have exclusive jurisdiction over claimant's need for hearing aids arising from his current hearing loss condition.[3] We therefore proceed to the merits on this issue.

On review, claimant argues that he need only establish that his compensable hearing loss condition is a material contributing cause for his ongoing need for hearing aids. We disagree. Where the condition at issue is a combined or consequential condition under ORS 656.005(7)(a), the carrier is only liable for those medical services directed to medical conditions caused in major part by the injury. See ORS 656.245(1)(a). Here, contrary to claimant's argument, we are persuaded by the expert medical evidence that claimant's current hearing loss condition involves a consequential or combined condition, i.e., a combination of his accepted "pre-retirement" industrial hearing loss and his noncompensable presbycusis.[4] Further, because we have previously found that claimant's "post-retirement" hearing loss occupational disease claim is not compensable, claimant must show that his current need for hearing aids is causally related to his accepted "pre-retirement" industrial hearing loss.

As the ALJ found, the record does not establish that claimant's current need for medical treatment (hearing aids) is caused in major part by his compensable hearing loss.[5] Rather, a preponderance of the evidence indicates that claimant's noncompensable presbycusis is the major contributing cause of his current need for hearing aids. Consequently, claimant's hearing aid claim is not compensable.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our July 22, 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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[3] We distinguish this case from Randy R. Kacalek, 49 Van Natta 475, on recon 49 Van Natta 1121 (1997), in which we dismissed the claimant's request for hearing for lack of jurisdiction based on Shipley. In Kacalek, as in Shipley, the sole issue at hearing was whether the claimant's need for treatment was related to his compensable injury. In this case, however, as noted above, claimant is asserting a claim for a new, unaccepted condition in addition to seeking medical services allegedly related to his accepted "pre-retirement" loss of hearing.

[4] As noted in our prior order, Dr. Owens reported that claimant's industrial-related hearing loss constituted a material part of claimant's current hearing loss, but because claimant had not been exposed to work-related noise for the past 12 years (since his retirement), the further deterioration in his hearing was due to presbycusis. (Ex. 14).

[5] The employer has also submitted a Memorandum of Additional Authorities. Referring to amended ORS 656.262(w), the employer asserts that claimant's prior argument that its failure to contest a previous permanent disability award precluded its current denial is contrary to the recent statutory amendment. As acknowledged by the employer in its submission, we previously disagreed with claimant's "Messmer" argument, finding that no part of claimant's prior award was based on presbycusis. Inasmuch as we adhere to that finding, it is unnecessary to address the effect, if any, amended ORS 656.262(w) has on this case.

In the Matter of the Compensation of
BRIAN M. EGGMAN, Claimant
WCB Case No. 94-01068
ORDER ON REVIEW
Allen, Stortz, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Daughtry's order that upheld the self-insured employer's denial of claimant's aggravation claim. In its respondent's brief, the employer contends that, if an aggravation claim is established, claimant is not entitled to temporary disability compensation. On review, the issues are aggravation and temporary disability benefits. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize as follows:

In October 1991, claimant experienced a compensable low back injury, which the employer accepted as "low back and left leg pain secondary to a left L5-S1 herniated disc." Dr. Hubbard, claimant's then-treating physician, performed a hemilaminectomy, medial facetectomy, and disc removal at L5-S1. On March 9, 1993, Dr. Hubbard released claimant to light duty work with restrictions on lifting, sitting, standing, bending and twisting. (Ex. 142). Claimant returned to work at the employer. No light work was instituted. (Ex. 144-2). Claimant worked four hours per day at his regular job, which required occasional lifting of 60 pounds, bending and twisting. After performing this work, claimant's symptoms increased. In May 1993, claimant quit his employment because of increased pain with any lifting, bending and standing. (Tr. 7).

On May 24, 1993, the employer issued a Notice of Closure that established claimant's medically stationary date as April 16, 1993, and awarded 38 percent unscheduled permanent disability.

On January 18, 1994, Dr. Bald performed an arbiter's examination. (Ex. 148). A January 26, 1994 Order on Reconsideration reduced claimant's unscheduled permanent disability award to 36 percent. At hearing, the ALJ increased claimant's unscheduled permanent disability award to a total of 40 percent.[1]

In January 1994 and again in June and July 1994, claimant sought treatment from Dr. Ball for progressively worsening low back pain. On August 25, 1994, claimant was referred to Dr. Demakas, neurosurgeon, for evaluation of his low back and left leg condition. (Ex. 152). An October 1994 MRI revealed extensive epidural scarring at L4-5 and L5-S1 with nerve root displacement. (Ex. 153). On February 23, 1995, Dr. Demakas authorized time loss as of December 1994. (Ex. 156).

The employer's medical examiners concluded that claimant's condition had not worsened and the employer denied claimant's aggravation claim on May 11, 1995, as amended December 4, 1995.

On September 6, 1995, Dr. Heusner evaluated claimant's condition for Dr. Demakas. Dr. Heusner found epidural scarring and a recurrent disc at L5-S1 for which she recommended surgery. (Ex. 112). Dr. Heusner stated that claimant "is incapacitated and unable to resume tasks of daily living." Id. On December 21, 1995, claimant filed a formal claim for aggravation. On that form, Dr. Ball stated that claimant had been unable to work since June 23, 1994. (Ex. 165).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the employer has submitted an Administrative Order issued by the Department of Consumer and Business Services, Workers' Compensation Division, which issued on August 18, 1997. The employer requests that we either supplement the record or take administrative notice of this document.

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[1] The parties do not dispute the permanent disability award on review.

On review, we are limited to the record developed at hearing. ORS 656.295; Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). We may, however, take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(2). The Department's order in this case is an act of a state agency, which is expressly subject to judicial notice under ORS 40.090(2). See Rodney J. Thurman, 44 Van Natta 1572, 1573 (1992). Therefore, we take official notice of the order's existence. We conclude, however, that the order has very limited relevance to the issues before us.

The issues are aggravation and entitlement to temporary disability benefits. The Department's order, on the other hand, is an order finding that a proposed surgery is inappropriate, pursuant to ORS 656.327. Because the issue of a treatment dispute under ORS 656.327 is not before us, the document has little probative value in our review.

Aggravation

The ALJ found that claimant proved an "actual worsening" of his compensable 1991 low back injury claim. However, the ALJ concluded that claimant failed to establish an aggravation, because he failed to prove that the worsening resulted in a loss of earning capacity. We disagree.

In Jason S. Palmer, 48 Van Natta 2394 (1996), which issued subsequent to the ALJ's order, the Board considered the effect of amended ORS 656.273(1) on prior case law interpreting former ORS 656.273(1). The Board noted that, under the previous case law, the phrase "worsened condition" in former ORS 656.273(1) was defined as a symptomatic or pathological worsening which resulted in either loss of earning capacity, in the case of an unscheduled condition, or loss of use or function, in the case of a scheduled condition. Thus, under the former statute and prior case law, in order to establish a compensable aggravation, a claimant not only had to establish a physical worsening, but also prove that the physical worsening had caused diminished earning capacity or increased loss of use or function.

After considering the text and context of amended ORS 656.273(1), along with the relevant legislative history, the Board concluded that the amended statute was intended to focus on the worker's physical condition, rather than on a loss of earning capacity or loss of use or function in a legal sense. Id. at 2398. Accordingly, claimant can prove an aggravation by medical evidence of an "actual worsening of the compensable condition." ORS 656.273(1).

Subsequent to the Board's decision in Palmer, the court concluded that an "actual worsening" is established by direct medical evidence that a condition has worsened, and held that proof of a pathological worsening is required to establish a compensable aggravation claim under amended ORS 656.273. SAIF v. Walker, 145 Or App 294, 305 (1996).[2]

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[2] In Walker, the claimant experienced increased symptoms that exceeded the symptoms he had experienced at the time of claim closure. Comparing the claimant's attending physician's report at the time of claim closure, which indicated that claimant's symptoms were episodic, with the physician's later report, which indicated that claimant's symptoms were severe and disabling, the Board found that the claimant's increased symptoms were more than the waxing and waning contemplated at the time of closure, and that, therefore, the claimant had established a compensable aggravation claim.

After considering the text and context of amended ORS 656.273, together with the legislative history, the court concluded that, 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. The court held that proof of a pathological worsening is required to establish a compensable aggravation claim under amended ORS 656.273, (and thereby overruling the Board's conclusion in Carmen C. Neill, 47 Van Natta 2371 (1995), that an "actual worsening" could be established not only by a pathological worsening, but by a symptomatic worsening of the compensable condition that is greater than anticipated by the prior award of permanent disability). In this case, claimant has established a pathological worsening of his condition.

Here, the ALJ found that claimant's compensable L5-S1 condition had pathologically worsened.[3] The employer does not dispute the ALJ's finding. (Respondent's Brief at 1). Because claimant's condition has pathologically worsened, we conclude that claimant has proved an "actual worsening," thereby establishing a compensable aggravation.

Entitlement to Temporary Disability Benefits

The employer asserts that, if the aggravation denial is set aside, claimant is not entitled to additional temporary disability benefits because he has withdrawn from the labor market. Claimant first argues that the employer's argument concerning entitlement to temporary disability benefits is not yet ripe for adjudication, as the employer has not begun to process the claim. We do not agree. Instead, we find that claimant waived his right to assert any procedural defects in the insurer's cross-request.

At hearing, the employer raised the cross-issue of claimant's entitlement to additional temporary disability, contending that claimant had withdrawn from the labor market prior to his aggravation claim. (Tr. 5). Claimant raised no objection to consideration of the issue, nor did he seek a continuance for the purpose of responding to the temporary disability issue. See OAR 438-006-0091(3). Instead, claimant proceeded to litigate the entitlement issue on the merits.

It is well-established that failure to raise a procedural defect is a waiver of any procedural error. E.g., Thomas v. SAIF, 64 Or App 193 (1983) (when a party fails to object to proceeding with a hearing that is conducted as a result of a premature request, the party has waived its right to object). Therefore, claimant's failure to object constituted a valid waiver of any procedural error relating to the litigation of the temporary disability issue.

We now turn to the merits. To receive temporary total disability upon aggravation of a work-related injury, claimant must be in the work force at the time of the aggravation. Cutright v. Weyerhaeuser, 299 Or 290 (1985). The critical time for determining whether a claimant has "withdrawn" from the work force is at the time of his disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990). Because claimant was not employed at the time of disability, in order to prevail he must prove that he is willing to work and either: (1) he was making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would have been futile because of the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 257 (1989).[4]

Here, the insurer contends that claimant was not in the work force at the time of disability.

Claimant compensably injured his low back in October 1991 while lifting furniture as part of his regular work duties. On February 9, 1993, Dr. Hubbard released claimant to light work with restrictions. However, light duty was not implemented. Instead, claimant returned to his regular work, albeit at a reduced hourly schedule.

Claimant continued working until sometime in May 1993, when he left his employment because of increased low back symptoms with any lifting, bending and standing. Claimant did not return to work. Thus, claimant was not engaged in regular gainful employment when he first sought treatment for his worsened condition in June 1994.

However, prior to leaving work in May 1993, claimant was experiencing increased low back symptoms. Dr. Demakas, to whom claimant was referred in August 1994, reported that, despite the passage of time and a significant decrease in activities since leaving work, claimant continued to have progressively worsening radicular left leg pain, which was aggravated with any increase in activities.

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[3] The ALJ based his finding on Dr. Andersen's concession that the October 21, 1994, MRI revealed a pathological change in claimant's L5-S1 condition, namely, extensive epidural scarring with nerve root displacement. (Ex. 169-40). We also note that Dr. Demakas persuasively opined that the major contributing cause of the epidural scarring and claimant's current need for surgery was the compensable 1992 surgery. (Ex. 164).

[4] We note that the Court stated that the proper test is whether the claimant has "withdrawn from the work force" rather than "retired." Dawkins, 308 Or at 256, n. 1.

Following an MRI that revealed epidural scarring and a disc fragment at L5-S1, Dr. Heusner stated that claimant was incapacitated and unable to resume the tasks of daily living. On December 14, 1994, Dr. Demakas formally authorized time loss benefits, stating that claimant's ability to work was markedly limited at best. On December 21, 1995, Dr. Ball indicated that claimant had been unable to work since June 23, 1994.[5] (Ex. 165).

The record establishes that claimant left his former job because he was unable to perform the duties due to his compensable low back injury. The evidence also indicates that claimant's deteriorating low back condition prevented him from working after leaving his former job. Under these circumstances, we find that at the time of his disability claimant was in the work force. Accordingly, claimant is entitled to the payment of temporary disability benefits upon reopening of his aggravation claim.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the aggravation 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 concerning the aggravation issue is $4,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 23, 1996 is reversed in part and affirmed in part. That portion of the order that upheld the employer's aggravation denial is set aside and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on review regarding the aggravation issue, claimant's counsel is awarded a $4,000 attorney fee, payable by the employer. The remainder of the order is affirmed.

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[5] Both Dr. Anderson and Dr. Coletti opined that claimant had no new objective findings worthy of further diagnostic studies or treatment when comparing their current examinations with their examination in April 1993. (Exs. 157, 166). However, they did not discuss the MRI's revelation of a recurrent disc and epidural scarring, for which Dr. Heusner recommended surgery. (Id.; Ex. 169-40 through -50). We accordingly find their opinions that claimant had no change in his condition since April 1993 unpersuasive. Somers v. SAIF, 77 Or App 259 (1986).

In the Matter of the Compensation of
SIRIJEET S. JOHNSON, Claimant
Own Motion No. 96-0236M
OWN MOTION ORDER ON RECONSIDERATION
Liberty Northwest Insurance Corp., Insurance Carrier

Claimant requests reconsideration of our August 22, 1997 Order of Dismissal, which dismissed *without prejudice* his request for enforcement and penalties in this claim.

Claimant initially requested enforcement of our May 14, 1997 Own Motion Order Reviewing Carrier Closure, which set aside the insurer's March 21, 1997 Notice of Closure as premature. In addition, claimant requested a penalty for the insurer's allegedly unreasonable failure to timely pay temporary disability compensation, as well as "some kind of additional award" from the insurer.

In a June 26, 1997 letter, we reiterated to the parties that our May 14, 1997 order set aside the insurer's closure as premature, and directed it to pay temporary disability benefits as requested by claimant from March 5, 1997 through March 19, 1997. Our order further directed the insurer to recommence the payment of temporary disability benefits beginning the date it terminated those benefits, less any wages claimant received during that time, until claimant was declared medically stationary.

In a July 9, 1997 letter, the insurer advised that it had interpreted our May 14, 1997 order to direct it to pay claimant temporary disability compensation from March 5, 1997 through March 19, 1997. The insurer further reported that, according to Dr. Blum, claimant was not medically stationary and, thus, it was inappropriate to close claimant's claim. Finally, the insurer advised that it was "issuing a time loss check to [claimant] from 3/20/97 through the present and will continue to issue time loss checks every 2 weeks until [claimant] is released for and/or returns to work."

In a July 30, 1997 letter, we requested claimant's position regarding whether his requests had been satisfied, and whether he intended to pursue further action and/or penalties in this claim. In an August 4, 1997 letter, claimant notified the Board that he had "decided not to seek a penalty at THIS time." In that letter, claimant requested that he be given the opportunity to reopen the "penalty phase" of his request should the insurer not comply with our May 14, 1997 order. On August 22, 1997, we issued our Own Motion Order of Dismissal, in which we acknowledged that the insurer had complied with our May 14, 1997 order, and dismissed *without prejudice* claimant's requests for enforcement and penalties in this claim.[1]

On September 22, 1997, claimant requested that the Board reopen his request for penalties and a "determination order to be awarded." Claimant further requested review of the insurer's September 26, 1997 Notice of Closure of his claim.[2]

Enforcement

The Board has exclusive authority to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

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[1] In his August 25, 1997 letter, claimant expressed concern that our August 22, 1997 Order of Dismissal might extinguish his rights to reopen the penalty issue in his claim. Therefore, we clarify that the term "without prejudice," as utilized in our August 22, 1997 order, means that, although we dismissed claimant's motion, claimant is not barred from reasserting his initial requests for enforcement and penalty.

[2] On September 26, 1997, the insurer again closed claimant's claim. Claimant has requested review of that closure, as well as "the determination order to be awarded." This order issued on today's date addresses claimant's request for enforcement and penalty, as well as his request for an "additional award" from the insurer. Claimant's request for review of the insurer's September 26, 1997 Notice of Closure will be addressed in a separate order after the parties have submitted their respective positions and supporting medical evidence. However, because claimant's claim is in "Own Motion" status, no determination order will be issued in this claim. Furthermore, effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. Independent Paper Stock v. Wincer, 100 Or App 625 (1990). Therefore, to the extent that claimant is asking the Board to grant other workers' compensation benefits, the Board is without authority to award further permanent disability in this claim.

Moreover, the Board's authority extends to enforcing its Own Motion orders. See Jeffrey T. Knudson, 48 Van Natta 1708 (1996); Thomas L. Abel, 45 Van Natta 1768 (1993); David L. Waasdorp, 38 Van Natta 81 (1986).

Inasmuch as the insurer has complied with our order by paying claimant temporary disability compensation as directed by our order, we need not address the enforcement issue. See Lee R. Parker, 48 Van Natta 2473 (1996).

Penalties

Claimant requests penalties for the insurer's allegedly unreasonable failure to timely pay compensation in his claim. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due." The insurer's failure to timely pay compensation is not unreasonable if, from a legal standpoint, it has 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).

Here, the insurer contends that it interpreted our May 14, 1997 order to direct it to pay temporary disability only from March 5, 1997 through March 19, 1997, as claimant had requested. Our order specifically directed the insurer to pay compensation for those dates. The insurer did pay timely the amount our order directed it to pay (temporary disability from March 5, 1997 through March 19, 1997).

Our May 14, 1997 order further directed the insurer to recommence payment of temporary disability compensation beginning the date it had previously terminated the payment of those benefits, less any wages claimant received during that period, until claimant was medically stationary and the claim was properly closed. When the Board inquired by letter whether the insurer had recommenced payment of temporary disability as directed by our prior order, the insurer responded promptly by paying the amount owed rather than "resisting" the payment of time loss. In stating that it misinterpreted our order, the insurer explained that it "read" our order to mean that it was to pay only the amount specified by date in our order.

On this record, we do not find that the insurer unreasonably delayed claimant's time loss payments because it did, in fact, pay claimant timely for the dates specifically directed in our order. Rather, we are persuaded that the insurer legitimately misinterpreted our order because it promptly paid temporary disability benefits beginning March 20, 1997 subsequent to our letter. Therefore, we decline to penalize the insurer for unreasonably resisting payment of temporary disability. See International Paper Co. v. Huntley, 106 Or App at 107; Castle & Cook Inc. v. Porras, 103 Or App at 65. See also Debra D. Robinson, 49 Van Natta 786 (1997).

Entitlement to Other Awards

Claimant requests an "additional award" in this claim. However, the Board, in its Own Motion authority, may only authorize the payment of temporary disability compensation under specific circumstances. ORS 656.278. We do not have the authority under this statute to award "damages." Furthermore, although claimant is entitled to lifetime medical benefits related to his compensable injury, because his aggravation rights have expired, claimant's only entitlement to future disability compensation is limited to time loss benefits as prescribed by ORS 656.278. Therefore, we are unable to grant claimant's request for an "additional award" in this claim. See Charles H. Jones, 47 Van Natta 1546 (1995); David L. Grenbemer, 48 Van Natta 195 (1996).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 22, 1997 order in its entirety, and decline enforce our May 14, 1997 order or to authorize either a penalty or further benefits in this claim.[3] 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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[3] We again note that claimant has requested review of the insurer's September 26, 1997 closure of his claim. That review will be conducted by this forum under separate order following completion of the briefing and review process. This order does not affect claimant's entitlement to future temporary disability compensation in his 1990 injury claim.

In the Matter of the Compensation of
ESTON JONES, Claimant
WCB Case No. 97-03679
ORDER ON REVIEW (REMANDING)
Malagon, Moore, 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) Mongrain's order that dismissed claimant's hearing request regarding the SAIF Corporation's alleged denial of medical bills for his current condition. On review, the issue is the propriety of the ALJ's dismissal order. We vacate the ALJ's order and remand.

FINDINGS OF FACT

On May 2, 1997, claimant filed a hearing request that raised the issues of unreasonable claim processing and denial of medical benefits. On May 19, 1997, SAIF moved to dismiss the request for hearing. Attaching three letters that it had sent to claimant, SAIF asserted that the Hearing Division lacked jurisdiction over the medical services dispute. See Shipley v. SAIF, 147 Or App 26 (1997). Contending that SAIF had refused to pay compensation on the basis that his underlying condition was not compensable, claimant argued that the dispute should proceed to hearing.

Prior to the scheduled hearing, the ALJ dismissed claimant's hearing request for lack of jurisdiction. In granting the dismissal, the ALJ agreed with the argument in SAIF's motion.

CONCLUSIONS OF LAW AND OPINION

The Board has on occasion reviewed cases where an ALJ has dismissed a hearing request without conducting a hearing. In Richard L. Saunders, 46 Van Natta 1726 (1994), the employer moved to dismiss a request for hearing. Submitting supporting affidavit and exhibits, the employer contended that, inasmuch as the claimant was not a subject worker, the Hearings Division lacked jurisdiction over the dispute. Contending that he was an Oregon subject worker for an Oregon subject employer, the claimant argued that the motion for dismissal should be denied. Noting that the claimant did not dispute the facts recited in its motion, the employer replied that the dispute could be resolved without a hearing. Prior to the scheduled hearing, the ALJ (then Referee) dismissed the claimant's hearing request for lack of jurisdiction. The ALJ adopted the argument in the employer's motion that the claimant was not a subject worker.

On review, we concluded that it was not appropriate for the ALJ to reach the merits of the denial and dismiss the hearing request for lack of jurisdiction without taking any evidence.[1] In reaching this conclusion, we acknowledged that neither the claimant nor the employer apparently disputed the material facts surrounding the subjectivity issue. Nevertheless, we found that there was no express stipulation by the parties as to the relevant facts. Had there been such a stipulation, we reasoned that it would have been appropriate for the ALJ and this forum to perform our review function based on those stipulated and undisputed facts. However, we were unable to conclude that the parties mutually agreed to present the dispute for resolution based on stipulated facts. In fact, based on claimant's opposition to the employer's motion to dismiss the hearing request, we concluded that claimant desired that the matter proceed to hearing.

Therefore, we held that the ALJ's dismissal of the claimant's hearing request without first conducting a hearing was inappropriate. Because the ALJ improperly dismissed the claimant's request for hearing, and because no documentary or testimonial evidence was admitted, we further concluded that the record had been incompletely developed. See ORS 656.295(5). Accordingly, we remanded to the ALJ for an evidentiary hearing. Richard Saunders, 46 Van Natta at 1727.

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[1] We emphasized that disputes involving "matters concerning a claim" must be decided on the basis of a sufficiently developed hearing record. As authority for this proposition, we cited Nancy L. Cook, 45 Van Natta 977 (1993) (ALJ's role is to evaluate the entire record and produce an order containing an organized set of facts and conclusions of law with an explanation why the facts supported by the evidence lead to a conclusion).

More recently, in Sarah A. Strayer, 49 Van Natta 244, 245 (1997), we followed the Saunders rationale in finding that it was inappropriate for an ALJ to decide the merits of the parties' dispute regarding the necessity of the claimant attending a post-denial "IME" and dismiss the claimant's hearing request without conducting a hearing and taking any evidence. We noted in Strayer that there may have been factual issues in need of resolution, particularly with respect to the claimant's conduct in response to the carrier's scheduling of an IME. Because the ALJ dismissed the claimant's request for hearing without the admission of documentary or testimonial evidence, we concluded, as we had in Saunders, that the record had been incompletely developed. Accordingly, we remanded to the ALJ for further proceedings. Sarah A.Strayer, 49 Van Natta at 245-46.

In this case, the ALJ also dismissed claimant's hearing request without admitting any evidence or taking any testimony, even though claimant desired that the dispute proceed to hearing. Therefore, we conclude, as we did in Strayer and Saunders, that it was inappropriate for the ALJ to decide the merits of the parties' dispute and dismiss claimant's hearing request without conducting a hearing and taking any evidence.

As we also noted in Strayer and Saunders, should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction, or other necessary action. See ORS 656.295(5). Because the ALJ dismissed claimant's request for hearing, and because neither documentary nor testimonial evidence was admitted, we conclude that the record has been incompletely developed. Accordingly, we remand to ALJ Mongrain for further proceedings consistent with this order to be conducted in any manner that the ALJ determines will achieve substantial justice to all the parties.[2]

ORDER

The ALJ's order dated July 14, 1997 is vacated and claimant's hearing request is reinstated. The matter is remanded to ALJ Mongrain for further proceedings consistent with this order.

[2] On remand, the parties should once again address the issue of whether the Director has jurisdiction over this dispute. In doing so, the parties should address the affect of the previously approved claims disposition agreement (CDA) on the jurisdictional issue. The parties should also address the question of whether the current claim is for a "consequential condition," and, if so, what affect that may have on the jurisdictional issue. See Shipley v. SAIF, 147 Or App at 29.

In the Matter of the Compensation of
NATHANIEL B. MOSLEY, Claimant
WCB Case No. 96-10988
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that awarded an employer-paid attorney fee under ORS 656.382(2). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

A November 21, 1996 Order on Reconsideration awarded 66 percent scheduled permanent disability for loss of use or function of claimant's right knee.

The employer requested a hearing, seeking reduction of the award. At hearing, claimant defended the reconsideration award and requested an attorney fee.[1]

[1] The ALJ stated, "The processing agent/employer are seeking reduction in [the Order on Reconsideration] award and claimant is defending the award and requesting [an] assessed attorney fee should he prevail." (Tr. 1). Both parties specifically agreed with this statement of the issues at hearing. Id.

The ALJ reduced claimant's scheduled permanent disability award from 66 percent to 61 percent based on an apparent miscalculation in the reconsideration rating. The ALJ also awarded a $1,250 attorney fee under ORS 656.382(2).

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded an employer-paid attorney fee under ORS 656.382(2), reasoning that claimant's permanent disability award was reduced because of an undisputed miscalculation in the Order on Reconsideration award, not because of the employer's arguments. Assuming that the miscalculation could have been subject to stipulation by claimant (had it been brought to his attention earlier), the ALJ found that claimant had successfully defended against all of the employer's challenges to his compensation and concluded that claimant was entitled to an attorney fee under the statute.

The employer argues that no attorney fee is available under ORS 656.382(2) because the ALJ reduced claimant's permanent disability award. We agree.

Attorney fees may be awarded only as specifically authorized by statute. SAIF v. Allen, 320 Or 192, 200 (1994); Forney v. Western Stated Plywood, 297 Or 628, 632 (1984).

An award of attorney fees under ORS 656.382(2) requires:

> "(1) that an employer initiate a request for a hearing to obtain a disallowance or reduction in a claimant's award of compensation; (2) that the claimant's attorney perform legal services in defending that 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. Debbie Hunt-Elder, 145 Or App 110, 114-15 (1996) (citation omitted).

In this case, there is no dispute regarding the first two requirements. However, because the ALJ did "find" that claimant's award of compensation should be reduced, no fee is available under the statute.[2]

ORDER

The ALJ's order dated March 27, 1997, as reconsidered May 15, 1997, is reversed in part and affirmed in part. That portion of the order that awarded an attorney fee is reversed. The remainder of the order is affirmed.

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[2] Here, as in Tommy V. Drennen, 47 Van Natta 1524 (1995) and Vincent D. Drennen, 48 Van Natta 819 (1996), the Order on Reconsideration contained an apparent miscalculation or scrivener's error affecting the permanent disability award. In the Drennen cases, we assessed attorney fees under ORS 656.382(2), because the claimants successfully defended their compensation awards against the employers' requests for reduction beyond stipulated amounts. Tommy V. Drennen, 47 Van Natta 1524 (1995); Vincent D. Drennen, 48 Van Natta 819 (1996). Here, in contrast, there was no stipulated reduction, and claimant's compensation was reduced pursuant to the ALJ's order. The Drennen cases are distinguishable on both bases. Thus, because the present claimant defended the Order on Reconsideration award (without reservation) and the award was reduced, there is no basis for an attorney fee under the statute.

In the Matter of the Compensation of
JACQUELINE J. ROSSI, Claimant
WCB Case Nos. 95-09628 & 95-08655
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On August 5, 1997, on our own motion, we withdrew our prior order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's partial denial of claimant's right knee condition, involving congenital/developmental bilateral patella alta with lateral subluxation, poor patellar tracking and loss of articular cartilage. We withdrew our order for further consideration of the jurisdictional issue posed by the court's holding in SAIF v. Shipley, 147 Or App 26, rev allowed 326 Or 57 (1997). Having received the insurer's brief on this issue, we now proceed with our reconsideration.[1]

In Shipley, the court held that pursuant to ORS 656.245(6), the Board lacks jurisdiction to consider disputes that concern only the compensability of medical services.[2] There, the claimant received medical treatment for an off-the-job injury to his knee five years after closure of his compensable knee injury claim. The carrier denied that the claimant experienced a worsening of his compensable condition and declined to reopen the claim. The Hearings Division and Board assumed jurisdiction over the matter and determined that the claimant's medical services were compensably related to his accepted injury. On appeal, the carrier argued that the Board lacked jurisdiction because the case involved only a claim for medical benefits on a previously accepted claim. The claimant contended that, because the carrier denied the compensability of his current condition and need for treatment, it also denied the compensability of the "underlying claim" as described in ORS 656.245(6).

The court rejected the claimant's contention and agreed with the carrier that the Board lacked jurisdiction over the dispute. The court noted that the claimant never sought benefits for an aggravation of his accepted injury, nor did he seek to establish the compensability of a "new consequential condition." Rather, the court reasoned that the claimant sought only treatment of his current condition, contending that the treatment was compensable because it was materially related to his accepted injury. The court concluded that because the dispute concerned only the compensability of medical services under ORS 656.245, the case was subject to the exclusive jurisdiction of the Director under ORS 656.245(6).

Unlike the claimant in Shipley, who sought only treatment and did not seek to establish the compensability of a new consequential condition, claimant here is asserting the compensability of a new medical condition, i.e., a combined condition under ORS 656.005(7)(a)(B) involving her preexisting knee condition and her accepted right knee strain as well as the compensability of her surgery for that combined condition. (See Tr. 2, 3.) Therefore, the dispute in this case goes beyond a medical services dispute on a previously accepted claim. Although part of the benefits potentially flowing from a resolution of this dispute (if it were to be resolved in claimant's favor) would include medical services (surgery) for her current condition, the claim in this case is not as limited as the claimant's medical benefits claim in Shipley.

Consequently, unlike Shipley, we conclude that the Director does not have exclusive jurisdiction over the parties' dispute in this case under ORS 656.245(6). We distinguish this case from Randy R. Kacalek, 49 Van Natta 475, on recon, 49 Van Natta 1121 (1997), in which we dismissed the claimant's request for hearing for lack of jurisdiction. There, as in Shipley, by the time the case went to hearing, the sole issue was whether the claimant's need for treatment for his current condition was related to his compensable injury. The claimant was not asserting a claim for a new, unaccepted condition, as is claimant in this case.

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[1] Claimant did not submit a brief on reconsideration.

[2] 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."

A "claim" means a written request for compensation from a worker or someone on the worker's behalf, or any compensable injury of which the employer or carrier has notice or knowledge. ORS 656.005(6). As in this case, a claim for treatment may be tied to a claim for compensability of the condition giving rise to the claimed treatment. If both are denied, the denial necessarily involves a formal denial of the compensability of the "underlying claim," i.e., a denial of the claim for the underlying condition that gave rise to the need for treatment. Pursuant to ORS 656.245(6), the Board retains jurisdiction over the medical services/compensability dispute. See, e.g., Dean L. Watkins, 48 Van Natta 60 (1996); Richard L. Wheeler, 47 Van Natta 2011 (1995) (under ORS 656.245(6), the Board retains jurisdiction to determine whether a claimant's condition is causally related to the compensable injury).

Accordingly, 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
RICHARD A. SCHIEL, Claimant
Own Motion No. 97-0374M
OWN MOTION ORDER ON RECONSIDERATION (POSTPONING)
Glen Lasken, Claimant Attorney

Claimant requests reconsideration of our September 12, 1997 Order Postponing Action on Own Motion Request, in which we deferred action on the Own Motion matters in this claim pending the outcome of the scheduled medical services dispute review before the Director. Claimant objects to the wording of our order, asserting that the Board's postponement of these matters pending the Director review "could arguably prevent Claimant from raising the question of the compensability of his current condition at the Hearings Division." Claimant further objects to our order, contending that an Administrative Law Judge "could conceivably dismiss such a Request for Hearing in light of the wording of [the Board's] order."

In an August 12, 1997 letter, the self-insured employer notified claimant that Dr. Rosenbaum, who examined claimant at the employer's request, opined that the revision lumbar stabilization surgery proposed by Dr. Tiley, was "excessive, inappropriate and ineffectual." The employer further notified claimant that it had requested Director review of appropriateness of the proposed medical care.[1]

In his October 6, 1997 letter, claimant asserted that the employer is contending that claimant's current condition is not causally related to the accepted condition and that the employer is not responsible for claimant's current condition. The record does not contain these denials, nor do we find any other pending litigation in this claim.[2]

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[1] Jurisdiction over these types of medical services disputes currently resides with the Director subsequent to enactment of Senate Bill 369. See ORS 656.245(6), 656.260, 656.327 and 656.704(3).

[2] The employer submitted a Carrier's Own Motion Recommendation to the Board, in which it indicated that it disagreed that claimant's current condition is causally related to the accepted condition, that it is responsible for claimant's current condition, and that surgery or hospitalization is reasonable and necessary for claimant's compensable injury. However, in its August 12, 1997 letter to claimant, the employer certified "that there is no issue of causation or compensability of the underlying claim or condition." Furthermore, in its August 27, 1997 letter to the parties, the MRU stated that, on behalf of the Director, it had exclusive authority over all medical disputes for any reason other than a formal denial of the underlying claim. See ORS 656.245(6), 656.260, 656.327 and 656.704(3). The record does not indicate that a denial of the compensability of or responsibility for, claimant's current condition has been issued, or that a hearing request has been filed to appeal any denial issued in claimant's 1985 injury claim.

On August 27, 1997, the Medical Review Unit of the Workers' Compensation Division notified the parties of required action in the medical services dispute. The case number assigned to the medical services dispute is Medical Review File No. 12128. On August 29, 1997, we requested the parties' positions with respect to the pending "work force" issue. On September 12, 1997, we postponed action on the Own Motion matters pending resolution of the medical services dispute.[3]

It is generally the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we continue to defer action on this request for own motion relief pending issuance of the Director's order. After issuance of the order, the parties should advise the Board of their respective positions regarding own motion relief. Should claimant subsequently request a hearing with the Hearings Division to appeal any denial of compensability of or responsibility for his current condition, claimant is requested to notify the Board of that action. In that event, we would further consider postponement of the Own Motion matters to await resolution of any pending litigation at the Hearings Division.

Accordingly, our September 12, 1997 order is abated and withdrawn. On reconsideration, for the reasons expressed herein, we continue to postpone action pending resolution of the aforementioned medical services matter before the Director.

IT IS SO ORDERED.

[3] Our order listed all of the reasons for which the employer had stated in its recommendation that it opposed reopening of the claim, including that it disagreed that claimant's current condition was causally related to his compensable injury and that it was responsible for claimant's current condition. However, our order only postponed action on the medical services dispute pending before the Director, as neither causation nor responsibility disputes are within the Director's jurisdiction.

October 16, 1997 Cite as 49 Van Natta 1846 (1997)

In the Matter of the Compensation of
BRIAN J. TASCHEREAU, Claimant
WCB Case No. 96-09754
ORDER ON RECONSIDERATION
Gatti, Gatti, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our October 3, 1997 order that awarded claimant's attorney a fee of $3,000 for services at hearing and on review. Contending that the attorney fee is excessive, the employer requests a fee reduction.

In response, claimant's attorney asserts that he spent 10 to 15 hours handling this case at hearing and on review. He argues that the value of the interest regarding acceptance of the cervical strain is significant. Claimant's attorney contends that a reasonable attorney fee should be at least $4,500.

We determine the amount of claimant's counsel's attorney fee for services at the hearing and 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.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's cervical strain. Fifty-one exhibits were received into evidence, fourteen of which were generated or submitted by claimant's counsel. There were no depositions taken. The hearing lasted forty minutes and the transcript consists of twenty-two pages. Claimant testified on his own behalf. Claimant's counsel asserts that he spent 10 to 15 hours on this case at hearing and on review.

As compared to typical compensability cases, the issue here was of average complexity. The issues were whether claimant had established the existence of a cervical strain to a medical probability and whether there were sufficient objective findings of a cervical strain. On review, claimant did not dispute the ALJ's finding that he has been paid all compensation to which he was entitled arising out of the April 23, 1996 work incident. As claimant points out, however, the value of the claim may potentially include permanent disability benefits. We conclude that the claim's value and the benefits secured are of average proportions. The hearing was not lengthy, lasting only forty minutes. This does not, however, include the attorney's time spent preparing both his client and himself for the hearing. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering these factors, we reconsider the attorney fee award. Specifically, after consideration of the aforementioned factors, we conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding and the risk that claimant's counsel might go uncompensated. On reconsideration, we adhere to our October 3, 1997 order that awarded claimant's attorney a fee of $3,000 for services at hearing and on review, payable by the self-insured employer.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 3, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

October 16, 1997 Cite as 49 Van Natta 1847 (1997)

In the Matter of the Compensation of
RICHARD J. TASKINEN, Claimant
WCB Case No. 93-10255
ORDER ON REMAND (REMANDING TO DIRECTOR)
Quintin Estell, Claimant Attorney
Reinisch, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Quaker State Oil Company v. Taskinen, 147 Or App 245 (1997). The court has reversed our prior order, Richard J. Taskinen, 47 Van Natta 211 (1995), that had found that claimant's proposed low back surgery was appropriate medical treatment. Relying on the 1995 amendments to ORS 656.327(2), the court has determined that jurisdiction over the parties' medical services dispute rests with the Director. Consequently, the court has remanded with instructions to vacate our order and remand to the Director.

In accordance with the court's mandate, we vacate our February 2, 1995 order, as well as the Referee's (now Administrative Law Judge's) April 29, 1994 and July 26, 1994 orders. In addition, as instructed by the court, this matter is remanded to the Director for further action consistent with the court's decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. USHER, Claimant
Own Motion No. 97-0426M
OWN MOTION ORDER
Cigna Insurance Co., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable left palm contusion injury. Claimant's aggravation rights expired on April 28, 1994. The insurer opposes reopening 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 an August 6, 1997 chart note, Dr. Layman, claimant's treating physician, requested authorization to perform claimant's limited palmar fasciectomy. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

The insurer contends that claimant has retired, and, therefore, that he was not in the work force at the time of disability. Claimant contends that he qualifies for temporary disability compensation because he continued working until his compensable condition worsened requiring surgery. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was in the work force during the relevant time.

Claimant submitted a June 8, 1997 statement of earnings which indicates that he was working for Olsten Staffing Services at that time. Furthermore, in an October 1, 1997 prescription note, Dr. Layman asserted that:

> "[Claimant] has not retired from the work force and if he were not having surgery and recovery from that [surgery] he would be actively seeking work."

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 is hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD D. WORTON, Claimant
WCB Case No. 96-10587
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) McWilliams' order that: (1) found that claimant's claim was not prematurely closed; and (2) affirmed an Order on Reconsideration that awarded no permanent disability. On review, the issues are the scope of acceptance, 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 change.

We change the fourth sentence in the third paragraph on page 3 of the ALJ's order to read: Drs. Fuller and Reimer stated in their report that claimant had "a previous impairment of 10% relating to his lumbar spine and feel his present examination is contained within that impairment."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's claim was not prematurely closed and affirmed the Order on Reconsideration awarding no permanent disability. The ALJ further found that the accepted claim was a combined condition comprising both a lumbar strain and degenerative disease. Citing ORS 656.268(16), the ALJ further found that impairment from claimant's left sacroiliac joint sprain should be rated.

Scope of Acceptance

Claimant asserts that the left sacroiliac joint sprain diagnosed by medical arbiter, Dr. Gritzka, is included in claimant's accepted condition. On the other hand, SAIF argues that left sacroiliac joint sprain was not included in its acceptance and that no claim was made for that condition. SAIF further asserts that it did not accept a combined condition.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). "Merely paying or providing compensation shall not be considered as an acceptance of a claim or an admission of liability * * *." ORS 656.262(10). Where there is no specific acceptance, we look to the contemporaneous medical evidence to determine what condition the insurer accepted. See Cecilia A. Wahl, 44 Van Natta 2505 (1992).

The record does not contain a formal notice of acceptance which identifies the specific conditions SAIF accepted. However, the Order on Reconsideration lists the accepted condition as "lumbar strain superimposed onto degenerative disc disease at L4-5, L5-S1." In a report dated March 26, 1996, Drs. Fuller and Reimer, who examined claimant on SAIF's behalf, opined that the major cause of claimant's need for treatment was his low back strain superimposed on preexisting degenerative disc disease at L4-5 and L5-S1. These physicians also concluded that claimant's preexisting degenerative disc disease at L4 and L5 combined with claimant's January 25, 1996 injury to cause claimant's subsequent back pain and sciatica. (Ex. 12). Based on the report of Drs. Fuller and Reimer, in conjunction with the accepted condition identified in the Order on Reconsideration, we find that SAIF accepted a combined condition composed of low back strain superimposed on degenerative disc disease at L4-5 and L5-S1.

SAIF argues that the ALJ erred in finding that SAIF accepted the condition of left sacroiliac joint sprain. SAIF misinterprets the ALJ's order. The ALJ found, based on ORS 656.268(16), that any permanent disability related to claimant's left sacroiliac joint sprain was ratable. Such a finding does not equate with a conclusion that the left sacroiliac joint sprain has been accepted.

The left sacroiliac joint condition was not diagnosed until the medical arbiter exam, which was conducted after acceptance of the claim occurred. Thus, the condition was not within the scope of SAIF's acceptance. Although ORS 656.268(16) provides that conditions that are direct medical sequelae of the original accepted condition shall be rated if they are not specifically denied, the fact that such conditions "shall be rated" does not mean that such conditions have been formally accepted.

Consequently, if the persuasive medical evidence supports a conclusion that the left sacroiliac joint sprain is direct medical sequelae of the originally accepted low back strain superimposed on degenerative disc disease at L4-5 and L5-S1, then the disability from that condition is ratable if it has not been specifically denied. Nonetheless, because the left sacroiliac joint sprain condition has not been formally accepted (and it is unclear from this record whether a claim has even been made for this condition See ORS 656.262(7)(a)), any rating of this condition would not result in a conclusion that the condition has been accepted.

Premature Closure

Relying on the opinion of the medical arbiter, Dr. Gritzka, claimant argues that his claim has been prematurely closed. Claimant also argues that Dr. Sedgewick, his attending physician, did not consider the degenerative disc condition which combined with the low back strain condition when he found claimant medically stationary on June 26, 1996.

A claim shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). Claimant has the burden to prove that he was not medically stationary on the date of claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the July 15, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

Dr. Sedgewick, claimant's attending physician, found claimant medically stationary on June 26, 1996. In finding claimant's condition medically stationary, he stated:

> "Patient is diagnosed as a musculoligamentous strain of the left gluteal musculature, improved. He still has problems when he attempts to lift things over 50 to 60 pounds repetitively. This is probably related to his degenerative disc disease. At this time I think he can continue to work full duty without limitation. In terms of his degenerative disc would [sic] limit him to no lifting greater than 50 pounds. I don't think this is part of his accepted claim. At this time he is felt to be stationary." (Ex. 19).

Although Dr. Sedgewick concluded that the degenerative disc disease was not part of claimant's accepted claim, he did not recommend further treatment for the degenerative condition and stated only that the degenerative condition would limit claimant from lifting over 50 to 60 pounds.

Dr. Gritzka, the medical arbiter, indicated in his November 26, 1996 report that he did not think that claimant was stationary. Specifically, he stated:

> "I don't think the examinee has reached maximum medical improvement. His findings all point to a left SI joint problem. This was apparently discussed with Dr. Fuller. Dr. Tuscher has told the examinee that he thinks he has a left SI problem. I agreed that this is probably the case since the examinee's physical findings are so clear-cut. I think that he should return to Dr. Tuscher or some similar physician to have some manipulative therapy to his left SI joint as well as physical therapy, which would include corticosteroid phonophoresis to the left SI joint and a spinal stabilization program. I think the examinee is a candidate for SI joint infection with corticosteroids under fluoroscopy." (Ex. 27).

Although Dr. Gritzka opined, four months after the July 15, 1996 Notice of Closure, that he did not believe that claimant had reached a maximum medical improvement from the injury, Dr. Gritzka did not address claimant's condition at the time of closure. In addition, Dr. Gritzka apparently believed that claimant was not medically stationary based on the newly diagnosed sacroiliac joint sprain which we have found was not part of claimant's accepted claim. The only physician who examined claimant at the time of closure was Dr. Sedgewick, who opined that claimant's condition was medically stationary on that date and recommended no further treatment. Under such circumstances, claimant has not met his burden to show that his claim was prematurely closed.

Extent of Unscheduled Permanent Disability

In the event the claim is found not to be prematurely closed, claimant seeks an award of unscheduled permanent disability for his low back condition.

Claimant's claim was closed by a July 15, 1996 Notice of Closure. Therefore, the disability rating standards contained in WCD Admin. Order 96-051, as amended by WCD Admin. Order 96-068 apply to claimant's claim. OAR 436-035-003.

Impairment

Under OAR 436-035-0007(13), on reconsideration, impairment is determined by a medical arbiter where one is used "except where a preponderance of medical evidence establishes a different level of impairment." The disability standards define "preponderance of medical evidence" as meaning the more probative and more reliable medical opinion based upon factors including, but not limited to the most accurate history, on the most objective findings, sound medical principles or expressed with clear and concise reasoning. OAR 436-035-0005(10). See also Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well reasoned evaluation of the claimant's injury-related impairment).

Here, we do not find a different level of impairment from that established by the medical arbiter, Dr. Gritzka. As the ALJ found, Dr. Sedgewick did not conduct as thorough and complete an assessment of claimant's impairment as did Dr. Gritzka. In addition, Dr. Sedgewick had an incorrect understanding of what conditions claimant's accepted claim encompassed. Under such circumstances, we rely on the medical arbiter's report to rate claimant's impairment due to the injury.[1]

According to Dr. Gritzka, claimant has 55 degrees lumbar flexion, 10 degrees lumbar extension, 20 degrees right lateral flexion and 20 degrees left lateral flexion. Under OAR 436-035-0360(19),(20) and (21), claimant is entitled to 2 percent impairment for loss of lumbar flexion, 5 percent impairment for loss of lumbar extension, 1 percent for right lateral flexion and 1 percent for left lateral flexion. When these values are added, claimant is entitled to 9 percent impairment. See OAR 436-035-0360(22).

Because claimant has in excess of 5 percent impairment in his low back, he is not entitled to an award for unscheduled chronic condition impairment. OAR 436-035-0320(5)(a); Gregory D. Schultz, 47 Van Natta 2265, corrected 47 Van Natta 2297 (1995).

Under OAR 436-035-0270(3): "[i]n unscheduled claims, only impairment shall be rated for those workers who: (a) Return to regular work; or (b) The attending physician releases the worker to regular work and the work is available, but the worker fails or refuses to return to that job; or (c) The attending physician releases the worker to regular work, but the worker's employment is terminated for cause unrelated to the injury."

On May 14, 1996, Dr. Sedgewick indicated that claimant was released to regular work. However, in his June 26, 1996 closing report, Dr. Sedgewick indicated that claimant was medically stationary, but limited to no lifting greater than 50 pounds. There is no indication whether Dr. Sedgewick was familiar with the lifting requirements of claimant's regular work as a floor/carpet layer. As will be discussed below, claimant's regular work as a carpet layer is listed in the DOT as being in the heavy work category. Under the circumstances, we find that claimant was actually released to modified work by Dr. Sedgewick with no lifting over 50 pounds, rather than to his regular heavy work. Accordingly, we find that OAR 436-035-0270(3) does not apply and that claimant is entitled to have non-impairment factors rated.

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[1] Dr. Gritzka does not indicate which, if any, of claimant's permanent impairment is due to "left sacroiliac strain" as opposed to the accepted condition. However, because Dr. Gritzka considers the left sacroiliac strain condition to be direct medical sequelae of the compensable injury, we conclude that Dr. Gritzka took this condition into account in identifying impairment. The left sacroiliac strain has therefore been rated according to ORS 656.268(16).

Adaptability

For those workers who have rateable unscheduled impairment found in rules OAR 436-035-0320 through 436-035-0375, the adaptability value is measured by comparing Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. OAR 436-035-0310(2). The worker's BFC is an individual's demonstrated physical capacity before the injury or disease. OAR 436-035-0310(3)(a). The RFC means 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).

In this case, claimant did not undergo a second level physical capacity evaluation prior to the date of the injury. Therefore, claimant's base functional capacity is determined by the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. OAR 436-035-0310(4).

Claimant argues that the DOT for marble finisher DOT #861.664-010 with a strength of very heavy applies. However, the record contains no evidence that claimant has worked as a "marble finisher." The 801 claim form lists claimant's job at injury as "laminate installer." In addition, the record contains evidence that claimant worked in the "carpet laying business" for over 10 years or as a "floor installer" for the past 23 years. (Exs. 5; 12). Based on this evidence, we find that the most physically demanding job that the worker has successfully performed in the five years prior to determination is that of carpet layer. Therefore, the correct DOT code is that of carpet layer, DOT # 864.481-010 with a strength of heavy. Accordingly, we find that claimant's BFC is heavy.

The RFC is determined under OAR 436-035-0310(5). Under that rule, the RFC is the greatest capacity evidenced by the attending physician's release, or a preponderance of the evidence which includes but is not limited to a second-level PCE or WCE as defined in OAR 436-010-0040 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.

With regard to claimant's residual functional capacity, Dr. Gritzka limited claimant to 35 pounds on an occasional basis. He opined that claimant could stand, sit or walk for about 1 1/2 hours consecutively. Dr. Gritzka indicated that claimant was precluded from frequently stooping, crawling, twisting, climbing, crouching kneeling and balancing. Claimant is not precluded from reaching, pushing or pulling.

Based on Dr. Gritzka's opinion, claimant's RFC is in the medium/light category, which means that claimant can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently, but has restrictions. See OAR 436-035-0310(3)(g) and (l)(C). Thus, comparing claimant's BFC and RFC under OAR 436-035-0310(6), we find that claimant's adaptability factor is 4.

The value for claimant's age at claim closure (39 years) is 0. OAR 436-035-0290. The value for education is 0 since claimant has earned a high school diploma. OAR 436-035-0300(2)(b). Claimant's SVP is the highest SVP of any job he has met in the five years preceding claim closure. The DOT code "carpet layer" has an SVP of 7. Therefore, the value for the SVP is 1. OAR 436-035-0300(3) and (4).

The values for age (0) and education (1) are added together to equal 1. OAR 436-035-0280(4). This value is multiplied by the value for claimant's adaptability factor of 4 to equal 4. OAR 436-035-0280(5),(6). This value is added to claimant's impairment (9) for a total of 13 percent unscheduled permanent disability under the standards. OAR 436-035-0280(7).

The final issue is whether the record establishes that claimant has a prior award of permanent disability under Oregon Workers' Compensation Law which must be offset pursuant to OAR 436-035-0007(5). Under that rule, if a worker has a prior award of permanent disability under Oregon Workers' Compensation Law, the award shall be considered in subsequent claims pursuant to ORS 656.222 for scheduled disability and pursuant to ORS 656.214 for unscheduled disability. According to OAR 436-035-0007(5)(a), before offsetting the prior award, a determination shall be made as to whether or not there is a preponderance of medical evidence or opinion establishing that disability from the prior injury or disease was still present on the date of the injury or disease of the claim being determined. If disability from the prior injury or disease was not still present, an offset shall not be applied. OAR 436-035-0007(5)(a)(B).

The only evidence that claimant received a prior permanent disability award is contained in a report by Drs. Fuller and Reimer, who examined claimant on behalf of SAIF. These physicians stated: "We note that he has a previous impairment of 10% relating to his lumbar spine and feel that his present examination is contained within that impairment." (Ex. 12-6). Other than this reference in the medical report, there is no other evidence regarding a prior award. According to Dr. Gritzka, claimant's condition "is due to the injury of 1/25/96, and not due to other causes. There is no apportionment in this situation, in my opinion." (Ex. 27-7). Based on Dr. Gritzka's opinion, and assuming that there is sufficient evidence in this record that claimant has received a prior award of permanent disability for his back under Oregon workers' compensation law, claimant's current disability is not attributable to that prior injury. Under such circumstances, an offset shall not be applied. See OAR 436-035-0007(5)(a)(B).

Because our order has resulted in increased compensation, 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).

ORDER

The ALJ's order dated March 21, 1997 is affirmed in part and reversed in part. Claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability for his low back injury. Claimant's counsel is awarded an approved 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. The remainder of the order is affirmed.

In the Matter of the Compensation of
EDINE E. BUSCHER, Claimant
WCB Case No. 95-11982
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) found that the self-insured employer was precluded from denying claimant's left leg conditions; (2) set aside its denial of claimant's current left leg conditions; and (3) set aside its aggravation denial of the same conditions. On review, the issues are claim preclusion and, if the denial is not precluded, compensability and aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right calf on March 23, 1994. She initially sought treatment from Dr. Dickinson, orthopedist, who diagnosed a right calf strain (medial gastrocnemius muscle at the musculotendinous junction). On May 17, 1994, Dr. Dickinson advised the employer that claimant reported to him that she had recovered. On June 17, 1994, the employer accepted the claim as a "right calf strain now resolved."

On July 19, 1994, claimant returned to Dr. Dickinson, complaining of multiple reinjuries. He requested reopening of her right calf injury claim. (Ex. 6). On August 17, 1994, Dr. Dickinson ordered an MRI to rule out a tumor or infection. At the MRI, claimant complained of pain in the mid to lower left calf. On August 18, 1994, the employer accepted a "disabling right gastrolnemius (sic), muscle strain.

Dr. Marble examined claimant for the employer on September 27, 1994, regarding her right leg complaints. Dr. Marble diagnosed a probable tear of the gastrocnemius complex in the area of the musculotendonous juncture of the left leg and a possible posterior tibial nerve entrapment with mild peripheral entrapment neuropathy. He concluded that claimant's condition was not medically stationary. Dr. Dickinson concurred with Dr. Marble's opinion.

On November 3, 1994, claimant changed physicians to Dr. Beck, who reported that her complaints related to the left leg. He prescribed physical therapy.

On January 6, 1995, claimant changed physicians to Dr. Kaesche, who diagnosed a left gastrocnemius muscle strain. On January 16, 1995, Dr. Kaesche submitted a closing report, finding claimant medically stationary with no evidence of permanent impairment. The employer issued a Notice of Closure on February 8, 1995, which awarded no permanent disability benefits. Claimant requested reconsideration of the Notice of Closure and an arbiter examination. (Ex. 36C).

On October 11, 1995, Dr. Gritzka, medical arbiter, was instructed to examine claimant's right calf. Based on claimant's complaints of left calf cramping, swelling and decreased strength, he diagnosed an intermittent left tarsal tunnel syndrome resulting from the compensable injury. (Exs. 37, 37A). On October 27, 1995, an Order on Reconsideration issued which awarded 13 percent (17.55 degrees) for the left foot (lower leg), based on Dr. Gritzka's reduced range of motion findings. (Ex. 38). On October 30, 1995, claimant requested a hearing on the Order on Reconsideration. The insurer did not request a hearing.

On November 1, 1995, claimant sought treatment from Dr. McLarty, internist, for complaints of increasing left calf pain, left Achilles tendon pain, and pain across the ankle. Claimant was referred to Dr. Wells, orthopedic surgeon. He reported that claimant related her left calf, heel and ankle complaints to the March 1994 injury. (Ex. 45). On November 20, 1995, claimant returned to Dr. Kaesche, who found no calf tenderness. He diagnosed claimant with a probable tarsal tunnel syndrome, left ankle.

On January 5, 1996, claimant filed a claim for aggravation. (Ex. 51). On January 19, 1996, the employer denied the claim on the basis that claimant's current condition was not compensably related to the original injury. (Ex. 53). On January 23, 1996, Dr. Wells treated claimant's left tarsal tunnel condition by performing decompression surgery of the posterior tibial, medial and lateral plantar nerves of the left foot. On January 31, 1996, claimant appealed the January 19, 1996 denial.

At hearing, claimant withdrew her appeal of the Order on Reconsideration.

The ALJ found that the Order on Reconsideration had become final without the insurer having appealed the left leg conditions rated therein, including factors attributable to injury to the left tibial nerve. Consequently, the ALJ reasoned, claimant's left tibial nerve injury and tarsal tunnel syndrome had become compensable components of the claim pursuant to 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). The ALJ also found that claimant's tibial nerve injury had worsened subsequent to the last award of compensation and required medical treatment and disability. Accordingly, the ALJ concluded that claimant had established a compensable aggravation.

Subsequent to the date of the ALJ's order, the 1997 legislature enacted HB 2971, which amended ORS 656.262(10).[1] In Keith Topits, 49 Van Natta 1538 (1997), we held that, based on the plain and unambiguous language of the amended statute, a carrier's failure to appeal an Order on Reconsideration award does not preclude a carrier from denying compensability of a condition rated therein, provided that the condition has not been formally accepted. Our first inquiry, therefore, is whether the employer has formally accepted claimant's left leg conditions. We find that it has not.

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[1] Amended ORS 656.262(10) provides:

"Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order 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." (The amended portion of the statute is underlined.)

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449, 452 (1992). Here, the employer issued two acceptances: the first on June 17, 1994, for a right calf strain now resolved; the second on August 18, 1994, for a "disabling right gastrolnemius (sic), muscle strain." (Exs. 5A, 14A). There is no evidence of acceptance to contradict the two written acceptances. Thus, we find the acceptances to be limited to a right calf[2] strain and a right gastrocnemius strain.

Claimant, however, asserts that her injury was only to her left calf and that Dr. Dickinson was in error when he identified the original injury as an injury to the right calf. (Tr. 20, 23). On review, the employer contends that claimant has not carried her burden of proof to establish that her original injury was to her left, rather than right, leg. Specifically, the insurer argues that establishment of the original injury turns on claimant's credibility, and claimant is not credible.

The ALJ made no credibility finding. However, when the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Following our de novo review of the record, we conclude that claimant is not a credible witness.

Contemporary with the original injury, claimant filled out two documents identifying her injured body part as her right leg (Exs. A, 1). A claim Form 801 was processed by the employer indicating that claimant had injured her right calf and upper middle thigh while cleaning a room (Ex. 3). At hearing, claimant testified that the handwriting on page 1 of the Employee Accident Report (Ex. A) indicating part of body affected "RT calf and up middle thigh", was written by her, with the exception of the letters "RT", which, she averred, were written by Dr. Dickinson or some unknown person. (Tr. 21, 22). Claimant also acknowledged that she had filled out the description of the complaints and the nature and location of the injury portion of the Form 827 (Ex. 1). Again, she testified that the letters "RT", describing right leg calf, had not been written by her.

We find claimant's credibility is called into question when she testified that both her injury report and claim form had been falsified by Dr. Dickinson or some unknown person, particularly when the letters "RT" were written on the two forms in handwriting that appears to match the handwriting of claimant. More importantly, Exhibit A is not a report that was filled out by Dr. Dickinson or his staff. Rather, it was filled out at the employer and signed and dated by claimant. Claimant's insistence that the letters "RT" were added to each of the forms would imply that more than one person was involved in the alleged falsification. This we do not find believable. Accordingly, we find claimant not credible. Claimant's lack of credibility renders her testimony that her original injury involved the left leg unreliable and entitled to no weight.

Moreover, that claimant originally injured her right calf is supported by the contemporaneous medical records. On March 23, 1994, the day after her injury, claimant sought treatment from Dr. Dickinson with complaints of pain in her right calf. Dr. Dickinson reported a history of a right calf injury while claimant was pivoting to turn and felt a pop in her calf. (Exs. 1, 2). This is consistent with claimant's written Form 827. Dr. Dickinson diagnosed "strain, gastrocnemius (medial), right calf." (Ex. 1). On May 17, 1994, Dr. Dickinson reported that he had been treating claimant for an injury to her right leg that occurred on March 22, 1994, and that claimant had "indicated to me over the intervening period that she has recovered from the injury and is having no further problems." (Ex. 5).

The record also indicates that claimant first attributed her symptoms to the left leg at the time she returned to Dr. Dickinson for treatment four months later, on July 19, 1994. (Exs. 13, 58).[3] Dr. Dickinson's request for claim reopening in July 1994 was initially attributed to the left leg and later was changed to the right. (Exs. 6, 8, 12). When questioned about that confusion between claimant's right and left legs, Dr. Dickinson attested that, when claimant returned to him for treatment of symptoms in her left leg in July 1994, she insisted that he had been mistaken in his previous identification of the injury as involving the right, rather than the left, leg. (Ex. 58). Given claimant's lack of credibility, we are persuaded that claimant's accepted injury involved the right leg, and that the condition accepted by

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[2] The muscular swelling of the back of the leg below the knee, formed chiefly by the bellies of the gastrocnemius and soleus muscles. Stedman's Electronic Medical Dictionary, 1996 (based on Stedman's Medical Dictionary, 26th ed.).

[3] Henceforth, claimant's complaints and diagnoses related solely to the left rather than the right leg. (Exs. 13, 19, 21, 26, 27, 27A, 29, 31, 32, 34B).

the employer was a condition of the right leg only. Therefore, in accordance with our holding in Topits, we find that the employer is not precluded from denying claimant's left leg conditions by its failure to appeal the Order on Reconsideration's permanent disability award.[4]

Claimant has the burden to prove the compensability of her left leg conditions. ORS 656.266. Where, as here, the medical evidence as to the nature and cause of claimant's current left leg conditions 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).

Three doctors addressed the causation of claimant's current left leg condition. Dr. Dickinson opined that the March 1994 accident, which caused injury to claimant's right calf, was neither the material nor major cause of claimant's left leg conditions. He also opined that, even if claimant had initially experienced an injury to her left calf, it was not the major contributing cause of her current left tarsal tunnel (ankle) condition. (Ex. 59).

Dr. Kaesche also opined that the March 1994 accident to the right calf would not cause development of a left tarsal tunnel syndrome, and, even if one were to assume that the original injury involved the left rather than the right calf, it was medically improbable that claimant would develop a tarsal tunnel syndrome on the left side at a time so removed from claimant's history of a rupture of the plantaris muscle. (Exs. 48, 57).

Dr. McLarty, who had treated claimant solely for her left leg complaints, was the only physician to opine that claimant's left medial gastrocnemius muscle tear was the major contributing cause of her left tibial nerve entrapment secondary to muscle scarring. (Ex. 56). As noted above, we are not persuaded by Dr. McLarty's opinion, as it is based on an inaccurate history from claimant that her condition from the outset was a left medial gastrocnemius muscle tear.

After considering the record as a whole, we conclude that claimant has not proven by a preponderance of the evidence that her left leg conditions were caused in either major or material part by her March 1994 work injury or her compensable right leg injury. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We therefore reverse the ALJ's order on the issues of compensability and aggravation.

ORDER

The ALJ's order dated March 28, 1997 is reversed. The self-insured employer's denial of claimant's current condition and aggravation claim is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[4] We note that, because claimant withdrew her appeal of the Order on Reconsideration at hearing, the issue of the scheduled permanent disability award was no longer before the ALJ and, consequently, is not before us on review.

In the Matter of the Compensation of
RICHARD T. SHERMAN, Claimant
Own Motion No. 66-0448M
OWN MOTION ORDER OF ABATEMENT
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our September 19, 1997 Own Motion Order, in which we reopened the above referenced claim for the payment of temporary disability compensation.

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
MELISSA M. DONOVAN, Claimant
WCB Case No. 96-11174
ORDER ON RECONSIDERATION
Ernest M. Jenks, Claimant Attorney
Reinisch, et al, Defense Attorneys

The insurer requests reconsideration of our September 17, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order awarding attorney fees for claimant's counsel's services in obtaining rescission of a denied claim prior to hearing. On reconsideration, the insurer contends that we improperly raised an issue on review that neither party raised at hearing. The insurer further contends that it did not expressly deny the claim; therefore, claimant is not entitled to an attorney fee under ORS 656.386(1). Finally, the insurer contends that we erred in relying on the court's decision in Kimberly Quality Care v. Bowman, 148 Or App 292 (1997).

We disagree with the insurer's contention that we addressed an issue not raised by the parties at hearing. The sole issue at hearing was whether claimant was entitled to an attorney fee under ORS 656.386(1) for her counsel's services in obtaining a rescission of a denied claim prior to hearing. The parties more specifically identified the issue as whether the claim had been denied. (See Tr. 1). The ALJ's order addressed the question of whether the insurer had denied claimant's claim. Thus, we conclude that the issue of whether the claim was denied, within the meaning of ORS 656.386(1), was raised by the parties and addressed by the ALJ.

In addressing the issues raised at hearing, it is our obligation to apply the appropriate law. Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995); Daniel S. Field, 47 Van Natta 1457, 1458 (1995). In our decision in this case, we simply applied the appropriate law to resolve the issue of whether claimant's claim had been denied within the meaning of ORS 656.386(1).

The insurer further argues that we misinterpreted its response on the "response to issues" form. We acknowledged in our original order that the insurer's responses appeared to be inconsistent.[1] We consider both responses to be "express" statements, but we also consider them to be mutually exclusive statements. In determining which statement more accurately reflects the insurer's position, we looked to other indicators of the insurer's position, including its conduct in processing the claim. Based on the other indicators, we determined that the insurer's statement denying that a condition had been incorrectly omitted was entitled to greater weight; that is, that it more accurately reflected the insurer's position. We continue to adhere to that analysis.

We emphasize that we consider the insurer's response on the "response to issues" form to be an express statement, consistent with the court's analysis in Kimberly Quality Care v. Bowman, 148 Or App 292 (1997). Thus, we do not rely solely on the insurer's conduct to imply denial of the claim. Rather, we rely on the insurer's express statement on the "response to issues" form, which we consider to be an unequivocal denial of the claim.

The insurer argues that Bowman is inapposite. We disagree. Bowman addressed the very issue that is presented here. Specifically, Bowman addressed the question of whether there was a "denied claim" within the meaning of ORS 656.386(1) such that claimant was entitled to an attorney fee for her attorney's efforts in obtaining rescission of a denied claim prior to hearing. Under procedural facts similar to the present case, the court held that the employer's response on the "response to issues" form, indicating that claimant had not sustained a work-related injury or disease, constituted a denial with respect to the conditions that had not yet been accepted. Similarly, here, under the circumstances of this case, we find that the insurer's statement on the "response to issues" form, indicating that a condition had not been incorrectly omitted from the acceptance, constitutes a compensability denial of

[1] On the response to issues form, the insurer indicated that it denied that "a condition has been incorrectly omitted (scope of acceptance)." It also indicated that it denied "that the employer has denied the compensability of this claim." (Administrative Record). We considered these assertions to be inconsistent.

the condition that was not included in the acceptance. Accordingly, we continue to adhere to our position that this case is governed by Bowman.[2]

The insurer also argues, relying on Jerome M. Baldock, 48 Van Natta 355 (1996) that claimant is not entitled to an attorney fee under ORS 656.386(1) because there was no denial. We find that Baldock is distinguishable. In Baldock, we did not award claimant an attorney fee because we found that there was no "denied claim." In Baldock, claimant requested a hearing from a "de facto" denial, where the carrier never "expressly" denied the claim. By contrast, here, we have found that the insurer "expressly" denied the claim by its response on the "response to issues" form. In Bowman, the court recognized that after the employer responded on the "response to issues" form, the claim was no longer merely denied "de facto," but it had been expressly denied. Bowman, 148 Or App at 295. The court's reasoning applies as well in this case. Therefore, we reject the insurer's reliance on our decision in Baldock.

The insurer further argues that claimant's attorney was not instrumental in obtaining rescission of the denial. We disagree. The ALJ found, and we agree, that claimant's counsel was instrumental in obtaining rescission of the denial prior to hearing. Claimant's counsel not only filed a hearing request, but also marshalled evidence in support of compensability. The insurer did not accept the claim until the day of the hearing. (Tr. 1). Therefore, we find that claimant's counsel was instrumental in obtaining rescission of the denial prior to hearing.[3]

The insurer also argues that the ALJ did not have jurisdiction to address the attorney fee issue. We disagree. The parties agreed at hearing that the sole issue was claimant's entitlement to attorney fees under ORS 656.386(1). (Tr. 1-2). If there were any procedural defects to proceeding on this issue, the insurer waived them by agreeing to litigate the attorney fee issue. See Thomas v. SAIF, 64 Or App 193, 197 (1983). Therefore, we reject the insurer's argument that the ALJ lacked jurisdiction to address the attorney fee issue.

Finally, the insurer complains that we have improperly mixed claims processing with procedural litigation matters. We disagree. We have previously held on numerous occasions, relying on our decision in Emily M. Bowman, that a carrier's response on the "response to issues" form can constitute an express denial for the purpose of awarding attorney fees under ORS 656.386(1). See e.g., Elizabeth H. Nutter, 49 Van Natta 829 (1997); Robert D. Hannington, 49 Van Natta 135 (1997); Errol L. Schrock, 48 Van Natta 1613 (1996). The court has affirmed our decision in Bowman, agreeing with our analysis and conclusion. We are bound by the court's decision. Therefore, we decline the insurer's invitation to revisit our analysis on this issue.

Accordingly, we withdraw our September 17, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our September 17, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] We previously held, in Jason O. Rogers, 48 Van Natta 2361 (1996), that a response on the "response to issues" form denying that a condition had been incorrectly omitted from the acceptance, combined with a statement asserting that the Hearings Division lacked jurisdiction to provide any relief, did not constitute a denied claim for the purpose of awarding attorney fees under ORS 656.386(1). We find Rogers distinguishable from the present case. In Rogers, we relied on the carrier's assertion that the ALJ lacked jurisdiction to provide any relief to find that the carrier had not denied causation. 48 Van Natta at 2362. We further noted that the carrier had amended its denial to accept the contested conditions **prior** to its response to claimant's hearing request. 48 Van Natta at 2363 n.2. Here, by contrast, the insurer did not accept the contested condition until the day of the hearing.

[3] We note that the insurer's argument that claimant's counsel was not instrumental because he failed to argue that a response on the "response to issues" form constitutes an express denial goes to the issue of whether claimant's counsel is entitled to an attorney fee under ORS 656.386(1). The insurer's argument does **not** pertain to the question of claimant's counsel's efforts in obtaining rescission of the denial.

In the Matter of the Compensation of
KIM P. KENNEDY, Claimant
WCB Case No. 97-00202
ORDER ON RECONSIDERATION
Ann B. Witte, Claimant Attorney
Reinisch, et al, Defense Attorneys

The insurer requests reconsideration of our September 19, 1997 Order on Review which reversed an Administrative Law Judge's (ALJ's) order and set aside the insurer's denial of claimant's November 8, 1996 injury claim. On reconsideration, the insurer contends that claimant did not sustain an injury because she did not require medical treatment or incur disability as a result of the November 8, 1996 motor vehicle accident. Therefore, the insurer contends that the claim cannot be compensable. In response, claimant asserts that the insurer's motion should be denied.

Claimant, a school bus driver, was involved in a motor vehicle accident on November 8, 1996 when she lost consciousness while driving her bus. In our original order, we held, relying on Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991), that claimant's injury arose out of her employment because claimant faced an increased risk of injury as a result of her employment. On reconsideration, the insurer does not dispute our reasoning in the original order, but instead contends that the claim cannot be compensable because claimant did not sustain any injury as a result of the motor vehicle accident.[1]

So far as the record discloses, the insurer raises this issue for the first time on review. Neither the insurer's denial nor its counsel's discussion of the issues at hearing identified the issue that claimant suffered no injury as a result of the work incident. (See Ex. 12; Tr. 2-3, 5). The ALJ's order identified the issue as "whether claimant's injuries arose out of and in the course of her employment as a school bus driver," and the order did not address any contention that claimant suffered no injury at all. (See Opinion & Order at 1, 3-4). We are not inclined to consider issues that were not first raised by the parties at hearing. See Fister v. South Hills Health Care, 149 Or App 214, 218-19 (1997); Stevenson v. Blue Cross, 108 Or App 247, 252 (1991); Joyce B. Mauceri, 48 Van Natta 1631, 1631-32 (1996). Therefore, we are not inclined to consider whether claimant sustained an "injury" (that is, whether she required medical treatment or incurred disability) as a result of the November 8, 1996 incident.

However, if we were to consider the insurer's argument, we would find that claimant required medical treatment as a result of the November 8, 1996 incident. Therefore, we would conclude that claimant sustained a "compensable injury."

ORS 656.005(7)(a) defines a "compensable injury" as "an accidental injury *** arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" An injurious event that does not produce disability or a need for treatment does not give rise to a compensable claim. Theresa A. Snyder, 44 Van Natta 1191 (1992); see also Judith W. Hall, 47 Van Natta 929, 930 (1995).

Here, although claimant felt no ill effects immediately following the accident, she did experience "an extremely bad headache" the following day. (Tr. 8; see also Ex. B-1; 2; 3). While claimant underwent diagnostic studies and treatment related to her loss of consciousness, her headaches persisted. (Ex. 19-1). Approximately one month after the accident, claimant began seeing a chiropractor, Dr. Duncan, for her headaches. (Exs. 19-1, 23-2). Dr. Duncan made objective findings of right suboccipital and mid-back tenderness and restricted cervical range of motion. (Ex. 27-1). He diagnosed a cervical strain and post-concussive syndrome as the cause of claimant's headaches. (Ex. 27-1). Dr. Duncan opined that the cervical strain was caused by the motor vehicle accident itself. (Ex. 26). He treated claimant several times by providing cervical manipulation, until claimant's headaches resolved. (Ex. 27; Tr. 9). Thus, we would find that claimant required medical treatment as a result of the motor vehicle accident itself. Therefore, claimant has established a "compensable injury."

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[1] The insurer raised this issue in its respondent's brief; however, our original order did not expressly address the insurer's argument. We do so now.

Accordingly, we withdraw our September 19, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our September 19, 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
TERRY KUMP, Claimant
WCB Case No. 97-00078
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer 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 cervical disc degeneration condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has worked for the employer constructing circuit boards since 1993. In February 1996, claimant sought treatment for symptoms on the right side of his neck. Claimant eventually was diagnosed with a herniated disc at C6-7 and underwent surgery for the condition. (Exs. 13, 19).

The insurer issued denials of claimant's low back and cervical conditions.

CONCLUSIONS OF LAW AND OPINION

Although upholding the insurer's denial of claimant's low back condition, the ALJ found that claimant "sustained his burden of proof" with regard to the cervical condition. The insurer challenges this conclusion, asserting that, because the medical evidence shows that employment conditions were not the major contributing cause of the cervical condition, claimant failed to prove compensability.

Examining physicians Dr. Maukonen,[1] neurologist, and Dr. Smith, orthopedic surgeon, found that claimant had "degenerative cervical arthritis with a spontaneous herniated cervical disc without any precipitating trauma." (Ex. 28-5). Although finding that work activities contributed to a "pathological worsening of his cervical spondylosis," the panel thought that the major contributing cause of the condition and its worsening was "the natural aging process[.]" (Id. at 6, 7). Dr. Morris, one of claimant's treating physicians, agreed with the panel's report, further indicating that "claimant has wide-spread degenerative arthritis of the cervical spine." (Ex. 32).

Claimant asserts that the degenerative arthritis does not qualify as a "preexisting condition" under ORS 656.005(24)[2] because the medical evidence shows that the condition is the result of a "natural aging process." Claimant then states: "The only medical evidence indicates that the work activity did cause a pathological worsening. Any change to the natural aging process caused by work activities is a major change."

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[1] Dr. Maukonen also treated claimant one time in February 1996 before examining claimant on behalf of the insurer. (Ex. 1).

[2] ORS 656.005(24) provides:

"'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder 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 or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

Claimant apparently does not dispute that the claim is for an occupational disease, as he conceded at hearing. (Tr. 3). Consequently, whether the claim is analyzed under ORS 656.802(2)(a)[3] or 656.802(2)(b),[4] claimant must show that employment conditions were the major contributing cause of his neck condition or its worsening. Here, the medical evidence shows that work activities were not the major contributing cause of the cervical arthritis and herniated disc. Consequently, claimant failed to prove compensability. ORS 656.802(2).

Finally, claimant contends that, if his arthritis is considered to be a preexisting condition under ORS 656.005(24), the statute violates Article I, sections 10 and 20 of the Oregon Constitution. We decline to consider claimant's argument. First, he did not raise the constitutionality of the statute until review before the Board. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not presented at hearing). Furthermore, as discussed above, we would come to the same conclusion whether or not applying ORS 656.005(24).

ORDER

The ALJ's order dated May 13, 1997 is reversed in part and affirmed in part. The insurer's denial of claimant's cervical condition is reinstated and upheld. The ALJ's attorney fee award also is reversed. The remainder of the ALJ's order is affirmed.

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[3] ORS 656.802(2)(a) states:

"The worker must prove that employment conditions were the major contributing cause of the disease."

[4] 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.

In the Matter of the Compensation of
JANICE K. CONNELL, Claimant
Own Motion No. 94-0719M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hollander, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 14, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from November 22, 1994 through August 7, 1997. SAIF declared claimant medically stationary as of August 8, 1997. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 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).

On June 4, 1997, claimant underwent surgery to implant a spinal epidural catheter. The surgery was intended to prepare claimant's back for implant of an intrathecal morphine pump for pain control.

The pump was implanted by Dr. Burchiel, claimant's treating physician, on June 6, 1997. In an August 12, 1997 response to SAIF's inquiry, Dr. Burchiel opined that claimant was medically stationary as of August 8, 1997. In an August 21, 1997 medical report, Dr. Goodwin, neurosurgeon at the pain medicine clinic, opined that "there are no developments to indicate that [claimant] is unstable."

In a September 8, 1997 medical report, Ms. Brady, R.N., noted that claimant underwent tests which determined that her pump was malfunctioning. On September 22, 1997, claimant underwent surgery to remove the pump catheter which was restricting the flow of medicine to claimant's back, and to implant new catheter tubing intrathecally.

Here, claimant's treating physician opined that she was medically stationary on August 12, 1997, and SAIF closed her claim on August 14, 1997. It appears that claimant's condition worsened after claim closure, requiring that she undergo further surgery to correct problems with the implant. Therefore, we conclude that claimant's September 22, 1997 "post-closure" surgery was performed as a result of events which occurred after claim closure. See Sullivan v. Argonaut Ins. Co., 73 Or App at 694. Finally, Dr. Burchiel's opinion that claimant was medically stationary on August 12, 1997 is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant has not met her burden of proving that she was not medically stationary on the date her claim was closed. Therefore, we conclude that SAIF's closure was proper.[1]

Accordingly, we affirm SAIF's August 14, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] Claimant requests that, in the alternative, her claim be reopened for the payment of temporary disability compensation, effective September 22, 1997. Because we affirm SAIF's August 14, 1997 closure of her claim by this order, we acknowledge receipt of claimant's new request for Own Motion relief. That request will be processed as a separate request and will be considered by the Board upon receipt of SAIF's recommendation.

October 20, 1997 Cite as 49 Van Natta 1862 (1997)

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

The self-insured employer requests abatement and reconsideration of our September 18, 1997 Order on Reconsideration, in which we denied its request for en banc review and adhered to our previous decision setting aside the employer's current condition denial. In requesting reconsideration, the employer again requests en banc review of our July 18, 1997 Order on Review, as well as of our September 18, 1997 reconsideration order.

In order to consider this matter, we withdraw our September 18, 1997 reconsideration 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA R. FLOYD, Claimant
WCB Case Nos. 96-06033, 96-04985 & 96-04984
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Reinisch, et al, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys

On August 29, 1997, we abated our August 1, 1997 order, which among other decisions, affirmed an Administrative Law Judge's (ALJ's) penalty assessment and awarded attorney fees. We took this action to consider Jeld-Wen's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

In its request for reconsideration, Jeld-Wen asserts that its claim processing conduct was proper and challenges 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. Jeld-Wen also challenges the basis for our $1,000 attorney fee award and requests clarification regarding the total attorney fee granted by the ALJ's order and our decision. We address each contention in turn.

The ALJ assessed a penalty against Jeld-Wen pursuant to ORS 656.262(11) and an additional attorney fee pursuant to ORS 656.382(1), finding that the employer acted unreasonably and did not follow the proper procedure in processing claimant's claim. The ALJ cited several instances of unreasonable conduct, including the inappropriateness of Jeld-Wen's aggravation denial,[1] the attempt to deny compensability without any supporting evidence, and the untimeliness of the responsibility disclaimer. On review, we adopted and affirmed the ALJ's determination, noting that where a penalty has been assessed on amounts due, an additional attorney fee may be assessed for separate unreasonable acts. See, e.g., Lucille G. Major, 47 Van Natta 617, 619 (1995); see also Anette D. Batey, 48 Van Natta 1880 (1996) (where the carrier's misconduct violates separate processing requirements, both a penalty and an assessed attorney fee may be appropriate).

On reconsideration, Jeld-Wen contends that its claim processing was not unreasonable because: (1) it did, ultimately, correspond with the Department concerning claimant's claim; (2) it paid interim compensation on the claim until another carrier denied the compensability of claimant's condition; and (3) it was authorized to deny claimant's claim by virtue of ORS 656.262(6)(c). We reject each argument.

Although Jeld-Wen did correspond with the Department, it did not do so prior to denying claimant's claim nor did it do so to report that claimant's claim was in need of determination pursuant to ORS 656.268, as required by ORS 656.277. Rather, Jeld-Wen wrote to the Department on April 29, 1996 requesting the designation of a paying agent and asserting that it was denying only responsibility for claimant's condition (as of January 1996). In light of the express direction of ORS 656.277 to refer reclassification claims to the Department and Jeld-Wen's failure to comply with this procedure, we adhere to our determination that Jeld-Wen's aggravation denial was inappropriate and unreasonable. Furthermore, the fact that Jeld-Wen paid some interim compensation on the claim does not mitigate its other unreasonable conduct in processing the claim (such as the untimely disclaimer and the later attempt to deny compensability).

In addition, ORS 656.262(6)(c) does not provide a statutory basis for Jeld-Wen's denial of an aggravation of the September 1995 accepted injury.[2] ORS 656.262(6)(c) allows a carrier that has accepted a combined or consequential condition to issue a "current condition" denial under certain circumstances.[3] In this case, there is no evidence that Jeld-Wen accepted a combined or consequential

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[1] The ALJ found, and we agreed, that Jeld-Wen's denial of an aggravation of claimant's September 22, 1995 injury was procedurally improper because the claim should have been referred to the Department pursuant to ORS 656.277.

[2] We note that Jeld-Wen did not refer to, or rely upon, this provision in its April 1996 denials of claimant's back condition, nor did it raise the ORS 656.262(6)(c) issue at hearing.

[3] This section allows a carrier that has accepted a combined or consequential condition under ORS 656.005(7) to later deny the compensability of that condition "if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

condition. At the time it attempted to deny an aggravation of claimant's low back condition, it had only accepted a nondisabling back strain. Moreover, ORS 656.262(6)(c) does not address aggravation claims nor does it authorize the issuance of an aggravation denial when the carrier receives notice that an accepted nondisabling condition has become disabling. ORS 656.277, on the other hand, deals directly with this situation, and, as noted above, expressly requires that the carrier refer the claim to Department for determination and reclassification.

As noted at the outset, Jeld-Wen also seeks clarification regarding the time period on which the penalty is based and the manner in which the penalty is to be paid. Pursuant to ORS 656.262(11), the penalty is based on amounts then due at the date of the hearing as a result of this order. See, e.g., John C. Beaver, 47 Van Natta 165 (1995). Furthermore, as specifically set forth in the statute, the penalty is to be paid one-half to the worker and one-half to the worker's attorney if the worker is represented by counsel.[4]

Finally, Jeld-Wen challenges the $1,000 attorney fee we awarded pursuant to ORS 656.386(1), asserting that compensability was not in issue at the hearing. For the reasons set forth in our order, we adhere to our determination that claimant's attorney is entitled to the fee for prevailing over Jeld-Wen's "denied claim" at hearing. This $1,000 fee is in addition to, and not in place of, the $1,000 attorney fee awarded by the ALJ pursuant to ORS 656.308(2)(d).[5]

Because penalties and attorney fees were the only issues raised on reconsideration, claimant's counsel is not entitled to an attorney fee for services on reconsideration. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986) (penalties and attorney fees are not "compensation" for the purposes of ORS 656.382(2)).

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our August 1, 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] As claimant indicates in her response, Jeld-Wen has already paid the 25 percent penalty to claimant based on amounts due through the time of hearing.

[5] Pursuant to ORS 656.308(2)(d), the ALJ was authorized to award a separate, reasonable attorney fee based on claimant's counsel's appearance and active and meaningful participation in the hearing in which claimant finally prevailed against Jeld-Wen's responsibility denial. See, e.g., Julie M. Baldie, 47 Van Natta 2249 (1995) (A fee awarded pursuant to ORS 656.308(2)(d) may be in addition to any fee awarded under ORS 656.386(1)).

In the Matter of the Compensation of
BILLY A. SPRINGS, Claimant
Own Motion No. 95-0370M
OWN MOTION ORDER OF ABATEMENT
Kasia Quillinan, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our September 19, 1997 Own Motion Order Reviewing Carrier Closure, in which we set aside SAIF's July 14, 1997, Notice of Closure as premature.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DUDLEY I. GEE, Claimant
WCB Case No. C702575
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Furniss, Shearer, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Bock and Biehl.

On October 8, 1997, we received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The CDA provides that claimant has settled his third party cause of action. Although the specific amount of the settlement is not provided, the parties represent that the insurer's statutory share would be approximately $19,712.65.[1] The sole consideration for the CDA is the carrier's partial release of $17,212.65 of its $19,712.65 assertable third party lien.

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

In the present case, the parties have expressly stipulated that the insurer's statutory share of the settlement is approximately $19,712.65 and the insurer has agreed to reduce its lien by $17,212.65 (an ascertainable amount). Thus, although the exact amount of the third party settlement is unknown, the amount of the insurer's otherwise recoverable lien and the amount of its waiver are known. Under such circumstances, we find that the "value" of the consideration flowing to claimant under the CDA ($17,212.65) is sufficiently ascertainable to gain Board approval.[2] See Anthony G. Allen, 49 Van Natta 460 (1997).

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

IT IS SO ORDERED.

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[1] The CDA indicates that the insurer's statutory share would be the amount of the final lien, $20,212.65, of which, $500 has been waived, leaving a net lien of $19,712.65. In consideration of a partial release by the insurer of its statutory share in the amount of $17,212.65, the CDA provides that claimant releases his rights to all workers' compensation benefits allowed by law. We interpret the CDA as providing that the insurer's potentially recoverable lien is $19,712.65 and that the consideration for the agreement if the insurer's waiver of $17,212.65 of that lien.

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

In the Matter of the Compensation of
GREGG MULDROW, Claimant
WCB Case No. 96-06766
ORDER ON REVIEW (REMANDING)
Schneider, et al, Claimant Attorneys
SAFECO Legal, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) denied claimant's motion to postpone/continue the hearing to obtain additional medical evidence to address a compensability issue; (2) determined that the insurer's written denial encompassed compensability of claimant's left shoulder impingement syndrome; (3) upheld the insurer's denial of claimant's occupational disease claim for a left shoulder impingement syndrome; and (4) declined to award penalties and attorney fees for an allegedly unreasonable responsibility denial. On review, claimant seeks remand to the ALJ to allow him to address the compensability issue. On review, the issues are remand, hearings procedure, compensability, responsibility, penalties and attorney fees. We vacate the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and supplementation. We do not adopt the last sentence of the findings of fact.

On June 14, 1996, the insurer issued a denial that denied only responsibility for claimant's left shoulder impingement syndrome. (Ex. 8). By letter dated July 18, 1996, claimant, pro se at that time, requested a hearing. In its "Response to Issues," the insurer checked boxes indicating it was denying: (1) that "claimant sustained a work-related injury or occupational disease;" and (2) "other," explaining that it "relies upon [the] denial of 6-14-96; [being] aware of no other relief to which claimant is entitled."

At hearing, the insurer amended its denial to include compensability of claimant's left shoulder impingement syndrome condition.

CONCLUSIONS OF LAW AND OPINION

At hearing, the ALJ allowed the insurer to amend its June 14, 1996 written denial to include the compensability issue. (Tr. 6-13). However, the ALJ also found that this June 14, 1996 written denial denied compensability of claimant's occupational disease claim for a left shoulder impingement syndrome. The ALJ found support for this finding in the insurer's August 13, 1996 "Response to Issues," which denied that claimant sustained a work-related accidental injury or occupational disease. Id. The ALJ also denied claimant's attorney's request to reset the case or hold the record open to allow him to respond to the compensability issue. On review, claimant requests that we remand to the ALJ to allow him to present evidence regarding the compensability issue.

We may remand to the ALJ for further evidence taking if we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Based on the following reasoning, we conclude that remand to the ALJ is appropriate in this case.

The initial question is whether the insurer's June 14, 1996 denial notified claimant that the insurer was denying compensability of his claim. We find that it did not. The first paragraph of the denial stated that a claim had been received for the specific diagnosis of "left shoulder impingement syndrome." (Ex. 8-1). The second paragraph of the denial provided the basis for the denial of that claim, stating:

> "Medical information we have received indicates to us that [claimant's left shoulder impingement syndrome] is a long-standing, chronic problem and preexisted prior to [claimant] coming to work for [the insured]. Therefore, we are denying responsibility of [claimant's] left-shoulder impingement syndrome claim. [Claimant] should file this claim

> with any employers and insurers who may have contributed to [his] injury, to protect [his] claims coverage now that we have denied responsibility only of this claim." (Ex. 8-1) (emphasis supplied).

This denial tracks the requirements in OAR 438-005-0053(2), which provides the three elements required in a notice of denial of responsibility. Specifically, this denial identifies the condition for which responsibility is being denied, states the factual and legal reasons for the denial, and advises claimant to file separate claims against other potentially responsible carriers in order to protect his rights to obtain benefits on the claim. OAR 438-005-0053(2)(a), (b), (c). Furthermore, the denial specifically states that the carrier is denying "responsibility only" of the claim, without mentioning compensability. Therefore, we conclude that this denial denies only responsibility and not compensability.

At hearing, the ALJ allowed the insurer's counsel to amend the denial to include compensability. (Tr. 9). In response, claimant's attorney requested that the hearing be "reset" because he was not prepared to proceed on the newly raised compensability issue. Id. The ALJ initially determined that the hearing would proceed but, in response to claimant's attorney's request, the record would be held open to allow claimant's attorney to submit a report from Dr. Hanley, consulting surgeon. (Tr. 11). However, after learning that claimant's attorney had a copy of the insurer's "Response to Issues" in his file, and determining that the denial denied that the work activities caused the preexisting condition, the ALJ declined to leave the record open and proceeded with the hearing. (Tr. 11-13).

In SAIF v. Ledin, 149 Or App 94 (1997), the court recently clarified that a carrier may amend its denial at hearing. In making this clarification, the court stressed that its earlier decision in Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993), did not hold that a carrier could not amend its denial at hearing. Instead, the court emphasized that its statement in Tattoo that "[e]mployers are bound by the express language of their denials" must be read in context, explaining that Tattoo "held that the claimant could not rely on the testimony of the claims examiner [to demonstrate the employer's intent to impermissibly prospectively deny treatment]: '[E]mployers are bound by the express language of their denials and the testimony of the claims examiner here is irrelevant.'" SAIF v. Ledin, 149 Or App at 98. (Citation omitted, emphasis in original).

Therefore, pursuant to Ledin, a carrier is not precluded from amending its denial at hearing; however, extrinsic evidence may not be used to interpret the express language of a denial. Thus, here, although the insurer is allowed to amend its denial at hearing, extrinsic evidence regarding that denial may not be used in interpreting the initial denial.[1]

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[1] We note that, after the briefing schedule, the insurer submitted a copy of Kimberly Quality Care v. Bowman, 148 Or App 292 (1997), for our consideration. It is permissible for any party to provide supplemental authorities to assist the Board in its review. See Betty L. Juneau, 38 Van Natta 553, 556 (1986). However, for the following reasons, we find Bowman distinguishable.

In Bowman, the court affirmed a Board order that awarded claimant an assessed attorney fee pursuant to ORS 656.386(1) for having obtained rescission of the denial of a claim prior to a decision by the ALJ. The court concluded that the insurer's check-the-box notation on the hearing response form met the definition of a "denied claim" under ORS 656.386(1), which provides that:

> "[f]or 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 is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

In reaching this conclusion, the court noted that, although the check-the-box notation did not meet the requirements for a denial under ORS 656.262(9), it clearly expressed the employer's denial of compensability. The court held that, when an express denial of compensation is rescinded and the claimant's attorney is instrumental in obtaining that rescission, ORS 656.386(1) provides for an award of attorney fees.

Thus, in Bowman, the issue was whether the "Response to Issues" constituted a "denied claim" under a definition which is limited to the purposes of ORS 656.386(1) in determining whether an assessed attorney fee is appropriate. The present case does not involve application of ORS 656.386(1). Therefore, the definition of a "denied claim" under that statute does not apply here. In addition, unlike Bowman, the insurer in the present case issued an express, written denial. Finally, as discussed above, Ledin provides that extrinsic evidence may not be used in interpreting the express language of a denial. However, even if we considered the insurer's "Response to Issues," the result would not change. In this regard, the insurer stated in its response that it relied on the June 14, 1996 denial, which we have determined denied only responsibility and not compensability.

Our rules expressly provide that amendments to the issues raised and relief requested at hearing "shall be freely allowed." OAR 438-006-0031, OAR 438-006-0036. Where such an amendment is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. OAR 436-006-0091(3); John E. Noyer, 46 Van Natta 395 (1994). A party's remedy for surprise and prejudice created by a late-raised issue is a motion of continuance. Id.; OAR 438-006-0031, OAR 438-006-0036.

Here, at hearing, claimant's attorney asserted that he was surprised by the carrier's amendment of its denial to include the issue of compensability and, in effect, requested a continuance by requesting that the hearing be "reset" or the record be held open to allow him to respond to the newly raised compensability issue. In response, the insurer contended that claimant's attorney was not "surprised" by the introduction of the compensability issue at hearing because its August 13, 1996 "Response to Issues" raised the compensability issue. (Tr. 9-10). However, as discussed above, the insurer may not rely on extrinsic evidence to interpret the express language of its denial, which denied only responsibility. Given the court's recent holding in Ledin, and consistent with OAR 438-006-0036, we conclude that the ALJ was correct in allowing the insurer to amend its denial at hearing. We also conclude, on the other hand, that claimant's request for continuance to respond to the newly raised issue should have been granted as well, because we find that claimant was surprised by the introduction of the compensability issue at hearing. Therefore, under the facts of this case, remand for further development of the record will achieve substantial justice and avoid any prejudice against claimant that might result if he is not allowed to address the newly raised issue.

Accordingly, we vacate the ALJ's order dated April 16, 1997, and remand this case to ALJ Neal to allow claimant an opportunity to respond to the compensability issue. The ALJ may conduct these further proceedings consistent with this order in any manner that she finds will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.[2]

IT IS SO ORDERED.

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[2] Because we are remanding the case to the ALJ, we do not address the remaining issues. The parties may direct their arguments regarding those issues to the ALJ on remand.

In the Matter of the Compensation of
DANIEL D. LATHROP, Claimant
Own Motion No. 97-0194M
OWN MOTION ORDER OF ABATEMENT
Shelley K. Edling, Claimant Attorney
SAIF Legal Department, Defense Attorney

Claimant requests reconsideration of our September 23, 1997 Own Motion Order, in which we modified the SAIF Corporation July 31, 1997, Notice of Closure to award claimant temporary partial disability from May 7, 1997, through June 20, 1997.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. DONNELLY, Claimant
WCB Case Nos. 94-13449, 94-13398, 94-13448 & 94-13399
ORDER ON RECONSIDERATION
Quintin Estell, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

On July 23, 1997, we abated 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. This action was taken in response to the SAIF Corporation's and claimant's motions for reconsideration. Having received responses and supplemental briefs from all the parties, we proceed with our reconsideration.

Claimant has worked as a well driller for the employer since 1988. In April 1990, Liberty Northwest Insurance Corporation, the employer's workers' compensation carrier, accepted a nondisabling claim for lumbosacral strain resulting from a December 1989 industrial injury. Effective October 1992, coverage was changed from Liberty to SAIF. In August 1994, claimant again sought treatment for his low back; an MRI showed degenerative disc disease throughout the spine.

Our order first addressed whether claimant had proved the compensability of his lumbar spine condition. We agreed with the ALJ that claimant proved compensability only for the condition at L6-S1. Proceeding to responsibility and applying the last injurious exposure rule, we also concluded that SAIF was liable for the condition.

Claimant challenges that portion of the order finding that he did not prove compensability of his entire spine. We find our order sufficient with regard to the compensability issue and continue to adhere, without modification, to our conclusion that claimant proved only compensability for the condition at L6-S1.

In addressing responsibility, our order found that initial responsibility should be assigned to Liberty because "claimant first received treatment for the compensable condition in 1989 before experiencing time loss in 1994" and Liberty was the insurer in 1989. We further found, however, that responsibility shifted from Liberty to SAIF after interpreting the medical evidence as showing that claimant's work during SAIF's coverage independently contributed to the cause or worsening of the compensable condition.

SAIF asserts that the medical evidence shows only that claimant's condition symptomatically worsened during its period of coverage and that such a showing is insufficient to shift responsibility to it. Liberty disagrees that claimant first received treatment for his compensable condition in 1989 and argues that initial responsibility should be assigned to SAIF. We agree with Liberty's contention.[1]

Subsequent to our order, the Supreme Court decided Roseburg Forest Products v. Long, 325 Or 305 (1997), which, like this case, concerned the application of the last injurious exposure rule in the context of successive insurers of one employer. The Court first considered the correctness of the Court of Appeals' decision in Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, adhered to as modified 138 Or App 9 (1995),[2] that an employer can be found responsible if employment conditions are of the kind that could cause the compensable condition even though those employment conditions were not the actual cause of the compensable condition. Based on prior precedent, the Court held that, "once

[1] In our first order, we found that claimant first sought treatment for his compensable degenerative L6-S1 disc condition in 1989. However on reconsideration, we find that claimant's 1989 treatment was for a different condition; i.e. lumbosacral strain. Claimant's first treatment for his compensable condition (degenerative disc disease of L6-S1) occurred in 1994, while SAIF was providing coverage.

[2] Strametz was reversed by the Supreme Court after the Court found that substantial evidence supported the Board's finding that it was impossible for employment conditions at the employer against which the claim was filed to have contributed to the claimant's disease. 325 Or 439, 444-45 (1997).

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." 325 Or at 313.

The Court further held that the last injurious exposure rule applied to successive insurers of a single employer. It stated:

> "As applied in that context, the rule makes the last insurer of an employer fully responsible for the claimant's occupational disease unless that insurer proves either: (1) that it was impossible for workplace conditions at the time that it insured the employer to have caused the disease in this particular case or (2) that the disease was caused solely by employment conditions at a time when the employer was insured by one or more previous insurers." Id. at 314.

Because this case concerns the application of the last injurious exposure rule in the context of successive insurers for a single employer, we proceed to analyze this case pursuant to Long. First, as the last insurer, SAIF is fully responsible for claimant's L6-S1 condition unless it can satisfy either of the two conditions for shifting responsibility to Liberty, the prior insurer.

As stated in our prior order, examining orthopedist, Dr. Laycoe, who we found provided the most persuasive opinion, explained "each year of [claimant's] employment has carried the same detrimental effect" and that work conditions before SAIF's coverage were the major contributing cause of claimant's L6-S1 condition only because claimant had "more years of employment" before that date than after that date. (Ex. 28-2). We find that such evidence shows that claimant's entire work period, both before and during SAIF's coverage, contributed to his L6-S1 condition. Consequently, we conclude that SAIF did not show that it was impossible for workplace conditions during its coverage to have caused the disease or that the disease was caused solely by employment conditions during Liberty's coverage. Accordingly, SAIF remains responsible for the L6-S1 condition.

On reconsideration, as supplemented and modified herein, we adhere to and republish our June 27, 1997 order. The parties' right of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVE W. HOOTEN, Claimant
WCB Case Nos. 97-02848 & 97-00786
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that increased claimant's scheduled permanent disability award for loss of use or function of the right foot from 15 percent (20.25 degrees), as awarded by an Order on Reconsideration, to 21 percent (28.35 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant sustained a compensable crush injury on January 17, 1996 when his right forefoot was caught under a press. (Ex. 3-9). His treating doctor, Dr. Young, ultimately had to amputate most of claimant's right middle toe (through the base of the proximal phalanx) and the top portion of his fourth toe (through the distal half of the middle phalanx) as a result of the injury. (Ex. 3-15). By June 14, 1996, Dr. Young determined that claimant was medically stationary and able to return to his regular work without restriction. (Ex. 3-42). The claim was closed by a July 3, 1996 Notice of Closure awarding temporary disability and scheduled permanent disability for loss of the third and fourth toes. (Ex. 3-45).

Claimant requested reconsideration and examination by a medical arbiter. He was examined by Dr. Smith, as medical arbiter, on October 1, 1996. Dr. Smith was advised that claimant sustained a crush injury to the right foot with multiple injuries to the toes, and asked to determine permanent impairment resulting from the accepted injury. (Ex. 8-2). Dr. Smith measured range of motion of the ankles and toes and performed a sensory examination, which showed hyperthesia over the medial-distal quarter of the sole of claimant's right foot and over the plantar aspect of the first and second toes. (Ex. 10-2). Dr. Smith also determined that claimant was significantly limited in any activities requiring repetitive pressure on the ball of the right foot because of pain arising from nerve damage caused by the crush injury. (Ex. 10-3).

Based on the medical arbiter's findings, a January 17, 1997 Order on Reconsideration increased claimant's award to 15 percent of the right foot/ankle. (Ex. B-1). Both the employer and claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on the arbiter's findings, the ALJ determined that claimant was entitled to a total award of 21 percent. In addition to the 15 percent awarded by the Order on Reconsideration, the ALJ's award included 2 percent for loss of ankle motion and 5 percent for a chronic condition of the right foot.

On review, the employer contends that claimant's scheduled permanent disability award should be reduced because he has not established that his loss of sensation and loss of ankle motion are related to his accepted injury. The employer also argues that claimant does not have a chronic condition. We adopt and affirm the ALJ's determination that claimant is entitled to scheduled permanent disability for loss of sensation and for a chronic condition in his right foot.[1] We agree with the employer, however, that claimant has not established that his ankle impairment is related to his compensable crush injury.

The record reflects no injury to claimant's right ankle. The compensable crush injury involved only the right forefoot. The medical arbiter included the active range of motion of both ankles in his report because he was specifically directed to do so by the Department. (See Ex. 8-2). The arbiter did not, however, relate claimant's right ankle impairment to the accepted condition, nor did he describe this impairment as "consistent with" the compensable injury. Consequently, we will not presume that claimant's right ankle impairment is caused by his compensable crush injury. Compare SAIF v. Danboise, 147 Or App 550 (1997) (when the record discloses no other possible source of impairment, a medical report that rates cervical impairment and describes it as "consistent with" the compensable cervical strain injury is substantial evidence to support a finding that the impairment is due to the compensable injury).

We therefore calculate claimant's scheduled permanent disability award as follows: Pursuant to OAR 436-035-0150, claimant has a combined great toe impairment of 27 percent, which converts to 4 percent of the foot under OAR 436-035-0180(2). Claimant is also entitled to 3 percent for the amputation of his third toe and 2 percent for the amputation of his fourth toe. OAR 436-035-0140(4); 436-035-0180(3). In addition, claimant is entitled to 5 percent for loss of sensation pursuant to OAR 436-035-0500 as well as 5 percent for a chronic condition under OAR 436-035-0010(5), since he is significantly limited in the repetitive use of his right foot. Combining these various impairment values entitles claimant to a total scheduled permanent disability award of 19 percent of the right foot.

ORDER

The ALJ's order dated May 12, 1997 is modified. In lieu of the ALJ's award and in addition to the Order on Reconsideration's award of 15 percent (20.25 degrees) scheduled permanent disability, claimant is awarded 4 percent scheduled permanent disability (5.4 degrees) for a total scheduled permanent disability award of 19 percent (25.65 degrees) of the right foot. Claimant's out-of-compensation attorney fee, as granted by the ALJ's order, shall be adjusted accordingly.

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[1] Indeed, the medical arbiter specifically found that claimant was substantially limited in the repetitive use of his right foot because of *nerve injuries resulting from the accident*. (Ex. 10-3).

In the Matter of the Compensation of
DONALD L. ODELL, Claimant
WCB Case No. 96-10082
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Ronald Atwood & Associates, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration awarding claimant 3 percent (9.60 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant, age 42 at the time of hearing, worked as a fifth hand paper machine operator. His duties included cleaning rolls of paper, pushing, pulling and carrying slabs of paper, and bringing stubs back to the machines. Claimant lifted and pulled slabs of paper weighing 50 to 75 pounds a piece approximately 20 time a day. He also pushed 400 slabs of paper across the floor about 40 times per day. Claimant also pulled, lifted and dumped trash (weighing about 50 pounds) into a dumpster, and engaged in other clean up activities involving lifting and carrying of rolled up paper weighing 50 to 75 pounds.

Claimant compensably injured his low back in December 1992. He was diagnosed with a lumbar strain, and ultimately received a 5 percent unscheduled permanent disability award for that injury.

Claimant reinjured his back at work in September 1995. The insurer accepted a low back strain, sciatica and L5-S1 degenerative disc. The claim was closed by a July 30, 1996 Determination Order awarding 3 percent unscheduled permanent disability. An October 15, 1996 Order on Reconsideration affirmed the Determination Order in all respects.

CONCLUSIONS OF LAW AND OPINION

The only issue in dispute in this case is whether claimant's job at injury should be given a base functional capacity (BFC) of "heavy" or "medium." In closing the claim, the Department determined that claimant was working as a "Paper Machine Operator," DOT 539.362-014, which has a BFC of medium. This determination was used by the Order on Reconsideration and the ALJ.

On review, claimant continues to assert that his BFC should be heavy, because his actual work exceeds the strength requirements of a paper machine operator. Specifically, claimant asserts that because he was also performing the duties of a Pulp-Press Tender, DOT No. 532-685-026, a combination of both DOT Codes most accurately describes his duties and therefore he should be given a BFC of heavy.

Under the applicable standards, a worker's BFC is evidenced by the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply. OAR 436-035-0310(4)(a).

We agree with the ALJ that claimant was not performing the duties of a pulp-press tender, and therefore that job cannot be used as a basis for his BFC. We find, however, that in addition to performing certain duties of a paper machine operator, claimant was also performing significant aspects of DOT 539.687-010, paper and pulp Winder Helper.[1] Therefore, a combination of those two DOT

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[1] The job of Winder Helper includes the following tasks:

"Threads paper through drier and calendar rolls and wraps end around roll core; * * * Lifts full rolls from winding reel onto dolly, using hoist, and pushes them to finishing area; * * * Pulls broke from drier and calendar rolls. Cleans calendar rolls. * * * May push rolls of paper into position on scales for weighing and mark rolls of paper for shipment * * * ."

codes (539.362-104 and 539.687.010) most accurately describe claimant's duties and the highest strength for the combination of codes (heavy) shall apply. See James R. Mannheimer, 49 Van Natta 227 (1997) (finding that the claimant "performed significant aspects of both" job descriptions, a cabinet maker with a strength category of medium and a plastic top assembler (furniture) with a strength of heavy, and applying the highest strength rating pursuant to former OAR 436-35-310(4)(a)).

In comparing claimant's BFC (heavy) to his residual functional capacity (RFC) of medium/light, he is assigned a value of 4 for adaptability. See OAR 436-035-0310(6). When the adaptability factor (4) is multiplied by the age/education factor (3), the result is 12. Because claimant has a prior claim in which he was awarded unscheduled permanent disability for his low back, that prior 5 percent award must be considered in recalculating his current unscheduled award.[2] See OAR 436-035-0007(5)(c). Indeed, claimant does not dispute the Department's reduction of his current unscheduled disability award by his prior 5 percent unscheduled permanent disability award. Consequently, adding claimant's social-vocational factors (12) to the impairment related to claimant's current injury (2)[3] equals 14, which, when reduced by claimant's prior 5 percent award, entitles claimant to an award of 9 percent unscheduled permanent disability.

ORDER

The ALJ's order dated April 3, 1997 is modified. In addition to the Order on Reconsideration's and ALJ's unscheduled permanent disability award of 3 percent (9.6 degrees), claimant is awarded 6 percent (19.2 degrees) for a total award to date of 9 percent (28.8 degrees) unscheduled permanent partial disability. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to the attorney.

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[2] See also Karen S. Maldonado, 48 Van Natta 2512 (1996); Mary A. Vogelaar, 42 Van Natta 2846 (1990) (if a worker suffers from disability due to preexisting injuries and has received unscheduled permanent disability for such disability, the prior disability award is considered in arriving at the appropriate permanent disability for the current injury).

[3] Claimant also does not dispute the Department's determination that he is entitled to a value of 2 for impairment due to the current injury. (See Ex. 32-5.)

Board Member Bock specially concurring.

I write separately to address the concern raised by the dissent that the majority opinion resolves this case in a matter not presented by the parties. For the following reasons, I believe that the majority has the authority to take judicial notice of DOT Code descriptions other than those raised or relied upon by the parties and to match such DOT Code descriptions to evidence of a claimant's job duties set forth in the record. Consequently, I do not believe the majority's resolution of this case is fundamentally unfair or inappropriate.

Oregon has adopted evidentiary rules that govern judicial notice of adjudicative facts and law.[1] See ORS 40.060 et. seq. Because OAR 436-035-0310 mandates the use of the Dictionary of Occupational Titles (DOT)[2] to determine strength categories, it is appropriate for this forum to take judicial notice of DOT Codes that match the duties of the claimant's job as established by the record.

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[1] ORS 40.065 sets forth the kinds of facts that may be judicially noticed and provides that

"A judicially noticed fact must be one not subject to reasonable dispute in that it is either:

"(1) Generally known within the territorial jurisdiction of the trial court; or

"(2) Capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned."

[2] The DOT is used frequently within the workers' compensation community and its accuracy cannot reasonably be questioned.

We are not acting without precedent in resorting to judicial notice of such informational sources to clarify an issue in dispute. For example, in Oregon State Bar v. Security Escrows, Inc., 233 Or 80 (1962), the Oregon Supreme Court noted that it was "justified in taking judicial notice of the fact that badly drawn instruments create not only needless litigation but needless loss and liability" in a discussion involving documents vesting property rights. Similarly, in Beswick v. State Industrial Accident Commission, 248 Or 456 (1967), the Court concluded that it was appropriate to take judicial notice "that either kind of flying is an activity fraught with great risk of harm to the pilot if either a mechanical or human failure should occur," despite there being "nothing in the record to suggest that fire-observation missions are substantially more dangerous than cropdusting missions."

Furthermore, the commentary accompanying the Oregon Rules of Evidence states, in pertinent part, that "[r]ule 201(b) [ORS 40.065] differs from Oregon's former statutory scheme in attempting to provide broad guidelines for judicial notice of facts, rather than enumerating specific categories of facts subject to judicial notice, as in ORS 41.410. Because Oregon courts did not bind themselves in the past to noticing only those matters set out in ORS 41.410, the new guidelines, although broad, do not change Oregon law."

The adoption of administrative rules that, by reference, incorporate the DOT permits us to take judicial notice of the information contained therein under ORS 40.090.[3] This section sets forth the kinds of law that may be judicially noticed, and includes, *inter alia*, "[r]egulations, ordinances and similar legislative enactments issued by or under the authority of the United States or any state, territory or possession of the United States." As the commentary notes, "[t]he Legislative Assembly believes that a broader approach is more in keeping with the goal of judicial notice: to expedite the administration of justice." The legislature therefore adopted ORS 40.090 (Rule 202), "which greatly expands the scope of judicial notice of law in this state."[4]

In this case, the parties' decision not to discuss a DOT code that is applicable to the undisputed facts does not mean that this forum is precluded from taking judicial notice of that job description. Where, as here, the evidence establishes that, at the time of his injury, claimant was performing significant aspects of a specific DOT job description, I believe it is appropriate to resolve the parties' dispute by relying upon that applicable description, even if that specific DOT code number was not expressly cited by the parties.

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[3] I recognize that, in Groshong v. Montgomery Ward Co., 73 Or App 403 (1985), the court held it was improper for the Board to take judicial notice of the DOT Code on review. Groshong is distinguishable from the case at hand on several grounds. First, Groshong was decided at a time when the applicable administrative rules did not specifically reference the DOT and require that it be used as a basis for assigning a strength category and specific vocational preparation (SVP) value, as do the current rules. See OAR 436-035-0300(3)(a); OAR 436-035-0310(4)(a). In fact, the court's opinion was premised upon the absence of a reference to the DOT in the administrative rules. Id. at 407. Furthermore, in Groshong, the court objected to the Board's use of DOT data to develop facts (evidence) concerning the claimant's job duties. In this case, we are not relying on the DOT code to develop facts concerning claimant's actual work duties--those are already in the record by virtue of claimant's affidavit. Rather, we are using the DOT Code just as the administrative rules require us to do: as a standard for rating the strength requirements of claimant's job at injury.

[4] The commentary also states that:

"[ORS 40.090] Subsection (2) provides for judicial notice of all official acts of the legislative, executive and judicial departments of this state, the United States and any other state, territory or other jurisdiction of the United States. It is based upon former ORS 41.410(3), but is broader, in that it provides for judicial notice of official acts of the branches of other states and of territories and possessions of the United States. To this extent this subsection changes Oregon law.

"The expanded scope of judicial notice under subsection (2) is best illustrated by considering the types of acts of Oregon governmental agencies a court has already been able to notice under ORS 41.410(3). These include civil service commission rules * * *; regulations and official acts of the Department of Higher Education, * * *; statutes and regulations of the State Board of Forestry, * * *; the statutory authority of the Superintendent and the rules and regulations of the Board of Control of the Oregon Fairview Home as to release of inmates * * * ; and rules of a state agency filed with the Secretary of State for compilation and publication, such as rules of the Public Utility Commission * * * . Under the similar California provision, California courts have taken judicial notice of a wide variety of administrative and executive acts, including proceedings and reports of Congressional committees, records of the California State Board of Education and the records of a county planning commission." (Citations omitted)

Board Member Moller dissenting.

The majority has found that claimant has established a base functional capacity of "heavy" because his job involved significant aspects of two job descriptions, DOT 539.362-014, "Paper Machine Operator" (medium strength) and DOT 539.687-010, "Winder Helper," (heavy strength). Because I disagree with the majority's reliance on a job title that was not cited and argued by the parties, respectfully I dissent.[1]

At hearing and on review, claimant asserted that his job at the time of injury was "Press-Pulp Tender" (DOT 532.685-026) rather than Paper Machine Operator, or that he was performing a combination of both job descriptions. Both the ALJ at hearing and the majority on review found that claimant's job included the duties of a Paper Machine Operator, but did not involve duties associated with the Press-Pulp Tender job. At no time did claimant contend that his job at injury was that of a paper and pulp Winder Helper, or that his duties involved a combination of that job title and Paper Machine Operator. Because claimant did not raise this argument (and the insurer therefore did not have the opportunity to respond with either additional evidence or argument), I believe the majority erred in deciding the case on this basis. See Fister v. South Hills Health Care, 149 Or App 214, 218-19 (1997) (Board held to have improperly deviated from its well-established practice of only considering issues raised at hearing where it sustains evidentiary objection first raised on review); see also Donald A. Hacker, 37 Van Natta 706 (1985) (fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue; such an opportunity does not exist if there is no notice that the issue is in controversy).

Based upon the record, as framed by the issues and arguments raised by the parties, I would affirm the ALJ's order. Because the majority resolves the case by relying on a job description that was not raised by the parties, I respectfully dissent.

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[1] I do not disagree with the specially concurring opinion that we have the authority to take judicial notice of the DOT Code descriptions. I do not, however, agree that we should exercise that authority given the posture of this case.

October 22, 1997 Cite as 49 Van Natta 1875 (1997)

In the Matter of the Compensation of
PAUL W. SMITH, Claimant
WCB Case No. 97-01736
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the SAIF Corporation's denial of his "new injury" claim for a left foot stress fracture; and (2) declined to award an insurer-paid attorney fee under ORS 656.386(1). On review, claimant contends he is entitled to an attorney fee for SAIF's "pre-hearing" acceptance of his left foot fracture condition.[1]

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

Contrary to claimant's contention, he did not prevail over SAIF's February 14, 1997 denial of claimant's "new" occupational disease claim for a left foot stress fracture. While SAIF has accepted this condition as a part of claimant's March 19, 1996 claim, it has not accepted claimant's condition as a new occupational disease. That was the basis for SAIF's February 14, 1996 denial which the ALJ correctly upheld. Accordingly, we agree with the ALJ that claimant is not entitled to an attorney fee pursuant to ORS 656.386(1).

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[1] We note that claimant has moved to consolidate this case with WCB Case No. 96-10061. On this date, we have dismissed claimant's request for review in WCB Case No. 96-10061. Therefore, claimant's request for consolidation is rendered moot.

ORDER

The ALJ's order dated June 3, 1997, as reconsidered June 30, 1997, is affirmed.

October 22, 1997 Cite as 49 Van Natta 1876 (1997)

In the Matter of the Compensation of
PAUL W. SMITH, Claimant
WCB Case No. 96-10061
ORDER OF DISMISSAL
Charles Robinowitz, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order denying a request for additional attorney fees. We have reviewed this request to determine if we have jurisdiction to consider this matter. On review, the issue is jurisdiction and, if so, attorney fees. We conclude that we lack jurisdiction, and dismiss the request.

FINDINGS OF FACT

On April 30, 1997, ALJ Nichols issued an Opinion and Order which: (1) set aside the insurer's denial of claimant's plantar fasciitis and plantar calcaneal heel syndrome; (2) assessed a penalty for unreasonable claims processing against the SAIF Corporation; and (3) awarded claimant's attorney an assessed fee of $4,000 under ORS 656.386(1). The order contained a statement explaining the parties' rights of appeal under ORS 656.289(3).

On June 25, 1997, claimant filed a Motion for Supplemental Award of Attorney Fees, requesting that the ALJ reconsider the attorney fee granted by the April 30, 1997 order. On July 1, 1997, ALJ Nichols issued an order that denied claimant's request.[1] Because more than 30 days had passed since the April 30, 1997 order had issued, the ALJ responded that the order had become final. The order contained a statement explaining the parties' rights of appeal under ORS 656.289(3).

On July 14, 1997, the Board received claimant's request for review of the ALJ's July 1, 1997 order.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, claimant requested Board review of the ALJ's July 1, 1997 order denying reconsideration within 30 days of its issuance. However, as noted by the ALJ, the July 1, 1997 order issued more than 30 days after the April 30, 1997 Opinion and Order. Furthermore, the April 30, 1997 order has neither been abated, withdrawn, stayed, modified, nor republished.

The ALJ's July 1, 1997 order contained a statement of appeal rights. However, an ALJ cannot extend the appeal period beyond the time permitted by statute. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986). Since the 30-day statutory appeal period from the ALJ's April 30, 1997 order elapsed unabated without a timely request for Board review, it has become final by operation of law. See ORS 656.289(3); Wright, 80 Or App at 444. Consequently, the July 1, 1997 order is a nullity. See Leon C. Buzard, 40 Van Natta 595 (1988); James McCormac, 43 Van Natta 133 (1991).

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[1] On June 3, 1997, ALJ Brazeau issued an order in 97-01736, as reconsidered on June 30, 1997, which: (1) upheld the SAIF Corporation's denial of claimant's "new injury" claim for a left foot stress fracture; and (2) declined to award an insurer-paid attorney fee under ORS 656.386(1). Claimant has moved the Board to consolidate Board review of WCB Case Nos. 96-10061 and 97-01736, as well as to approve "consolidation" of his opening brief(s). Because we dismiss claimant's request for review in WCB Case No. 96-10061, claimant's request to consolidate is rendered moot.

Based on the foregoing reasoning, we lack jurisdiction to consider claimant's request for Board review of either the April 30, 1997 Opinion and Order or the July 1, 1997 Order Denying Reconsideration. See Leon C. Buzard, 40 Van Natta at 595; Jess H. Knowland, 46 Van Natta 1008 (1994). Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

October 24, 1997 Cite as 49 Van Natta 1877 (1997)

In the Matter of the Compensation of
LARRY W. BURKE, Claimant
WCB Case Nos. 96-08283, 95-13502, 96-03937 & 96-03539
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys
Lane, Powell, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation (Lemax General Contractors, Inc.) requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral hearing loss condition; and (2) upheld the responsibility denials of Liberty Northwest/Snow Mountain Pine, SAIF/Willamina Lumber Company, and Liberty Northwest/Willamina Lumber Company for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

Claimant, age 49 at the time of hearing, has had several different types of employment in his adult life. Between 1966 and 1969, he served in the military. For at least 18 months, he was in Viet Nam, serving as a crew chief for a helicopter crew. The noise exposure was high, but claimant used hearing protection.

Between 1969 and 1983, claimant held various jobs, including railway brakeman, and heavy equipment operator, mill maintenance worker, sawmill construction worker, and industrial mechanic. Although claimant characterized some of these jobs as noisy, he did not wear hearing protection and did not detect any hearing loss.

In late 1983, claimant began working as a millwright for Snow Mountain Pine, insured by Liberty. He spent nearly five years in this job, working around noisy machinery without hearing protection. During this time, he began to notice problems with his hearing. Between 1989 and mid-1991, claimant worked for Stricklan and Stricklan, insured by Argonaut, in sawmill construction. The noise level was high, but he wore no hearing protection.

Beginning on September 9, 1991, claimant went to work for Lemax General Contractors, insured by SAIF. He worked mostly outdoors, as a welder. Claimant did not consider this work particularly noisy, although he was hearing ringing in his ears by this time. On September 23, 1991, claimant sought treatment from Dr. Pfendler, an otolaryngologist. Dr. Pfendler performed audiometric testing and diagnosed "high-frequency bilateral neurosensory loss." He recommended that claimant use maximum protection from noise exposure. Claimant did not begin using such protection. Claimant left SAIF/Lemax's employ on November 1, 1991.

Later in November 1991, claimant went to work for Willamina Lumber Company, who was then insured by SAIF. He worked as an operational millwright inside the mill, and was often exposed to noisy operating machinery. At first, claimant wore no hearing protection, but began to do so in early July 1992. He has worn hearing protection regularly since that time. On April 1, 1994, Liberty became Willamina's insurer. Claimant's job remained the same.

Claimant filed an occupational disease claim for hearing loss with Willamina in October 1995. The claim was denied by both Liberty/Willamina and SAIF/Willamina. In November 1995, claimant was examined by Dr. Hodgson, an otolaryngologist, who performed audiometric testing. In February 1996, audiologist Maurer reviewed claimant's medical records. He opined that claimant's hearing loss preexisted his employment with Willamina.

In March 1996, Dr. Pfendler was asked to do a comparative analysis of claimant's audiometric testing from September and November 1991 and November 1995. He concluded that there had been no additional hearing loss between 1991 and 1995.

Claimant filed bilateral hearing loss claims against SAIF/Lemax and Liberty/Snow Mountain Pine. Both claims were denied.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's bilateral hearing loss was compensable under ORS 656.802 and that SAIF/Lemax was initially responsible for the condition under the "last injurious exposure rule" because claimant first sought treatment while he was employed by Lemax. The ALJ further found that SAIF/Lemax could not shift responsibility to some other employer because it was possible that claimant's exposure at Lemax contributed to his condition and because claimant's condition did not actually worsen during his subsequent employment with Willamina.

On review, SAIF/Lemax cites Beneficiaries of Strametz v. Spectrum Motorwerks, 325 Or 439 (1997), and Roseburg Forest Products v. Long, 325 Or 305 (1997), and argues that it cannot properly be held responsible under the last injurious exposure rule. Specifically, SAIF/Lemax asserts that the medical evidence establishes that the employment conditions at Lemax did not cause claimant's hearing loss condition.[1] We disagree.

In Long, the Oregon Supreme Court considered aspects of the last injurious exposure rule when a claimant has a compensable occupational disease that is caused by working conditions at a single employer who has had a series of carriers. Citing to its earlier decision in Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), the Court held that:

> "[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 it 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."

Shortly thereafter, in Strametz, the Court considered the application of the last injurious exposure rule in an initial claim context. In reversing the decision of the Court of Appeals,[2] the 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. Citing the "either/or" test it articulated in Long, the Court concluded:

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[1] Citing Donald J. Boies, 48 Van Natta 1259 on recon 48 Van Natta 1861 (1996), SAIF/Lemax also asserts that the ALJ erred in finding that claimant first sought medical treatment for his compensable condition while he was employed by Lemax. We reject this contention. In Boies, we relied on Norman L. Selthon, 45 Van Natta 2358 (1993), and held that audiometric tests obtained pursuant to OSHA requirements do not constitute medical treatment for purposes of determining the onset of disability. In this case, unlike Boies and Selthon, claimant sought out an otolaryngologist for treatment because he had noticed a progressive loss of hearing. (See Ex. 1). The examination and testing by Dr. Pfendler was not done at the behest of the employer for purposes of OSHA compliance, but rather on claimant's own initiative to address a perceived problem with his hearing.

[2] In Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, adhered to as modified, 138 Or App 9 (1995), the court held that under the last injurious exposure rule the employer on the risk at the time the claimant first sought treatment would be liable if the evidence established that the conditions of that employment were of the type that could have caused the claimant's occupational disease, even though that employment could not have been the actual cause of the disease.

> "Under the last injurious exposure rule, the employer that would otherwise be held responsible for a claimant's occupational disease may avoid responsibility by proving that conditions of its employment could not have caused the disease or that a previous employment was the sole cause of the disease." 325 Or at 445.

Reading these two decisions together, we conclude that in order for an employer that would otherwise be held responsible under the last injurious exposure rule (i.e. SAIF/Lemax in this case) to shift responsibility to a prior employer, the employer that would otherwise be held responsible must still establish that it is *impossible* for that particular employment exposure to have caused or contributed to the claimant's condition or that the disease was caused solely by conditions that preexisted the employment at issue. Evidence that the employment conditions probably did not cause or contribute to the claimant's condition is not enough. See, e.g., Lance D. Farleigh, 49 Van Natta 1423 (1997). The carrier that would otherwise be held responsible must show that an earlier employment was the sole cause of the claimant's disability or that it was impossible for the later employment to have contributed to the claimant's condition.

In this case, although the medical evidence establishes it was not likely that claimant's short employment exposure at SAIF/Lemax caused or contributed to his hearing loss, SAIF/Lemax has not shown by a preponderance of the evidence that it was *impossible* for conditions at its work place to have caused the disease or that the disease was caused *solely* by conditions at his previous employments. Indeed, both Dr. Pfendler and Dr. Hodgson specifically indicated that it was possible (but not probable) that claimant's employment at SAIF/Lemax contributed to his condition.[3] (Exs. 34A-20; 35-24). Dr. Hodgson's opinion was based on the understanding that claimant used tools including a hand-held grinder, welding torch, gas welder and other hand-held construction drills during his employment at Lemax. (Ex. 35-24).

Dr. Maurer, who performed a records review, testified that claimant's hearing loss preexisted his employment at Lemax and that this employment could not have caused the hearing loss that was measured by Dr. Pfendler on September 23, 1991. (Ex. 36). Although Dr. Maurer could not attribute any of claimant's hearing loss to his exposure at SAIF/Lemax, he did not address whether it was impossible for the conditions at this workplace to have contributed to claimant's condition or opine that claimant's condition was solely caused one or more of his prior employments.

Consequently, on this record, we conclude SAIF/Lemax may not avoid responsibility for claimant's bilateral hearing loss condition.

ORDER

The ALJ's order dated March 5, 1997 as amended April 22, 1997, is affirmed.

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[3] Dr. Pfendler testified that it is "extremely unlikely" that this exposure contributed to claimant's hearing loss (Ex. 34A-20, 34A-21), but did not rule out any contribution whatsoever.

In the Matter of the Compensation of
GUY A. LAWRENCE, Claimant
WCB Case No. 96-05226
ORDER DENYING RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our September 24, 1997 Order on Review that vacated an Administrative Law Judge's (ALJ's) order and remanded the case for further development of the record regarding the "compensability/rule of proof" issue arising from the admission of Dr. Miller's "post-hearing" report. Specifically, SAIF argues that claimant did not properly raise the "last injurious exposure rule of proof" at hearing and even if he did, SAIF further argues that the medical evidence does not warrant remand.

After reviewing SAIF's motion, we have nothing further to add to our order.[1] Accordingly, the motion is denied. We adhere to our September 24, 1997 order. The parties' rights of appeal shall continue to run from our September 24, 1997 Order.

IT IS SO ORDERED.

[1] Furthermore, most, if not all, of SAIF's contentions can be addressed by the ALJ on remand. In addition, should either party disagree with the ALJ's subsequent conclusions, the aggrieved party can also present any and all of its arguments (including objections to our decision to remand this case) to the Board on appeal from the ALJ's eventual order.

October 24, 1997 Cite as 49 Van Natta 1880 (1997)

In the Matter of the Compensation of
WILLIAM R. SHAPTON, Claimant
WCB Case Nos. 96-06273 & 96-04455
ORDER OF ABATEMENT
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

By Order on Reconsideration dated September 25, 1997, we adhered to and republished our August 27, 1997 Order on Review that: (1) set aside the insurer's denial of claimant's aggravation claim for a low back condition; and (2) assessed a penalty-related attorney fee of $500 for the insurer's untimely discovery. Announcing that the parties have entered into settlement negotiations and expect to finalize a settlement agreement within 10 days, the insurer seeks abatement of our prior orders pending finalization and filing of the settlement agreement.

In light of the insurer's announcement, we withdraw our August 27 and September 25, 1997 orders. On receipt of the parties' executed settlement agreement, 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
ROBERT L. SMITH, Claimant
WCB Case Nos. 96-08046 & 96-03518
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Reinisch, et al, Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Kemper Insurance Company (Kemper) requests review of that portion of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's low back condition; and (2) upheld Fireman's Fund Insurance Company's (Fireman's) denial of the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the ALJ concluded that Kemper had accepted claimant's lumbar degenerative disc disease pursuant its acceptance of a disc herniation in the August 1990 stipulation. We agree that claimant's accepted claim with Kemper includes lumbar degenerative disc disease, but do so based on the following reasoning.

Claim acceptance is an act through which the carrier acknowledges responsibility for the claim and obligates itself to provide the benefits due under law. Gene C. Dalton, 43 Van Natta 1191 (1991). Acceptance of a claim may be accomplished by checking the appropriate options on an 801 Form. U. S. Bakery v. Duval, 86 Or App 120 (1987).

Here, Kemper accepted claimant's claim by checking that option on the 801 Form. (Ex. 9). On the 801 Form, claimant listed his condition as "low back pain (overuse)" (Id.). In an attachment that accompanied the 801 Form, claimant attributed his low back pain, overuse, and swelling to pressure on a nerve and further degeneration of a lower back disc. (Ex. 10). In addition, at the time of Kemper's acceptance, both Dr. Jones and Dr. Kitchel indicated that claimant's low back condition was attributable to lumbar degenerative disc disease. (Exs. 5-8). Based on this, we conclude that Kemper accepted claimant's lumbar degenerative disc disease.

Inasmuch as claimant's current condition is attributable to lumbar degenerative disc disease, a condition which we have herein concluded is part of claimant's accepted claim with Kemper, we agree with the ALJ that Kemper's denial must be set aside.

Responsibility

We adopt the conclusions and reasoning set forth in the ALJ's order.

Attorney Fee/Board Review

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by Kemper Insurance Company. 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 April 9, 1997 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $1,200, payable by Kemper Insurance Company.

In the Matter of the Compensation of
ROGER GRIFFITH, Claimant
WCB Case No. 96-09282
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock, and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's claim for a vascular condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the 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.

ORDER

The ALJ's order dated May 27, 1997 is affirmed. For services on review, claimant's counsel is awarded a reasonable fee of $1,200, payable by the SAIF Corporation.

Board Member Moller dissenting.

The majority concludes that claimant carried his burden of proving that his vascular condition is compensable. For the following reasons, I dissent.

The ALJ relied on Dr. Libby's opinion to conclude that claimant had established that the July 1, 1996 work incident was the major contributing cause of claimant's need for treatment for his combined condition. Dr. Libby opined that the work incident was the major contributing cause. The substance of his reasoning is set forth in Exhibit 41 where he states: "The [work-related] trauma precipitated clotting in the deep system which would not have occurred if the patient had no trauma. Thus, although the varicose veins have the risk of deep venous clotting, the trauma was the precipitating cause, thus the major contributor * * *" (Ex 41-3)

In Deitz v. Ramuda, 130 Or App 397 (1994) the court held that the determination of "major cause" under ORS 656.005(7)(a)(b) requires an evaluation and weighing of the relative contribution of different causal factors and deciding which is the primary cause. Id. at 401-402. The fact that a work injury may be an immediate or precipitating cause is not sufficient to establish major cause absent a comparison of the relative contribution of all causal factors. Id. at 401; See also SAIF v. Nehl, 149 Or App 309 (1997) (court agrees, on reconsideration, that reliance on "immediate cause" is incorrect test contemplated by ORS 656.005(7)(a)(B).)

Here, Dr. Libby's opinion is based on precisely the type of reasoning rejected by the court in Deitz. That is, Dr. Libby opines that the work injury is the major contributing cause of claimant's need for treatment for the combined condition because it was the precipitating event that led claimant to seek medical treatment. Therefore, on this record, claimant has not established that his claim is compensable. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
SYLVESTER K. HECKY, Deceased, Claimant
WCB Case Nos. 97-01638 & 95-12174
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Gayle Hecky-Kurup (claimant) requests review of that portion of Administrative Law Judge (ALJ) Neal's order that upheld the SAIF Corporation's denial of her claim as the alleged beneficiary of the deceased worker. On review, the issue is whether, for purposes of ORS 656.005(2)(a), claimant lived "in a state of abandonment" from the decedent at the time of his death. We affirm.

FINDINGS OF FACT

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

Claimant married the decedent, Sylvester Hecky, in 1971. They lived in California and had three daughters. In November 1985, claimant and the decedent separated and the decedent moved to Hawaii. Within a year, the three daughters joined the decedent in Hawaii and claimant continued to reside in California. The daughters lived with their father in Hawaii until July 1990.

Between 1986 and September 1994, claimant lived off and on with Robert Kurup. She assumed his last name and they filed joint tax returns. Claimant and Robert Kurup also had two sons, one born in 1987 and another born in 1990. After claimant separated from Robert Kurup in 1994, she obtained a court order for support, which he has occasionally paid.

Meanwhile, in November 1990, the decedent obtained a marriage license in Hawaii and went through a wedding ceremony with his girlfriend, Gina. Thereafter, until January 1995, the decedent and Gina lived together as husband and wife, even though the decedent and claimant had never obtained a divorce. During this time, two of the decedent's daughters moved to Hawaii, although one returned to live in California in the summer of 1994.

In January 1995, the decedent left Gina and moved in with his oldest daughter, who still lived in Hawaii. Then, in June 1995, he moved back to California. He looked for work and spent some time with his daughters. During this month, the decedent and claimant saw each other several times at family gatherings. The decedent also helped claimant pay for groceries during June 1995 and paid one of her utility bills.

In late June 1995, the decedent moved to Oregon and began working for the employer as a truck driver. He was killed on July 1, 1995 in a truck accident. A claim was prepared on the decedent's behalf, which SAIF accepted and paid benefits to his dependent children. SAIF denied claimant's claim for survivor benefits on the ground she was abandoned by the decedent.

CONCLUSIONS OF LAW AND OPINION

The definition of "beneficiary" in ORS 656.005(2) includes the "wife" of a worker who is entitled to receive payments under ORS Chapter 656. The statute further provides that "beneficiary" does not include:

> "(a) A spouse of an injured worker living in a state of abandonment for more than one year at the time of the injury or subsequently. A spouse who has lived separate and apart from the worker for a period of two years and who has not during that time received or attempted by process of law to collect funds for support or maintenance is considered living in a state of abandonment." ORS 656.005(2)(a).

Relying on this statutory exception to the definition of beneficiary, the ALJ determined that claimant was not entitled to benefits pursuant to ORS 656.204 because she she lived in a "state of abandonment" from the decedent. Specifically, the ALJ determined that, even if claimant had received some money from the decedent in the two years before his death, this money did not amount to "funds for support or maintenence" under ORS 656.005(2)(a).

On review, claimant asserts that she periodically received funds for support or maintenance from the decedent on behalf of her or her children in the two years before his death. Claimant also argues that she was not living in a state of abandonment, because her separation from the decedent was consensual and voluntary. We reject both contentions.

Claimant concedes that she lived separate and apart from the decedent for many years, including the two years prior to his death. Claimant also admitted that the decedent never paid her child support or spousal support, and that she never attempted to collect such support by process of law. (Ex. 7). She further admitted that claimant sent her no money in the two years before his death. (Tr. 21). In fact, the record establishes only that, in the two years prior to his death, the decedent assisted claimant with groceries during the month of June 1995 and paid one utility bill on claimant's behalf during this same time. Claimant also testified that the decedent may have provided his daughters April and Heather with some money for school and clothing in the last two years of his life. (Tr. 21-23).

We agree with the ALJ that the limited monetary contributions the decedent made to (or on behalf of) claimant in the last month of his life do not constitute "funds for support and maintenance." That term, as used in ORS 656.005(2)(a), contemplates something more than the de minimis amount indicated by the record in this case. See, e.g., Samuel Harris, DCD, 6 Van Natta 215 (1971) (where the decedent and his widow had lived separate and apart for years and the the only evidence of "support" was the widow's testimony that she received a nominal amount of money from the decedent shortly before his death, the widow was not a "beneficiary" within the meaning of ORS 656.005(2)).

Claimant also argues that the concept of "abandonment" in ORS 656.005(2)(a) is equivalent to the concept of "desertion" as grounds for divorce, and that, under Oregon divorce law, "desertion" requires that the separation be against the will, and without the consent of, the complaining spouse. See Blair v. Blair, 124 Or 611 (1928) ("where there is consent to the separation by the party claiming desertion, it would not constitute grounds for divorce"). We find nothing in the text or context of ORS 656.005(2)(a) to suggest that the legislature intended to equate "abandonment" under workers' compensation law with the divorce law concept of "desertion."[1] Indeed, under workers' compensation law, a married couple's separation by mutual consent does not preclude a finding that the claimant had been living in a state of abandonment prior to the deceased worker's death. See, e.g., Randall Cannon, DCD, 28 Van Natta 607 (1982) (the claimant was considered to be living in a state of abandonment where she and the deceased worker had parted by mutual consent more than a year prior to the decedent's death).

Consequently, like the ALJ, we consider claimant to be "living in a state of abandonment," and therefore not entitled to spousal benefits under ORS 656.204.

ORDER

The ALJ's order dated May 21, 1997 is affirmed.

[1] We further note that Oregon has abolished the doctrines of fault and in pari delicto in suits for the annulment or dissolution of a marriage or for separation. See ORS 107.036.

In the Matter of the Compensation of
SONJA A. FARRELL, Claimant
WCB Case No. 96-05403
ORDER ON REVIEW
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Mills' order that affirmed the Order on Reconsideration award of 7 percent (10.5 degrees) scheduled permanent partial disability (PPD) for loss of use or function of the left knee. On review, the issues are scope of review, remand, evidence and extent of scheduled PPD.

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

Claimant's brief on review includes a report of a medical study that is not otherwise in the record. We treat claimant's submission of this new report as a motion for remand for submission of additional evidence, and we deny that motion. Claimant offers the new report in support of her contention that her left knee condition was not medically stationary when her claim was closed. Because claimant did not raise this premature closure issue at hearing, it is not a proper issue before the Board on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). Consequently, remand for inclusion of the new report would not change the ultimate disposition of this case.

ORDER

The ALJ's January 27, 1997 order is affirmed.

October 28, 1997 Cite as 49 Van Natta 1885 (1997)

In the Matter of the Compensation of
RONALD P. KLEFMAN, Claimant
WCB Case Nos. 95-11139, 95-06440, 95-11138, 95-03622 & 9503621
ORDER ON REVIEW
David J. Lefkowitz, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board en banc.[1]

The SAIF Corporation, on behalf of the Oregon Department of Veteran's Affairs, requests review of those portions of Administrative Law Judge (ALJ) Schultz' order that: (1) set aside SAIF's subjectivity denial/responsibility disclaimer of claimant's right knee injury claim; (2) upheld *de facto* denials of subjectivity from Elmo Lambert and Judith Klefman, dba Satori Associates; and (3) set aside the Director's determination that claimant was not a subject worker for Elmo Lambert and Satori Associates. Claimant cross-requests review of that portion of the ALJ's order which declined to grant an assessed attorney fee. On review, the issues are jurisdiction, subjectivity, and attorney fees. We reverse in part and vacate in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was a subject worker for the Oregon Department of Veteran's Affairs (ODVA) and set aside the Director's determination that claimant was not a subject worker. The ALJ also set aside SAIF's subjectivity denial. In addition the ALJ upheld *de facto* subjectivity denials from Elmo Lambert and Satori Associates.

Before addressing the merits, we briefly recite the relevant procedural history. Claimant filed a claim against ODVA, which is insured by SAIF. A claim was also filed against Elmo Lambert and Satori Associates, neither of whom had workers' compensation insurance. SAIF issued a formal denial April 3, 1995 on the basis that claimant was not a subject worker of ODVA. Claimant requested a hearing concerning that denial which was assigned WCB Case No. 95-03621. Claimant also requested a hearing concerning a *de facto* denial of subjectivity by Elmo Lambert (WCB Case No. 95-03622) and a *de facto* denial of subjectivity by Satori Associates (WCB Case No. 95-06440). Thereafter, on October 23, 1995, the Director determined that claimant was not a subject worker of Elmo Lambert. Claimant requested a hearing concerning this determination which was assigned WCB Case No. 95-11138. Also on October 23, 1995, the Director determined that claimant was not a subject worker of Satori Associates. Claimant's request for hearing concerning this determination was assigned WCB Case No. 95-11139. All of these requests for hearing were consolidated and heard by the ALJ at the December 23, 1996 hearing.

[1] Member Moller has recused himself from participation in the review of this case. OAR 438-011-0023.

On January 22, 1997, the ALJ issued an Opinion and Order which "set aside" the Director's determination that claimant was not a subject worker and remanded the matter to the Director for processing of claimant's claim for benefits as a subject worker of ODVA. The ALJ also set aside SAIF's April 3, 1995 denial and upheld the *de facto* denials of subjectivity of Elmo Lambert and Satori Associates. The order indicated that appellate jurisdiction over the order rested with the Court of Appeals.

On February 18, 1997, the ALJ abated his Opinion and Order. On February 20, 1997, the Director filed a Notice of Intent to Review the ALJ's order. On February 22, 1997, the Director withdrew the Notice of Intent to Review. On March 13, 1997, the ALJ issued an Order on Reconsideration in which the ALJ indicated that his prior order should have only addressed the issue of subjectivity. However, the ALJ republished the "Order" portion of his Opinion and Order in its entirety.

The first issue to be addressed is whether the Board has appellate jurisdiction over any of these matters. In Lankford v. Copeland, 141 Or App 138 (1996), the court held that review of an ALJ's order affirming the Director's determination that the claimant was not a subject worker was not a matter concerning a claim within the meaning of ORS 656.704(3). Thus, the court concluded that review of the ALJ's order rested with the court under ORS 183.482. The court explained that the Director must first determine whether a claimant may seek compensation under the Workers' Compensation Act before claimant's right to receive compensation and the amount thereof become an issue. Lankford, 141 Or App at 142-43.

Pursuant to the court's decision in Lankford, the Board clearly does not have appellate jurisdiction over claimant's requests for hearing concerning the Director's determination that he was not a subject worker of either Elmo Lambert or Satori Associates. (WCB Case Nos. 95-11138 and 95-11139).[2] Rather, the ALJ's order concerning those issues was entered on behalf of the Director.[3] Similarly, claimant's requests for hearing concerning the *de facto* subjectivity denials of Elmo Lambert and Satori Associates, involve the same determination made by the ALJ on the behalf of the Director, *i.e.*, was claimant a subject worker of Elmo Lambert or Satori Associates[4]. Consequently, claimant's requests for hearing regarding the *de facto* denials of subjectivity of Elmo Lambert (WCB Case No. 95-03622) and Satori Associates (WCB Case No. 95-06440) are not within the Board's appellate jurisdiction.

The only hearing request that remains is WCB Case No. 95-03621, concerning SAIF's April 3, 1995 denial. At the time of the December 1996 hearing, the Board's rules did not allow for consolidation of additional issues with issues concerning a Director's determination of "non-subjectivity." See former OAR 438-006-0038. Thus, claimant's requests for hearing concerning the Director's "subjectivity" determinations regarding Elmo Lambert and Satori Associates should not have been consolidated with claimant's request for hearing concerning SAIF's denial.[5] However, given our decision above with regards to the other hearing requests filed by claimant, the only viable request for hearing that is within our jurisdiction concerns SAIF's denial. Since SAIF was a party to the hearing and no party contends that the record has been insufficiently developed, it would neither achieve administrative efficiency nor substantial justice to remand this matter for the issuance of an order that only addresses SAIF's denial (a denial that has been thoroughly litigated).

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[2] SAIF has submitted a copy of the Director's August 21, 1997 Final Order, which determined that claimant was a subject worker of Satori Associates, and asks that the Board take administrative notice of the order. As noted above, we do not have jurisdiction over that portion of the ALJ's order and therefore, the Director's final determination does not affect the matter before the Board. Consequently, we do not find it necessary to take administrative notice of the Director's order.

[3] Although there were no administrative rules which specifically authorized the ALJ to sit as the Director's Hearings Officer in this matter, the Director has subsequently adopted such rules. See OAR 436-002-0001 et seq. (WCB Admin. Order 97-058, effective August 1, 1997).

[4] Because the parties agreed that compensability was not at issue, we interpret claimant's request for hearings concerning the *de facto* denials of Elmo Lambert and Satori Associates as addressing only subjectivity. (Tr. 14-16, 18, 19). The Hearings Division would have jurisdiction over any dispute involving compensability as it is a matter concerning a claim. See ORS 656.704(3).

[5] Former OAR 438-006-0038 has since been repealed and the Director's current rules allow an appeal of a Director's "non-subjectivity" determination to be consolidated with other issues, provided that the ALJ issues separate order. See OAR 436-002-0030

The only remaining jurisdictional question regards whether the court's decision in Lankford is applicable to a subjectivity determination that is made by an insurer or self-insured employer. As noted above, the Lankford court held that a Director's determination of subjectivity is not a matter concerning a claim. Under ORS 656.054, compensable injuries to a subject worker while in the employ of a noncomplying employer are compensable to the same extent of if the employer had workers' compensation insurance. Because such an employer does not have compensation insurance, it follows that there is not an insurer to process the claimant's claim. Consequently, the Director is statutorily directed to assign the claimant's claim to an assigned claims agent. ORS 656.054(1). In performing this statutory function, the Director is empowered to decide whether the alleged noncomplying employer and the claimant are subject to ORS Chapter 656. ORS 656.726(3).

However, where the employer against whom the claim is made has workers' compensation insurance, it is not necessary, nor required by statute, for the Director to make a determination regarding whether or not the employer or the claimant are subject to ORS Chapter 656. Rather, that is the function of an insurer or self-insured employer who must process a worker's claim pursuant to ORS 656.262. Thus, although the issue (subjectivity) is the same, the processing of the claim is different when an employer has compensation insurance. That is, the insurer, rather than the Director, makes the initial determination with regard to a worker's subjectivity.

The Lankford court indicated that a worker's subjectivity is not a "matter concerning a claim" unless and until the Director has made a determination regarding subjectivity. Here, in contrast, SAIF has made that "determination" by issuing its April 23, 1995 denial. Inasmuch as the Director was not involved in that decision, we do not find the holding in Lankford applicable. Rather, where an insurer or self-insured employer issues a denial based on a worker's alleged lack of subjectivity, that denial is a "matter concerning a claim." i.e., the denial directly affects the worker's entitlement to compensation or the amount thereof as described in ORS 656.704. Accordingly, we conclude that we have appellate jurisdiction over the ALJ's decision in WCB Case No. 95-03621. We now proceed to the merits.

The ALJ concluded that claimant was a subject worker of ODVA. We disagree.

When deciding whether a person comes under workers' compensation law, the first inquiry is whether the person is a worker under ORS 656.005(30) and the judicially created "right to control" test and if so, whether the worker is "nonsubject" under one of the exceptions created by ORS 656.027. See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 630-631 (1994). If the relationship between the parties cannot be established by the "right to control" test, it is permissible to apply the "nature of the work" test. Id., at 622 n. 6.

The principal factors to be considered under the "right to control" test are: (1) direct evidence of the right to, or the exercise of control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Castle Homes, Inc. v. Whaite, 95 Or App 269, 272 (1989). None of those factors are dispositive; rather, they are to be viewed in their totality. Cy Investment, Inc. v. Natl. Council on Comp. Ins., 128 Or App 579, 583 (1994).

Here, the only connection between ODVA and claimant is the fact that ODVA is the conservator of Elmo Lambert's trust. As the conservator, ODVA authorized and administered payment of claimant's salary from the trust and owned the van that claimant was operating at the time of the injury. ODVA did not hire claimant nor did it have any control over his work schedule or the method claimant performed his work activities. Those duties were performed by Satori Associates, Elmo Lambert's guardian. (Tr. 49, 61). In addition, Satori Associates, rather than ODVA, had the right to fire claimant or other drivers, as Ms. Klefman testified that she would quit scheduling a driver that was determined to be inappropriate. (Tr. 140). Finally, neither claimant nor any driver was allowed to use the van unless permission was given by Ms. Klefman. (Tr. 154). On this record, claimant has not established that ODVA was his employee at the time of injury. The fact that ODVA was the conservator of the trust which paid claimant and owned the van is insufficient to establish that ODVA had a "right to control" claimant's work activities.[6] Accordingly, SAIF's denial must be upheld.

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[6] Assuming that the employment relationship between claimant and ODVA could not be determined by application of the "right to control" test, claimant's claim would fail under the "nature of the work" test. In this regard, there is no evidence which suggests that ODVA's "business" included arranging for transportation for beneficiaries of administered trusts. See Woody v. Waibel, 276 Or 189, 195-198 (1976).

Because we have concluded that SAIF's denial should be upheld, claimant's request for an attorney fee is moot.

ORDER

The ALJ's order dated January 22, 1997, as reconsidered March 13, 1997, is reversed in part and vacated in part. That portion of the ALJ's order which set aside SAIF's denial is reversed. The denial is reinstated and upheld. Insofar as SAIF's request for review pertains to an appeal of those portions of the ALJ's order that pertained to the Director's Subjectivity Determinations (WCB Case Nos. 95-11138; 95-11139; 95-03622; and 95-06440), those portions of the request for review are dismissed.

In the Matter of the Compensation of
ELLIS D. McROBERTS, Claimant
WCB Case No. 96-09013
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral hearing loss. On review, the issue is responsibility.

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

Following the ALJ's order, the Supreme Court issued its opinion in Roseburg Forest Products v. Long, 325 Or 305 (1997), which addressed the imposition of responsibility for a claim under the last injurious exposure rule between or among successive insurers of a single employer. The Court held:

> "[T]he most recent insurer is fully responsible for the claimant's occupational disease unless the insurer proves either: (1) that it was impossible for workplace conditions at the time it insured the employer to have caused the disease in this particular case or (2) that the disease was caused solely by employment conditions at a time when the employer was insured by one or more previous insurers." 325 Or at 308.

Here, claimant worked for the same employer from 1956 to 1996. The issue is whether SAIF, the last and only carrier in this proceeding, is responsible under the last injurious exposure rule for claimant's bilateral hearing loss. We agree with the ALJ's reasoning and conclusion that the record shows that claimant's occupational disease was caused solely by employment conditions prior to SAIF's coverage. Consequently, we agree that SAIF is not liable. Long, 325 Or at 308, 314.

ORDER

The ALJ's order dated May 2, 1997 is affirmed.

In the Matter of the Compensation of
STEVEN A. ROSSETTO, Claimant
WCB Case No. 96-05836
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's claim for a right foot injury. In its reply brief, the employer moves to strike claimant's respondent's brief as untimely. On review, the issues are compensability and motion to strike.

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

Motion to Strike Brief

The employer has moved to strike claimant's respondent's brief, which was due on or before August 25, 1997, on the ground that the brief was untimely filed. The employer relies on the fact that the post office cancellation on the envelope containing the brief is dated August 27, 1997.

Under OAR 438-005-0046(1)(c), briefs are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." In this case, the certificate of service attached to the brief indicates that it was deposited in the mail on August 25, 1997. Thus, under the applicable administrative rule, claimant's respondent's brief was timely filed. See Thomas P. Harris, 48 Van Natta 985 (1996). Consequently, the motion to strike is denied.

Compensability

The employer argues that the ALJ erred in applying the material contributing cause standard. Specifically, the employer argues that, if claimant's work contributed to his right foot fractures, it combined with a preexisting neuropathy condition. Thus, the employer argues that the major contributing cause standard applies.

We conclude that even if the major contributing cause standard of ORS 656.005(7)(a)(B) applies, claimant has met his burden of proof. Thus, we agree with the ALJ that claimant's right foot injury is compensable.

Several physicians addressed the cause of claimant's right foot condition. Drs. Palmer, Mon Pere and Spindel believed that the major contributing cause of claimant's right foot condition was a preexisting neuropathy condition, Charcot-Marie-Tooth disease. We do not find the opinions of Drs. Palmer, Mon Pere and Spindel to be persuasive. Although these physicians indicate that Charcot-Marie-Tooth is the major contributing cause of claimant's right foot fractures, they fail to explain how the preexisting condition caused or contributed to the right foot fractures. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (conclusory and unexplained medical opinion rejected).

Dr. Weller also believed that claimant had Type II Charcot-Marie-Tooth. However, Dr. Weller did not specifically address the cause of claimant's right foot condition.

Dr. Beaman and Drs. Snodgrass, Fuller and Dordevich opined that the cause of claimant's right foot fractures was an injury at work. Dr. Snodgrass did not agree that claimant had Charcot-Marie-Tooth disease. However, Dr. Snodgrass indicated that even if claimant did have the condition, although the reduced sensation from the disease might cause an individual to keep walking on the fracture, worsening it, the question would still turn on the cause of the fracture. According to Dr. Snodgrass, the stress fracture was caused by a work injury.

After reviewing this record, we find the most persuasive medical opinion to be that of Dr. Beaman. Dr. Beaman agreed with Drs. Snodgrass, Fuller and Dordevich that to a reasonable medical probability claimant's injuries at work were the major contributing cause of claimant's right foot condition. Dr. Beaman opined that claimant sustained repetitive trauma to his foot which became symptomatic in April of 1996. Dr. Beaman noted that claimant recalled a specific episode when he sustained multiple blows to his foot. Dr. Beaman believed this trauma initiated a neuropathic process within claimant's foot. (Ex. 21). We find Dr. Beaman's opinion to be well-reasoned and based on a complete history.[1] Somers v. SAIF, 77 Or App 259, 263 (1986). Under such circumstances, we find his opinion regarding the cause of claimant's right foot condition to be the most persuasive. Consequently, even assuming that claimant's injury combined with an underlying neurological condition, we find that he has established that the work injury is the major contributing cause of the disability and need for treatment of the combined condition. 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 $1,200, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 31, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

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[1] Although Dr. Beaman was unsure of the specific diagnosis of claimant's neurological condition, we do not find that this detracts from the persuasiveness of his opinion. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988) (lack of definitive diagnosis does not per se defeat the claim).

In the Matter of the Compensation of
EFREN QUINTERO, Claimant
Own Motion No. 97-0288M
OWN MOTION ORDER OF ABATEMENT
Robert E. Nelson, Claimant Attorney

Claimant requests reconsideration of our October 6, 1997 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH M. SCHWALB, Claimant
WCB Case No. 96-03765
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that: (1) affirmed the Order on Reconsideration award of 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the right hand; and (2) awarded temporary total disability from April 13, 1995 through May 4, 1995.[1] On review, the issues are extent of scheduled permanent disability and temporary total disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the fourth paragraph on page 3, we change the second sentence to read: "Claimant was awarded temporary disability for the period December 9, 1994 through December 19, 1994, and from January 10, 1995 through January 13, 1995."

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

An Opinion and Order dated September 7, 1995 set aside SAIF's February 3, 1995 denial of "spongiotic dermatitis, bilateral hands" and remanded claimant's vesicular fingertip dermatitis condition to SAIF for acceptance. (Ex. 13-3). The Board adopted and affirmed the ALJ's order on March 15, 1996. (Ex. 29). On March 27, 1996, SAIF accepted vesicular fingertip dermatitis. (Ex. 31).

A Notice of Closure dated December 8, 1995, as corrected January 11, 1996, awarded temporary disability but no permanent disability. (Exs. 19, 22). SAIF's Notice of Closure Summary dated January 11, 1996 referred to the accepted compensable condition as "Bilateral Contact Dermatitis." (Ex. 21). Claimant requested reconsideration and raised issues of temporary disability and permanent disability. (Ex. 23).

A medical arbiter was appointed to examine claimant's "bilateral contact dermatitis" condition. (Ex. 27-2). Dr. Weiss reported that claimant's dermatitis had gradually recurred on the right palm. (Ex. 28-1). He concluded that claimant had a "Class II impairment with signs and symptoms of skin disorder being present, requiring intermittent treatment, and there is a mild limitation in performing some work activities." (Ex. 28-2).

On April 12, 1996, the Order on Reconsideration issued, awarding claimant 15 percent (22.5 degrees) scheduled permanent disability. (Ex. 32). The worksheet attached to the Order on Reconsideration noted: "Accepted condition per 1503 form dated 1-11-96: 'bilateral contact dermatitis.'" (Ex. 32-3).

SAIF requested a hearing, arguing that claimant was not entitled to a permanent disability award because the impairment found by the arbiter was not for the accepted fingertip condition. The ALJ found that, from the very beginning, claimant's condition involved not only the fingers, but the palms of his hands. The ALJ determined that claimant suffered from one condition that had been primarily described as bilateral contact dermatitis. The ALJ concluded that the condition rated by the arbiter was not a new or separate condition. Rather, claimant had experienced a flare up of the accepted condition. The ALJ affirmed the 15 percent permanent disability award.

On review, SAIF argues that the "law of the case" is that claimant's accepted condition is vesicular fingertip dermatitis. SAIF contends that the ALJ erroneously expanded the compensable condition to include a "hand condition" as described in the medical arbiter's report. We disagree.

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[1] Although claimant filed a cross-request for review, he did not raise any additional issues on review.

The ALJ is correct that the record establishes that claimant's condition from the beginning has involved claimant's hands, including the palms and fingers. Claimant worked as an oiler and developed a skin condition on his hands in November 1994. (Ex. 2). On December 13, 1994, Dr. Brown found vesiculating eruptions on the palms of claimant's hands. (Id.) On December 20, 1994, Dr. Brown diagnosed vesicular hand dermatitis. (Id.) Claimant's "801" form signed on December 20, 1994, referred to a bad rash and blistering on both hands. (Ex. 3). The "827" form signed by Dr. Brown in January 1995 diagnosed "spongiotic dermatitis hands" and referred to "[v]esiculating dermatitis palms of hands." (Ex. 6).

On February 3, 1995, SAIF denied claimant's "condition diagnosed as spongiotic dermatitis, bilateral hands." (Ex. 7).

Dr. Brown's subsequent reports continued to refer to claimant's "hand" dermatitis. (Exs. 8, 9, 10). Dr. Brown referred claimant to Dr. Storrs. On May 21, 1995, Dr. Storrs and Dr. Cicoria reported claimant's history of problems involving his hands, which had occurred on his fingertips, all his fingers and his palms. (Ex. 12-1). At the time of their examinations, claimant had extensive vesicles over the fingertips bilaterally. (Ex. 12-2). They concluded that claimant had "work related vesicular fingertip dermatitis." (Ex. 12-3). Dr. Storrs and Dr. Cicoria also referred to claimant's condition as "hand eczema" and "hand dermatitis." (Exs. 12-3, -4).

On June 5, 1995, a hearing was held on SAIF's February 3, 1995 denial of claimant's "spongiotic dermatitis, bilateral hands." On September 7, 1995, an Opinion and Order issued which set aside the February 3, 1995 denial and remanded claimant's "vesicular fingertip dermatitis" to SAIF for acceptance. (Ex. 13).

On October 23, 1995, SAIF sent a letter to Dr. Brown, asking whether claimant's "bilateral contact dermatitis" was medically stationary and, if so, whether he suffered any permanent residuals as a result of "bilateral contact dermatitis[.]" (Ex. 16). Dr. Brown's November 27, 1995 report referred to claimant's "hand dermatitis." (Ex. 18). In SAIF's Notice of Closure summary dated January 11, 1996, SAIF referred to the accepted condition as "Bilateral Contact Dermatitis." (Ex. 21). After claimant requested reconsideration of the Notice of Closure, the Appellate Unit sent a list of questions to the medical arbiter, referring to the accepted condition as "bilateral contact dermatitis." (Ex. 27-2)

After the Board issued its Order on Review affirming the September 7, 1995 Opinion and Order on March 15, 1996 (Ex. 29), SAIF issued a notice of acceptance of "[v]esicular fingertip dermatitis" on March 27, 1996. (Ex. 31).

We agree with the ALJ that the record establishes that claimant's dermatitis condition from the beginning has involved not only the fingers, but also the hands. Although SAIF referred to the accepted condition as "bilateral contact dermatitis" in its documents closing the claim (Exs. 16, 21), its acceptance referred only to "[v]esicular fingertip dermatitis." (Ex. 31). The ALJ's September 7, 1995 Opinion and Order remanded claimant's "vesicular fingertip dermatitis" to SAIF for acceptance. (Ex. 13). However, the Opinion and Order also set aside the entire February 3, 1995 denial, which referred to claimant's "condition diagnosed as spongiotic dermatitis, bilateral hands." (Ex. 7). By setting aside the entire denial, the ALJ also set aside SAIF's denial of claimant's bilateral hand dermatitis condition. Under these circumstances, we agree with the ALJ that claimant has class II impairment that is due to the compensable injury and he is entitled to an award of 15 percent scheduled permanent disability.[2]

Alternatively, even if claimant's accepted condition was limited only to vesicular fingertip dermatitis, we conclude that ORS 656.268(16) applies to this case. SAIF confuses the scope of its acceptance with whether or not a particular condition is ratable. ORS 656.268(16) provides:

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[2] The extent of scheduled permanent disability is evaluated as of the date of the Order on Reconsideration, applying the standards effective as of the date of the Determination Order or Notice of Closure. ORS 656.283(7); 656.295(5); OAR 436-035-0003(2). Here, claimant became medically stationary on November 6, 1995, and his claim was closed by Notice of Closure on December 8, 1995, as corrected January 11, 1996. (Exs. 19, 22). Accordingly, the applicable standards are set forth in WCD Admin. Order 6-1992 (effective March 13, 1992), as amended by WCD Admin. Orders 93-056 (effective December 14, 1993), 95-060 (effective August 23, 1995 (Temp.)), 95-063 (effective September 21, 1995 (Temp.)), 96-068 (effective August 19, 1996 (Temp.)), and 96-072 (effective February 15, 1997). OAR 436-035-0003(1), (2), and (3).

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

A finding that a condition is a "direct medical sequelae" to the original accepted condition and should be rated does not mean that the "sequelae" condition has been formally accepted. See Richard D. Worton, 49 Van Natta 1849 (1997). In other words, if the persuasive medical evidence supports a conclusion that claimant's dermatitis on the right palm is direct medical sequelae of the originally accepted vesicular fingertip dermatitis, then the disability from that condition is ratable if it has not been specifically denied.

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. SAIF v. Danboise, 147 Or App 550, 552-53 (1997). However, where the treating physician or medical arbiter attributes the claimant's impairment to causes other than the compensable injury, the opinion is not considered persuasive evidence of injury-related impairment. Marcia G. Williams, 49 Van Natta 313, on recon 49 Van Natta 612 (1997).

We agree with the ALJ that claimant's permanent impairment is related to the compensable vesicular fingertip dermatitis condition. In reporting claimant's history, Dr. Weiss said that claimant sustained dermatitis of the hands and fingers in November 1994. (Ex. 28-1). Dr. Weiss reported that claimant's "dermatitis consisted of vesicles, with patchy areas of scaling and some fissuring, involving the palmar aspects of the fingers, spreading slowly to involve the palms as well." (Id.) Dr. Weiss indicated that after June 1995, claimant's hands cleared, except for a recent mild flare up involving the right palm. Dr. Weiss concluded that claimant had class II impairment with signs and symptoms of skin disorder being present, requiring intermittent treatment, and mild limitation in performing some work activities. (Ex. 28-2). Although claimant's treating physician, Dr. Brown, reported on November 27, 1995 that claimant did not have any permanent residuals, he made a "permanent recommendation" that claimant not attempt any jobs that entail a lot of friction to the skin of his hands. (Ex. 18). Dr. Brown's recommendation was consistent with Dr. Weiss' conclusion that claimant has permanent impairment.

In responding to the inquiry about claimant's impairment, Dr. Weiss did not indicate that any impairment was due to causes other than the compensable injury. Moreover, the impairment of a right palm dermatitis is consistent with claimant's accepted vesicular fingertip dermatitis condition. Because Dr. Weiss did not attribute the findings to causes other than the compensable condition and the impairment findings are consistent with the compensable condition, we find that the impairment is due to the compensable condition. Danboise, 147 Or App at 552-53.

Moreover, Dr. Weiss' report, as supported by Dr. Brown's reports, supports a conclusion that claimant's right palm dermatitis constitutes "direct medical sequelae" of the originally accepted vesicular fingertip dermatitis. Therefore, because SAIF has not specifically denied the right palm dermatitis, the disability from that condition is ratable pursuant to ORS 656.268(16). We agree with the ALJ that claimant has class II impairment that is due to the compensable injury and he is entitled to an award of 15 percent scheduled permanent disability.

Temporary Total Disability

We adopt the ALJ's reasoning and conclusion in the March 7, 1997 Order on Reconsideration that claimant is entitled to temporary total disability benefits from April 13, 1995 through May 4, 1995.

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

ORDER

The ALJ's order dated January 14, 1997, as reconsidered March 7, 1997, is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the SAIF Corporation.

Board Member Haynes specially concurring.

I agree with the lead opinion that claimant has class II impairment that is due to the compensable injury and he is entitled to an award of 15 percent scheduled permanent disability. The lead opinion decides the case on two alternative grounds. I write separately only to express my opinion that the second analysis, which concludes that claimant's disability is ratable pursuant to ORS 656.268(16), is more persuasive.

In the Matter of the Compensation of
HERBERT M. DAVIS, Claimant
WCB Case No. AF-97010
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Garaventa's order that declined to award claimant's counsel an "out-of-compensation" attorney fee payable from claimant's future permanent disability for an accepted right carpal tunnel syndrome condition. Alternatively, claimant seeks a carrier-paid attorney fee under amended ORS 656.386(1)(b)(B) and (C). In its brief, SAIF contends that the ALJ erred in granted claimant an approved attorney fee out of interim compensation. On review, the issues are attorney fees (out-of-compensation and carrier-paid).

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

Assuming without deciding that amended ORS 656.386(1)(b)(C) is retroactively applicable to this case, we conclude that claimant has not satisfied the requirements of that provision. On December 31, 1996, claimant requested SAIF to accept his right carpal tunnel syndrome as a "new medical condition." (Claimant's Motion for Order Approving Attorney Fees).[1] SAIF accepted claimant's right carpal tunnel syndrome on February 18, 1997. (Id.) Because SAIF's acceptance occurred within 90 days of claimant's request, amended ORS 656.386(1)(b)(C) has not been satisfied. Consequently, claimant is not entitled to an assessed attorney fee on this basis.

Finally, we agree with the ALJ that claimant's counsel is entitled to an approved attorney fee out of interim compensation. See OAR 438-015-0030.

ORDER

The ALJ's order dated May 6, 1997, as reconsidered July 14, 1997, is affirmed.

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[1] Because claimant was seeking acceptance of a "new medical condition" rather than challenging SAIF's initial acceptance, amended ORS 656.386(1)(b)(B) is not applicable.

In the Matter of the Compensation of
EVA SYNAK, Claimant
WCB Case No. 96-10925
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which upheld the self-insured employer's denial of claimant's current headache condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant experienced a compensable injury when her head was struck by a falling object on September 19, 1994. Claimant was diagnosed with post-concussion cephalgia (headache). The employer accepted a nondisabling "post-concussion syndrome." (Ex. 18). Dr. Zivin, neurologist, examined claimant on December 21, 1994, for her headache condition. Dr. Zivin noted that claimant's headaches, which he attributed to her head injury, had a number of migrainous features. (Ex. 19). Dr. Ramsthel, internist, declared claimant medically stationary with no permanent disability as of August 15, 1995. (Ex. 32).

On November 1, 1995, claimant returned to Ramsthel, complaining of headache and scalp sensitivity. (Ex. 33). She was treated conservatively through January 11, 1996.

On August 7, 1996, claimant returned to Dr. Ramsthel, complaining of headaches and scalp and neck sensitivity. (Ex. 37). Dr. Ramsthel referred claimant to Dr. Zivin, who diagnosed claimant's current condition as migraine headaches. He based his diagnosis on claimant's history of the episodic nature of the headaches, their global distribution, and the considerable sensitivity of the scalp. (Ex. 39). Dr. Zivin opined that claimant's current treatment was related solely to her migraine headaches and that claimant's 1994 injury was not even a material contributing cause of the current migraine headache condition. (Ex. 43). Dr. Ramsthel initially concurred with Dr. Zivin's reports in their entirety. (Ex. 44).

Subsequently, Dr. Ramsthel opined that claimant's headaches were not true migraine headaches, but "migraine-type" symptoms caused by the September 1994 injury. (Ex. 45).

In evaluating medical opinions, we rely on those that are both well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 263 (1986). Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no reason not to defer to Dr. Ramsthel's opinion.

When Dr. Zivin examined claimant in December 1994, he noted that claimant's sporadic headaches, which he attributed to her head injury, had a number of migrainous features, namely impaired concentration, photophobia, intolerance of noise, and a sense of pressure in the head with a duration of up to two days. He also noted that it was not unusal in post head trauma for persons to have a headache pattern similar to that of claimant. (Ex. 19). However, when he reevaluated claimant's headaches in September 1996, he diagnosed them as migraine headaches and opined that claimant's compensable September 1994 injury was not even a material cause. (Exs. 39, 43).

Dr. Zivin offered no explanation for his changed opinion, failing to discuss why migraine headaches would suddenly and "idiopathically" appear, or how the earlier accepted post-concussion migraine-type symptoms had resolved and the current headaches, although in the same location and of the same character, changed to true migraine headaches. Finally, to the extent that Dr. Zivin explained that millions of people suffer from migraine headaches who have not had a head injury, he did not explain how such a generalization would apply to claimant's specific situation. E.g., John L. Bjerkvig, 48 Van Natta 1254 (1996). Consequently, we do not find his opinion persuasive.

Moreover, although Dr. Ramsthel initially concurred with Dr. Zivin's opinion, he subsequently reviewed claimant's medical record and concluded that claimant was still experiencing post-concussion syndrome and specifically concurred with Dr. Ziven's December 1994 report that claimant's headaches have migrainous type features. Dr. Ramsthel explained that claimant's headaches are not true migraines, as they are neither unilateral nor throbbing, which are key features of true migraines. Finally, Dr. Ramsthel opined that there was greater than a medical probability that claimant's September 1994 compensable injury was the cause of claimant's current headache condition. (Ex. 45).

We find Dr. Ramsthel's opinion more persuasive than that of Dr. Zivin. Claimant has accordingly proven the compensability of her current headache condition and need for treatment.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 10, 1997, is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing. For services at hearing and on review, claimant's attorney is awarded $4,500, to be paid by the employer.

In the Matter of the Compensation of
JIM WHEELER, Claimant
WCB Case No. 97-00623
ORDER ON RECONSIDERATION
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our September 30, 1997 Order on Review that reversed the Administrative Law Judge's (ALJ's) order setting aside the insurer's denial of claimant's left knee injury claim. Claimant asserts that his motion is "based upon failure of the Workers' Compensation Board to analyze this under SAIF v. Nehl, 148 Or App 309 (1997) [sic]" and that such decision "requires the Board to uphold the decision of the ALJ."

In SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309, 311 (1997), the court considered compensability under ORS 656.005(7)(a)(B), stating that, "regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major contributing cause of claimant's need for treatment, the combined condition is compensable." Here, as explained in our order, we found insufficient evidence that claimant sustained a work injury; rather, we found that the record showed only that a preexisting condition was the major contributing cause of claimant's need for treatment. Consequently, in the absence of a "combined condition," ORS 656.005(7)(a)(B) was not applied and the claim failed under ORS 656.005(7)(a).

Because Nehl concerned ORS 656.005(7)(a)(B) and that statute is not relevant here, we find it to have little bearing on this case. Furthermore, to the extent the case applies, it supports our conclusion that, because claimant failed to show that any work injury was the major contributing cause of his need for treatment, he failed to prove compensability.

Accordingly, we withdraw our September 30, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our September 30, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
YVONNE C. FISH, Claimant
WCB Case Nos. 97-00030 & 96-09756
ORDER ON REVIEW
G. Joseph Gorciak, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its denial of claimant's current back condition; and (2) affirmed an Order on Reconsideration which found claimant's claim prematurely closed. On review, the issues are compensability and premature closure.

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

We agree with the ALJ that claimant has established compensability of her current back condition. However, in doing so, we do not rely on the opinion of Dr. Berselli. We find the opinions of Dr. Berselli and Drs. Duff, Watson and Laycoe to be unpersuasive for the following reasons. First, we agree, for the reasons given by the ALJ, that there is insufficient evidence that claimant had a preexisting low back condition. Although the record supports a conclusion that claimant has a long history of preexisting cervical and upper back problems, the record also reveals that claimant had only limited treatment for her low back and no recent low back treatment prior to the March 1996 injury. Thus, we find the examining physicians' and Dr. Berselli's opinion that claimant has a preexisting condition to be conclusory, unexplained and unsupported by the record.[1]

We also find Dr. Berselli's opinion to be unpersuasive for an additional reason. Specifically, we find Dr. Berselli's opinion to be inconsistent. In Exhibit 103, Dr. Berselli indicated that claimant's lumbar condition was secondary to the March 1996 injury. In another report, however, Dr. Berselli indicated that he was unable to state whether claimant's disability was due to her preexisting problem or her March 1996 injury. (Ex. 90). In other medical reports, Dr. Berselli concurred with reports of Drs. Watson, Laycoe and Duff which attributed claimant's condition to a preexisting condition rather than the March 1996 injury. (Exs. 87, 97). Because we find Dr. Berselli's opinion to be inconsistent and unexplained, we find it unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

We rely, instead, on the opinions of Drs. Jura and Noall. We find these physicians' opinions persuasive for the following reasons. First, we find their opinions that claimant does not have a preexisting low back condition to be consistent with the contemporaneous medical record, which does not support a conclusion that claimant had a significant preexisting low back condition. In addition, Dr. Noall treated claimant for her prior upper back and neck problems. Thus, he was familiar with claimant's prior problems and is in a good position to comment on whether the current low back problems are related to the previous cervical and upper back problems. Dr. Noall opined that the low back symptoms were not related to claimant's previous upper back and neck symptoms and attributed them to the March 1996 injury instead.

Dr. Jura, claimant's most recent attending physician for the low back condition, also opined that preexisting conditions were not contributing to claimant's low back condition and that the major cause of claimant's need for treatment for that condition was the work injury. There is no indication that Drs. Noall and Jura had inaccurate histories. Accordingly, based on the opinions of Drs. Jura and Noall, we agree with the ALJ that claimant has established compensability of her 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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[1] We disagree with the ALJ's conclusion that Dr. Berselli concurred with only the portion of the examining physicians' report dealing with permanent disability. As far as the record shows, Dr. Berselli did not limit his concurrence to only a portion of the report.

ORDER

The ALJ's order dated March 20, 1997 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
CLAY R. HERRING, Claimant
WCB Case No. 96-09901
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Lipton's order that increased claimant's scheduled permanent disability award for loss of use or function of the right knee from 21 percent (31.5 degrees), as awarded by an Order on Reconsideration, to 28 percent (42 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except the last 2 paragraphs.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

Claimant twisted his right knee at work on February 2, 1995. SAIF accepted a torn medial meniscus of the right knee. (Claimant actually had a torn right knee anterior cruciate ligament at the time, not a torn meniscus.) Claimant was released to full duty work on May 31, 1995.

An August 1, 1995 Notice of Closure awarded temporary disability and 15 percent scheduled permanent disability, based on Grade 3 anterior cruciate ligament (ACL) instability. The Notice of Closure became final.

On August 4, 1995, claimant experienced a worsened right knee condition which was eventually diagnosed as a torn medial meniscus. SAIF reaffirmed the torn meniscus as an accepted condition and stated that it had accepted the ACL condition.

On September 12, 1995 and October 13, 1995, respectively, Dr. Baskin performed a partial medial meniscectomy and an ACL reconstruction on claimant's right knee.

A July 2, 1996 Notice of Closure awarded no additional permanent disability compensation. Claimant requested reconsideration and an examination by a panel of 3 medical arbiters. On August 28, 1996, Dr. Martens performed a medical arbiter's examination. An October 9, 1996 Order on Reconsideration increased claimant's scheduled permanent disability to 21 percent.

On October 18, 1996, a panel of medical arbiters examined claimant.

The ALJ found claimant entitled to a total of 28 percent scheduled permanent disability for his right knee condition. SAIF argues that claimant has not established that his right knee condition worsened since the prior (final) 15 percent permanent disability award. We agree with SAIF.

ORS 656.273 provides, in relevant part: "After the last arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury."

OAR 436-035-007(8)(b) and (c) provide:

"(b) When an actual worsening of the worker's compensable condition occurs, the extent of permanent disability shall be redetermined. When an actual worsening of the worker's compensable condition does not occur, the extent of disability shall not be redetermined, but shall remain unchanged.

"(c) * * *There shall be no redetermination for those conditions which are either unchanged or improved. * * *"

The Supreme Court has stated:

"The threshold requirement to recover increased PPD or PTD is a greater permanent injury than formerly existed * * * . On a worsening claim for addition PPD or PTD, the referee, Evaluation Division and Board should first compare the claimant's present medical condition with the condition at the time of the earlier award or arrangement of compensation. If that condition is unchanged or improved, no further inquiry is necessary, for there has been no worsening." Stepp v. SAIF, 304 Or 375, 381 (1987) (footnote omitted).

Thus, under the statute, the threshold question is whether claimant's right knee condition has worsened since the prior 15 percent permanent disability award. See Peter Gevers, 49 Van Natta 1228 (1997). If the "permanent worsening" threshold is not satisfied, claimant's permanent disability is not redetermined under the standards. See Gayle S. Johnson, 48 Van Natta 381, aff'd mem 143 Or App 629 (1996).

Claimant seeks scheduled impairment ratings for: (1) lost right knee range of motion; (2) a partial medial meniscectomy; and (3) a chronic condition preventing some repetitive use of the right knee. See OAR 436-035-0007(22); 436-035-0230(5); 436-035-0010(5). We consider claimant's arguments, the standards, and the record, comparing claimant's right knee condition at the time of the prior award with his current condition, to determine whether the condition has worsened. See Buddenberg v. Southcoast Lumber, 112 Or App 148, 152 (1992) ("A worker is entitled to additional compensation under ORS 656.273(1) only if the worsened condition increases the extent of disability as defined in the standards)".

When the initial claim was closed, claimant was released to full duty work. His 15 percent impairment rating was based on Grade 3 laxity of the right knee ACL.

After the ACL reconstruction, Dr. Baskin, treating surgeon, released claimant to return to regular work as of May 29, 1996. Dr. Baskin stated that claimant "does not have a normal knee, although it is functioning normally at this time." (Ex. 28).

Dr. Martens, medical arbiter, opined that claimant is not significantly limited in his ability to repetitively use his right knee due to the work injury. (Ex. 35-4). He found a less than Grade I instability in the anterior drawer of the right knee and commented that claimant "has had excellent reconstruction" of the right ACL. (Id.) Dr. Martens also measured claimant's right knee extension at 143 degrees and his left knee extension as 148 degrees. (Ex. 35-3).

The arbiter panel measured claimant's right knee extension as 135 degrees and his left knee extension as 141 degrees. (Ex. 37-3). The panel reported crepitation in both knees, but no residual ligamentous instability, noting that claimant "had an excellent surgical repair." (Exs. 37-4-5). The panel also opined that claimant does have a chronic right knee condition which limits its repetitive use.

Claimant contends that the injured right knee should not be compared with the left knee to evaluate range of motion loss because there is medical evidence of left knee crepitation. See OAR 436-35-0007(22). However, we have previously held that evidence of crepitation in the contralateral knee is not sufficient to establish a "history of injury or disease" such that the injured knee range of motion is evaluated other than by comparison with the contralateral knee. See Kathleen A. Beber, 49 Van Natta 1404 (1997); Kenneth A. Mutzel, 48 Van Natta 2122 (1996). Accordingly, in the present case, claimant's injured right knee range of motion is compared with his uninjured left knee to evaluate lost range of motion.

Assuming, without deciding, that claimant's right knee range of motion is most accurately measured by the arbiter panel, he would have 2.4 percent loss of use or function of his right knee, based on lost range of motion. Again assuming, without deciding, that claimant has a chronic right knee condition under OAR 436-035-0010(5), he would have 5 percent loss of use or function of his right knee on this basis. Further assuming, without deciding, that claimant's recent surgery represents lost use or function of his right knee, claimant would also be entitled to 5 percent loss of use or function of his right knee on this basis.[1] When these assumed values (2.4, 5, 5) are combined, the total (12) is less than the prior 15 percent award. Under these circumstances, we conclude that claimant has not established that his right knee condition worsened since the prior award and he is therefore not entitled to have his scheduled permanent disability for his right knee redetermined.

ORDER

The ALJ's order dated February 3, 1997, as corrected February 13, 1997, is reversed. In lieu of the ALJ's award and the Order on Reconsideration's award, the Notice of Closure is reinstated and affirmed. The ALJ's attorney fee award is reversed.

[1] Considering the medical experts' agreement that claimant had excellent surgical results, we find it more likely than not that claimant's condition is better, not worse, as a result of his surgery. In this regard, we note that claimant's ACL laxity is less now than it was before reconstruction.

In the Matter of the Compensation of
PHILLIP S. KELSEY, Claimant
WCB Case No. 96-07301
ORDER ON REVIEW
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that upheld the SAIF Corporation's denial of his claim for a left shoulder and mid-back injury. On review, the issue is compensability.

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

It is claimant's burden to prove that it is more likely than not that he sustained an accidental injury in the course and scope of his employment. ORS 656.266. Because claimant has a prior history of left shoulder and mid-back pain, we agree with the ALJ that the issue of whether the claimed condition is related to the work incident is a complex medical question. Thus, while claimant's testimony is probative, the resolution of this issue turns largely on an analysis of the medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993). As noted by the ALJ, there is no medical opinion which supports compensability. Moreover, Dr. Henderson, claimant's current treating physician, opined that the work incident did not play a role in causing claimant's condition. (Ex. 31). Accordingly, we agree with the ALJ that claimant has failed to establish that his left shoulder and mid-back condition is compensable.

ORDER

The ALJ's order dated May 30, 1997 is affirmed.

In the Matter of the Compensation of
TRACIE L. MARTIN, Claimant
WCB Case No. 94-12729
ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Martin v. Hewlett-Packard Co., 148 Or App 472 (1997). The court has reversed and remanded our prior order which affirmed an Order on Reconsideration that declined to award claimant scheduled permanent disability for a left wrist condition. Tracie L. Martin, 48 Van Natta 717 (1996). Holding that we erred in concluding that claimant presented no evidence of permanent impairment, the court has remanded for reconsideration.

FINDINGS OF FACT

Claimant has an accepted left carpal tunnel syndrome claim. On February 2, 1994, Dr. Warren, treating physician, declared claimant medically stationary. He found decreased pinpoint discrimination in all five fingers of claimant's left hand. (Ex. 18-2). He also stated that claimant "is obviously unable to perform repetitive heavy grasping with the left hand and forearm." (Id.).

Claimant was examined by Dr. Radecki on behalf of the self-insured employer. Dr. Radecki believed that claimant's subjective findings indicated severe functional overlay with clear psychosomatically generated complaints. Dr. Radecki found that claimant's objective nerve conductions showed superb motor function of her hand intrinsic muscles and superb sensory function. In addition, Dr. Radecki found that claimant's range of motion was totally normal.

Dr. Radecki's findings were not ratified by Dr. Warren.

A July 28, 1994 Notice of Closure awarded claimant temporary disability compensation only. An October 12, 1994 Order on Reconsideration affirmed the Notice of Closure. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had established 14 percent (21 degrees) scheduled permanent disability for her left forearm based on the findings of Dr. Warren. On Board review, we reversed the ALJ's order and reinstated and affirmed the Order on Reconsideration awarding no permanent disability benefits. We reasoned that Dr. Warren's findings did not support an award of permanent disability since there was no medical evidence that Dr. Warren's left forearm findings were permanent. Tracie L. Martin, 48 Van Natta at 717.

The court reversed our order. The court reasoned that in view of Dr. Warren's finding that claimant was medically stationary, at least one reasonable finding was that the impairment described in the report was not reasonably expected to improve from medical treatment or the passage of time. On this basis, the court held that we erred as a matter of law in concluding that claimant presented no evidence of permanent impairment and remanded this matter for reconsideration.

On remand, the self-insured employer argues that there is not a preponderance of the evidence in the record which establishes the permanency of claimant's impairment. In response, claimant argues that the court has determined as a matter of law that there was evidence of permanent impairment and that the 14 percent scheduled permanent disability awarded by the ALJ should be affirmed.

As previously stated, the court has held that we erred in concluding that there was no evidence that claimant's disability was permanent. Such a conclusion does not equate to a holding that claimant has sustained permanent impairment. Were that the case, the court would have expressly instructed us to reinstate the ALJ's permanent disability award. Instead, the court has reversed our decision and remanded for reconsideration of whether claimant has sustained permanent impairment as a result of her compensable injury. Consistent with that directive, we proceed with our reconsideration.

In evaluating claimant's permanent disability, we may consider only the opinions of a treating physician or a medical arbiter. See ORS 656.245(2)(b)(B); Koitzsch v. Liberty Northwest Insurance Corp., 125 Or App 666, 670 (1994) (With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability). In this record, the only physician in the record whose findings may be used to rate claimant's impairment is Dr. Warren.

Although Dr. Warren noted that claimant returned to her regular work and that surgery was not recommended, Dr. Warren noted decreased pinpoint sensation in all five digits of the left hand, tingling and pain with firm grip on the left. Dr. Warren indicated that claimant "is obviously unable to perform repetitive heavy grasping activities with the left hand and forearm." (Ex. 18-2).

In reporting claimant's impairment findings, Dr. Warren also found that claimant was medically stationary. Dr. Warren did not indicate that with further medical treatment or the passage of time, claimant's condition would improve. After further consideration of Dr. Warren's report, including the context of Dr. Warren's impairment findings contained therein, we conclude that Dr. Warren considered these limitations to be permanent.

Dr. Radecki has opined that claimant has no permanent disability; however, he is neither an attending physician nor a medical arbiter. In addition, Dr. Warren has not ratified Dr. Radecki's findings. Under such circumstances, Dr. Radecki's opinions cannot be considered in rating claimant's permanent disability.[1] See ORS 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442 (1994); Alex J. Como, 44 Van Natta 221 (1992)). Consequently, based on this record, we find no persuasive reason not to rely on Dr. Warren's permanent impairment findings. See Weiland v. SAIF, 64 Or App 810, 814 (1983) (We give greater weight to the opinion of claimant's treating physician unless there are persuasive reasons not to do so). Thus, we affirm the ALJ's permanent disability award.

In cases in which a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307(5), 656.308(2), 656.382 or 656.386. ORS 656.388(1). In accordance with the aforementioned statute, we award the following attorney fees for claimant's counsel's services at hearing, Board review, before the court, and on remand.

Here, the employer requested Board review of the ALJ's order, and, after reconsideration on remand, we have found the compensation awarded to claimant by that order should not be disallowed or reversed. Accordingly, claimant's attorney is entitled to an assessed fee for services on Board review and on remand. 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 and remand is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's brief on review, his attorney's statement of services on Board review, and claimant's brief on remand), the complexity of the issue, and the value of the interest involved.

Because claimant also appealed our prior decision to the court and that appeal has resulted in "increased" compensation (in that our prior order awarded no permanent disability and on remand, we have awarded 14 percent scheduled permanent disability), claimant's counsel is also entitled to an out-of-compensation attorney fee. See ORS 656.386(2). Consequently, we approve an "out-of-compensation" attorney fee equal to 25 percent of this "increased" compensation. However, the total "out-of-compensation" attorney fee awarded by the ALJ's order and this order shall not to exceed $3,800. See ORS 656.388(1); ORS 656.386(2); OAR 438-015-0055(1).

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[1] The employer also relies on chart notes of Dr. Stanley as support for its argument that claimant has no permanent impairment. Dr. Stanley indicated that claimant seemed to have marked functional overlay. However, because Dr. Stanley was not claimant's attending physician at the time of claim closure, we may not rely on his opinion in evaluating claimant's permanent disability. ORS 656.245(2)(b)(B).

Accordingly, on reconsideration, the ALJ's order dated August 31, 1995 is affirmed. For services before the Court of Appeals, claimant's attorney is awarded 25 percent of the additional compensation created by this order. However, the total "out-of-compensation" attorney fee awarded by this order and the ALJ's order shall not exceed $3,800, payable directly to claimant's counsel. For services on Board review and on remand, claimant's attorney is awarded $1,500, payable by the employer.

IT IS SO ORDERED.

In the Matter of the Compensation of
KELLIE J. NICHOLS, Claimant
WCB Case No. 96-06233
ORDER OF DISMISSAL
Bottini, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) McWilliams' order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. Because the record does not establish that the request was timely filed with the Board or that all parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On September 5, 1997, the ALJ issued an Opinion and Order that upheld the employer's denial of claimant's aggravation claim for a low back condition. The order contained a statement that any party dissatisfied with the order could request Board review. The statement provided that review "shall be mailed to the Board * * * with copies of such request mailed to all other parties to this proceeding." This was followed with: **"BOTH OF THESE ACTIONS MUST BE TAKEN WITHIN 30 DAYS OF THE ADMINISTRATIVE LAW JUDGE'S ORDER."**

On October 9, 1997, the Board received claimant's letter dated October 1, 1997 that requested review of the ALJ's order. Claimant's letter had been forwarded to the Board by the Workers' Compensation Division, where it had been received on October 6, 1997. Claimant's letter did not indicate that copies had been provided to the other parties to the proceeding.

On October 14, 1997, the Board mailed a computer-generated letter to the parties, acknowledging claimant's "request" for Board review. On October 20, 1997, the Board received a letter from the employer's attorney forwarding to the Board a copy of claimant's letter and explaining that the letter had been received by the employer on October 6, 1997.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or app 847, 852 (1983).

"Filing" of a request for review is the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. OAR 438-005-0046(1)(b). Failure to timely file the request for review requires dismissal of the request for review. Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992).

Here, the 30th day after the ALJ's September 5, 1997 order was Sunday, October 5, 1997. Therefore, October 6, 1997 was the final day to perfect a timely request for review of the ALJ's order.

See Anita L. Clifton, 43 Van Natta 1921 (1991). Claimant's letter, however, was not received by the Board until October 9,1997, more than 30 days from the ALJ's September 5, 1997 order.[1] Consequently, claimant's request for review must be dismissed as untimely filed with the Board.[2]

Accordingly, based on the foregoing reasoning, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

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[1] We note that the Workers' Compensation Division received claimant's letter on October 6, 1997, within the 30-day appeal period. Because the Division is not a "permanently staffed office of the Board," however, the Division's receipt of claimant's request for review does not constitute "filing" of the request. See Carol L. Athearn, 47 Van Natta 811 (1995).

If claimant can establish that she mailed a request for review to the Board within 30 days of the ALJ's order, she may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days from the date of this order, claimant must file her written submission as soon as possible.

[2] Acknowledging that the employer received a copy of claimant's request for review on October 6, 1997, its counsel moves to dismiss claimant's request for review on the basis that "the Board did not receive a copy [of claimant's request for review] nor did our office receive a copy." A true copy of any thing delivered for filing must be simultaneously served personally or by mailing by first-class mail, postage prepaid, through the United States Postal Service, to each other party, or to their attorneys. OAR 438-005-0046(2)(a). Providing copies to attorneys, however, is not a jurisdictional requirement because counsel is not a "party." See ORS 656.005(21); Robert Casperson, 38 Van Natta 420, 421 (1986). Consequently, we deny the employer's motion to dismiss on the ground that claimant failed to provide a copy of her request for Board review to the employer's attorney.

October 30, 1997 Cite as 49 Van Natta 1904 (1997)

In the Matter of the Compensation of
BASILIO A. SANDOVAL, Claimant
WCB Case No. 97-00224
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that increased claimant's unscheduled permanent disability for a lumbar strain condition from the zero awarded by an Order on Reconsideration to 28 percent (89.6 degrees). In his brief, claimant asserts that the ALJ's award should be increased. 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 exception of the final paragraph, and as supplemented.

A November 22, 1996 Order on Reconsideration affirmed the August 27, 1996 Determination Order. (Ex. 20).

The medical arbiter panel commented in their report that the straight leg raising check related to claimant's range of motion findings indicated invalidity of the findings. (Ex. 18-4).

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted lumbar strain claim. Claimant's attending physician at the time of claim closure was Dr. Ames. On May 10, 1996, a summary of claimant's functional capacities after completion of a work hardening program was provided to Dr. Ames. (Ex. 8).

On May 24, 1996, Dr. Bennington-Davis, psychiatrist, Dr. Olson, neurosurgeon, and Dr. Wilson, orthopedic surgeon, examined claimant for the insurer. (Exs. 9, 10). Dr. Bennington-Davis diagnosed claimant with a pain disorder condition. (Ex. 9). Dr. Ames concurred with the insurer-arranged medical examiner's (IME) reports. (Ex. 11). A July 5, 1996 Determination Order awarded 17 percent unscheduled permanent disability for the low back, based on an impairment value of 5 for a chronic strain condition. (Ex. 14).

The insurer sought an addendum to the May 24, 1996 closing report from the IME panel. The panel indicated that claimant did not have a chronic condition. (Ex. 15). On August 7, 1996, the insurer requested an amended Determination Order. (Ex. 15B). Upon receiving Dr. Ames' concurrence with the addendum, the Department issued an amended Determination Order on August 27, 1996, that reduced claimant's unscheduled permanent disability award to zero. (Ex. 17). Claimant requested reconsideration. On October 12, 1996, Dr. Gabr, Dr. Nonweiler and Dr. Scheinberg performed a medical arbiter examination. (Ex. 18). A November 22, 1996 Order on Reconsideration affirmed the August 27, 1996 Determination Order in all respects.

Relying on the arbiter panel's report, the ALJ modified the Order on Reconsideration, finding that claimant proved entitlement to 28 percent unscheduled permanent disability, based on a loss of range of motion in the low back of 16 percent. The insurer challenges this conclusion, asserting that claimant's loss of range of motion is due to claimant's noncompensable pain disorder and, therefore, claimant is not entitled to permanent disability. Claimant argues that he is entitled to an additional 7 percent unscheduled permanent disability, for a total of 35 percent unscheduled permanent disability,[1] for the following reasons: (1) the impairment value should be 14 instead of 16; (2) the adaptability value should be 4 instead of 2, based on a Base Functional Capacity (BFC) of "heavy" instead of "medium," and a Residual Functional Capacity (RFC) of "sedentary" instead of "light;" and (3) the age and education value should be 3 instead of 4, based on a specific vocational preparation (SVP) time of 3 as a dairy farm worker, DOT 410.684-010. We agree with the insurer that claimant has failed to prove that his impairment is due to the compensable injury, reasoning as follows.

Impairment

To be entitled to permanent disability compensation for his low back strain, claimant must establish that the impairment is due to his compensable injury. ORS 656.214(2). If a treating physician or medical arbiter[2] makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe those findings as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550 (1997) (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

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[1] Claimant also requests an additional impairment value of 5 percent for a chronic condition if Gregory Schultz, 47 Van Natta 2265 (1995), is overturned on appeal. In Schultz, we concluded that the Board had no authority to invalidate the Director's rule, former OAR 436-35-320(5)(a), which governs chronic condition impairment. The rule provides:

> "Unscheduled chronic condition impairment is considered after all other unscheduled impairment within the body area, if any, has been rated and combined under these rules. Where the total unscheduled impairment within a body area is equal to or in excess of 5%, the worker is not entitled to any unscheduled chronic condition impairment."

[2] OAR 436-035-0007(13) provides that, 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. Like the ALJ, we find that the medical arbiter panel provided the more persuasive medical opinion addressing claimant's permanent impairment. Dr. Ames, the attending physician, initially ratified the IME panel's evaluation and addendum, which concluded that claimant's range of motion findings were not due to the accepted condition and that he had no chronic condition. However, he later changed his opinion without explanation. Because the arbiter's examination was conducted closer in time to the reconsideration order and because the panel's report is a more thorough and well-reasoned evaluation of claimant's impairment, we conclude that the medical evidence does not preponderate against a level of impairment different than that determined by the arbiter panel. See Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

impairment is due to the compensable injury). However, where there is evidence that a noncompensable condition may be contributing to the claimant's impairment, we will not presume that the arbiter's impairment findings are due to the compensable injury. See, e.g., Dave Perlman, Jr., 47 Van Natta 709 (1995); Julie A. Widby, 46 Van Natta 1065 (1994) (where the medical arbiter made impairment findings but also provided comments pertaining to other causes of the claimant's impairment, the medical arbiter's findings were not persuasive evidence of impairment due to the injury).

Here, claimant, who was working as a milker-herdsman, injured his low back in October 1994 when a cow fell on him. In April 1995, claimant's symptoms worsened when he drove a tractor for a long period of time. In August 1995, claimant sought emergency room treatment for various complaints, including dizziness and numbness of his arms, legs, and across the back of his neck, and thoracic back pain. Claimant's neurological examination was normal. (Ex. 4). On August 22, 1995, Dr. Jarvis noted that claimant's symptoms had improved and diagnosed claimant with a chronic lumbar strain on the left and a recent medication reaction/anxiety reaction resolved. Dr. Jarvis released claimant to regular work, but noted that claimant had some ongoing symptomatology. (Ex. 2). On September 26, 1995, the insurer accepted a disabling lumbar strain.

Claimant returned to work, but continued to seek treatment for his complaints. After an MRI revealed no evidence of disc herniation or nerve root compression, claimant entered a work hardening program. He completed the program on May 10, 1996, with little progress noted. The work hardening discharge note indicates that claimant continued to offer multiple, variable neck, back and pelvis pain complaints. (Exs. 8-2). In May 1996, Dr. Bennington-Davis, psychiatrist, who examined claimant and reviewed his records for the insurer, diagnosed claimant with pain syndrome, based on his multiple somatic complaints unverified by physical examination or laboratories. (Ex. 9). Drs. Olson and Wilson, who performed a physical assessment, opined that claimant demonstrated considerable symptom magnification. (Ex. 10-3).

The arbiter panel reported that claimant's pain diagram showed persistent low back pain, aching from the base of the neck to the toe of the left foot, and on the lateral left leg, numbness and stabbing pain across the left lumbar area, the left groin, and the left inside of the leg and foot. (Ex. 18-1). The medical arbiter panel noted that there was a psychological component to claimant's injury and that there was no objective orthopedic or neurologic injury by examination or their record review. (Ex. 18-5). They reported that the straight leg raising check yielded invalid findings. (Ex. 18-4). They also stated that claimant had no objective loss due to the injury. (Ex. 18-3). Under these circumstances, we conclude that the medical arbiter's findings of reduced range of motion in the low back is not persuasive evidence of impairment due to the injury. Because claimant has not established impairment due to the injury, no award of unscheduled permanent disability shall be allowed. OAR 436-035-0270(2). Accordingly, we need not address claimant's arguments regarding an increase in unscheduled permanent disability.

ORDER

The ALJ's order dated May 1, 1997, is reversed. The Order on Reconsideration, which awarded no unscheduled permanent disability for claimant's low back strain, is affirmed. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
HERBERT K. SHINN, Claimant
Own Motion No. 66-0117M
OWN MOTION ORDER ON RECONSIDERATION
SAIF Legal Department, Defense Attorney

Claimant requested reconsideration of our October 6, 1997 Own Motion Order. In that order, we declined to authorize payment for medical services and temporary disability compensation for claimant's current right hip dislocation condition because the record contained no medical evidence as to the relationship between the current right hip condition and the compensable 1955 injury claim. Given this complete lack of medical evidence regarding causation, we were unable to conclude that claimant had established a causal relationship between his current condition and his compensable injury. However, we invited the parties to supplement the record with medical evidence regarding whether claimant's current right hip dislocation was causally related to the compensable injury. In his reconsideration request, although claimant argues that his current right hip condition is related to the 1955 injury claim, he submits no medical evidence in support of his argument.

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). Nevertheless, claimant has the burden of proving that the requested medical services and temporary disability compensation are compensably related to the compensable injury. ORS 656.266.

Our initial order presented a brief history of this claim, which we repeat here for ease of reference. On August 5, 1955, claimant sustained an injury to his left tibia and fibula, his humerus and his right pelvis. The physician's records indicate that the treatment provided included open reduction and plating of fractures, closed reduction for his right hip dislocation, and a cast to his left leg. The left leg injury resulted in an "above-the-knee" amputation. On October 9, 1990 and February 5, 1991, the Board reopened claimant's claim for payment of prosthetic repairs and injury-related medical services. On January 10, 1992, the Board authorized payment for a new prosthesis. On October 1, 1992, the Board again reopened the claim for payment of prosthetic services for a modified socket.

On June 9, 1993 and July 8, 1993, the Board issued orders denying payment for medical services related to claimant's right hip dislocation which occurred during a January 1993 skiing accident. Based on the medical record, we determined that the right hip dislocation was an indirect or "consequential" condition, requiring claimant to prove that the work injury was the major contributing cause of the right hip dislocation pursuant to ORS 656.005(7)(a)(A).[1] Finding that the medical record did not meet this standard of proof, we denied authorization of payment for medical services. In an August 6, 1993 reconsideration order, we authorized the payment of a diagnostic report.

On August 5, 1997, SAIF submitted claimant's request for medical services for his 1955 right hip and left "above-the-knee" amputation injury. SAIF recommended that the Board deny the provision of the requested medical services. Thereafter, we requested the parties to submit their positions and any supporting medical evidence regarding the compensability of the requested medical services. SAIF responded by sending copies of the February 13, 1997 operative report, as well as a recommendation to deny the authorization of temporary disability compensation for claimant's surgery. Those records did not contain any medical opinion as to whether claimant's current right hip dislocation is related to his

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

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

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

compensable injury. No response was received from claimant. Based on the record before us, we determined that claimant had failed to establish a causal relationship between his current right hip dislocation and his compensable injury.

In his request for reconsideration, claimant explains that he lost his balance and fell while walking on flat ground with a ski and dislocated his right hip when he tried to get back up. Claimant asserts that his right hip dislocates easily because of the previous trauma: (1) the dislocation of his right hip in the work injury in August 1955; (2) an October 1955 surgical dislocation and cutting of ligaments to remove a bone spicule that broke off in the original work injury; and (3) further cutting of ligaments when a right artificial hip replacement was done in 1983 due to arthritis caused by the original work injury. Therefore, claimant asserts, he would not have dislocated his right hip if it were not for the original work injury. However, claimant submits no medical evidence to support his assertions.

In contrast, in SAIF's recommendation against authorizing reopening of the claim, it asserts that claimant's current right hip dislocation was due to a ski trip incident. SAIF also submits no supporting medical evidence.

The issue of the contribution of claimant's compensable injury to his current right hip dislocation condition is a complex medical question, the resolution of which requires medical evidence. See Uris v. Compensation Dept., 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). Therefore, claimant's lay opinion regarding causation is not sufficient. However, claimant need not demonstrate medical causation to a scientific certainty. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Ford v. SAIF, 71 Or App 825, rev den 299 Or 118 (1985). The appropriate measure of certainty in a workers' compensation claim is reasonable medical probability. Coday v. Willamette Tug & Barge, 250 Or 39, 47 (1968).

In addition, medical evidence is needed to establish the standard of proof required in this case. Depending on the medical evidence, the standard of proof could be material contributing cause or major contributing cause. In this regard, medical services for conditions resulting from a compensable injury are compensable if the need for treatment bears a material relationship to the compensable condition. Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994) (holding that former ORS 656.005(7)(a) did not apply to claims for continued medical treatment of a compensable condition; therefore, the applicable statute was ORS 656.245(1), which required only a material relationship to the compensable condition). This appears to be claimant's theory of the case.

On the other hand, where the current condition is a consequence of the compensable injury, the claimant must prove that the compensable injury is the major contributing cause of the allegedly consequential current condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (holding that, when a condition or need for treatment is caused by the compensable condition, as opposed to the industrial accident, the major contributing cause standard is applied). This appears to be SAIF's theory of the case.

However, because the record contains no medical evidence regarding the causal relationship between claimant's current right hip dislocation and the compensable 1955 work injury, we are unable to determine what standard of proof applies and whether claimant has met that standard. Furthermore, because we are unable to determine a causal relationship, we are likewise unable to find that claimant is entitled to temporary disability for surgery for his right hip dislocation condition. Nevertheless, we again stress that, should the parties wish to supplement the record with medical evidence and opinion regarding whether claimant's current right hip dislocation was causally related to his original injury, they may do so provided that the additional evidence is filed within 30 days from the date of this order.

Accordingly, our October 6, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish or October 6, 1997 order effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order. We will reconsider this order if further evidence is forthcoming within 30 days after the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
COLE E. THEANDER, Claimant
WCB Case No. 96-11017
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order, as reconsidered, that awarded his attorney a fee of $500 for services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

The issue in dispute was the compensability of claimant's exposure to blood. Ten exhibits were received into evidence, five of which were submitted by claimant's counsel. (Exs. 3A, 3B, 3C, 5A, and 6). There were no depositions taken. The hearing lasted one and one-half hours and the transcript consists of 30 pages. At hearing, claimant's attorney brought to the insurer's attention an unpaid medical bill that the insurer agreed to pay. Claimant was the only witness to testify. Claimant's counsel submitted an affidavit describing counsel's time expenditures as follows: (1) four hours of legal assistant time; and (2) thirteen hours of claimant's counsel's time, which included time performing legal research, three separate meetings with claimant, phone conferences with claimant and other counsel, and preparation for and appearance at hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded an attorney fee of $500 for claimant's counsel's services at hearing. Claimant contends that the fee is inadequate and requests a fee of $3,000. The insurer asks that we adopt and affirm the ALJ's order.

We begin with a brief summary of the facts. Claimant's hands were roughened and the skin was broken as a direct result of the frequent hand washing required by his work as an ambulance paramedic. On October 11, 1996, while working on an overdose patient, claimant's hands were exposed to blood from this patient. Although claimant was wearing gloves, at least one glove had torn while the patient was being transported. Considering the patient's HIV risk, claimant underwent prophylactic medical treatment for the blood exposure. Although the insurer agreed to pay claimant's medical bills "for diagnostic purposes," it denied claimant's injury claim by a denial dated November 6, 1996, as amended December 20, 1996. (Exs. 4, 5).

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

Our review of the record reveals the following information regarding the attorney fee issue. The issue in dispute was the compensability of claimant's exposure to blood. Ten exhibits were received into evidence, five of which were submitted by claimant's counsel. (Exs. 3A, 3B, 3C, 5A, and 6). There were no depositions taken. The hearing lasted one and one-half hours and the transcript consists of 30 pages. At hearing, claimant's attorney brought to the insurer's attention an unpaid medical bill that the insurer agreed to pay. Claimant was the only witness to testify. Claimant's counsel submitted an affidavit describing counsel's time expenditures as follows: (1) four hours of legal assistant time; and (2) thirteen hours of claimant's counsel's time, which included time performing legal research, three separate meetings with claimant, phone conferences with claimant and other counsel, and preparation for and appearance at hearing.

Claimant's counsel and his legal assistant spent a total of 17 hours preparing and presenting this case. As compared to typical compensability cases, the issue here was of below average complexity. As the ALJ found, Alan L. Hussey, 47 Van Natta 1302, on recon 47 Van Natta 1460 (1995), was directly on point and, based on the reasoning in Hussey, the ALJ found claimant's injury claim compensable. However, neither party cited Hussey in its closing arguments. We conclude that the claim's value and the benefits secured are of modest proportions. As in Hussey, it has been determined that an injury caused by work activities (here, the broken skin on claimant's hand caused by the frequent hand washing required by his work) was exposed to another person's blood, resulting in the need for prophylactic medical treatment. It has not been established that claimant was exposed to nor that he had contracted any blood borne pathogens. Opinion and Order, page 4.

The record was small, consisting of only ten exhibits. The hearing was not lengthy, lasting only one and one-half hours. However, claimant's counsel's examination of claimant established that the condition of claimant's hands (being roughened and with broken skin) was caused by his work activities, establishing the necessary causal connection. In addition, claimant's counsel skillfully advocated claimant's claim. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering these factors, we find the ALJ's $500 award to be inadequate. Specifically, after consideration of the aforementioned factors, we conclude that $1,500 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated April 4, 1997, as reconsidered April 25, 1997, is affirmed in part and modified in part. In lieu of the ALJ's $500 attorney fee award, claimant's counsel is awarded a $1,500 attorney fee, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
CHERYL T. TORKKO, Claimant
WCB Case No. 95-01511
ORDER ON REMAND
Foss, Whitty, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Torkko v. SAIF, 147 Or App 678 (1997). The court reversed our prior order, Cheryl T. Torkko, 48 Van Natta 227 (1996), that reversed the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's head, neck and back injury claim. Citing SAIF v. Marin, 139 Or App 518 (1995), rev den 323 Or 535 (1996), the court concluded that we incorrectly focused on whether the employer had control of the instrumentality of injury in determining that claimant's claim was not compensable. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, who taught elementary school, drove into the parking lot which was owned and maintained by the school district, and which was used almost exclusively by teachers. Claimant parked in her customary spot near the entrance to her classroom shortly before school began. She exited the car and closed the driver's door. She then opened the left rear door to retrieve a bag containing classroom materials. After getting the bag, she closed the door and turned to her left to walk toward the school, striking her head on the side mirror of a van that was parked in the space next to her car. Claimant sought medical attention for her head, neck and back. The SAIF Corporation denied her injury claim on the ground that claimant was not in the course and scope of her employment at the time of injury. (Ex. 4).

Relying on Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the ALJ set aside SAIF's denial, finding that claimant's injury occurred in the course of her employment and that there was a sufficient causal connection between her "parking lot" injury and her employment.

On review, relying on Montgomery Ward v. Malinen, 71 Or App 457 (1984), we reversed, finding that claimant's injury did not arise out of her employment. Cheryl T. Torkko, 48 Van Natta at 228. In reaching our conclusion, we reasoned that claimant's injury arose from a hazard, the van, over which the employer had no control.

Citing SAIF v. Marin, 139 Or App 518, rev den 323 Or 535 (1996), the court reversed, reiterating that, under the "arising out of" standard, we should not focus on individual factors (like control), but rather on "the totality of the events that gave rise to [the] claimant's injury." Reasoning that we had improperly focused on whether the employer controlled the instrumentality that caused claimant's injury, the court concluded that the proper focus is on whether her injury (which was caused when her head struck the mirror on a co-worker's van parked adjacent to her car in her employer's parking lot while she was walking from her car to her classroom) is causally connected with her employment. Consequently, the court remanded for reconsideration.

SAIF, citing Fred Meyer, Inc. v. Hayes, 325 Or 592, 601 (1997), and Redman Industries v. Lang, 326 Or 32 (1997), argues that claimant's injury did not "arise out of" her employment.[1] SAIF reasons that claimant was not required to park in a designated area and that there was no evidence that parking in the employer's parking lot increased the risk that claimant would walk into a rear view mirror on a coworker's van. SAIF's premise is inapposite, as the Court has identified the proper test as "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."

On December 6, 1994, claimant parked her car in her customary space in the employer's parking lot. As she prepared to enter the school shortly before her regular teaching day began, she was injured when her head struck a mirror on a coworker's van parked in an adjacent space while she was taking school materials from her car to her classroom.

We find the circumstances of this case analogous to those in Lisa M. Bean, 48 Van Natta 1216 (1996). In Bean, the claimant arrived at work and parked in the employer-controlled parking lot. She was struck by a co-worker's vehicle when she was walking through the parking lot to enter her immediate work area. We found no evidence that the claimant engaged in any activity that removed her from normal ingress to work. We concluded that the situation presented a "neutral risk;" i.e., neither personal nor directly employment-related. In accordance with the rationale articulated by the court in SAIF v. Marin, that walking through an employer-controlled parking lot while going to and from work is, "in a general sense," a condition of the employee's employment, we concluded that the circumstances of claimant's injury (walking to her work site after parking in the employer-controlled parking lot when she was struck by a co-worker's vehicle) were sufficient to find the requisite causal connection required under Norpac Foods v. Gilmore, 318 Or 363 (1994), and SAIF v. Marin. Accordingly, we held that the claimant's injuries "arose out of" her employment.

In this case, as in Lisa M. Bean, claimant was walking to her work site after parking in the employer-controlled parking lot. There is no evidence that claimant engaged in any activity that removed her from her normal ingress to work.[2] Also as in Bean, this situation presents a "neutral risk;" i.e., neither personal nor directly employment-related.

Here, there is sufficient risk of an accident attendant on walking through the employer's parking lot, whether being hit by, or hitting, a co-worker's car. Thus, considering that claimant was walking to her work site after parking in the employer-controlled parking lot when she struck the mirror on a co-

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[1] SAIF does not dispute that the injury occurred "in the course of" claimant's employment. (Appellant's Supplemental Brief at 1).

[2] See Larson, 1 Workmen's Compensation Law, Section 15.42(b), 4 -101 (1995) (injuries incurred in employer-controlled parking lots are given the same status as those that occur on the main premises; viz., they are compensable to the same degree they would be compensable on the main premises).

worker's vehicle, we conclude that a sufficient causal connection has been satisfied.[3] Because we are persuaded that claimant's injuries "arose out of" her employment, we hold that her claim is compensable. Consequently, the denial is set aside and the claim is remanded to SAIF for processing according to law.

In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or Board, then the ALJ, Board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). Here, because claimant did not finally prevail until issuance of our Order on Remand, statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum. Nonetheless, pursuant to its appellate judgment, the court has already granted $5,080.15 as a carrier-paid attorney fee.

Inasmuch as neither party challenges the statutory basis for such an award, we shall likewise not examine that question. See Mark L. Hadley, 47 Van Natta 725, 726 (1995). In any event, after considering the factors set forth in OAR 438-015-0010(4), we find that such an award represents a reasonable attorney fee for claimant's counsel's "pre-remand" services.

Finally, we turn to a determination of a reasonable attorney fee for claimant's counsel's services on Board review. After consideration of the factors recited in the aforementioned rule, we find that a reasonable attorney fee for claimant's counsel's services on Board review is $687.50, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's supplemental response and her counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we affirm the ALJ's order dated June 5, 1995.

IT IS SO ORDERED.

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[3] SAIF also analogized the situation in this case to that in William F. Gilmore, 46 Van Natta 999 (1994). In Gilmore, the claimant felt his knee "grab/lock up" and "pop" as he entered his car in the employer's parking lot. We found that, other than the mere fact that claimant's injury occurred on the employer's premises, the injury did not result from an ordinary risk of, or incidental to, his employment and, therefore, did not "arise out of" his employment. Accordingly, we held that the claimant's injury was not causally related to his work. Here, unlike Gilmore, the risk of the injury originated from a risk to which the work environment exposed claimant; i.e., striking the mirror of a co-worker's vehicle parked in an employer's parking lot.

In the Matter of the Compensation of
LINDA M. GREENHAW, Claimant
WCB Case No. 96-04113
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Gilroy Law Firm, Defense Attorneys

The insurer requests reconsideration of our October 3, 1997 Order on Review that set aside its partial denial of claimant's right carpal tunnel syndrome. The insurer contends that we erred in assuming that Dr. Thayer had an accurate history of the mechanism of injury, when that history differed from claimant's testimony at hearing. The insurer also contends that we should have deferred to the ALJ's assessment of the mechanism of injury, because only the ALJ had the opportunity to view claimant's demonstration of how she was injured.

We addressed the insurer's first contention in our original order, noting that nothing in claimant's testimony was contrary to or inconsistent with Dr. Thayer's understanding of the mechanism of injury. We continue to adhere to that finding on reconsideration.

We further note that our assumption that Dr. Thayer obtained a complete medical history when he examined claimant was based on evidence in the record. Specifically, we noted that Dr. Thayer asked claimant whether her wrist was bent or straight when she sustained the injury, while the attorneys did not ask that question during the hearing. (Compare transcript with Ex. 18-9). We

continue to adhere to our finding that Dr. Thayer's opinion was based on a complete and accurate understanding of claimant's history and the mechanism of injury.

Finally, we note that our review is limited to the record on review. We must rely on claimant's verbal description of the mechanism of injury, as reflected in the transcript, not on a demonstration which we are unable to view. Although the ALJ viewed claimant's demonstration, we need not defer to the ALJ's conclusions about whether the demonstration is consistent with the remainder of the record. On de novo review, it is our obligation to determine whether claimant's testimony, as reflected in the transcript, is consistent with the rest of the record or not. In this case, we concluded that claimant's testimony was consistent with Dr. Thayer's understanding of the mechanism of injury. We continue to adhere to that conclusion.

Accordingly, we withdraw our October 3, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our October 3, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 3, 1997 Cite as 49 Van Natta 1913 (1997)

In the Matter of the Compensation of
GORDON L. ELLIOT, Claimant
Own Motion No. 97-0471M
OWN MOTION ORDER
Pozzi, Wilson, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left knee strain injury. Claimant's aggravation rights expired on April 8, 1993. SAIF recommends denying claimant's request of temporary disability benefits 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 August 7, 1997 letter, Dr. North, claimant's treating physician, requested authorization to perform a total left total knee arthroplasty. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

Claimant contends that he is in the work force because his compensable injury has made efforts to seek work futile. Assuming that claimant's contention is correct, claimant must also establish, in addition to "futility" that he is willing to work. Dawkins, 308 Or at 258. In this regard, even though a physician may opine that the claimant is unable to work due to a compensable injury, if the claimant has not demonstrated a willingness to work, he/she is not considered a member of the work force, and thus, is not entitled to temporary disability benefits. See Stephen v. Oregon Shipyards, 115 Or App 521 (1992); Martin L. Moynahan, 48 Van Natta 103 (1996).

There is no evidence in this record which establishes that claimant is willing to work. In fact, the only evidence regarding claimant's current work status supports the opposite conclusion. In an August 5, 1997 chart note, Dr. North indicates that claimant is retired. Under these circumstances, we conclude that claimant has not established that he was in the work force at the time of his disability.

Accordingly, claimant's request for temporary disability compensation is denied.

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

IT IS SO ORDERED.

November 3, 1997 Cite as 49 Van Natta 1914 (1997)

In the Matter of the Compensation of
REED HANKS, Claimant
WCB Case No. 96-04004
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

On September 10, 1997, we abated our August 26, 1997 order that, in part, awarded an assessed fee to claimant's attorney of $3,000 for services at hearing and on review. We took this action to consider claimant's motion for reconsideration contending that his counsel submitted a statement of services requesting an attorney fee of $8,000 and further asserting that SAIF submitted an objection to the request. Our Order of Abatement explained that the record did not contain claimant's counsel's statement of services or SAIF's objection and requested that the parties submit such materials, along with their respective arguments concerning the amount of the assessed attorney fee. Having received those submissions, we proceed with our reconsideration.

In requesting an $8,000 attorney fee, claimant contends that his counsel devoted 46.5 hours at hearing and 12 hours on review. Claimant further argues that "this is a very complex case" which included depositions of two physicians and testimony at hearing from claimant's treating physician. SAIF asserts "this is a typical workers' compensation case," noting that the record consists of 31 exhibits, none of which were generated by claimant and the hearing lasted 2 hours and 15 minutes, resulting in a 69-page transcript. SAIF further contends that the benefit to claimant was limited to the payment for insulin therapy. In light of such factors, SAIF contends that the $3,000 attorney fee awarded in the Order on Review is appropriate.

We consider the factors set forth in OAR 438-015-0010(4) in deciding a reasonable attorney fee. These factors are:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

As SAIF noted, the record consisted of 31 exhibits, including two depositions in which claimant's attorney participated; both depositions lasted for one hour and 5 minutes. All of the documents were generated by SAIF. The hearing lasted 2 hours and 15 minutes and included testimony by claimant and her treating physician. According to claimant's counsel, he devoted a total of 58.5 hours to the case. In light of these circumstances, we find the nature of the proceeding to be average.

We find the case to have been complex in that it necessitated medical evidence of the effect of claimant's quadriplegia on his diabetic condition. The benefit secured, treatment for claimant's diabetes, is slightly above average. Finally, both attorneys showed skill in the case, there was a risk that claimant's attorney could go uncompensated, and there was no assertion of frivolous issues or defense.

After considering these factors, we find that a reasonable attorney fee for claimant's attorney's services at hearing and on review is $7,500. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and evaluating claimant's counsel's submission in light of SAIF's objection), the medical complexity of the case, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

On reconsideration, as supplemented and modified herein, we adhere to and republish our August 27, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 3, 1997 Cite as 49 Van Natta 1915 (1997)

In the Matter of the Compensation of
EDWARD M. JANUARY, Claimant
WCB Case No. 96-08893
ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

The SAIF Corporation requests reconsidation of our September 15, 1997 Order on Review that set aside SAIF's denial of claimant's aggravation claim. In its motion for reconsideration, SAIF contends that the record lacks medical evidence of objective findings supporting claimant's aggravation claim. In order to allow sufficient time to consider SAIF's motion, we abated our order on October 15, 1997.

Having received claimant's response to SAIF's motion, we proceed with our reconsideration.

SAIF contends that our conclusion that Dr. Kelly's finding of "muscle tightness" in the paraspinous muscles constituted an "objective finding" is incorrect. Specifically, SAIF argues that Dr. Kelly did not suggest that claimant's muscle tightness in the paraspinous muscles represented a worsening of the compensable condition. We disagree with SAIF's contention. Dr. Kelly was specifically asked what claimant's objective findings were. Dr. Kelly identified limited forward flexion secondary to voluntary guarding and muscle tightness at the paraspinous muscles beginning at about L3 and extending to the sacrum.[1] (Ex. 38). We continue to find that Dr. Kelly's finding of muscle tightness in the paraspinous muscles constitutes an "objective finding." See Tony D. Houck, 48 Van Natta 2443, 2449 (1996). In addition, Dr. Moore also made findings of "marked limitation" of motion. (Ex. 23). We likewise conclude that this constitutes an "objective finding." Accordingly, we decline to alter our prior holding.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideraton is $250, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response), the complexity of the issue, and the value of the interest involved. This award is in addition to the attorney fee granted by our prior order.

As supplemented herein, we adhere to and republish our September 15, 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] In addressing whether claimant's low back condition had sustained an actual worsening, Dr. Kelly indicated that claimant was "most notably" limited in range of motion secondary to voluntary guarding. Dr. Kelly concluded that "[t]here was no other objective findings which would substantiate the worsening." (Ex. 38). We do not read this portion of Dr. Kelly's report as retracting her previous statement that claimant's objective findings included muscle tightness.

In the Matter of the Compensation of
BILLY A. SPRINGS, Claimant
Own Motion No. 95-0370M
OWN MOTION ORDER ON RECONSIDERATION
Kasia Quillinan, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our September 19, 1997 Own Motion Order Reviewing Carrier Closure, in which we set aside SAIF's July 14, 1997, Notice of Closure as premature. On October 20, 1997, in order to full consider this matter, we abated our prior order and granted claimant an opportunity to respond. After receiving claimant's response, and further considering the matter, we make the following conclusions.

With its request for reconsideration, SAIF submitted a September 25, 1997 letter from Dr. Berselli, claimant former treating physician. In his letter, Dr. Berselli, indicates that he is not sure whether or not claimant requires the additional surgery proposed by Dr. Thomas, but recommended that a bone scan be performed to determine if there was a gross loosening, noted by Dr. Thomas, of the left knee prosthesis. Dr. Berselli acknowledged that he had not seen claimant since July 9, 1997.

With his response, claimant submits further medical evidence from Dr. Thomas, his current treating physician. In an October 10, 1997 letter, Dr. Thomas indicated that a bone scan was not necessary and explained that, "[r]egardless whether the components are grossly loose, the [claimant] has a fractured cement mantle and malposition of [claimant's] components, as well as marked laxity in all planes, suggestive of ligatmentous instability."

In our prior order, we found that the opinion of Dr. Thomas was more persuasive than the opinion of Dr. Berselli. We continue to adhere to that conclusion. Dr. Berselli's opinion is equivocal at best, and is based on a misunderstanding of Dr. Thomas' surgery. In contrast, Dr. Thomas persuasively explains that his recommendation for surgery is not based upon a "loosening" of the component, but rather is based on a fractured cement mantle and malposition of the components. Based on Dr. Thomas' opinion, we continue to conclude that the July 14, 1997 Notice of Closure was premature.

On reconsideration, as supplemented herein, we adhere to and republish our September 19, 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
DARLENE A. BUSH, Claimant
WCB Case No. C702655
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Philip Garrow, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On October 16, 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.

The first page of the agreement provides that claimant has fully released all of her workers' compensation benefits, including penalties and attorney fees. However, in the body of the CDA (page 2, number 12), the parties have revised the provision by means of interlineation to indicate that all rights to temporary disability, permanent disability, vocational rehabilitation, aggravation rights, and survivor benefits have been released. The language specifically releasing "attorney fees" and "penalties," has been deleted from the provision by means of interlineation.

In light of such circumstances, we interpret the parties' intention in the CDA to be that claimant fully releases all "non-medical service" benefits allowed by ORS 656.236 except for penalties and attorney fees. We conclude that the reference to a full release of "penalties and attorney fees" on the first page of the CDA is a clerical error. By this order, we correct that error.

In conclusion, the agreement, as clarified and amended 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 $300.50, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK A. DAVIDSON, Claimant
WCB Case Nos. 96-05227, 96-05189, 96-05188, 96-05187, 96-05186, 96-05185, 96-05184, 96-05183, 96-05191, 96-05190 & 96-02407
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney
Wallace & Klor, Defense Attorneys
Moscato, et al, Defense Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld Weyerhaeuser Company's and the SAIF Corporation's denials of claimant's occupational disease claim for a low back condition. On review, the issues are compensability and, if the claim is found compensable, responsibility. We reverse in part and affirm in part.

EXHIBITS

The second paragraph of the ALJ's Opinion and Order is corrected as follows. The first sentence is corrected to read: "Exhibits 1 through 111, 67A, 90A, 94A, 104A, 105A, 105AA, and 105AAA were admitted into the record at the time of the hearing." The second sentence of the paragraph is deleted.

FINDINGS OF FACT

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

We replace the second paragraph of the ALJ's findings of fact with the following paragraphs:

"In May 1981, claimant sustained an on-the-job injury while employed by Weyerhaeuser, as a result of which he experienced pain and other symptoms in his low back and right leg, down to the heel of his right foot. Claimant missed little work as a result of this injury.

"However, claimant's symptoms continued and, in February 1982, he sought treatment with Dr. Adams. At that time, he was experiencing low back and left hip pain. (Ex. 4-1). A February 1982 x-ray revealed a pars interarticularis defect at L5 on the right. (Ex. 3). Dr. Adams also noted that claimant had spina bifida occulta of S1. (Ex. 4-2). Subsequently, Dr. Adams diagnosed claimant's February 1982 condition as a lumbosacral strain superimposed upon unilateral spondylolysis and spina bifida occulta of L-5. (Ex. 18-1). Claimant continued working, however, with occasional time off from work into the mid-1980s."

We replace the second sentence of the third paragraph of the ALJ's findings of fact with the following:

"Claimant visited Dr. Adams who diagnosed 'unilateral spondylolysis on the right at L-5 and spina bifida occulta with early degenerative changes at L-3/L-4. . . superimposed on an acute back strain.' (Ex. 18-2). X-rays taken in June 1985 revealed some impaction spurs between L-3 and L-4, but Dr. Adams noted that the disc spaces appeared well-maintained. (Ex. 18-2; see also Ex. 13-1)."

After the first sentence of the fourth paragraph of the ALJ's findings of fact, we add the following: "X-rays taken at Dr. Raaf's request revealed early degenerative disc disease at L3-4 and L4-5. (Ex. 21). Dr. Raaf diagnosed ligament and muscle strain of the dorsal, lumbar and sacral areas, with radicular symptoms in the legs, more marked in the left leg, as well as spina bifida occulta in the lumbar area and pars interarticularis defect on the right at L5, based on x-rays. (Ex. 23-6)."

The first sentence of the seventh paragraph of the ALJ's findings of fact is corrected as follows: "Claimant received no medical treatment for his back condition from December 1986 through October 1991."

In the second sentence of the eighth paragraph of the ALJ's findings of fact, we add "at L3-4" after the phrase "significant degenerative disease." After the second sentence of that paragraph, we add the following: "Drs. Kho and Perry also noted that claimant's congenital factors of spina bifida occulta and the pars defect at L5 were not contributing to his current need for treatment. (Ex. 62-4)."

After the third sentence of the ninth paragraph of the ALJ's findings of fact, we add the following: "X-rays taken by Dr. Bert revealed 'considerable disc space narrowing at [L]4-5 and almost complete absence of the disc at [L]3-4 with osteophyte impingement.' (Ex. 67-1). Dr. Bert diagnosed degenerative post-traumatic disc disease at L3-4 and L4-5 with significant mechanical pain and instability. (Id.)."

We replace the third sentence of the tenth paragraph of the ALJ's findings of fact with the following: "Rosenbaum opined that claimant's long history of timber falling activity, including his work at Weyerhaeuser, contributed to claimant's musculoskeletal strain symptomotology, but the Weyerhaeuser employment did not contribute to the degenerative disc disease. (Ex. 69-5). Dr. Rosenbaum believed that claimant's congenital right-sided spondylolysis of L5, S1 was asymptomatic and unrelated to claimant's current symptom complex. (Ex. 69 at 5-6). Dr. Rosenbaum further opined that claimant's June 1985 work injury while employed at Weyerhaeuser did not cause the degenerative findings, and that the degenerative disc disease is not 'post-traumatic' in the sense of an industrial injury. (Ex. 69-6)."

At the end of the eleventh paragraph of the ALJ's findings of fact, we add the following: "The physicians felt that the unilateral spondylolysis and spina bifida occulta, noted in 1985, were incidental findings. (Ex. 93-5)."

At the end of the fourteenth paragraph of the ALJ's findings of fact, we add the following: "Dr. Rosenbaum felt that the 1986 [sic] injury is wholly unrelated to the cause or progression of claimant's degenerative disc disease. (Ex. 107-2)."

CONCLUSIONS OF LAW AND OPINION

Compensability

Reasoning that claimant's degenerative disc disease preexisted the 1985 work injury, the ALJ held that it was claimant's burden to prove, under ORS 656.802(2)(b), that work exposure was the major contributing cause of claimant's "combined condition" (the accepted strain superimposed on preexisting degenerative disc disease) and pathological worsening of the disease. The ALJ concluded that only the opinion of Dr. Bert, claimant's treating physician, supported compensability, but it was insufficient to carry claimant's burden.

On review, claimant contends that all his work experience as a timber cutter caused his occupational disease. Therefore, because claimant had no preexisting condition when he started work as a timber cutter in 1978, the preexisting condition analysis is not appropriate. Consequently, claimant contends that compensability of this occupational disease claim should be analyzed under ORS 656.802(2)(a). Claimant further contends that the preponderance of medical opinion establishes compensability of claimant's occupational disease under ORS 656.802(2)(a). We agree.

ORS 656.802(2)(b)[1] applies when the occupational disease claim is based on the worsening of a preexisting disease or condition, and the preexisting disease has combined with a compensable injury as provided in ORS 656.005(7)(a)(B).[2] Thus, we must first determine whether claimant has a preexisting disease or condition. Beverly J. Kellow, 49 Van Natta 741, 742 (1997).

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[1] ORS 656.802(2)(b) provides that "[i]f the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease."

[2] 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."

A "preexisting condition" is defined 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 . . . occupational disease[.]" ORS 656.005(24). Here, claimant contends that his approximately seventeen years of employment as a timber cutter, from 1978 until 1995, are the major contributing cause of his degenerative disc disease at L3-4 and L4-5. This is an initial claim for an occupational disease for degenerative disc disease at L3-4 and L4-5. Therefore, the onset of this occupational disease claim is 1978, when claimant began employment as a logger. Thus, the question is whether claimant had any disease or condition that preexisted the beginning of his employment as a timber cutter in 1978. See Clifford T. Upp, 48 Van Natta 2236 (1996); Esther L. Mace, 48 Van Natta 1168 (1996).

Prior to 1978, when claimant began working as a logger for Weyerhaeuser, he had had no significant problems with his back. Claimant's 1978 pre-employment physical indicated no back problems. (Ex. 1). Although claimant injured his back in 1974 when he fell through a dock, that was not a significant injury since claimant's back pain resolved quickly without causing him to take time off work. (Exs. 4-1, 23-3; Tr. 21, 22, 42-43). There is no evidence that claimant's degenerative disc disease preceded the onset of his occupational disease claim in 1978. Indeed, the earliest evidence of degenerative disc disease is a 1985 x-ray, which revealed early degenerative changes at L3-4. (See Ex. 18-2).

Claimant also has congenital spinal conditions, which include a pars interarticularis defect (also referred to as "spondylolysis") at the L5 level on the right (Ex. 3), levoscoliosis (Ex. 13-1), and spina bifida occulta of L5 (Exs. 4-1, 18-1). There is no evidence, however, that these conditions caused claimant any problems. (See Ex. 69-5). Rather, they appear to be merely incidental findings. (Ex. 93-5). Although these conditions preexisted the onset of claimant's occupational disease claim, there is no evidence that these congenital conditions **combined** with an otherwise compensable injury to cause or prolong disability or the need for treatment. Clifford T. Upp, 48 Van Natta at 2236-37; Susan A. Michl, 48 Van Natta 1752 (1996). Therefore, we find that claimant did not have a preexisting condition that combined with a compensable injury. Accordingly, we conclude that claimant is not required to establish compensability of his occupational disease claim under ORS 656.802(2)(b).

In order to establish compensability of his occupational disease claim, claimant "must prove that employment conditions were the major contributing cause of the disease." ORS 656.802(2)(a). A finding of "major" causation requires that the 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).

Dr. Bert, claimant's current treating physician, diagnosed claimant's condition as "degenerative post-traumatic disc disease" at L3-4 and L4-5. (Ex. 67-1). Dr. Bert explained that by characterizing claimant's degenerative disease as "post-traumatic," he did not mean that claimant's condition was caused by a single traumatic back injury. (Ex. 90-3). Rather, Dr. Bert believed that claimant's entire work experience as a timber faller, including his work injuries of 1981, 1985 and 1987, was the major cause of claimant's degenerative back condition. (Id.). Dr. Bert further explained that claimant's disc degeneration was very advanced for a person of his age and could only reasonably be explained by claimant's work history in the timber industry. (Ex. 90 at 3-4).

Examining physicians Drs. Rosenbaum, Gancher and Bald do not directly disagree with Dr. Bert. While Dr. Rosenbaum disagrees in general with Dr. Bert that degenerative disc disease is a work-related condition, Dr. Rosenbaum also opines that if work contributed to claimant's degenerative disc disease, all the work after 1978 contributed, not just the Weyerhaueser employment. (Ex. 107). Dr. Rosenbaum also disagrees with Dr. Bert's characterization of claimant's degenerative disease as "post-traumatic." However, Dr. Rosenbaum focuses on whether a particular injury could have caused the degenerative changes seen, while Dr. Bert focuses on claimant's entire work history in the logging industry. (See Exs. 69-6, 107; compare Ex. 90-3). Drs. Gancher and Bald also opine that claimant's degenerative disc disease is unrelated to claimant's work exposure at Weyerhaueser, but they do not dispute that all claimant's work exposure could have caused his current back condition. (See Ex. 93 at 5-6). Specifically, Drs. Gancher and Bald opine that it is likely that claimant has "idiopathic degenerative lumbar spondylitic disease either from cumulative trauma as a result of working in the woods for ten years, or simply, for idiopathic and as yet unkown causes." (Ex. 93-6). Only Drs. Wilson and James opined that claimant's degenerative disc disease was unrelated in any way to his work activities. (Ex. 94A at 6-7).

When medical opinions differ, we rely on opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, we find Dr. Bert's opinion to be most persuasive. Dr. Bert provided consistent, well-reasoned opinions, based on a complete and accurate medical history. Moreover, we find that Dr. Bert's opinion focuses most clearly on the relevant work exposure involved in this case. By contrast, the examining physicians focus primarily on whether a particular work exposure caused claimant's degenerative disc disease. In addition, we do not find the opinion of Drs. Wilson and James persuasive because they, unlike all the other physicians who treated or examined claimant, found no organic basis for claimant's symptoms. (Ex. 94A-7). Therefore, we rely on Dr. Bert's opinion to find that claimant's degenerative disc disease at L3-4 and L4-5 is a compensable occupational disease.

Responsibility

Having found that claimant's occupational disease claim is compensable, we turn now to the determination of which employer is responsible.

When a worker's occupational disease could have been caused by two or more employments, the "last injurious exposure rule" (LIER) of assigning liability determines which employment is responsible for the disease. Bracke v. Baza'r, 93 Or 239, 245-46 (1982). Under that rule, liability is assigned to the last employer whose employment could have materially contributed to claimant's condition. Id. at 244; United Parcel Service v. Likos, 143 Or App 486, 488 (1996). If a worker receives treatment for a compensable condition before experiencing time loss due to that condition, the date that the worker first received treatment related to the compensable condition determines the assignment of initial responsibility for the claim, unless subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 400 (1993), rev den 319 Or 81 (1994). The dispositive date is the date when the worker first sought treatment for symptoms, even though the compensable condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Here, claimant was employed as a timber faller by numerous employers from 1978 until November 1995. We have determined that claimant's cumulative employment as a timber faller, from 1978 to 1995, is the major contributing cause of his occupational disease claim for degenerative disc disease at the L3-4 and L4-5 levels. Claimant worked as a timber faller at all his employments in the timber industry. (Tr. 26-27). Therefore, we find that all of claimant's employment in the timber industry from 1978 to 1995 could have contributed to his disease. Likos, 143 Or App at 490.

It is unclear when claimant first received treatment for the symptoms of degenerative disc disease at L3-4 and L4-5. Claimant's low back condition was first diagnosed as an occupational disease on September 20, 1995, when claimant sought treatment from Dr. Brett for his low back discomfort. (Ex. 67). Claimant may have also received treatment for degenerative disc disease of the low back prior to September 1995. (See e.g., Ex. 55). However, regardless of when claimant first received treatment for the symptoms of degenerative disc disease, the evidence establishes that claimant's employment for Jim Loomis Cutting from September 6, 1995 until November 17, 1995, independently contributed to a pathological worsening of claimant's disease. (Ex. 106). As the last employer whose employment contributed to a worsening of claimant's occupational disease, Jim Loomis Cutting is liable for the claim. Likos, 143 Or App at 488; Timm, 125 Or App at 400. Therefore, SAIF, as insurer for Jim Loomis Cutting, is responsible for claimant's occupational disease.

Attorney fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,500, payable by the SAIF Corporation on behalf of Jim Loomis Cutting. 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 21, 1997 is reversed in part and affirmed in part. The SAIF Corporation's May 23, 1996 denial on behalf of Jim Loomis Cutting is set aside, and the claim is remanded to SAIF for processing in accordance with law. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded an attorney fee in the amount of $5,500 for his services at hearing and on review, payable by SAIF on behalf of Jim Loomis Cutting.

In the Matter of the Compensation of
SHARON K. MADUZIA, Claimant
WCB Case No. C702661
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Black, et al, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On October 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 her compensable injury. We approve the proposed disposition.

By handwritten addition, the first page of the agreement provides that $3,125 will be paid to claimant's attorney as an attorney fee and $9,375 will be paid to claimant. SAIF's counsel and SAIF's claims adjuster apparently approved the handwritten additions to the first page of the CDA, but neither claimant nor her attorney initialed the handwritten additions. On page 3 (lines 3-18), the CDA provides that claimant releases her rights to "non-medical services" workers' compensation benefits with the exception of certain rights to penalties and attorney fees, but the amount of consideration for claimant's release has been left blank. On page 4, lines 1 through 3, the CDA provides, in handwriting, that the amount to be paid to claimant under the agreement is $9,375 and the amount to be paid to claimant's attorney is $3,125 for a total of $12,500. All parties and their respective counsels have initialed the handwritten additions on page 4.

Based on the handwritten additions to the CDA, as approved by all parties and their attorneys on page 4, we interpret the CDA as providing that claimant releases her rights to all workers' compensation benefits permitted by ORS 656.236 (with the exception of certain penalties and attorney fees reserved on page 3 of the agreement and medical services) in exchange for $12,500, less a $3,125 attorney fee.

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 $3,125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA BARBER, Claimant
WCB Case No. 96-08948
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) reduced claimant's scheduled permanent disability award for loss of use or function of the right forearm (wrist) from 26 percent (39 degrees), as awarded by an Order on Reconsideration, to 20 percent (30 degrees); and (2) awarded an employer-paid attorney fee under ORS 656.382(2). In her respondent's brief, claimant contends that her permanent disability award should be increased. In reply, the employer asserts that claimant may not make such an argument in the absence of a timely filed cross-request for review. On review, the issues are the employer's procedural objection, extent of scheduled permanent disability, and attorney fees. We reject the employer's procedural objection, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception. We do not adopt the ALJ's findings of ultimate fact regarding loss of strength impairment or chronic condition impairment.

CONCLUSIONS OF LAW AND OPINION

Procedural Matter

The employer argues that we do not have jurisdiction to address claimant's contention that her permanent disability award should be increased. The employer bases its argument on the fact that claimant did not formally request review but, instead, raised the issue of increased permanent disability in her respondent's brief. We disagree with the employer's argument.

The employer was the sole party to formally request review of the ALJ's order. Nonetheless, when a non-appealing party raises other issues in its respondent's brief, we are authorized to address those issues, provided that the formal request for review has not been withdrawn. Eder v. Pilcher Construction, 89 Or App 425 (1988); Neely v. SAIF, 43 Or App 319, 323, rev den 288 Or 493 (1980); Jimmie Parkerson, 35 Van Natta 1247, 1250 (1983); see also Kordon v. Mercer Industries, 308 Or 290 (1989) (Court held that where claimant sought review of permanent partial disability award by requesting permanent total disability and insurer responded in its brief that the award should be reduced, insurer had made a cross request for review such that claimant was entitled to attorney fees when the Board affirmed the award).

Here, the employer's formal request for review has not been withdrawn. Consequently, we are authorized to consider the issue of increased permanent disability raised in claimant's brief. Likewise, in accordance with ORA 656.295 (5)and (6), we are authorized to make any disposition of the case as we deem appropriate, including reaching issues that were before the ALJ but not raised by the parties on review. See ORS 656.295(5), (6); Destael v. Nicolai Co., 80 Or App 596 (1986); Miller v. SAIF, 78 Or App 158 (1986); Neely v. SAIF, 43 Or App at 323.

Extent of Scheduled Permanent Disability

Claimant, who has an accepted bilateral carpal tunnel syndrome claim, requested reconsideration of a Notice of Closure award of 4 percent scheduled permanent disability for each forearm. Relying on a medical arbiter's report, an Order on Reconsideration awarded 2 percent scheduled permanent disability for the left forearm and 26 percent scheduled permanent disability for the right forearm, in lieu of the scheduled permanent disability awarded by the Notice of Closure. At hearing and on review, the parties only dispute the 26 percent scheduled permanent disability award for the right forearm.

In her written closing arguments, claimant conceded that she was not entitled to the 2 percent award for loss of range of motion in the right wrist, which the Appellate Reviewer awarded as the result of a scrivener's error. (Exs. 7-2, 8-5). Therefore, on review, as at hearing, the issue regarding extent of

scheduled permanent disability for the right forearm involves whether claimant is entitled to impairment ratings for loss of strength, loss of sensation, and/or loss of repetitive use. As the ALJ found, the applicable standards are found at WCD Order 96-051. OAR 436-035-0003(1), (2).

As a preliminary matter, we agree with the ALJ's statement that, as the party that requested a hearing regarding the Order on Reconsideration, the employer had the burden of proving that claimant's permanent disability award should be reduced. See Roberto Rodriguez, 46 Van Natta 1723 (1994); Lanny K. Sigfridson, 49 Van Natta 1433 (1997). In reaching this conclusion, we note that the employer's reliance on Marcia G. Williams, 49 Van Natta 313 (1997), does not support its position because we did not address the burden of proof issue in Williams. Instead we found that, regardless of which party had the burden of proof, the claimant was not entitled to a permanent disability award for the compensable condition. Id.

Turning to the merits, we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough and well-reasoned evaluation of the claimant's injury-related impairment. Kenneth W. Matlack, 46 Van Natta 1631 (1994). The employer disputes the ALJ's finding that, as a neurologist, Dr. Bell (the medical arbiter) has more expertise regarding claimant's impairment due to the carpal tunnel syndrome than the attending physician, Dr. Van Allen, who is an orthopedic surgeon. However, even disregarding Dr. Bell's expertise as a neurologist, we agree with the ALJ's reasoning that Dr. Bell's opinion provides the most thorough and well-reasoned evaluation of the claimant's injury-related impairment.

The employer argues that Dr. Van Allen related claimant's symptoms to conditions other than the accepted carpal tunnel syndrome. Dr. Van Allen stated that claimant had "some intermittent symptoms but they do not seem to be related to her carpal tunnel." (Ex. 4-1). However, we find that Dr. Van Allen's next sentence describes these "intermittent symptoms" as "intermittent numbness on the right side in the ulnar nerve distribution but [claimant] has no positive provocative signs over either the cubital tunnel or ulnar tunnel." Id. Dr. Van Allen identified no other "intermittent symptoms." We do not find Dr. Van Allen's reference to intermittent numbness in the ulnar distribution on the right means that none of claimant's symptoms were due to the compensable carpal tunnel syndrome, only that those ulnar symptoms were not related to the compensable condition. Furthermore, Dr. Bell identified no sensory loss on the right side in the ulnar nerve distribution. (Ex. 7). In addition, Dr. Bell found none of claimant's findings invalid. (Ex. 7-4).

Loss of Sensation Impairment

We adopt the ALJ's reasoning and conclusions regarding claimant's 18 percent loss of sensation impairment in the right hand.

Loss of Strength Impairment

The ALJ found that Dr. Bell's report supported a loss of strength graded at 5-/5 pursuant to former OAR 436-035-0007(18) and rated the strength loss at 2 percent. We disagree.

The ALJ and the Board must apply the standards for evaluation of disability adopted by the Director pursuant to ORS 656.726. ORS 656.283(7); 656.295(5). Here, former OAR 436-035-0007(18) provides, in relevant part:

> "To 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. The grade of strength shall be reported by the physician and assigned a percentage value from the table in subsection (a) of this section." (Emphasis added).

Thus, the applicable rule explicitly requires that the grade of strength be reported by the physician. No allowance is made for applying a different grade of strength than that reported by the physician. The table at former OAR 436-035-0007(18)(a) provides a value of 0% for a grade of strength of 5/5 and a value of 5% for a grade of strength of 5-/5.

Dr. Bell reported that strength testing revealed 5/5 strength throughout the upper extremities, although he noted reduced strength in the right abductor pollicis brevis. (Ex. 7-2, -3). Based on Dr. Bell's notation regarding reduced strength in the right abductor pollicis brevis, the Appellate Reviewer and the ALJ adjusted Dr. Bell's 5/5 grade of strength to 5-/5. However, pursuant to former OAR 436-035-0007(18), the grade of strength must be reported by the physician. Dr. Bell reported a strength grade of 5/5; therefore, claimant has a strength grade of 5/5, which results in a rating of zero percent. Former OAR 436-035-0007(18)(a).

Chronic Condition Impairment

The ALJ determined that claimant had failed to establish a chronic condition impairment pursuant to the applicable rules. We disagree.

Former OAR 436-035-0010(5) provides, in relevant 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) [.]" (Emphasis added).

The previous version of this rule was found at former OAR 436-35-010(6) and provided for a scheduled chronic condition impairment "when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition[.]" WCD Admin. Order 6-1992 (emphasis added).

The ALJ interpreted the change in language regarding scheduled chronic condition impairment from "unable to repetitively use a body part" to "significantly limited in the repetitive use" of a body part as requiring a higher degree of impairment under the applicable rule, which was not supported by Dr. Bell's opinion. We disagree.

To be entitled to permanent disability compensation for a scheduled chronic condition under former OAR 436-35-010(6), a worker was required to establish, by a preponderance of persuasive medical evidence, that she or he was unable to repetitively use a body part due to a chronic medical condition. In interpreting former OAR 436-35-010(6), we compared the language of that rule with the language of the prior rule regarding chronic condition impairment, former OAR 436-35-010(7) [WCD Admin. Order 15-1990 (Temp.)], which allowed a 5 percent award for "[c]hronic conditions limiting repetitive use" of the injured body part and determined that there must be medical evidence of at least a partial loss of ability to repetitively use the body part. Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993); See Weckesser v. Jet Delivery Systems, 132 Or App 325, 328 (1995) (court relied on Board's interpretation of former OAR 436-35-010(6) as requiring at least a partial loss of ability to repetitively use the body part to establish chronic condition impairment).

We do not find the change of language from "unable to repetitively use a body part" in former OAR 436-35-010(6) to "significantly limited in the repetitive use" of a body part in former OAR 436-035-0010(5), the applicable rule in the present case, represents a requirement of either a higher degree of impairment or a higher standard of proof to establish chronic condition impairment. To the contrary, the change from "unable" to "significantly limited" logically represents a lower degree of impairment or standard of proof. This interpretation is supported by the Director's comments regarding the fiscal and economic impact regarding these changes. Specifically, the Director stated "[t]he chronic condition changes should only affect a very small percentage of claims (less than 5%). Any increased cost will be offset by reduced litigation costs." (Statement of Need and Fiscal Impact Before the Director of the Department of Consumer and Business Services of the State of Oregon, October 11, 1995). If the Director expected increased cost due to the change in language, it stands to reason that he reduced the standard of proof with that change in language.

In response to the question whether claimant is "significantly limited in the ability to repetitively use the hands, wrists, forearms as the result of the diagnosed chronic and permanent medical conditions," Dr. Bell stated that claimant's "symptoms would be limited in her ability to repetitively use the wrist for flexion/extension, or prolonged flexion activities." (Ex. 7-3). We find that Dr. Bell's opinion establishes that claimant is significantly limited in the repetitive use of her right wrist. Although Dr. Bell did not use the term "significantly limited" in rendering his opinion, he answered affirmatively a question phrased in those terms. In any event, "magic words" are not required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992) (No incantation of "magic words" or statutory language is required); Jesus Munoz, 48 Van Natta 953, 954 (1996). Thus, we find that claimant is entitled to 5 percent for scheduled chronic condition impairment.

The loss of sensation impairment (18 percent) is combined with the chronic condition impairment (5 percent) for a total scheduled permanent disability award of 22 percent. Former OAR 436-035-0007(17).

Attorney Fees

As noted above, claimant agreed that, allowing for the scrivener's error, the award of 26 percent scheduled permanent disability for loss of use or function of the right forearm (wrist) made by the Order on Reconsideration, should be reduced to 24 percent. The ALJ actually reduced the award to 20 percent. However, reasoning that the employer sought even further reduction in the scheduled permanent disability award, the ALJ awarded an assessed attorney fee under ORS 656.382(2) for claimant's successful defense against the employer's challenge to the loss of strength and loss of sensation components of claimant's scheduled permanent disability award for the right forearm (wrist). In reaching this conclusion, the ALJ relied on Roseburg Forest Products v. Boqua, 147 Or App 197 (1997), and reasoned that the various components of claimant's right scheduled permanent disability award, while admittedly for the same condition, should be treated the same as separate conditions in awarding assessed attorney fees. We disagree.

In Boqua, the court affirmed our order in Rodney V. Boqua, 48 Van Natta 357 (1995), which had awarded the claimant a carrier-paid attorney fee under ORS 656.382(2) for successfully defending at hearing one of several permanent disability awards granted by an Order on Reconsideration. Noting that the claimant's permanent disability awards for two other conditions had been reduced, the carrier contended in Boqua that the claimant was not entitled to an attorney fee under ORS 656.382(2) for defending a permanent disability award for another condition because his "overall" compensation had been reduced. The court disagreed. Inasmuch as the claimant had successfully defeated the carrier's attempt at the hearing to reduce his compensation award for one of the contested conditions, the court held that he was entitled to an attorney fee reasonably incurred in that effort. The court specifically noted that, when the carrier sought review of the disability awards before the ALJ, it treated and challenged each condition separately.

Here, the employer challenged only the scheduled permanent disability awarded for the right forearm, which involved only one condition - the right carpal tunnel syndrome. Although the permanent disability for one condition may comprise several components, only successful defense of the award for a separate condition entitles claimant to an assessed fee under ORS 656.382(2).[1] Boqua, 147 Or App at 202; Pamela R. Covey, 49 Van Natta 813 (1997) (where temporary disability was awarded only for one condition, although it was broken down into separate time periods, and the total temporary disability award was reduced, the claimant was not entitled to an assessed attorney fee under ORS 656.382(2)).

[1] We note that ORS 656.382(2) provides for an assessed attorney fee where the carrier requests a hearing or review and the "compensation awarded" is "not disallowed or reduced." Furthermore, the criteria for rating scheduled permanent partial disability is "the permanent loss of use or function of the injured member due to the industrial injury" and compensation is paid per degree of disability in the injured body part(s), e.g., arm(s), leg(s), hand(s). ORS 656.214(2) through (4); OAR 436-035-0010(2). Thus, where a carrier challenges a scheduled permanent partial disability award, the challenge is to the disability awarded for loss of use or function of a body part (member). It follows that, if the "compensation" awarded for permanent partial disability of a particular body part (member) is not reduced, an assessed fee under ORS 656.382(2) is appropriate. Conversely, if the compensation for permanent partial disability of a particular body part (member) is reduced, no assessed fee under ORS 656.382(2) may be awarded.

Because this case does not involve right scheduled permanent disability awards for separate conditions, we find that Boqua is not controlling. Therefore, we reverse the ALJ's decision to award an attorney fee pursuant to ORS 656.382(2).

Despite our reversal of the ALJ's attorney fee award pursuant to ORS 656.382(2), we have found claimant entitled to 22 percent right scheduled permanent disability, which is an increase over the ALJ's award. Therefore, claimant's compensation as awarded by the ALJ's order has not been disallowed or reduced on review. Thus, claimant's attorney is entitled to an assessed fee for services on Board review regarding the extent of scheduled 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 regarding the permanent disability issue is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the scheduled permanent disability issue (as represented by claimant's respondent's brief and 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 an attorney fee for her counsel's services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Finally, inasmuch as our order results in increased scheduled permanent disability 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 scheduled permanent disability benefits resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

ORDER

The ALJ's order dated May 7, 1997 is reversed in part and modified in part. That portion of the ALJ's order that awarded an assessed fee pursuant to ORS 656.382(2) is reversed. In lieu of the Order on Reconsideration's award of 26 percent (39 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist) and in addition to the ALJ's award of 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist), claimant is awarded 2 percent (3 degrees) for a total award to date of 22 percent (33 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, payable by the self-insured employer. 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.

November 3, 1997 Cite as 49 Van Natta 1927 (1997)

In the Matter of the Compensation of
CALVIN W. GRAHAM, Claimant
Own Motion No. 97-0390M
OWN MOTION ORDER ON RECONSIDERATION

On September 19, 1997, the Board issued an Own Motion Order in which we reopened claimant's 1991 claim for the payment of temporary disability compensation. On October 1, 1997, the Board received claimant's submission which we interpreted as a request for reconsideration. In order to fully consider the matter, the Board issued an Own Motion Order of Abatement on October 7, 1997.

After further considering the matter, we find that our Order of Abatement was not appropriate. Although claimant submitted additional evidence concerning his receipt of temporary disability benefits on another claim, such evidence was unnecessary as our September 19, 1997 Order found that claimant was in the work force and authorized reopening of claimant's June 1991 claim. Because the evidence submitted by claimant is consistent with our prior conclusion, it was not necessary to abate and reconsider our prior order.

Under these circumstances we find it appropriate to republish our prior order. Accordingly, on reconsideration, we adhere to and republish our September 19, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

November 6, 1997 Cite as 49 Van Natta 1928 (1997)

In the Matter of the Compensation of
CORRINE BIRRER, Claimant
Own Motion No. 97-0466M
OWN MOTION ORDER
Schneider, et al, Claimant Attorneys
Argonaut Insurance Co., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for her compensable 1980 right knee injury. Claimant's aggravation rights on that claim expired on March 27, 1986. The insurer recommends against reopening claimant's claim, contending that claimant was not in the work force at the time of the current disability.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

It is undisputed that claimant's compensable condition has worsened requiring surgery. Specifically, on September 30, 1997, Dr. McLean, claimant's treating surgeon, performed an arthroscopy and debridement on claimant's right knee. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

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

The insurer contends that claimant was not in the work force at the time of disability regarding the right knee injury claim because she was receiving workers' compensation benefits regarding a separate compensable wrist injury claim with another carrier. Claimant contends that she remained in the work force at the time her compensable right knee injury worsened requiring surgery. Claimant has the burden of proof on this issue.

By definition, while claimant is receiving time loss due to a compensable injury, she remains in the work force because she was unable to work due to a compensable injury. See Michael C. Johnstone, 48 Van Natta 761 (1996); William L. Halbrook, 46 Van Natta 79 (1994); Dawkins v. Pacific Motor Trucking, 308 Or at 258. Here, claimant sustained a work-related right wrist injury, which was accepted by another carrier in July 1996.

Claimant treated with Drs. Rabie and Wright regarding the right wrist injury. As a result of that right wrist injury, claimant's physicians limited her to modified work and, in January 1997, claimant was released from work due to the compensable right wrist condition. In a July 15, 1997 chart note, Dr. Rabie noted that he was keeping claimant off work and was waiting for an opinion from Dr. Wright as to whether claimant could return to modified work with the employer. If claimant was unable to return to modified work, Dr. Rabie advised that vocational counseling would be required.

In a July 16, 1997 chart note, Dr. Wright authorized time loss due to the wrist injury from July 17, 1997 through August 15, 1997. In addition, in an August 13, 1997 chart note, Dr. Rabie noted that claimant was still waiting for the carrier to provide vocational assessment or rehabilitation. Dr. Rabie

further noted that an ergonomic specialist was going to check claimant's work site to see if it was possible to accommodate claimant. Dr. Rabie also stated that he was releasing claimant for modified duty through September 30, 1997, provided that he first saw the modified job description because the last modified job was not successful.

On this record, we find that claimant remained in the work force at the time of the compensable right knee surgery on September 30, 1997. The medical records establish that claimant continued to perform modified work or was on time loss due to the another compensable injury until the date of surgery for the compensable right knee surgery.

Accordingly, we authorize the reopening of claimant's 1980 right knee injury claim to provide temporary disability compensation beginning September 30, 1997, the date claimant was hospitalized for right knee surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

If claimant is due any concurrent temporary disability compensation as a result of this order, the insurer may petition the Workers' Compensation Division for a pro rata distribution of payments. OAR 436-060-0020(8) and (9); Michael C. Johnstone, 48 Van Natta at 761; William L. Halbrook, 46 Van Natta at 79.

Finally, claimant contends that she is entitled to a penalty for the insurer's failure to pay temporary disability benefits regarding her right knee injury claim. We disagree.

Pursuant to ORS 656.262(11), if a carrier unreasonable delays or unreasonable refuses to pay compensation, the carrier is liable for a penalty up to 25 percent of the "amounts then due." However, when a claim is under the Board's own motion jurisdiction, as this claim is, no compensation is due claimant until the Board issues an order authorizing reopening the claim. Therefore, prior to an order authorizing reopening, there are no "amounts then due" upon which to base a penalty. John D. McCollum, 44 Van Natta 2057 (1992); Thomas L. Abel, 44 Van Natta 1039, on recon 44 Van Natta 1189 (1992); Fredrick D. Oxford, 42 Van Natta 476 (1990). Therefore, there is no basis for a penalty in this case.

However, 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.

November 6, 1997 Cite as 49 Van Natta 1929 (1997)

In the Matter of the Compensation of
KIP D. BREITMEYER, Claimant
WCB Case No. 96-11267
ORDER ON RECONSIDERATION
Linerud Law Firm, Claimant Attorney
Reinisch, et al, Defense Attorneys

The insurer requests reconsideration of our October 9, 1997, Order on Review that reversed that portion of the Administrative Law Judge's (ALJ's) order upholding the insurer's denial of claimant's neck injury claim. The primary issue was whether claimant proved legal causation of a neck injury, which he alleged occurred on October 31, 1996, while cleaning the dump box on his dump truck.

In deciding that claimant proved compensability, we first noted claimant's consistent reporting of the injury to medical providers. We further found that claimant's wife's testimony provided "some corroboration" of the injury. We then discussed testimony from two witnesses that they had seen claimant after October 31, 1996, and that he had not exhibited pain behavior. We decided that, even assuming the veracity of such evidence, in the absence of persuasive medical evidence that claimant necessarily would have exhibited pain behavior following the incident, the testimony did not disprove the occurrence of the injurious incident.

We did find, however, that claimant's failure to report the injury until November 4, 1996 was "troublesome" and "undermine[d] the reliability of claimant's testimony[.]" Weighing this factor against the evidence supporting credibility and the neutral effect of the evidence indicating a lack of noticeable pain behavior, we found that the reporting delay was not sufficient to conclude that claimant was not credible.

In challenging our order, the insurer first asserts that the "tone and nature of the ALJ's order" showed that the ALJ had made credibility findings based on demeanor and, consequently, we should have deferred to such findings rather than proceeding with our own assessment of credibility. As the insurer acknowledges, except for testimony by Marie Sayre, the ALJ stated that "it is not possible to state that the witnesses were not truthful in their testimony[.]" Instead, relying on the "sum total of evidence" and "aggregate evidence," the ALJ concluded that claimant did not prove legal causation. We find these express statements by the ALJ as showing that the ALJ did not make demeanor-based credibility findings. Thus, we properly made our own assessment of credibility.

The insurer further contends that our analysis began with an assumption that claimant was credible because there was insufficient affirmative evidence supporting claimant's credibility. In particular, according to the insurer, the fact that claimant consistently reported his injury to medical providers should be considered a "neutral factor"; the insurer further contends that any corroboration of the injury by claimant's wife, Anita Breitmeyer, is outweighed by inconsistencies between claimant's testimony and his wife's testimony concerning claimant's behavior the weekend before he sought medical treatment.

We disagree with the insurer that our order did not place the burden on claimant to prove legal causation of his injury. Most of the discussion in the order consisted of assessing claimant's credibility; in particular, we weighed the factors supporting and refuting the persuasiveness of claimant's testimony. Consequently, we reject the insurer's contention that we simply assumed claimant's veracity and limited our analysis to whether the insurer overcame such assumption.

Furthermore, we disagree that a worker's consistent reporting of the details of an injury to medical providers is a "neutral factor" in determining credibility. As our prior orders show, such evidence is considered as supporting credibility. E.g., Robert J. Ruch, 48 Van Natta 1579, 1580 (1996). We continue to adhere to this approach.

We turn to the insurer's assertion that Anita Breitmeyer's testimony "flatly contradicted" claimant's testimony concerning the weekend following the injury and, thus, that portion of her testimony corroborating claimant's report to her of the injury should not be found reliable. With regard to the weekend, claimant testified that he "went from the chair to the couch, because [his arm] was hurting me after awhile sitting up." (Tr. 37). Claimant also stated that he "pretty much laid around the house" on Saturday and Sunday. (Id. at 38). By Monday morning, however, claimant "felt pretty good." (Id. at 41).

Anita Breitmeyer testified that she could not remember whether claimant was in pain over the weekend, stating that "he was feeling some pain, but he doesn't really complain too much about it, until it really hurts." (Id. at 189). Later, in response to a question whether claimant "was in a lot of pain over the weekend," she stated:

> "Well, I can't remember how much pain he was having and -- I just know like on Saturday, he felt pretty good. By Sunday, he didn't even go to church, because he was in pretty much -- you know, a little bit more pain. And then by Monday morning, * * * he was really hurting. 'Cause it seemed he couldn't even get out of bed almost. That's what I saw, 'cause he was really hurting in the morning, and he said he couldn't even hardly feel his fingers." (Id. at 194).

We do not agree with the insurer's characterization of Anita Breitmeyer's testimony as "flatly contradict[ing]" claimant's testimony. Her testimony that claimant "felt pretty good" on Saturday does not correspond with claimant's testimony that he "laid around the house" on that day. Anita Breitmeyer, however, also indicated that her recall of that weekend was not sharp and that claimant did not easily complain of pain. In this context, we continue to conclude that Anita Breitmeyer's testimony is sufficiently reliable to prove that claimant told her about the October 31, 1996, injury when he returned home that evening.

Finally, we emphasize that assessment of credibility in this case was a difficult and close question. Claimant's injury was unwitnessed and, as discussed in our order, he did not immediately report it. The parties disputed numerous facts. For the reasons discussed in our order, however, we continue to adhere to the reasoning and conclusions in our order.

Accordingly, we withdraw our October 9, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our October 9, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 6, 1997 Cite as 49 Van Natta 1931 (1997)

In the Matter of the Compensation of
LOYD D. LONG, Claimant
WCB Case Nos. 94-06167, 94-02921, 94-06166, 94-04183,
94-06165, 94-04388, 94-06164, 94-06163 & 94-05787
ORDER ON REMAND
Aller & Morrison, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
John E. Snarskis, Defense Attorneys
Thomas A. Anderson, Defense Attorney
Jerome P. Larkin (Saif), Defense Attorney
Reinisch, et al, Defense Attorneys

This matter is before the Board on remand from the Supreme Court. Roseburg Forest Products v. Long, 325 Or App 305 (1997). Our prior order had affirmed a then-arbitrator's order that found Roseburg Forest Products responsible (as self-insured employer) for claimant's hearing loss condition. Loyd D. Long, 47 Van Natta 1435 (1995).[1] In resolving the responsibility issue, we relied on the Court of Appeals decision in Strametz v. Spectrum Motorwerks, 135 Or App 67, 74, 138 Or App 9 (1995), rev'd Beneficiaries of Strametz v. Spectrum Motorwerks, 325 Or 439, 445 (July 3, 1997). The Supreme Court reversed the Court of Appeals' opinion which had affirmed our order, reasoning that we had applied an incorrect legal standard. Accordingly, the Court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the pertinent facts. Claimant worked for the employer, Roseburg Forest Products (RFP), from 1960 until his retirement in September 1993. During that period, RFP had several insurance arrangements. From September 27, 1960 to November 9, 1965, the State Industrial Accident Fund insured RFP. Fireman's Fund then insured RFP from November 10, 1965 to June 30, 1970. From July 1, 1970 to June 30, 1976, Wausau insured RFP. Industrial Indemnity assumed the risk from July 1, 1976 to June 30, 1980, at which time RFP became self-insured for the remainder of claimant's employment.

RFP tested claimant's hearing in 1972. That test revealed that claimant had sustained significant high-frequency hearing loss in both ears. RFP then began a program of hearing protection, which resulted in claimant regularly wearing hearing protection at work. Claimant did not miss work nor did

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[1] At the time of the ALJ's order, the hearing was conducted as an arbitration proceeding under former ORS 656.307(2). Under that statute, we reviewed an "arbitrator's" order for errors of law. Subsequent to the ALJ's order, the legislature amended the statute to provide for de novo review. See Or Laws 1995, 68th Leg., Reg. Sess., Section 36. Because we have previously determined that amended ORS 656.307(2) is retroactively applicable, we apply the amended statute and review de novo. See Rito N. Nunez, 48 Van Natta 786, 788 (1996).

he seek medical treatment until 1989, when, during RFP's period of self-insurance, Dr. Scott evaluated his hearing loss. In 1994, an audiologist, Dr. Ediger, performed an examination of claimant and reviewed claimant's medical record. Dr. Ediger opined that claimant's hearing loss from 1972 to 1994 had not exceeded the amount due to normal aging (presbycusis). (Ex. 5-4). However, Dr. Ediger opined that the major contributing cause of claimant's industrial hearing loss was noise exposure at RFP. Id.

Claimant filed a workers' compensation claim for bilateral hearing loss. All carriers conceded that claimant had a compensable hearing loss claim. The only dispute concerned responsibility for claimant's hearing loss condition.

The ALJ determined that RFP in its self-insured status was responsible for claimant's hearing loss claim. The ALJ reasoned that initial responsibility for claimant's condition should be assigned to the self-insured employer because claimant, while never disabled, first sought treatment in 1989 while RFP was self-insured. Concluding that the self-insured employer could only escape responsibility for claimant's hearing loss claim if it could show that claimant's employment after 1980 could not possibly have caused the occupational disease, the ALJ found that the self-insured employer failed to sustain its burden of proof.

We affirmed the ALJ, citing Strametz. Loyd D. Long, 47 Van Natta at 1435. The Court of Appeals affirmed without opinion. Roseburg Forest Products v. Long, 140 Or App 452 (1996). RFP then successfully petitioned for Supreme Court review.

Relying on Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), the Court stated that, when a worker invokes the last injurious exposure rule (LIER) to establish a prima facie case against the last employer, that employer may avoid responsibility by proving that the disability in a particular case was caused solely by conditions at one or more previous employments. By the same logic, the Court reasoned that the later employer may also escape responsibility by proving that its working conditions could not possibly have caused the claimant's occupational disease.

The Court also addressed the question of whether LIER (as a rule of assignment) applied to successive insurers of a single employer. Reasoning that, as with multiple employers, the rule is likewise useful in determining which of multiple insurers is financially responsible and serves the same risk-spreading function among those insurers, the Court held that LIER also applied to successive insurers of a single employer.

Turning to this case, the Supreme Court concluded that we had applied a different legal standard from that stated in its opinion and, thus, committed an error of law. Consequently, the Court reversed and remanded with instructions to apply the correct legal standard. Having recited the factual and procedural background of the claim, we commence our analysis of the responsibility issue, applying the proper legal standard.

The parties do not dispute the ALJ's initial assignment of responsibility to the self-insured employer. See Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994) (If the claimant receives treatment for the condition before experiencing time loss due to the condition, the date the claimant first sought treatment for the compensable condition is determinative for the purpose of assigning initial responsibility). Consequently, the issue is whether responsibility shifts from RFP in its self-insured status to an earlier insurer. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, mod 73 Or App 223, rev den 299 Or 203 (1985).

The ALJ concluded that the self-insured employer was responsible for claimant's hearing loss claim because it did not establish that it was impossible for employment conditions after 1980 to have caused claimant's hearing loss. However, as the Court's Long analysis demonstrates, responsibility can still be shifted backwards to an earlier carrier if employment conditions at one or more previous employments were the sole cause of the occupational disease. Because we agree with the ALJ's reasoning that the medical evidence does not establish the "impossibility" prong of the Supreme Court's two-part test, the question then is whether the record establishes that work exposure prior to 1980 was the sole cause of claimant's hearing loss. For the following reasons, we conclude that it does.

Dr. Ediger, who provided the only medical opinion on the causation issue, evaluated claimant's hearing loss condition and reviewed the results of his hearing loss tests from 1972 to 1994. (Ex. 5). Dr. Ediger stated that significant high frequency hearing loss was already present in 1972. (Ex. 5-3). After analyzing the pattern of claimant's hearing loss as revealed in the numerous hearing tests conducted during claimant's employment, Dr. Ediger concluded that claimant's hearing loss after 1972 had not exceeded the amount expected from presbycusis. (Ex. 5-4). Dr. Ediger specifically opined that industrial noise after 1980, when RFP became self-insured, had not contributed to his hearing loss. Id.

In his deposition, Dr. Ediger testified that claimant's noise induced hearing loss occurred prior to 1972. (Ex. 14-35). Once again, Dr. Ediger specifically ruled out any "post-1980" contribution to claimant's noise induced hearing loss. Id. Dr. Ediger's uncontradicted opinion regarding causation is well reasoned and based on an accurate and complete history.[2] Accordingly, based on that opinion, we conclude that the self-insured employer has established that the sole cause of claimant's hearing loss was his employment before 1980 (when RFP became self-insured). Somers v. SAIF, 77 Or App 259 (1986).[3]

Consequently, responsibility shifts from the self-insured employer to insurers on the risk prior to 1980. Further, because Dr. Ediger opined that claimant's industrial hearing loss occurred prior to 1972, we also find that Industrial Indemnity is not responsible for claimant's hearing loss because, based on Dr. Ediger's opinion, it has also established that the sole cause of claimant's hearing loss was employment prior to July 1, 1976, when it assumed the risk. Therefore, responsibility shifts to employment prior to that date. The next insurer (Wausau) was on the risk (1970 to 1976) during the period in which Dr. Ediger stated that claimant's hearing loss occurred (prior to 1972). Therefore, because Wausau cannot establish that prior employment was the sole cause of claimant's hearing loss or that it was impossible for claimant's employment while it was on the risk to have contributed to claimant's hearing loss condition, Wausau is responsible for claimant's work-related hearing loss. Because the ALJ concluded otherwise, we reverse.

Accordingly, on remand, the ALJ's order dated November 8, 1994 is reversed in part, modified in part, and affirmed in part. RFP's denial, as a self-insured employer, is reinstated and upheld. Wausau's denial is set aside and the claim is remanded to that insurer for processing in accordance with law. Wausau, rather than RFP, is responsible for the ALJ's attorney fee award and for reimbursing the SAIF Corporation for monies paid during the period that SAIF was the designated paying agent under the ORS 656.307 order. In the event that RFP has already reimbursed SAIF, Wausau shall likewise reimburse RFP. The remainder of the ALJ's order is affirmed.

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[2] We acknowledge Dr. Ediger's testimony that he did not personally know whether equipment used in earlier hearing tests were properly calibrated or whether proper testing protocol was observed in those tests. (Ex. 14-25, 26). However, Dr. Ediger expressed no reservation in relying on prior hearing loss tests in forming his opinion on causation. The parties also devote considerable attention to the issue of whether claimant always wore hearing protection during his "post-1980" employment. However, we need not resolve that issue because, regardless of whether claimant wore hearing protection 100 percent of the time, the hearing tests conducted in this case do not support a finding that claimant's employment after 1980 contributed to his hearing loss.

[3] Wausau contends that, because presbycusis tables are statistically based, they cannot eliminate the possibility that a portion of claimant's hearing loss occurred during RFP's period of self-insurance. We agree, which is one reason why we have concluded that the self-insured employer did not establish that it was "impossible" for employment after 1980 to have contributed to claimant's hearing loss. However, we are unwilling to conclude, as Wausau suggests, that a finding that the self-insured employer failed to satisfy the "impossibility" prong of the Long test necessarily requires a finding that employment prior to 1980 was not the "sole cause" of claimant's hearing loss. To the contrary, we are persuaded that, based on our review of Dr. Ediger's medical report and deposition testimony, claimant's employment prior to 1980 (specifically that prior to 1972) was the sole cause of claimant's hearing loss.

Board Chair Hall dissenting.

I agree with the majority that Roseburg Forest Products, as self-insured emplo prove that it was "impossible" for employment conditions while it was on the risk to claimant's hearing loss. However, I disagree with its finding that the self-insured employer s burden of proving that work exposure prior to 1980 was the "sole cause" of claimant's industria loss. Therefore, I must respectfully dissent.

Dr. Ediger provides the only medical opinion on causation. Thus, the determination of whether the self-insured employer satisfied its burden of shifting responsibility to an earlier carrier turns on our analysis of Dr. Ediger's medical opinion. The majority correctly notes Dr. Ediger's opinion that industrial noise after 1980, when Roseburg Forest Products became self-insured, did not contribute to claimant's hearing loss. (Ex. 5-4). However, the basis for that opinion by Dr. Ediger is statistically-based presbycusis tables which define the average amount of hearing loss a person would experience due to aging. (Ex. 14-14). That is, Dr. Ediger believes that there has been no post-1980 industrial contribution because the worsened hearing loss after 1980 is no greater than that which could be attributed to presbycusis. Because they are statistically-based, the presbycusis tables cannot rule out injurious exposure or actual contribution to claimant's hearing loss after 1980. (Ex. 14-14 to14-17). Indeed, Dr. Ediger does not rule out injurious exposure after 1980; his opinion that there was no contribution to claimant's hearing loss after 1980 rests entirely on the statistical contribution of presbycusis. (Ex. 5-4).

We have previously held that medical evidence grounded in statistical analysis is not persuasive because it is not sufficiently directed to a claimant's particular circumstances. See Steven H. Newman, 47 Van Natta 244, 246 (1995); Catherine M. Grimes, 46 Van Natta 1861, 1862 (1994); Mark Ostermiller, 46 Van Natta 1556, 1558, on recon 46 Van Natta 1785 (1994). In this case, we should not find Dr. Ediger's opinion persuasive because of his reliance on statistically-based presbycusis tables that are not directed toward this claimant's particular circumstances.

Therefore, in the absence of an express statement by Dr. Ediger that claimant's post-1980 employment was not injurious, I would find that the self-insured employer failed to sustain its burden of proving that employment prior to 1980 was the "sole cause" of claimant's industrial hearing loss. Accordingly, I would find the self-insured employer responsible for claimant's industrial hearing loss. Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
MARGARET M. MORGAN, Claimant
WCB Case No. 96-10923
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that affirmed an Order on Reconsideration, which affirmed a Notice of Closure's award of 24 percent (76.8 degrees) unscheduled permanent disability for claimant's low back injury. In its brief, the self-insured employer objects to our consideration of documents attached to claimant's brief that were not admitted into evidence. On review, the issues are evidence, and extent of scheduled and 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

Evidence

We need not decide whether we can consider the material attached to claimant's brief (a portion of the Dictionary of Occupational Titles and diagrams from the Guides to the Evaluation of Permanent Impairment) because our determination of the extent of disability issues would be the same regardless of whether we considered those documents.

Unscheduled Permanent disability

The parties stipulated that claimant's permanent impairment as found by the Notice of Closure and Order on Reconsideration is 24 percent. The primary dispute was whether the Department correctly determined that claimant was not entitled to social/vocational values for age, education and adaptability because she had returned to "regular work." See OAR 436-035-0270(3)(a). Although acknowledging that claimant's work site had been substantially modified, the ALJ nonetheless found that claimant had returned to "regular work" because she was substantially performing her pre-injury job. Thus, the ALJ affirmed the reconsideration order's finding that claimant's permanent disability should be based entirely on permanent impairment.

On review, citing George Hamlin, 48 Van Natta 491 (1996), claimant contends that she did not return to "regular work" in light of the modifications to her job site.[1] (Ex. 56A). For the following reasons, we agree with the ALJ that claimant did return to regular work and is therefore not entitled to a calculation of age, education and adaptability factors.

In Vincent D. Drennen, 48 Van Natta 819, 820 (1996), we held that a claimant did not return to "regular work" when he modified his regular work duties to avoid bending, stooping, twisting, and heavy lifting as much as he could. In Drennen, we cited several other cases as support for our determination. See Kathy R. Monfort, 47 Van Natta 906, 907 (1995) (Where the claimant no longer performed her full range of job duties, she had not returned to regular work); Jim M. Greene, 46 Van Natta 1527, 1529 (1994) (Because the claimant no longer performed the full range of his duties when he returned to work, the claimant did not return to his regular work); Kathleen M. Glenn, 46 Van Natta 1130, 1131 (1994) (Where the release to work was not given on the basis of medical evaluation, it was not persuasive evidence that the claimant was able to perform her regular work duties); George O. Hamlin, 46 Van Natta 491, 493 (1994) (The claimant did not return to "regular" job when he returned to former bus driving job, but could no longer operate manual steering buses).

However, in Drennen, as well as in Monfort, Glenn, Greene and Hamlin, the claimant's "post-injury" job duties were modified from what they consisted of "pre-injury." Thus, in those cases, we determined that the claimant had not returned to "regular work" and therefore was entitled to a determination of values for age education and adaptability.

In this case, claimant's work site was substantially modified. However, the record indicates that claimant has been released for regular full-time work. (Ex. 57). The record does not establish that there has been any change in the job duties that claimant performed prior to her injury. Therefore, we conclude that claimant returned to the same job that she held at the time of injury.[2] Accordingly, we conclude that claimant did return to "regular work" and, thus, agree with the ALJ that her permanent disability should be based entirely on permanent impairment. It follows that the ALJ correctly affirmed the unscheduled award granted by the Notice of Closure and affirmed by the reconsideration order.

Scheduled Permanent Disability

At hearing, claimant alleged entitlement to an award of scheduled permanent disability for loss of plantar sensation due to left S1 radiculopathy. Although concluding that S1 radiculopathy was part of the accepted low back condition, the ALJ declined to award scheduled permanent disability for loss of plantar sensation. The ALJ reasoned that claimant was not entitled to such an award because Dr. Byers, claimant's attending physician, did not note any loss of sensation in her closing examination, and

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[1] The proposed job site modifications cost $2,499 and included repositioning of claimant's computer, a drop-down extension for her typewriter, an ergonomic keyboard tray, an adjustable height stool, new filing cabinets and a foot rest. (Ex. 56A).

[2] The dissent contends that claimant has permanent limitations on her "ability" to perform her regular work. However, the dissent does not cite any evidence that claimant has not been able to perform her job at injury. The dissent also neglects to note that OAR 436-035-0005(17) does not reference work site modifications in the determination of whether a claimant has returned to "regular work." The fact remains that there is no evidence that claimant is not performing her job at injury or one substantially similar in nature, duties, responsibilities, knowledge, skills or abilities, which is all OAR 436-035-0005(17) requires. Finally, the dissent surmises that future employers will not be able to accommodate claimant's disability. However, we decline to decide this case based on speculation regarding the actions of future employers.

because a medical arbiter, Dr. Rand, did not state which nerve was responsible of the decreased sensation to pinprick in claimant's foot that he noted on examination, or whether the sensory loss was due to a nerve root injury.[3]

Claimant contends that the ALJ should have made a scheduled award, citing Kim Danboise, 47 Van Natta 2163, on recon 47 Van Natta 2281 (1995), aff'd SAIF v. Danboise, 147 Or App 550 (1997). We agree.

OAR 436-035-0200(1) allows for 5 percent impairment for partial loss of plantar sensation in the foot and 10 percent impairment for total loss of sensation. If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that the impairment is due to the compensable injury. Kim E. Danboise, 47 Van Natta at 2164. However, where the medical arbiter attributes the claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not considered persuasive evidence of injury-related impairment. Julie A. Widby, 46 Van Natta 1065 (1994).[4]

In this case, the medical arbiter, Dr. Rand, was specifically asked to perform an examination of claimant's lumbar spine and lower extremities and describe any objective findings "resulting from the accepted injury." (Ex. 64-4, emphasis in original). Dr. Rand was then requested to describe sensation loss in the plantar surface of the foot/feet as either total or partial due to nerve root injury. Dr. Rand referred the reader to his examination findings. (Ex. 64-5). There, Dr. Rand reported that claimant's "sensation is decreased with pinprick of the lateral left foot, in the region of the foot." (Ex. 64-3).

Given that Dr. Rand was specifically asked to describe impairment findings due to the compensable injury, because he did not attribute his findings to causes other than the compensable injury, and because his plantar sensation findings are consistent with claimant's low back injury, we conclude that the medical arbiter's report establishes a loss of plantar sensation due to the compensable injury. Kim E. Danboise, 47 Van Natta at 2164. Moreover, because Dr. Rand termed claimant's plantar sensation as "decreased," we find that claimant's plantar sensory deficit is partial rather than total. OAR 436-035-0200(1). Thus, claimant is entitled to 5 percent scheduled permanent disability for loss of plantar sensation.

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

ORDER

The ALJ's order dated April 30, 1997 is modified in part and affirmed in part. In addition to the Order on Reconsideration award of 24 percent (76.8 degrees) unscheduled permanent disability, claimant

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[3] Dr. Marble performed a medical arbiter's examination on October 31, 1996, prior to issuance of the December 4, 1996 Order on Reconsideration. (Ex. 62). However, Dr. Marble's report was not considered because he had previously participated in an employer-arranged examination of claimant in April 1995. (Ex. 63). Dr. Rand's December 18, 1996 examination occurred after issuance of the reconsideration order, but was properly considered at hearing pursuant to ORS 656.268(6)(e). Larry A. Thorpe, 48 Van Natta 2608, 2610 (1996) (ORS 656.268(6)(e), which specifically authorizes the admission at hearing of a medical arbiter report that was not prepared in time for use in the reconsideration proceeding, constitutes an exception to the general limitation on "post-reconsideration" evidence in ORS 656.283(7)).

[4] 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, 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 Dr. Rand's medical arbiter examination provided the most persuasive medical opinion addressing claimant's permanent impairment. Inasmuch as permanent disability is rated at the time of the December 4, 1996 reconsideration order, Dr. Rand's December 18, 1996 evaluation of claimant's permanent impairment is more probative than that of Dr. Byers, who performed a closing examination in July 1996. (Ex. 57). Moreover, it is unclear from Dr. Byers' report whether she performed a plantar sensory loss examination. Id.

is awarded 5 percent (6.75 degrees) scheduled permanent disability for her left foot. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the employer directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

Board Chair Hall concurring in part and dissenting in part.

While I agree with the majority's finding that claimant is entitled to scheduled permanent disability for loss of plantar sensation, I part company with their conclusion that claimant returned to "regular work." Because I believe that claimant did not return to her "regular work," and is, therefore, entitled to have her social/vocational factors calculated, I must respectfully dissent from that portion of the majority's order that declines to award additional unscheduled permanent disability

To begin, OAR 436-035-0270(3) provides that social/vocational factors are not available to injured workers who return to "regular work." Such work means the job the claimant was doing at the time of injury or a job substantially similar in nature, duties, responsibilities, knowledge, skills and abilities. OAR 436-035-0005(17).[1]

Based on these rules, I would find that, when she returned to work, claimant was not doing the same job as at the time of injury or a substantially similar job. The focus here is on the rule's inclusion of "and abilities." From my examination of the record, I am persuaded that claimant would not be able to work at her pre-injury job without extensive job site modifications. (Ex. 56-2). These modifications, outlined in the majority's opinion, were specifically made to eliminate the physical aspects of claimant's former job that she could no longer perform. Thus, I would conclude that claimant did not return to the job she was doing at the time of injury or one substantially similar in abilities

The majority notes claimant's release to full time work. (Ex. 57). However, the work release is given in the context of substantial work modifications. The record makes clear that claimant has physical limitations that affect her ability to perform her normal job duties, making work-site modifications essential. (Ex. 64-5, 6).

ORS 656.214(5) still defines the criteria for rating unscheduled permanent disability as "permanent loss of earning capacity." Earning capacity is to be calculated using the standards, such as OAR 436-035-0270(3), specified in ORS 656.726(3)(f). Thus, OAR 436-035-0005(17) must be interpreted and applied consistent with ORS 656.214(5) and the purpose of compensating an injured worker for lost earning capacity.[2]

The evidence in this case establishes that claimant suffers permanent limitations on her ability to perform her regular work. The rule, by incorporating "abilities" in the analysis of "regular work," recognizes the loss of earning capacity claimant has suffered in this case. Regardless of whether claimant can perform all the duties and functions of her pre-injury with this employer (after the substantial modifications or accommodations by this employer), it is inappropriate to judge claimant's disability based on such accommodations or expect future employers to undertake the substantial modifications needed to enable claimant to perform her "regular" data entry work.[3]

In conclusion, I respectfully submit that the majority errs in its interpretation of the administrative rule and its application to the facts of this case. For this reason, I must respectfully dissent.

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[1] The majority asserts that there is no evidence that claimant is not performing her job at injury or one substantially similar in nature, duties, responsibilities, knowledge, skills or abilities. I must disagree. The record contains ample evidence that demonstrates that claimant does not possess the same abilities she had before her compensable injury. (Exs. 56, 64). Whether such a change in abilities occurred is the focus of the extent of disability issue in this case.

[2] The majority notes that OAR 436-035-0005(17) does not reference work site modifications in the determination of whether a claimant has returned to regular work. It would be surprising if it did since it is well-settled that disability is determined without regard to special employer accomodations, employer sympathy or a claimant's extraordinary efforts to be employed. See Harris v. SAIF, 292 Or 683, 695 (1982).

[3] The majority asserts that I would decide this case based on speculation regarding the actions of future employers. The majority's assertion notwithstanding, I am not predicting whether future employers will or will not make accomodations for claimant. Rather, I am stating that it is inappropriate to expect future employers to have to accomodate claimant's disability.

In the Matter of the Compensation of
LAURA A. GROVES, Claimant
WCB Case No. C701978
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Cole, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members en banc.

On August 6, 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 the parties agreed pursuant to ORS 656.236 to settle claimant's claim for compensation and payments of any kind due or claimed, except compensable medical services, for a total sum of $0.00. The self-insured employer agreed not to seek reimbursement for time loss benefits and medical and other expenses paid subsequent to September 3, 1996.[1]

On August 12, 1997, we wrote the parties noting that the total consideration for claimant's relinquishment of her "non-medical" benefits was the self-insured employer's agreement not to seek reimbursement for time loss benefits, medical and other expenses paid to claimant subsequent to September 3, 1996, which were allegedly attributable to a noncompensable condition. We further noted that it appeared that claimant's temporary disability award had become final. We further requested the parties' positions regarding the effect on the CDA, if any, of Timothy W. Moore, 44 Van Natta 2060 (1992) (where an overpayment has apparently been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the CDA). In addition, we indicated we would consider any additional information or supplementation of the CDA the parties wished to provide.

On October 14, 1997, we received the parties' amended CDA. On October 22, 1997, we again wrote the parties. We noted that the amended agreement made reference to enclosed documents, but that the referenced documents had not been enclosed. In addition, we noted that the amended CDA provided that claimant released her rights to workers' compensation benefits, except medical services, in exchange for no monetary consideration. However, we also recognized that the CDA provided that the "parties represent that the consideration * * * for this Claim Disposition Agreement is a forbearance by [the employer] of its lawful entitlement to seek damages for fraud/misrepresentation in civil proceedings * * * ." We requested that the parties address the issue of whether the self-insured employer's forbearance of its civil cause of action against claimant could constitute consideration for the CDA.

In response to our request, the parties' attorneys have submitted the missing documents and have provided legal authority for the proposition that the consideration of "forbearance" is valid consideration for a contract in Oregon.

The Board has not previously addressed the issue of whether "forbearance" can constitute consideration for a CDA under ORS 656.236. After considering this matter and the authorities cited by the parties, we agree that the employer's forbearance of its civil action against claimant constitutes valid consideration for the CDA. In this regard, Oregon courts have held that forbearance of a claim coupled with an actual agreement to forbear is valid consideration for an agreement. Marriage of DeCair, 131 Or App 413, 418 (1994) (forbearance of a right to enforce a lien constituted consideration for an agreement); Reid Strutt, Inc. v. Wagner, 65 Or App 475, 479 (1983) (forbearance in taking action to force removal of railroad tracks along an easement was consideration for an agreement to pave a road). Here, the employer has agreed not to assert its right to a civil cause of action against claimant in exchange for

[1] The agreement indicated that the employer had developed evidence that claimant's medical condition related to the injury was, in all probability, medically stationary and unrelated to the accepted claim on or about September 3, 1996 and that claimant subsequently received medical and time loss benefits to which she was not legally entitled.

claimant's release of her rights to "non-medical service" workers compensation benefits. Accordingly, we find that claimant's release of rights under the CDA is for valuable consideration and that the CDA meets the standard for approval under ORS 656.236(1)(a).

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.

IT IS SO ORDERED.

November 7, 1997 Cite as 49 Van Natta 1939 (1997)

In the Matter of the Compensation of
TIMOTHY R. MARINO, Claimant
Own Motion No. 97-0455M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable right index finger puncture wound injury claim. Claimant's aggravation rights on that claim expired on May 15, 1997. The insurer recommends reopening.

Because claimant's aggravation rights have expired, his claim is governed by ORS 656.278. Under that statute, we may reopen a claim for the payment of temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. 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.

While working on May 15, 1992, claimant sustained a puncture wound on his right index finger with a hypodermic needle that had been used by a person at high risk for infectious disease. At that time, claimant received medical treatment, including a hepatitis B vaccination.

Subsequently, claimant gradually developed fatigue and sought further medical treatment. Ultimately, claimant was diagnosed with hepatitis C and, on July 1, 1997, underwent a liver biopsy. On this record, we are persuaded that claimant's compensable injury has worsened requiring outpatient surgery.[1]

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation (partial or total, depending on verification) beginning July 1, 1997, the date of the outpatient surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] Dr. Albaugh, claimant's treating physician, performed the liver biopsy and designated the report of that procedure as an "operative report." Given the fact that the physician performing the procedure classifies it as an "operation," we find that the liver biopsy represents an outpatient surgery.

In the Matter of the Compensation of
DANIEL C. BEAN, Claimant
Own Motion No. 92-0042M
OWN MOTION ORDER

Claimant, pro se,[1] requests Board review of the insurer's action in decreasing his temporary total disability benefit payments by 25 percent. Specifically, claimant contends that the insurer has misinterpreted a September 18, 1986 Stipulation as allowing it to make such a reduction. In addition, claimant requests penalties for the insurer's allegedly unreasonable reduction of his temporary disability compensation.

Claimant compensably injured his low back on January 10, 1980. Claimant's aggravation rights regarding that injury expired on November 4, 1985. By Own Motion Order dated March 26, 1992, the Board authorized reopening claimant's low back injury claim to provide temporary total disability compensation beginning the date claimant was hospitalized for surgery. On March 14, 1996, the insurer issued a Notice of Closure closing the claim. However, on April 12, 1996, the Board set aside that closure as premature. Claimant's claim remains open and he continues to receive temporary disability benefits.

However, by letter dated August 28, 1997, the insurer notified claimant that it would begin to offset a $41,000 prepayment pursuant to the terms of a September 18, 1986 Stipulation signed by claimant. Specifically, the insurer stated that, effective the next pay period, claimant's temporary disability check would be in the amount of $819.19. This amount reflected a reduction of $273.07 (25 percent of claimant's temporary disability check) to begin covering the offset.

The Board in its own motion authority has sole jurisdiction to enforce its own motion orders. Thomas L. Abel, 45 Van Natta 1768 (1993); Darlene M. Welfl, 44 Van Natta 235 (1992); Ivan Davis, 40 Van Natta 1752 (1988). The issue in this case concerns the legal effect of a contract (the stipulation) on the compensation awarded by our March 26, 1992 order.

The terms of a written agreement to settle a workers' compensation claim are interpreted using the standard rules of contract construction. See Trevitts v. Hoffman-Marmolejo, 138 Or App 455, 459 (1996); Good Samaritan Hospital v. Stoddard, 126 Or App 69, rev den 319 Or 572 (1994) (applying law of contracts to workers' compensation settlement agreement). The intent of the parties is to be pursued, if possible. ORS 42.240. Generally, contract interpretation consists of two steps. First, a determination is made as to whether, as a matter of law, the terms of the agreement are ambiguous. Taylor v. Cabax Saw Mill, 142 Or App 121 (1996); Timberline Equip. v. St. Paul Fire and Mar. Ins., 281 Or 639, 643 (1978). A contract is not ambiguous if it has only one sensible and reasonable interpretation. P & C Construction Co. v. American Diversified, 101 Or App 51, 56 (1990); D & D Co. v. Kaufman, 139 Or App 459 (1996). Only if the terms are ambiguous do we proceed to the second step: the "determination of the 'objectively reasonable construction of the terms' in the light of the parties' intentions and other extrinsic evidence." Taylor v. Cabax Saw Mill, 142 Or App at 125 (quoting Williams v. Wise, 139 Or App 276, 281 (1996)).

The September 18, 1986 Stipulation provided, in part, that in settlement of a request for hearing on a Determination Order issued on April 10, 1986, claimant withdrew "all issues, except the issue relating to the extent of claimant's permanent disability" and acknowledged "that by withdrawing all issues he will be barred from asserting those issues or any other issues raisable at this time subsequent to the date that this Stipulation is approved." In addition, the parties:

> "stipulated and agreed that this matter be compromised and settled, subject to the Workers' Compensation Board approving the payment of $41,000 to the claimant, Daniel C. Bean. This payment shall be considered a pre-payment of compensation and the employer/carrier shall be entitled to offset said pre-payment, dollar for dollar, against any additional compensation to which this claimant may become entitled at any time in the future with the exception of benefits payable pursuant to ORS 656.245."

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[1] Although represented by counsel at the time of the September 18, 1986 Stipulation, claimant is apparently unrepresented at this time.

The parties, including claimant and his then-attorney, signed the Stipulation and it was approved by an Administrative Law Judge (ALJ) (referred to as a "Referee" at that time) on September 18, 1986.

We find the language of this Stipulation unambiguous. The language clearly states that the $41,000 payment to claimant was a pre-payment that the employer/carrier is entitled to offset against any additional compensation to which claimant may become entitled at any time in the future with the exception of benefits under ORS 656.245.[2]

Claimant argues that this $41,000 is a pre-payment, not an overpayment. Thus, claimant argues, because it is not an overpayment, he is not obligated to pay it back. However, claimant overlooks the clear terms of the Stipulation providing that the employer/carrier is entitled to offset the $41,000 payment against any additional compensation to which claimant may become entitled at any time in the future. Thus, according to the unambiguous terms of the Stipulation, claimant is obligated to pay back the $41,000 pre-payment from future compensation, excepting benefits under ORS 656.245. But see Robert D. Surina, 40 Van Natta 1855 (1988) (Board disapproved a proposed Stipulation containing a provision allowing an offset of the proceeds granted by the Stipulation against any compensation to which the claimant may become entitled in the future from the insurer, concluding that such an arrangement violated the statutory scheme in existence at that time); Caterino Garcia, 40 Van Natta 1846 (1988) (same).[3]

Furthermore, we find that the insurer has applied the correct method of offsetting the pre-payment in installments pursuant to ORS 656.268(15)(a), which provides:

> "An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insurer 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."

The legislature enacted ORS 656.268(15) as part of Senate Bill 369 (SB 369) on June 7, 1995. The court has held that SB 369 applies retroactively, unless a specific exception has been provided. See Volk v. America West Airlines, 135 Or App 565 (1995). There is no specific exception regarding ORS 656.268(15). Furthermore, Section 66(1) of SB 369, the retroactivity section addressed by the court in Volk, provides that "this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act[.]"

Claimant's claim was open at the time of the effective date of the Act (June 7, 1995) pursuant to our March 26, 1992 order. Therefore, because claimant's claim existed on the effective date of the Act, ORS 656.268(15) applies to claimant's claim and limits recovery of the $41,000 pre-payment to installments of 25 percent of claimant's temporary disability compensation payments. Finis O. Adams, 49 Van Natta 1274 (1997).

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[2] We note that ORS 656.245 pertains to medical service benefits, not temporary disability benefits.

[3] We note that the legislature has since amended several of the statutes relied on in Surina and Garcia to find that the proposed Stipulations in those cases violated the existing statutory scheme and legislative intent. For example, former ORS 656.236 was amended in 1990 and 1995 to allow releases of any matter concerning a claim that the parties consider reasonable, with some limitations. Nevertheless, the point we are making in citing Surina and Garcia is that, if the September 18, 1986 Stipulation had been submitted to the Board for approval back in 1986, the Board may not have approved it under the law that existed at that time. That said, the fact is that the September 18, 1986 Stipulation was approved by an ALJ and was not appealed to the Board. Thus, the September 18, 1986 Stipulation is final by operation of law and the Board will not now modify that contractual agreement. Moreover, no party is seeking rescission of the September 18, 1986 Stipulation, an issue that would be a "matter concerning a claim" under ORS 656.283(1), with jurisdiction lying with the Hearings Division, not the Board in its own motion authority. Accordingly, having found the September 18, 1986 Stipulation final by operation of law, we will enforce that contract/order.

For the reasons explained above, we find that the insurer is entitled to offset the $41,000 pre-payment made by the September 18, 1986 Stipulation. In addition, we find that the manner in which the insurer is recovering the pre-payment is correct under ORS 656.268(15). Therefore, since there has been no unreasonable claims processing, there is no basis for a penalty.

Accordingly, we deny claimant's request for reinstatement of the amounts offset and penalties.

IT IS SO ORDERED.

In the Matter of the Compensation of
MADELINE L. MURRAY, Claimant
WCB Case No. 96-10030
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that awarded 6 percent (19.2 degrees) unscheduled permanent disability for claimant's thoracic condition, whereas an Order on Reconsideration had awarded none. Claimant cross-requests review of that portion of the order that declined to award unscheduled permanent disability for a lumbar condition. On review, the issue is extent of permanent disability.

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

Claimant's attorney is entitled to an assessed fee for services on review regarding the thoracic claim. 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 thoracic claim is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order, dated March 11, 1997, is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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[1] We do not rely on claimant's concession, (Br. p. 5), that the medical arbiter's thoracic right rotation measurements are invalid under the standards, because the medical arbiter did not say that they are invalid. See Teri S. Callahan, 49 Van Natta 548, 549 (1997) (The validity of range of motion testing must be determined by the medical examiner performing the tests. Accordingly, claimant is entitled to the following thoracic range of motion ratings: 2.67 (flexion); 2 (right rotation); 1 (left rotation), for a combined total of 5.67, rounded to 6 percent, as determined by the ALJ.

In the Matter of the Compensation of
PATTI E. BOLLES, Claimant
WCB Case No. 96-02432
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that affirmed a Director's order suspending compensation pursuant to ORS 656.262(15). On review, the issue is suspension of compensation under ORS 656.262(14) and 656.262(15). We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed her claim on October 8, 1995. On November 11, 1995, the self-insured employer began paying temporary disability benefits. In December 1995, the employer attempted to obtain a recorded statement from claimant. Claimant, through her attorney, refused to allow a recorded interview. Thereafter, counsel for the employer informed claimant's attorney of its "request and demand" pursuant to ORS 656.262(14) for claimant's deposition. Counsel further indicated that a recorded statement also would satisfy the request. Claimant's attorney responded that he did "not recognize any procedure permitting pre-hearing deposition of our client/claimant," but further stated that claimant would be available for an unrecorded statement.

The employer's counsel then requested the Director to suspend compensation. On January 24, 1996, the Director (through his designated representative) granted the request and ordered the suspension of benefits. Reasoning that claimant was required by ORS 656.262(14) to submit to the employer's request for a deposition or recorded statement, and finding insufficient justification for her refusal to do so, the Director found that she did not cooperate with the investigation of her claim.

The employer continued to pay temporary disability through March 3, 1996. Pursuant to the Director's order, the employer did not pay such benefits from March 3, 1996 through March 16, 1996. Claimant thereafter participated in a deposition. Although the employer resumed payment of temporary disability, it eventually denied the claim.

ORS 656.262(14) and (15) provide in part:

> "(14) Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. * * *
>
> "(15) If the director finds that a worker fails to reasonably cooperate with an investigation, * * * the director shall suspend all or part of the payment of compensation after notice to the worker. * * *"[1]

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[1] The remaining part of subsection (15) provides:

"If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 90 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate, and remand the claim to the insurer or self-insured employer to accept or deny the claim."

Based on the language of ORS 656.262(14), the ALJ found that claimant was required to submit to the employer's request for a deposition or recorded statement. Finding that her refusal to do so was unjustified, the ALJ concluded that the Director correctly suspended benefits under ORS 656.262(15). Claimant disagrees with the ALJ's interpretation of ORS 656.262(14), asserting that the obligation to "fully cooperate" does not include a deposition or recorded statement. Relying on legislative history, claimant contends that the "duty to cooperate" extends only to "interviews and information gathering."

In interpreting ORS 656.262(14) and (15), our first task is to discern what the legislature intended when it enacted the statute. ORS 174.020. We begin by examining the text and context of the statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). Only if those sources do not reveal legislative intent do we resort to legislative history and other extrinsic aids. Id. at 611-12.

Because this is an appeal from the Director's suspension order, we begin our textual analysis with the Director's suspension authority under ORS 656.262(15).[2] Subsection (15) directs the Director to suspend the payment of compensation if he finds that the worker "fail[ed] to reasonably cooperate with an investigation" of the claim. Thus, the statutory directive is contingent on the Director's finding that the worker failed to "reasonably cooperate" with the claim investigation.

The term "reasonably" is an inexact term that expresses a complete legislative policy. See Schoch v. Leupold & Stevens, 325 Or 112, 117 (1997) (the statutory term "reasonable" in ORS 656.386(1) is an inexact term that expresses a complete legislative policy regarding attorney fee awards). Because it is inexact, the term delegates authority to the Director to determine, either by rule or by order, what constitutes "reasonable cooperation" with the investigation of the claim. Compare Schoch, 325 Or at 117-18 (the term "reasonable" delegates authority to the Board to determine what constitutes a reasonable attorney fee). By its terms, the delegation of authority under ORS 656.262(15) is to the Director alone.

The Director's exercise of authority is not without limits, however, because his determination of "reasonable cooperation" must be consistent with the legislature's intended meaning. The Supreme Court has described inexact statutory terms as "embodying complete expressions of legislative meaning, even though that meaning may not always be obvious." Springfield Education Assn. v. School Dist., 290 Or 217, 224 (1980). When applying such terms to specific facts, whether by order or by rule, the task of the agency is to determine whether the legislature intended the compass of the words to include those facts. Id. While recognizing that inexact terms are capable of contradictory applications, the Springfield Court stated:

> "Whether any possible meaning comes within the intended meaning [of an inexact statutory term] depends upon the policy which the word or phrase is intended to convey. Thus, when we refer to a term representing a complete legislative expression, we refer to a completed legislative policy judgment having been made.
>
> "Whether certain facts are within the intended meaning depends upon the policy that inheres in the term by its use in a statute which is intended to accomplish certain legislative purposes. * * * Where the applicability of the term is not certain, its meaning is not a question of lexigraphy, but rather a question of the policy which is incorporated in the legislative choice of that word. The processes of administrative application of such terms and judicial review must be performed to effectuate the complete legislative policy judgment which such terms represent." Id. at 225-26 (Emphasis supplied.)

If the agency responsible for applying the inexact statutory term elects to interpret the statute by issuing orders on a case-by-case basis, rather than by promulgating rules, the Springfield Court instructs:

> "[I]t is necessary for the agency to express in its order, to the degree appropriate to the magnitude or complexity of the contested case, its reasoning demonstrating the tendency of the order to advance the policy embodied in the words of the statute. Explicit reasoning will enable the court on judicial review to give an appropriate degree of credence to the agency interpretation." Id. at 228.

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[2] Our authority to review the Director's suspension order is in ORS 656.283(1), which provides that "any party...may at any time request a hearing on any matter concerning a claim...."

Applying the Springfield analysis to this case, we must determine whether the Director's application of the term "reasonable cooperation" in ORS 656.262(15) to the facts of this case was consistent with, and tended to effectuate, the general legislative policy judgment expressed in the statute itself. This determination is a question of law. See Springfield, 290 Or at 224.

The legislature's general policy judgment is expressed in ORS 656.262(14), which begins with a broad statement charging injured workers with the "duty to cooperate and assist" carriers in the investigation of claims for compensation. The next sentence is more specific, stating that the "[i]njured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques."

The Director interpreted ORS 656.262(14) to require an injured worker to make himself available for a deposition or recorded statement requested by a carrier. Because claimant did not make himself available for a deposition or recorded statement, the Director concluded that claimant did not "reasonably cooperate" with the carrier's claim investigation. In reaching this conclusion, the Director implicitly found that claimant's offer to submit to an unrecorded statement was not "reasonable cooperation."

We conclude that the Director's interpretation of ORS 656.262(14) is consistent with the language of the statute. The term "submit" is defined as "to yield oneself to the power or authority of another" and "to allow oneself to be subjected to some kind of treatment." Random House Webster's College Dictionary 1331 (Glencoe ed. 1991). The term "cooperate" means "to work or act together or jointly for a common purpose or benefit" and "to work or act with others willingly and agreeably." Id. at 300. Based on the plain and ordinary meanings of the terms "submit" and "cooperate" in subsection (14), we conclude that the legislature expressed the policy judgment to have injured workers not only work together with carriers in the investigations of their claims, but also to yield to the information gathering techniques employed by carriers in those investigations.

We further conclude that the legislature intended the terms "formal or informal information gathering techniques" to include a recorded statement or deposition. The third sentence of ORS 656.262(14) states that, for represented workers, the claimant's attorney may be present "during any personal or telephonic interview or deposition." When this sentence is read in conjunction with the preceding sentence, which states that "workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques," the term "formal or informal information gathering techniques" is most reasonably construed to include a recorded statement or deposition. Any other interpretation would render superfluous the inclusion of "deposition" in the statute. That is, if "deposition" was not considered to be a type of "other formal or informal information gathering techniques," the statute would be providing for the presence of the worker's attorney during a proceeding that is not otherwise allowed. Furthermore, because a deposition is preceded by an oath administered to the deponent and is recorded by stenographic or other means, see ORCP 38, 39, it is similar to testimony taken at an administrative or court proceeding and is therefore most consistent with a "formal information gathering technique."[3]

Claimant argues that we should construe "deposition" consistent with the Board's former rule providing that "depositions are not permitted over objections unless the presiding referee or his or her delegate finds that extraordinary circumstances justify the deposition." Former OAR 438-06-055. However, the current version of the rule provides that "[d]epositions of claimants are permitted in the manner prescribed by ORS 656.262(14)." OAR 438-006-0055. Thus, the current rule does not conflict with our construction of ORS 656.262(14). Consistent with the policy judgment expressed in the text of ORS 656.262(14), we conclude that the legislature intended an injured worker's "duty to cooperate" with a carrier's claim investigation to include yielding to a deposition or recorded statement requested by the carrier.[4]

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[3] While there may be other "formal information gathering techniques" (e.g., interrogatory), our holding in this case is limited to depositions.

[4] In reaching this conclusion, we emphasize that we do not consider it inappropriate for a claimant to suggest an alternative method for gathering information regarding a claim. If the parties are able to reach a mutually satisfactory accommodation, the intention expressed in the statute has been satisfied. Nonetheless, where such an accommodation cannot be achieved, as in this case, the statute is clear and unequivocal: the injured worker "shall submit to and shall fully cooperate." (Emphasis added.)

Because the legislature's intent is apparent from the statutory text and context, we do not need to resort to legislative history to construe the statute. PGE, 317 Or at 610. In any case, we are not convinced by claimant's argument that, because legislative testimony concerning ORS 656.262(14) did not specifically refer to "deposition," the legislature did not intend such a proceeding to be included in the "duty to cooperate." We are more persuaded by the statute's inclusion of the term "deposition" and the context of that term within the provision.

Based on our construction of ORS 656.262(14), we find that the Director's suspension of compensation in this case was consistent with, and tended to effectuate, the legislative policy judgment expressed in the statute.[5] In addition, the Director's order articulated sufficient reasoning to support the suspension, explaining that claimant did not cooperate with the claim investigation when she refused to yield to a recorded statement or deposition, as required under ORS 656.262(14). Accordingly, the Director acted properly within the scope of his authority under ORS 656.262(15) to suspend the payment of compensation.

ORDER

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

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[5] We have de novo review authority and, thus, make factual findings anew based on our review of the evidentiary record developed at hearing. See Destael v. Nicolai Co., 80 Or App 596, 600 (1986). In the exercise of that authority, we found, as did the Director and the ALJ, that claimant flatly refused the employer's request to make herself available for a deposition or recorded statement.

Our review authority is more limited, however, when it comes to the legal question of whether the Director's suspension of compensation under the particular circumstances of a case was within the legislative policy expressed in ORS 656.262(14) and (15). Consistent with the Court's direction in Springfield, we may not usurp the range of authority which the legislature has delegated specifically to the Director under ORS 656.262(15), by substituting our own judgment for the Director's. Here, the Director has expressed in his order sufficient reasoning to support his conclusion that claimant's refusal to make herself available for a deposition or recorded statement warranted the suspension of compensation. Accordingly, the Director's order in this case passes muster under the Springfield analysis.

Board Members Biehl and Chair Hall dissenting.

We agree with the majority's construction of ORS 656.262(14) that a deposition or recorded statement is encompassed in the statutory term "formal information gathering technique." We disagree, however, with the majority's conclusion that the delegation of authority under ORS 656.262(15) is "to the Director alone."

The focus of our disagreement is ORS 656.262(15) and the majority's deference to the Director's conclusion that claimant did not "reasonably cooperate" with the investigation of her claim. Whatever "deference" is owed under the Supreme Court's analysis in Springfield is reserved for the "agency" charged with the duty to decide whether claimant's actions constituted "reasonable cooperation" with the claim investigation. If that "agency" is only the "Director," then the majority's deference to, and acceptance of, the Director's interpretation of the statutorily inexact terms is probably correct. The majority's position in this regard is best captured in footnote 5, wherein the majority concludes that the Board cannot substitute our own judgment for that of the Director. If, however, the Board is itself an "agency" within the scope articulated in Springfield, then the Board is on equal footing with the Director to define inexact statutory terms on a case by case basis.

While ORS 656.262(15) states that the Director makes the finding as to whether a worker has reasonably cooperated, the Board also has de novo review authority of the Director's suspension order. The majority recognizes our authority arises out of ORS 656.283(1) because this case is a matter concerning a claim. See footnote 2. The majority limits such review to the Director's factual findings. As to the Director's interpretation of law, the majority limits Board review to what is akin to review by the Supreme Court (i.e., is the Director's interpretation within "limits" "consistent with the legislature's intended meaning").[1] On its face, however, the statute does not limit the Board's scope of review in

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[1] It should be noted that the majority, despite espousing a limited standard of review, goes on to offer its own original construction of statutory terms (e.g., "submit," "cooperate," "formal or informal information gathering techniques," "depositions"). It is based upon the majority's own original interpretation of the statutory terms ("our construction of") that the majority concludes the Director's suspension of benefits was consistent with legislative policy.

this instance. In the dissent's view, the Board is authorized to decide whether a worker has or has not "reasonably cooperated" with the claim investigation. Because we would not limit the nature of Board review as the majority has, we respectfully dissent.

November 10, 1997 Cite as 49 Van Natta 1947 (1997)

In the Matter of the Compensation of
SIRIJEET S. JOHNSON, Claimant
Own Motion No. 96-0236M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Liberty Northwest Insurance Corp., Insurance Carrier

Claimant, pro se,[1] requests reconsideration of our August 22, 1997 Own Motion Order of Dismissal, as reconsidered on October 16, 1997. In our initial order, we dismissed *without prejudice* claimant's request for enforcement and penalties in this claim. Our October 16, 1997 Own Motion Order on Reconsideration addressed claimant's renewed request for enforcement and penalties regarding this claim. In that reconsideration order, we: (1) found that, because the insurer had complied with our May 14, 1997 Own Motion Order Reviewing Carrier Closure by paying claimant temporary disability compensation as directed by that order, we did not need to address the enforcement issue; (2) declined to grant his request for "some kind of additional award" from the insurer, reasoning that we did not have the statutory authority to make any "additional award;" and (3) declined to grant claimant's request for a penalty for the insurer's allegedly unreasonable failure to timely pay temporary disability compensation, finding that the insurer had legitimately misinterpreted our May 14, 1997 order.

In his current request for reconsideration, claimant contests only the penalty issue, contending that there was no basis for finding the insurer "misinterpreted" our prior order because claimant and his attorney had advised the insurer it was ordered to pay the temporary disability compensation in question. Based on the following reasoning, we continue to find that the insurer had "legitimate doubt" as to its liability for payment of the temporary disability benefits in question at the time it initially failed to pay those benefits.

Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due." 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).

Our May 14, 1997 order set aside the insurer's March 21, 1997 Notice of Closure as premature and specifically directed the insurer to pay claimant temporary disability compensation for the weeks of March 5, 1997 through March 19, 1997. The insurer timely paid these benefits.

However, our May 14, 1997 order also directed the directed the insurer to recommence payment of temporary disability compensation beginning the date it had previously terminated the payment of those benefits, less any wages claimant received during that period, until claimant was medically stationary and the claim was properly closed. By letter dated June 26, 1997, the Board inquired whether the insurer had recommenced payment of temporary disability as directed by our prior order. The insurer responded promptly by paying the amount owed rather than "resisting" the payment of time loss. In stating that it misinterpreted our order, the insurer explained that it "read" our order to mean that it was to pay only the amount specified by date in our order.

On this record, we find that the insurer had "legitimate doubt" at the time it initially failed to reinstate the temporary disability benefits and, instead, only paid the temporary disability benefits due

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[1] Although claimant was previously represented regarding this claim, he is unrepresented at present.

from March 5, 1997 through March 19, 1997. Furthermore, when we inquired as to whether the insurer had reinstated the temporary disability benefits, it promptly paid temporary disability benefits beginning March 20, 1997. Therefore, we do not find that the insurer unreasonably delayed claimant's time loss payments because it did, in fact, pay claimant timely for the dates specifically directed in our order. Rather, we are persuaded that the insurer had "legitimate doubt" as to any further liability for temporary disability on this claim prior to our June 26, 1997 letter. After receiving that letter, the insurer promptly paid temporary disability benefits beginning March 20, 1997. Therefore, we decline to penalize the insurer for unreasonably resisting payment of temporary disability. See International Paper Co. v. Huntley, 106 Or App at 107; Castle & Cook Inc. v. Porras, 103 Or App at 65.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 22, 1997 order in its entirety, as reconsidered on October 16, 1997.[2] 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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[2] We again note that claimant has requested review of the insurer's September 26, 1997 closure of his claim. That review will be conducted by this forum under separate order following completion of the briefing and review process. The present order does not affect claimant's entitlement to future temporary disability compensation in his 1990 injury claim.

November 10, 1997 Cite as 49 Van Natta 1948 (1997)

In the Matter of the Compensation of
DEBRA L. RIDENOUR, Claimant
WCB Case No. 97-0267M
OWN MOTION ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our October 3, 1997 Own Motion Order which declined to authorize the reopening of her 1987 injury claim with the SAIF Corporation. Our order was based, in part on the Board's October 3, 1997 Order on Review which reinstated and upheld SAIF's denial of responsibility in this claim. In addition, the Board's Order on Review found that claimant had suffered a "new injury" and set aside Aetna Casualty Company's denial of the same condition. Specifically, claimant notes that Aetna has requested judicial review and requests that our Own Motion Order be abated pending the decision by the Court of Appeals. On reconsideration, we deny claimant's request. for the following reasoning.

Pursuant to OAR 438-012-0050, the Board's rules do not provide for holding a case in abeyance pending judicial review. Our rules do provide, however, that, under extraordinary circumstances, "the Board may, on its own motion, reconsider any prior Board order." OAR 438-012-0065(3). Thus, in the event that the court (or the Board on remand) were to find SAIF ultimately responsible for claimant's current condition under her 1987 injury claim, claimant may request reconsideration under OAR 438-012-0065(3) at that time.

Accordingly, we withdraw our October 3, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our October 3, 1997 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVE M. SULENTIC, Claimant
WCB Case No. 97-01235
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial insofar as it pertained to claimant's L2-3 degenerative disc disease. Relying on the "post-hearing" amendments to ORS 656.262(10), the employer requests remand for a hearing on the merits of the compensability of claimant's low back condition claim. In response, claimant agrees that remand is warranted. On review, the issue is remand. We vacate the ALJ's order and remand.

On February 4, 1997, the employer issued a denial, denying claimant's aggravation claim, as well as compensability of claimant's claim for L2-3 degenerative disc disease. Claimant requested a hearing. The ALJ upheld the aggravation denial. However, the ALJ set aside the denial of L2-3 degenerative disc disease on the ground that the employer's denial was precluded, consistent with the court's decisions in Messmer v. Deluxe Cabinet Works, 130 Or App 254, 258 (1994) (Messmer I) and Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II). The employer requested review.

On review, the employer contends that the court's decisions in Messmer I and Messmer II have been legislatively overruled by the amendments to ORS 656.262(10)[1] enacted by House Bill 2971. Therefore, the employer requests that the case be remanded to the ALJ for a hearing on the merits of the compensability of claimant's claim for L2-3 degenerative disc disease. Claimant agrees that the matter should be remanded to the ALJ.

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, relying on the court's Messmer decisions, the ALJ found that the employer's denial of claimant's L2-3 degenerative disc disease was precluded. Because the ALJ found that the Messmer decisions governed the compensability issue, the ALJ did not address the merits of the compensability of claimant's claim for L2-3 degenerative disc disease.

We have previously held that the amendments to ORS 656.262(10) overruled the court's decisions in Messmer I and Messmer II. Keith Topits, 49 Van Natta 1538 (1997). The amendments to ORS 656.262(10) became effective on July 25, 1997 and, pursuant to Section 2[2] of the Act, applied retroactively to claims existing on the effective date of the Act. Because this case existed on July 25, 1997, we find that amended ORS 656.262(10) applies to this case.

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[1] ORS 656.262(10) now provides, in material part:

"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 condtion has been formally accepted." (Emphasis added to identify amended language).

[2] 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."

In this case, the parties agree that remand is appropriate. We treat the parties' agreement as a concession that a "compelling reason" exists for remand. Therefore, we find that a compelling basis exists for remand in this case. See Refugio Guzman, 39 Van Natta 757, on recon 39 Van Natta 808 (1987) (When Board "new injury" carrier responsible for the claim and ALJ has neither made credibility findings nor rated claimant's permanent disability claim under his aggravation claim with another carrier, there was a compelling reason to remand).

Accordingly, we vacate the ALJ's order and remand this matter to ALJ Kekauoha for the taking of additional evidence on the issue of the compensability of claimant's L2-3 degenerative disc disease claim. Consistent with this order, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and insure the development of a complete record regarding the compensability issue. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VALENTINA I. BOGOMAZ, Claimant
WCB Case No. 96-09304
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant was not procedurally entitled to temporary disability for the period of July 9, 1996 through July 11, 1996 or for the period beginning July 26, 1996; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to pay such benefits. The insurer cross-requests review of that portion of the ALJ's order that awarded an attorney fee pursuant to ORS 656.386(1) for prevailing over the alleged "de facto" denial of claimant's left forearm tendinitis. On review, the issues are entitlement to temporary disability, penalties and attorney fees. We 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 worked as a housekeeper in a convalescent facility. In the spring of 1996, she began to notice pain in her right forearm. On July 9, 1996, she sought medical treatment for her right forearm. Dr. Sullivan diagnosed tendinitis, and recommended that claimant rest her arm for two weeks. On July 10, 1996, claimant made a formal claim for right arm tendinitis.

Claimant was offered and accepted sedentary work (duties that did not require the use of her arms and hands). On July 12, 1996, she returned to work at her regular hours and pay, as a companion to residents in the employer's facility. Claimant continued to perform this light duty work until July 25, 1996. On that day, the employer advised her that, as of the next day, she was to begin working the night shift, because there was no "sitter" work available during the day shift.

Meanwhile, on July 26, 1996, claimant returned to Dr. Sullivan complaining of bilateral forearm tendinitis. Dr. Sullivan injected both elbows and released claimant for light duty work. Claimant did not show up for work the night of July 26, 1996, and refused the new schedule because she did not want to work the night shift.

On July 31, 1996, the employer received claimant's report of injury (dated July 27, 1996), which identified an injury to both arms. By letter dated August 1, 1996, the employer again offered claimant modified work as a "sitter" during the day shift. Claimant also declined this offer and did not return to work.

On October 7, 1996, the employer accepted claimant's claim for nondisabling right forearm tendinitis. By letter dated October 11, 1996, claimant's counsel requested that the claim be reclassified as disabling and that the employer accept both the right and left forearm tendinitis.

Claimant filed a request for hearing on October 15, 1996, seeking temporary disability from July 9, 1996. Pursuant to a November 6, 1996 Determination Order, the claim was reclassified as disabling and referred to the insurer for appropriate action. On November 21, 1996, claimant filed a supplemental request for hearing, alleging a "de facto" denial. Thereafter, on November 27, 1996, the insurer accepted the claim for disabling right forearm tendinitis. On December 31, 1996, the employer accepted both left and right forearm tendinitis as nondisabling, noting that the Determination Order was "under challenge."

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The ALJ found that, pursuant to ORS 656.210, claimant was not entitled to temporary disability for the first three days of her disability.[1] In addition, the ALJ determined that claimant was not procedurally entitled to temporary disability for the period beginning on July 26, 1996 because she did not leave work for reasons related to her compensable injury. Specifically, the ALJ found that claimant left work because of her unwillingness to work the night shift, rather than because of her work-related disability.

On review, claimant argues that she became entitled to temporary disability as of July 26, 1996 because her original modified job was discontinued and the employer did not strictly comply with the requirements of OAR 436-060-0030(5)(c) in offering her other modified work. Like the ALJ, we find that claimant has not established a procedural entitlement to temporary disability compensation.

"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).

After being off work for three days, claimant returned to modified work (as a "sitter") at her regular wage on July 12, 1996. The offer of modified work which claimant accepted specified that "hours of work will be flexible and posted by your supervisor as with all employees" and also that scheduled working days will be "regular schedule or as posted." (Ex. 10). Contrary to claimant's contention, we do not consider this modified job to have ended or the offer of work withdrawn simply because the employer changed her schedule to the night shift as of July 26, 1996 when there was no light duty work available during her regular day hours. The modified job (on terms previously described) remained available, albeit on a different schedule.

Furthermore, claimant does not contest the ALJ's finding that she "left work" as of July 26, 1996 for reasons unrelated to her compensable injury. Since the record fails to establish that claimant was absent from work due to her compensable condition or that she sustained diminished earning capacity

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[1] Pursuant to ORS 656.210(3), no temporary disability payment is recoverable for the first three days of lost work unless the worker is totally disabled after the injury and the total disability continues for at least 14 consecutive days or unless the worker is hospitalized within 14 days of the first onset of total disability.

attributable to her injury, she is not entitled to interim compensation for the time period at issue. See Weyerhaeuser Co. v. Bergstrom, 77 Or App at 427; 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); compare Joseph E. Bridwell, 49 Van Natta 1061, on recon, 49 Van Natta 1452 (1997) (despite the fact he was terminated shortly after his compensable injury, the claimant was entitled to interim compensation because he remained disabled from performing his regular work and experienced injury-related diminished earning capacity).

Penalties

We adopt and affirm the ALJ's determination that no penalties are appropriate because no compensation is due claimant.

Attorney Fees

Citing ORS 656.386(1), the ALJ assessed a reasonable attorney fee for claimant's counsel's services related to obtaining acceptance (prior to hearing) of the allegedly "de facto" denied claim for left forearm tendinitis. On review, the insurer argues that the ALJ erred in awarding such a fee because this case did not involve a "denied claim" under ORS 656.386(1). We agree.

Claimant's attorney is entitled to an attorney fee "in such cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. Under the law in effect at the time claimant made the claim for left forearm tendinitis,[2] a "denied claim" was defined as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation."[3]

Here, no benefits for claimant's left forearm tendinitis have gone unpaid. Moreover, the record does not establish that the insurer refused to pay compensation on the express ground that claimant's left forearm tendinitis was not compensable or did not give rise to an entitlement to compensation. Therefore, under these circumstances, no "denied claim" has been established and no attorney fee is warranted under ORS 656.386(1). See Michael Galbraith, 48 Van Natta 351 (1996) (no "denied claim" where carrier paid all benefits for the compensable condition and did not expressly contend the condition was not compensable).

ORDER

The ALJ's order dated February 21, 1997 is affirmed in part and reversed in part. That part of the order awarding a $2,000 assessed attorney fee is reversed. The remainder of the ALJ's order is affirmed.

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[2] ORS 656.386(1) was amended by the 1997 Legislature, but the revisions that went into effect on July 25, 1997 were not made retroactive and are therefore not applicable to this case. See Stephenson v. Meyer, 150 Or App 300, 304 n.3 (1997) (noting that the 1997 revisions to ORS 656.386(1) were not made retroactive).

[3] Under the new law, a "denied claim" now includes, among other things, a claim for a condition omitted from the notice of acceptance, made pursuant to ORS 656.262(6)(d), to which the carrier does not respond within 30 days. Amended ORS 656.386(1)(b)(B).

In the Matter of the Compensation of
ROBERT C. GRAY, Claimant
WCB Case No. 96-08812
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that dismissed his request for hearing regarding the insurer's partial denial of claimant's right knee surgery claim. On review, the issues are jurisdiction and compensability. We reverse the ALJ's order, reinstate claimant's request for hearing, and uphold the insurer's denial.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Relying on SAIF v. Shipley, 147 Or App 26, rev allowed 326 Or 57 (1997), the ALJ concluded that since claimant's request for hearing concerned only medical services, the Hearings Division lacked jurisdiction over this dispute. For the reasons set forth below, we disagree that the Hearing Division lacks jurisdiction over this matter.

Subsequent to the ALJ's order, we issued our Order on Reconsideration in Jacqueline J. Rossi, 49 Van Natta 1844 (1997). In Rossi, we held that the Hearings Division had jurisdiction over a medical services dispute where the claimant was seeking to establish the compensability of a new "combined" condition under ORS 656.005(7)(a)(B). We distinguished this situation from the court's decision in Shipley, where the claimant sought only medical services for a compensable condition, reasoning that because the dispute concerned the compensability of a new condition, it necessarily involved the denial of an "underlying" claim. See also Charles Bertucci, on recon 49 Van Natta 1833 (1997) (Hearing Division has jurisdiction over medical services dispute where the claimant was seeking to establish compensability of a new condition under ORS 656.802).

Here, as in Rossi, claimant is seeking to establish the compensability of a "combined" condition, *i.e.*, the accepted right medical meniscus tear and the preexisting condition (Grade III chondromalacia, retropatellar changes and large patellar osteophyte). Thus, although the dispute concerns a claim for medical services, the claim is also for the "combined" condition that gives rise to the need for those services. Therefore, the insurer's formal denial is a denial of the underlying claim. Pursuant to ORS 656.245(6), the Hearings Division retains jurisdiction over the medical services/compensability dispute in this case. Rossi, 49 Van Natta at 1845. For these reasons, we reinstate claimant's request for hearing and proceed to the merits.

Remand

As a preliminary matter, claimant has made numerous motions which essentially request that this matter be remanded or consolidated with WCB Case No. 97-07854. That is the case number assigned to claimant's "supplemental" hearing request that apparently concerns the same issue that is present in this case, *i.e.*, the compensability of claimant's current condition and need for medical treatment.[1]

With regard to claimant's request for remand, we find no compelling basis which warrants remanding this matter to the ALJ. The Board may remand a matter to an ALJ if it is determined that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

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[1] The parties were advised that if they wished to postpone the hearing in WCB Case No.97-07854 pending the Board's decision in this case, they could present an appropriate motion at a suitable time to the assigned ALJ.

The initial hearing in this matter took place in December 1996, some three months prior to the court's decision in Shipley. The parties agreed that compensability was at issue and they were prepared to proceed on that issue. (Tr. 1). Forty-five exhibits were admitted into evidence concerning the compensability argument. Both parties submitted written closing arguments concerning the compensability issue. Based on this, we conclude that the parties believed that compensability was at issue and prepared their cases accordingly. Under these circumstances, we do not find that the record has been improperly, incompletely, or otherwise insufficiently developed. Consequently, we find no compelling reason to remand this matter to the ALJ and proceed with our *de novo* review of the record.[2]

Compensability/Medical Services

The medical evidence is in agreement that claimant has a preexisting right knee condition which combined with his 1995 compensable injury. (Exs. 52, 59, 62). Therefore, it is appropriate to analyze this claim under ORS 656.005(7)(a)(B) as a compensable injury combining with a preexisting condition.

In order to establish compensability under ORS 656.005(7)(a)(B), claimant must show that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997); Gregory C. Noble, 49 Van Natta 764, 767 (1997). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401(1994), rev dismissed 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta at 765-66.

Dr. Weintraub, an orthopedist who examined claimant at the request of the insurer, reported that claimant had medial joint arthritic change stemming from a medical menisectomy performed 20 years prior and significant degenerative retropatellar changes not due to any known injury. (Ex. 54). He opined that claimant's 1995 injury was not the cause of his need for right knee replacement surgery. (Id.) After reviewing x-rays, Dr. Weintraub opined that the 1995 injury was significant, but that the compensable injury was not the major cause of claimant's need for treatment. (Ex. 56). In a subsequent letter, Dr. Weintraub indicated that claimant's preexisting condition(s) combined with the industrial injury, but continued to opine that the major cause of claimant's current condition was the preexisting condition(s) and not the industrial injury. (Ex. 59).

Dr. Jones, claimant's treating orthopedist, opined that while claimant had degenerative problems prior to the 1995 injury, claimant was able to function. (Ex. 58A). Dr. Jones further noted that, while he could not tell if claimant's degenerative condition had changed as a result of the injury, claimant had experienced a marked increase in symptoms following the injury. (Id.) In a subsequent letter to the insurer, Dr. Jones indicated that he agreed with Dr. Weintraub's statement that claimant's preexisting condition combined with the industrial injury, but that the preexisting condition was the major cause of claimant's current condition. (Ex. 62).

Thereafter, Dr. Jones indicated claimant would not have needed knee replacement surgery prior to the July 1995 work incident unless the knee was symptomatic. (Ex. 69). Dr. Jones agreed that following the work injury claimant became subjectively symptomatic to the point that a total knee replacement was considered. (Id.). Finally, with regard to the need for knee replacement surgery, Dr. Jones agreed that claimant's symptoms dictated the need for surgery, but opined that the symptoms would not be present without the underlying degenerative condition which preexisting the 1995 work injury. (Id.)

On this record, claimant has not established that the 1995 work injury was the major contributing cause of his disability or need for medical treatment for his combined condition. While Dr. Jones indicated that claimant experienced a marked increased in symptoms which dictated knee

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[2] We note that with his appellant's brief, claimant submitted further documentary evidence which consists of a supplemental hearing request, a letter to the insurer, and a reply from the insurer's counsel. The apparent purpose of these submissions is to establish that the Hearings Division has jurisdiction over this matter. In light of our conclusion that the Hearings Division has jurisdiction over this matter, we find no reason to remand this matter for admission of those documents. Consequently, we do not consider those documents on review.

replacement surgery, he opined that those symptoms would not be present without the preexisting condition(s). (Ex. 69). Moreover, Dr. Jones agreed with Dr. Weintraub that the major cause of claimant's current condition was the preexisting condition(s). (Ex. 62). There is no other medical opinion in the record which establishes that claimant's work injury was the major contributing cause of claimant disability or need for treatment for the combined condition.[3] Under these circumstances, claimant has not established that his need for right knee replacement surgery is compensably related to his 1995 work injury. Accordingly, the insurer's denial must be upheld.[4] Nehl, 149 Or App at 313.

ORDER

The ALJ's order dated May 9, 1997 is reversed. Claimant's request for hearing is reinstated. The insurer's denial, dated August 6, 1996, is upheld.

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[3] While Dr. Mohler, consulting orthopedist, reported that while claimant's knee problems began prior to the 1995 injury the work-related fall "definitely aggravated" claimant's knee problem, he does not indicate that the work injury is the major cause of claimant's disability or need for medical treatment for the combined condition. (Ex. 57).

[4] We note that claimant has also raised an argument concerning the constitutionality of ORS 656.005(7)(a)(B). We have previously rejected this argument and decline to revisit this issue in this case. See Gary W. Benson, 48 Van Natta 1161, 1163 (1996).

In the Matter of the Compensation of
DORENE J. GOIN, Claimant
WCB Case No. C702732
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Black, et al, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On October 29, 1997, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

The first page of the proposed disposition agreement provides that the total due claimant is $3,000 and the total due claimant's attorney is $1,000, for a total consideration of $4,000. Page 4, lines 1 - 3 are consistent with these amounts. However, the total consideration on page 3, line 5 of the CDA has been changed to agree with the total consideration on page 1 and 4 of the CDA. Claimant and her attorney have initialed this change, but SAIF's representatives have not approved the change. Thus, we conclude that the agreement contained a typographical error and has been corrected by handwritten interlineation to provide a total consideration of $4,000, consistent with the first and fourth pages of the document.

As clarified by this order, the agreement is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $1,000, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DARREN D. HAYES, Claimant
WCB Case No. 96-03826
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that the Hearings Division had jurisdiction over claimant's aggravation claim; (2) set aside the employer's denial of claimant's aggravation claim for a left shoulder condition; (3) awarded interim compensation, less an offset for unemployment compensation received; and (4) assessed penalties for an allegedly unreasonable denial of claimant's left shoulder claim. On review, the issues are jurisdiction, aggravation, interim compensation, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. The claims processing agent's May 11, 1995 acceptance of a nondisabling "thoracic sprain" claim did not include notice of claimant's right to challenge the "nondisabling" classification within a year from the date of injury. (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

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

Aggravation

The ALJ found that, because the employer did not accept the left shoulder impingement condition until after claim closure, it necessarily followed that claimant's subsequent need for medical treatment and work restrictions relating to the left shoulder condition constituted a worsening *per se* of his condition. On review, the employer argues that claimant failed to establish an "actual worsening" as required by ORS 656.273(1). Claimant responds that he established a valid aggravation claim. In light of subsequent changes in the law enacted by the 1997 legislature, we need not address the aggravation issue. Instead, for the reasons discussed below, we find that amended ORS 656.262(7)(c) mandates reopening claimant's claim for processing regarding the post-closure accepted left shoulder condition.

Amended ORS 656.262(7)(c) provides, in relevant part: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." HB 2971, 69th Leg., Reg. Session, § 1 (July 25, 1997) (emphasis added). The amendments to ORS 656.262 applies to "all claims or causes of action existing 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." HB 2971, § 2. Because this claim existed on the effective date of HB 2971, and because the amendments to ORS 656.262 are intended to be fully retroactive, we apply amended ORS 656.262(7)(c) to this case. See Bay Area Hospital v. Landers, 150 Or App 154 (1997); Ronald D. Smith, Sr., 49 Van Natta 1807 (1997) (applying amended ORS 656.262(7)(c) retroactively and requiring the carrier to reopen the claimant's claim where a new condition was accepted post-closure).

Here, on February 10, 1995, claimant sustained a work injury, for which the employer accepted a thoracic strain injury. On June 9, 1995, the employer closed claimant's accepted thoracic sprain injury claim. Subsequently, at the time of the June 20, 1996 hearing, the employer accepted claimant's left shoulder impingement condition. Accordingly, consistent with amended ORS 656.262(7)(c), the employer must "reopen" the claim for processing of the left shoulder condition. Consequently, we affirm the ALJ's decision to set aside the employer's refusal to reopen the claim.

Interim Compensation

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

Penalties - Unreasonable Denial

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

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant's attorney submits a statement for services on review requesting a fee of $2,325. The employer argues that this fee is excessive. Claimant prevailed over the employer's request for review regarding the jurisdiction and interim compensation issues. In addition, claimant succeeded in defending the ALJ's decision to reopen his claim, albeit not on the grounds he argued. However, claimant's attorney is not entitled to an assessed fee for services on review defending the ALJ's penalty assessment. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Taking these factors into consideration, and considering the factors set forth 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 $1,800, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the jurisdiction, interim compensation, and "claim reopening" issues (as represented by claimant's respondent's brief, his counsel's statement of services, and the employer's objections), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated August 8, 1996, as reconsidered October 4, 1996, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,800, payable by the employer.

November 12, 1997 Cite as 49 Van Natta 1957 (1997)

In the Matter of the Compensation of
MARGARET KOUVA, Claimant
WCB Case Nos. 95-12514 & 95-07338
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) granted claimant's motion to continue the hearing for admission of "post hearing" depositions from two physicians; and (2) set aside SAIF's denial of her injury claim for cervical and right rotator cuff conditions. In her respondent's brief, claimant challenges the ALJ's $3,000 insurer-paid attorney fee award. On review, the issues are the ALJ's continuance ruling, compensability, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Ultimate Findings of Fact," with the following summary and supplementation.

SAIF accepted claimant's February 9, 1989 right shoulder injury claim for acute tendonitis and a frozen right shoulder. SAIF denied claimant's preexisting shoulder conditions, degenerative arthritis of the right acromioclavicular joint and mild right shoulder joint space narrowing. The denial was upheld by an April 1990 stipulation.

Claimant continued to work for the employer as a custodian until 1995 without significant right shoulder problems.

In February 1995, claimant experienced the onset of right shoulder pain while tossing garbage bags over her head into a dumpster at work. She continued working, but her symptoms increased until she sought treatment near the end of March 1995.

On June 14, 1995, SAIF issued a denial of claimant's claim for "acute strain-sprain right shoulder, arthritis right shoulder and cervical and lumbar spine, degenerative tear right rotator cuff." (Ex. 21). Claimant requested a hearing.

The hearing initially convened on September 12, 1995 before a prior ALJ. The parties agreed to a postponement to allow time for claimant to file an aggravation claim and for SAIF to process that claim. SAIF also agreed to schedule the depositions of Drs. Grossenbacher and Frabach, pursuant to claimant's request.

The hearing convened again on February 7, 1996 before the present ALJ. The ALJ granted claimant's motion to continue the hearing, over SAIF's objection, to allow rescheduling and admission of depositions of Drs. Grossenbacher and Frabach.

In April 1996, Dr. Grossenbacher performed open surgery on claimant's right shoulder.

CONCLUSIONS OF LAW AND OPINION

Continuance Ruling

SAIF argues that the ALJ abused his discretion in granting claimant's motion to continue the February 1996 hearing for the purpose of deposing Drs.Grossenbacher and Frabach and admitting their depositions. We disagree.

The Board's rule regarding continuances provides:

> "The parties shall be prepared to present all of their evidence at the scheduled hearing. Continuances are disfavored. An ALJ may continue a hearing for further proceedings. The ALJ shall state the specific reason for the continuance:
>
> "(1) If the time allocated for the scheduled hearing is insufficient to allow all parties to present their evidence and argument;
>
> "(2) Upon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence;
>
> "(3) Upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence or for any party to respond to an issue raised for the first time at a hearing; or
>
> "(4) For any reason that would justify postponement of a schedule hearing under OAR 438-06-081." OAR 438-06-091.

The rule is couched in permissive language[1] and contemplates that the exercise of authority to continue a hearing rests with the ALJ's discretion. See Sandra L. Booker, 48 Van Natta 2533 (1996); Randy L. Kling, 38 Van Natta 1046 (1986). Further, an ALJ may conduct a hearing in any manner that will achieve "substantial justice." ORS 656.283(7). Accordingly, we review the ALJ's continuance ruling for abuse of discretion under the applicable Board rule. See Georgia-Pacific Corp. v. Kight, 126 Or App 244, 246 (1994) (The court "will reverse the Board's decision to grant claimant's request for a continuance if the Board acted outside the range of discretion delegated to it by law or if it acted inconsistently with its own rules. . . .") (emphasis added).

Here, the parties agreed that the depositions of Drs. Grossenbacher and Frabach would be scheduled when the initial hearing was postponed. SAIF scheduled the depositions. SAIF now contends that claimant canceled the depositions. SAIF further contends that claimant has not established extraordinary circumstances justifying incomplete case preparation and that the ALJ therefore abused his discretion by continuing the hearing and admitting the depositions. See OAR 438-006-0081(4); 438-006-0091(4).

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[1] "An ALJ may continue a hearing...."

Claimant responds that she timely requested the doctors' depositions (before the initial hearing) and that she did not ask SAIF to permanently cancel the depositions. Because the depositions were postponed to accommodate filing and processing of an aggravation claim, claimant contends that she reasonably expected SAIF to reschedule them before the hearing convened again in September 1995. When SAIF did not reschedule the depositions and objected to claimant's request for a continuance to conduct them, claimant argued that she had exercised due diligence with her initial timely request and that nothing further was required of her.

There is no evidence in the record regarding the "canceling" of the depositions between the two hearings. However, SAIF acknowledges that claimant requested them before the initial hearing, and that it scheduled them as agreed. (Tr. 8). SAIF also acknowledges, "The reason we set up depositions is because we are the ones who are paying for the depositions and we are arranging for the court reporter and so forth." (Tr. 12). Considering SAIF's initial agreement, its initial scheduling, its practice of scheduling depositions, and the fact that the circumstances supporting the initial request remained unchanged throughout the postponement period,[2] claimant had reason to believe that SAIF would reschedule the depositions after they had been postponed. Under these circumstances, we conclude that claimant's initial timely request to depose the doctors constituted due diligence[3] under OAR 438-006-0091(2). Accordingly, we further conclude that it was not an abuse of discretion to allow the continuance and admit the depositions. Finally, we conclude that the ALJ's decision regarding this matter served "substantial justice."[4]

Compensability: Right Rotator Cuff Condition

We adopt the ALJ's opinion and conclusion on this issue. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

Compensability: Cervical Condition

The ALJ found claimant's cervical condition compensable, based on the opinion of Dr. Grossenbacher, treating physician. We disagree.

Claimant had a preexisting cervical degenerative condition at the time of her February 1995 work incident. It is undisputed that the lifting incident at work combined with the preexisting condition to cause claimant's subsequent cervical problems. (See Ex. 36-26).

Dr. Grossenbacher opined that claimant had either an aggravation of her underlying cervical degenerative condition or a cervical strain superimposed on the underlying condition. Dr. Grossenbacher was unable to say which would be a more accurate diagnosis. However, he concluded that the major cause of either would be the work incident, based on claimant's reporting. (Ex. 36-27). Dr. Grossenbacher's opinion in this regard is specifically and solely based on claimant's history that the work incident precipitated her cervical symptoms. (Ex. 36-30). There is no other medical opinion relating claimant's recent cervical problems to her lifting incident at work.[5]

In the absence of a medical opinion evaluating the relative contributions of the identified work and non-work related causes (here, the preexisting condition and the lifting incident at work), we conclude that the claim must fail under ORS 656.005(7)(a)(B). See Dietz v. Ramuda, 130 Or App 397 (1994), rev den 321 Or 416 (1995); Somers v. SAIF, 77 Or App 259 (1986).

Attorney Fees

The ALJ assessed a $3,000 attorney fee for services at the hearings level.

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[2] See OAR 438-007-0023; 438-006-0091(2); see also OAR 438-006-0091(3).

[3] Compare Ronny L. Breshears, 47 Van Natta 182, 183 (1995) (Where the insurer did not present circumstances justifying a second continuance, "due diligence" not established under OAR 438-06-091(2)).

[4] In reaching the latter conclusion, we note that Dr. Grossenbacher's opinion arising out of claimant's "post-hearing" shoulder surgery would probably have been admissible, even without a timely motion to continue the hearing for a deposition. See Cain v. Woolley Enterprises, 301 Or 650 (1986); Parmer v. Plaid Pantry # 54, 76 Or App 405 (1985). The result would be the same on the merits.

[5] Dr. Fuller opined that claimant's preexisting arthritis caused her recent cervical problems. (Ex. 37-57-8).

On review, claimant submits her counsel's statement of services and requests a fee of $9,362.50 for 47.375 hours of attorney services. SAIF objects to claimant's request, contending that the issues presented were "not unusual," and an appropriate fee would be $1,500.

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

After considering the above factors and applying them to this case, we find that $3,000 is a reasonable fee for claimant's counsel's services at hearing regarding the right shoulder condition issue. In particular, we have considered the value of the interest involved, the time devoted to the issue (as represented by the record, claimant's counsel's statement of services, which does not differentiate between services devoted to the various issues, and SAIF's objections), and the risk that claimant's counsel might go uncompensated. Finally, we note that claimant's counsel is not entitled to an attorney fee for services devoted to the unsuccessful cervical or aggravation claims, or the improper precautionary denial issue.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the right shoulder issue 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for services on review concerning the unsuccessful cervical claim.

ORDER

The ALJ's order dated May 28, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial of claimant's claim for a cervical condition is reversed. The denial is reinstated and upheld. The remainder of the order is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by SAIF.

In the Matter of the Compensation of
RONALD P. KLEFMAN, Claimant
WCB Case Nos. 95-11139, 95-06440, 95-11138, 95-03622 & 95-03621
ORDER ON RECONSIDERATION
David J. Lefkowitz, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Elmo Lambert requests reconsideration of that portion of our October 28, 1997 Order on Review that dismissed the SAIF Corporation's request for review insofar as it pertained to WCB Case No. 95-03622 (concerning a *de facto* denial of subjectivity by Elmo Lambert) and WCB Case No. 95-11139 (concerning the Director's determination that claimant was not a subject worker of Elmo Lambert). Specifically, Elmo Lambert requests that we clarify which portion of the ALJ's order is vacated and asks that claimant's request for hearing in the above-mentioned WCB Case numbers be dismissed.

To begin, our use of the term "vacated" on pages 1 and 6 of the order was misplaced. Because we concluded that the Board did not have appellate jurisdiction over the ALJ's order insofar as it pertained to claimant's requests for hearing concerning his subject worker status as to Elmo Lambert and Satori Associates, we dismissed SAIF's request for review insofar is it pertained to those matters. However, because of the same lack of appellate jurisdiction, we have no authority to "vacate" any portion of the ALJ's order which pertained to decisions made on behalf of the Director. Therefore, we delete the references to "vacating" the ALJ's order in part on pages 1 and 6 of our order.

With regard to dismissing claimant's requests for hearing in WCB Case Nos. 95-03622 and 95-11138, we decline to do so on the same basis discussed above. Both of those case numbers concern the issue of whether claimant was a subject worker of Elmo Lambert.[1] As noted above and in our prior order, we do not have appellate jurisdiction over any determination made by the ALJ on behalf of the Director.

Accordingly, we withdraw our prior order. On reconsideration, as supplemented herein, we adhere to and republish our October 28, 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 construed claimant's request for hearing in WCB Case No. 95-03622 as concerning a *de facto* denial of subjectivity by Elmo Lambert based on the parties' positions at hearing. Inasmuch as the Director subsequently issued a determination finding that claimant was not a subject worker of Elmo Lambert, the issue of a *de facto* denial of subjectivity was essentially encompassed within the Director's subjectivity determination. In other words, both hearing requests raised the same issue. Ideally, claimant's requests for hearing concerning the *de facto* denial of subjectivity by Elmo Lambert and the Director's determination of the same issue would have been assigned the same WCB Case number, i.e., claimant's hearing request from the Director's determination should have been processed as a supplemental hearing request from his earlier *de facto* denial hearing request. However, given the complicated procedural posture of this case, as well the timing of the court's decision in Lankford v. Copeland, 141 Or App 138 (1996), it is understandable that two WCB Case Numbers were assigned.

In the Matter of the Compensation of
TINA M. OWENS, Claimant
WCB Case No. 96-05716
ORDER ON REVIEW
Bogardus & Nichols, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that found that claimant's injury claim was time-barred under ORS 656.265(4). On review, the issue is timeliness of the claim, and, in the event the claim is timely, compensability.

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

The ALJ held that claimant's injury claim was time-barred under ORS 656.265. On review, claimant argues that her statements to her supervisor constituted employer knowledge of the injury for purposes of ORS 656.265(4)(a).

Pursuant to ORS 656.265, notice of an accident resulting in an injury or death shall be given not later than 90 days after the accident. ORS 656.265(4)(a) provides: "Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and: (a) The employer had knowledge of the injury or death."

Here, claimant gave written notice of the accident to the employer more than 90 days, but less than a year after the accident occurred. Claimant testified that she initially told her supervisor that she "didn't know why" she was having chest, arm and finger symptoms because she "didn't have a clue what it was." (Tr. 39, 40). After seeing a physician, claimant testified she told her supervisor that "it was a possibility" that her symptoms were related to work. (Tr. 51).

In Argonaut Insurance v. Mock, 95 Or App 1 (1989), the court discussed what constitutes employer knowledge of the injury under ORS 656.265(4)(a). The court stated:

> " * * * the 'knowledge of the injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate." Id at 5.

Here, we do not find claimant's conversations with her supervisor to be sufficient to constitute employer "knowledge of the claim." Based on claimant's testimony regarding what she told the supervisor, claimant was uncertain as to the cause of her problems and conveyed her uncertainty to her supervisor. She apparently stated vaguely that there was "a possibility" that the problems were related to work. She did not attribute the symptoms to any particular event or activity at work. Thus, we conclude that although the supervisor was aware that claimant had some kind of problem, he had no knowledge of how it occurred in relation to the employment. Under such circumstances, we do not find that a reasonable employer would have concluded that workers' compensation liability was a possibility or that it should investigate further. Accordingly, we affirm the ALJ's decision that the claim is time-barred.

ORDER

The ALJ's order dated April 2, 1997 is affirmed.

November 12, 1997 Cite as 49 Van Natta 1962 (1997)

In the Matter of the Compensation of
BACILIO VALEDEZ, Claimant
WCB Case No. 96-11423
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of claimant's right femur injury. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following correction and supplementation. Claimant was 59 years of age, not 60, at the time of the September 11, 1996 work incident.

As the ALJ found, the medical evidence establishes that the claim is governed by ORS 656.005(7)(a)(B), because there is medical evidence that claimant's preexisting right femur and hip conditions combined with the September 11, 1996 work incident to cause claimant's need for treatment. (Exs. 15, 19, 21A, 22, Tr. 36, 50-51). Therefore, to establish medical causation, claimant must prove that the September 11, 1996 incident was the major contributing cause of his disability and need for treatment of his right femur condition.

Dr. Graham, claimant's former treating physician, did not render an opinion on causation; instead, he deferred to Dr. Vigeland, claimant's treating surgeon. (Ex. 23, Tr. 19). Claimant urges us to rely on Dr. Vigeland's opinion based on his status as the treating surgeon.

Generally, deference is given to the treating physician who was able to observe the affected body part during surgery. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988). However, although Dr. Vigeland performed claimant's surgery, for the reasons explained by the ALJ, we find his opinion unpersuasive. In addition, Dr. Vigeland does not relate any surgical observations to his causation opinion. (Exs. 9, 17, 21A). Compare Argonaut Insurance Company v. Mageske, 93 Or App at 702 (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due

to congenital defect); Givens v. SAIF, 61 Or App 490, 494 (1983) (treating surgeon's opinion found persuasive where he indicated that he saw no evidence during surgery that the claimant's thoracic outlet syndrome was the result of a congenital defect or a compressed artery). Instead, Dr. Vigeland simply stated, without explanation, that the on-the-job incident when claimant tripped stubbing his right foot against a wooden platform was the major contributing cause of the right femur fracture condition, even considering claimant's preexisting arthritis and childhood surgeries. (Ex. 21A-2). See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical report); see also Marta I. Gomez, 46 Van Natta 1654 (1994) (the persuasiveness of a medical expert's opinion depends on the explanation that corresponds to the expert's opinion). Dr.Vigeland also noted that, although claimant may have had a "stiff hip," there was no fracture of the femur until the September 1996 work incident. Id.

However, the record shows that claimant's preexisting conditions involved more than a "stiff hip." X-rays taken in 1994 showed severe right hip arthritis and right femur deformity, osteoporosis, and osteopenia. Dr. Vigeland does not sufficiently weigh the relative contributions from these preexisting conditions and the work incident, which involved claimant striking his right foot against a four inch platform, to claimant's right femur fracture condition. See SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309, 312 (1997) (extent of a 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 the need for treatment of the combined condition); 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) (treating surgeon's opinion found unpersuasive where he relied on a temporal relationship without sufficiently weighing the relative contributions from the preexisting degenerative condition and the alleged injury).

Accordingly, we conclude that claimant failed to sustain his burden of proof under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated April 8, 1997 is affirmed.

November 13, 1997 Cite as 49 Van Natta 1963 (1997)

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

This matter is before the Board on remand from the Court of Appeals. Garibay v. Barrett Business Services, 148 Or App 496 (1997). The court has reversed our prior order, Manuel Garibay, 48 Van Natta 1476 (1996), that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome condition. Concluding that the employer's failure to issue a responsibility disclaimer under former ORS 656.308(2) barred it from asserting that claimant's condition was caused by a different employer, the court has remanded for reconsideration.

As determined by the court, the employer's denial of compensability was based solely on its contention that claimant's condition was brought on by an earlier employment. Because the employer had neglected to disclaim responsibility for the claim pursuant to ORS 656.308(2) (1990), the court has held that the employer is barred from asserting that claimant's carpal tunnel syndrome was caused by a different employer.

In light of the court's holding, we find that the employer is responsible for the claim. Accordingly, the employer's denial is set aside and the claim is remanded to the employer for processing pursuant to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
JON S. O'SHANE, Claimant
WCB Case No. 96-11510
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Otto's order that declined to authorize an offset. On review, the issue is offset. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has a January 1994 compensable low back strain injury claim with the insurer. It was closed without an award of permanent disability. Claimant also has a June 1994 compensable low back strain injury claim with the insurer. This claim was closed with a Determination Order that awarded only temporary disability. An Order on Reconsideration affirmed the Determination Order. Shortly after the Determination Order issued, the insurer provided claimant with an audit letter notifying him that he had been overpaid temporary disability in the amount of $2,959.26 and it would offset that amount against any future award of benefits.

The ALJ decided that, in the absence of an audit sheet or canceled checks, the insurer failed to prove the existence of an overpayment and denied the insurer's request to offset. The insurer challenges this conclusion, asserting that its audit letter is sufficient proof of an overpayment. Citing only to ORS 656.283(7)[1] and Ronald L. Tipton, 48 Van Natta 2521 (1996), claimant asserts that the insurer should be "barred" from raising the offset issue because it did not do so during reconsideration.

We first address claimant's argument. In Fister v. South Hills Health Care, 149 Or App 214, 219 (1997), the court held that the Board erred in considering the carrier's argument on review concerning the admissibility of the claimant's testimony under ORS 656.283(7). The court based its conclusion on the Board's well-established rule that we will consider only issues raised by the parties at hearing. 149 Or App at 218-19.

We find that such reasoning applies here. Claimant did not object to the insurer's request for offset at hearing but, instead, participated in the litigation of such issue. Consequently, we will not now entertain claimant's argument that the insurer was precluded in requesting the offset. Fister, 149 Or App at 218-19.

We turn to the merits of the offset. An ALJ may authorize an offset for overpaid temporary disability benefits if the carrier establishes its entitlement to a particular amount of overpayment by a preponderance of the evidence. Metro Rigging v. Tallent, 94 Or App 245, 248 (1988). In the absence of rebuttal evidence, a carrier can satisfy that burden by submitting evidence that: (1) shows how the payments of compensation were made; and (2) sets forth the method of calculating the claimed overpayment. E.g., Allen L. Frink, 42 Van Natta 2666 (1990).

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[1] ORS 656.283(7) provides, in relevant part:

"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, 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."

As we held in Francis I. Bowman, 45 Van Natta 500 (1993), we find such burden of proof satisfied with an audit letter stating that the claimant had been overpaid temporary disability for a certain time period and specifying the precise amount of the claimed overpayment. As discussed by the ALJ, we also have found that the carrier's audit sheet and canceled checks of compensation payments were sufficient to establishing an offset. We disagree, however, that only such evidence proves the existence of an overpayment. As in Bowman, the audit letter in this case stated the precise amount of the claimed overpayment and detailed the time periods when claimant was overpaid temporary disability. Claimant, through testimony or documents, in no way rebutted the receipt of such compensation or the amount claimed as overpaid. Such circumstances warrant the approval of an offset.

ORDER

The ALJ's order dated May 7, 1997 is reversed in part and affirmed in part. That portion of the order denying the insurer's motion to offset is reversed. The insurer is authorized to offset an overpayment of $2,959.26 against any future awards of compensation in the manner prescribed by law. The remainder of the order is affirmed.

November 13, 1997 Cite as 49 Van Natta 1965 (1997)

In the Matter of the Compensation of
DURWOOD McDOWELL, Claimant
Own Motion No. 95-0527M
OWN MOTION ORDER OF ABATEMENT
Kirby & Johnson, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our October 14, 1997 Own Motion Order Reviewing Carrier Closure, in which we affirmed the SAIF Corporation's May 27, 1997, Notice of Closure because he failed to meet his burden of proving that he was not medically stationary on the date his claim was closed.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL P. SENAY, Claimant
WCB Case No. 96-02885
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Ronald Atwood & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's injury claim for an umbilical hernia. On review, the issue is compensability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the ALJ's findings as supplemented below.

Claimant had no symptoms or physical findings of an umbilical hernia prior to the lifting incident at work.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's injury claim was compensable under a material contributing cause standard. On review, the insurer argues that the claim should be analyzed under a major contributing cause standard pursuant to ORS 656.005(7)(a)(B). Assuming that the insurer is correct, the treating physician's opinion persuasively establishes compensability under the stricter major contributing cause standard.

The facts in this case are not in dispute. Claimant was diagnosed with an umbilical hernia after lifting a 5-gallon water jug at work. At the time of this incident, claimant felt the immediate onset of "belly button" pain and that evening noted a bulge in that area. Although claimant had a congenital umbilical weakness, he had no symptoms or physical findings of an umbilical hernia prior to the lifting incident at work.

Dr. McCulley, the treating physician, opined that the lifting incident was the major contributing cause of the hernia, when compared with the congenital defect and claimant's weight. Dr. McCulley explained that the lifting incident probably caused a further tearing, which resulted in a protrusion. Dr. McCulley further explained that it was this protrusion, and not the congenital weakness, that caused the onset of symptoms and need for surgery. In support of his opinion, Dr. McCulley noted that neither he nor claimant had noted a protrusion in claimant's umbilical area prior to the lifting injury.

The insurer relies on the contrary opinions of its medical examiners. Dr. Blumberg opined that claimant's hernia was probably due in major part to his congenital weakness and a small, preexisting protrusion resulting from that weakness and intra-abdominal pressure due to claimant's girth. Dr. Blumberg further opined that claimant's current need for surgery is no different than it would have been the day prior to the lifting incident. Dr. Battalia concurred with Dr. Blumberg and further opined that the lifting incident merely caused the movement of abdominal membrane into a preexisting sac, resulting in symptoms and the identification of a bulge.

We defer to Dr. McCulley because he is the treating physician and has provided a well-reasoned opinion that is most consistent with the medical and lay evidence in this record. See Barnett v. SAIF, 122 Or App 279, 283 (1993); Weiland v. SAIF, 64 Or App 810 (1983). In particular, we note that Dr. McCulley provided surgical treatment for claimant's prior inguinal hernia and is, therefore, in the best position to assess the possible contribution of a preexisting umbilical weakness and/or protrusion. We reject the insurer's argument that his opinion is undermined by his incorrect assumption that claimant had undergone a surgical repair for his umbilical hernia. Dr. McCulley's opinion persuasively supports the conclusion that claimant's current need for treatment is due in major part to his lifting injury, regardless of the nature of that treatment. See SAIF v. Nehl, 148 Or App 101 (1997), on recon, 149 Or App 309 (1997).

Accordingly, we defer to Dr. McCulley and conclude that claimant has established compensability of his injury claim under either a major or a material contributing cause standard.

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 $1,200, 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 April 7, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
ALICE R. VOLLMER, Claimant
WCB Case No. 96-10913
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of claimant's right ankle injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of her employment.

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

Claimant argues that her employment put her in a position to be injured, because she was fulfilling a work duty, or at least on the employer's premises for an employment-related purpose, when she fractured her left ankle on November 19, 1996. Specifically, claimant contends that her injury arose out of her employment because the injury occurred when she was notifying the employer that she would not be working as scheduled that day. We disagree.

The employer's procedures for scheduling leave time are not disputed. Employees are expected to either submit a yellow leave slip (if requesting leave at least 24 hours in advance) or notify the employer by telephone (if the leave is previously unplanned). (Tr. 9-10, 39).

Claimant initially followed the proper procedure by telephoning the employer.[1] However, when she was not satisfied with the call-in method, she chose to drive to work so that she could notify the employer in person and discuss whether this time off would be treated as "scheduled" or "unscheduled" (i.e., with or without appropriate preauthorization). Claimant's "in person" workday notification method was not among those anticipated by the employer.[2] Instead, for her own reasons, she chose to present herself at her workplace even though she did not intend to work. Under these circumstances, we agree with the ALJ that claimant's injury did not "arise out of" her employment.

Regarding the "course and scope" prong of the employment relation test, we make the following additional findings. We note that the employer controlled the premises where claimant broke her ankle. In addition, it appears that the employer acquiesced in claimant's presence on the work premises.

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[1] Pursuant to the employer's notification policy, claimant could not properly follow the advance leave "yellow slip" procedure because she was due to begin her shift that morning.

[2] Nothing prevented claimant from continuing to pursue the prescribed "call-in" notification method.

However, we find that claimant was primarily there on a personal mission: She sought to ensure that her time off that day would be considered "scheduled," rather than "unscheduled." She was acting for her own personal benefit, not in furtherance of the employer's business purpose. Considering these additional circumstances, we also agree with the ALJ that claimant's injury did not occur within the course and scope of her employment. See Mir Iliafar, 49 Van Natta 499, 500 (1997); Danny R. Marshall, 45 Van Natta 550, 551 (1993).

ORDER

The ALJ's order dated May 15, 1997 is affirmed.

November 14, 1997 Cite as 49 Van Natta 1968 (1997)

In the Matter of the Compensation of
EDINE E. BUSCHER, Claimant
WCB Case No. 95-11982
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our October 17, 1997 Order on Review which reversed an Administrative Law Judge's (ALJ's) order that: (1) found that the self-insured employer was precluded from denying claimant's left leg conditions; (2) set aside its denial of claimant's current left leg conditions; (3) set aside its aggravation denial for the same conditions; and (4) awarded a penalty for a late payment of a permanent disability award. Noting that the employer did not contest the ALJ's penalty award, claimant seeks reinstatement of that portion of the ALJ's order. In addition, in light of the "post-ALJ order" adoption of amended ORS 656.262(10), claimant requests remand for the taking of additional evidence.

In order to allow us sufficient time to consider claimant's motion, our October 17, 1997 order is withdrawn. The employer is granted 14 days after the date of this order to submit a response to the motion. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
KIM P. KENNEDY, Claimant
WCB Case No. 97-00202
SECOND ORDER ON RECONSIDERATION
Ann B. Witte, Claimant Attorney
Reinisch, et al, Defense Attorneys

The insurer requests reconsideration of our October 17, 1997 Order on Reconsideration in which we adhered to and republished, as supplemented, our September 19, 1997 Order on Review. In our October 17, 1997 order, we found that claimant did sustain a "compensable injury" as the result of a work-related motor vehicle accident (MVA). The insurer contends that we erred in relying on Dr. Duncan's opinion to find that claimant sustained a "compensable injury." The insurer also argues that the treatment claimant received from chiropractor Dr. Duncan was not due to any injury caused by the work-related MVA. Finally, the insurer contends that we erred in finding that it failed to raise at hearing the issue of whether claimant sustained any injury in the MVA. Claimant has submitted a response to the insurer's motion and requests an additional assessed attorney fee for services on reconsideration. We begin by addressing the insurer's last contention.

In its second request for reconsideration, the insurer contends that we erred in holding that it first raised on review the issue of whether claimant sustained any injury as a result of the work-related MVA. We need not resolve this dispute because, even if we were to agree with the insurer's position, we would nevertheless find, for the reasons stated in our October 17, 1997 order, as well as in this order, that claimant established a "compensable injury" because she required medical treatment as a result of the MVA.

The insurer also contends that we erred in relying on Dr. Duncan's opinion to find that claimant sustained an injury in the MVA, because Dr. Duncan's opinion was based on an inaccurate history. Specifically, the insurer argues that Dr. Duncan's opinion cannot be relied upon because he was unaware that claimant had a history of headaches preceding the MVA. We disagree.

For a few days preceding the MVA, claimant had had a mild, bi-frontal headache. (Exs. B-1, 10 at 1-2). The day after the MVA, however, claimant awoke with "an extremely bad headache," with pain in the right lower back of her head, as well as on both sides of her head. (Tr. 8). Claimant's headaches persisted after the MVA, until she finally requested a chiropractic referral from her attending physician. (See Exs. 10-2, 19-1, 27-1). On examination, Dr. Duncan noted that claimant's main complaint was of constant right temporal headaches which radiated up from the right suboccipital area. (Ex. 27-1). Dr. Duncan believed that claimant's post-concussive syndrome, along with a cervical strain with fixation complex, were causing her headaches. (Id.).

There is no indication that Dr. Duncan was aware that claimant had had headaches prior to the MVA. However, there is also no medical evidence indicating that claimant's mild headaches prior to the MVA were in any way related to the headaches claimant developed following the MVA. Indeed, the description of claimant's headaches prior to the MVA (mild, bi-frontal) is significantly different from the description of her headaches after the MVA ("extremely bad," persistent, located in the right lower back and sides of the head). Therefore, we find that Dr. Duncan's lack of knowledge about claimant's earlier headaches does not materially affect his opinion regarding his treatment of claimant. We are not persuaded that Dr. Duncan's opinion must be discounted for this reason.

Furthermore, Dr. Lange, PhD., who conducted a mental health evaluation on November 18, 1996, and who was aware of claimant's history of headaches, also suspected that claimant may have hit her head in the MVA, since she complained of headaches. (Ex. 8-1). He too diagnosed mild post-concussive symptoms with "what might well be a mild head injury secondary to the MVA." (Ex. 8-2). Thus, the two practitioners who specifically commented on the cause of claimant's head symptoms, Drs. Lange and Duncan, believed that she was suffering from post-concussive symptoms due to the MVA. While we recognize that Dr. Lange's opinion is not stated in terms of reasonable medical probability, we also recognize that it does not contradict Dr. Duncan's opinion.

The insurer also argues that claimant never had a cervical strain. We disagree. We continue to rely on Dr. Duncan's examination, diagnoses, and opinion to find that claimant had a "cervical strain with fixation complex" resulting from the MVA. (Exs. 26, 27-1). We further find that Dr. Duncan's

diagnosis was supported by objective findings of tenderness in the mid-back and right suboccipital area, as well as restricted cervical range of motion.[1] (Ex. 27-1).

We do not find it significant that claimant did not complain of any injuries immediately after the accident, because claimant testified that her "aches and pains" developed the day after the accident. (Tr. 8). Nor do we find it significant that claimant does not recall striking her head during the accident, since claimant had no recall of the accident whatsoever.

Because we find no reason not to rely on Dr. Duncan's uncontradicted opinion, we conclude that Dr. Duncan treated claimant for symptoms resulting from the MVA. Therefore, we adhere to our prior conclusion that claimant sustained a "compensable injury" as a result of the work-related accident.

Claimant's counsel is entitled to an additional assessed attorney fee for services on reconsideration. 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 counsel's services on reconsideration is $300, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to the motion), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our October 17, 1997 Order on Reconsideration. 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 do not find it significant that other physicians found full range of cervical motion when examining claimant after the MVA, because there is no indication that those physicians and Dr. Duncan were applying the same standard of measurement to reach their conclusions. (Compare Exs. B-1, 3-2, 10-2 with Ex. 27-1).

In the Matter of the Compensation of
JANICE A. NEUENSCHWANDER, Claimant
WCB Case No. 96-10351
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of her injury claim for left elbow, left thigh, neck, head, mid-back and lower back conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant had been employed as a concrete delivery driver since April 1989. (Tr. 10-11). She drove a ten-yard mixer equipped with a "boosty," which is an extra axle that evenly distributes the weight. (Tr. 11, 13, 42). Before September 1996, claimant had not been involved in any accidents and had not received any tickets. (Tr. 12-13). She considered herself a good driver. (Tr. 13).

Claimant had used methamphetamines before her employment with employer. After she began her employment, she testified that she quit using methamphetamines because she did not want to jeopardize her job. (Tr. 20-21). She was aware of the employer's drug and alcohol policy, which provided for random testing. (Tr. 51-52). Claimant testified that, before September 20, 1996, she had not had methamphetamines for years. (Tr. 25).

Beginning on Friday evening, September 20, 1996, claimant began taking methamphetamines. (Tr. 24). She took methamphetamines during the day and the evening on Saturday. (Tr. 25). Claimant testified that she slept on Friday and Saturday night, but she did not remember how long she slept. (Tr. 24, 25). On Sunday, September 22, she took methamphetamines on and off throughout the day until approximately 9:00 p.m. (Tr. 19, 24). She went to bed approximately 2:00 a.m. and got up for work approximately 6:00 a.m. (Tr. 22).

At approximately 8:15 a.m. on Monday, September 23, 1996, she was delivering her second load of cement when she had an accident as she was making a 90 degree right-hand turn from the highway onto a two lane road. (Tr. 19, 27, 28). Claimant was familiar with the corner and knew she needed to be careful. (Tr. 18). There were two cars stopped at the stop sign, waiting to enter the highway. Claimant testified that she had never previously attempted that corner with two cars at the intersection. (Tr. 18, 45, 53-54). She said that the "boosty" hit a chunk of concrete on the edge of the road and caused the mixer to overturn. (Ex. 4A-2, Tr. 28). The mixer rolled over onto one of the vehicles waiting at the stop sign. (Tr. 28). At the time of the accident, visibility was good and the pavement was dry. (Tr. 5-6, 34, 77).

Following the accident, claimant submitted to an alcohol test. (Tr. 47, Ex. 3A). Claimant tested positive for methamphetamines and amphetamines. (Exs. 3C, 4C).

CONCLUSIONS OF LAW AND OPINION

Based on Dr. Jacobsen's opinion, the ALJ concluded that claimant's judgmental errors that caused the accident would not have occurred without her ingestion of controlled substances.

Under ORS 656.005(7)(b)(C), claimant must first establish a prima facie case of compensability. If established, then to defeat a finding of compensability under ORS 656.005(7)(b)(C), the insurer must prove, by the preponderance of the evidence, that claimant's "consumption of alcoholic beverages or the unlawful consumption of any controlled substance" was the major contributing cause of the injury. The parties did not dispute that claimant had established a prima facie case of compensability. (Tr. 1-2).

Claimant argues that the ALJ erred in finding that the insurer provided sufficient evidence to establish by a preponderance that drug use was the major contributing cause of the accident.[1] She contends that Dr. Jacobsen's opinion is not persuasive. We disagree.

Dr. Jacobsen performed his residency in internal medicine and has had a general practice in administrative medicine. (Tr. 79). He is certified by National Testing in Addiction Medicine, which has been his full-time practice for approximately ten years.[2] (Id.)

Dr. Jacobsen reviewed documents involving this case and listened to claimant's testimony. He testified that methamphetamine is the most potent of the general class of amphetamines, which are a controlled substance that affect the central nervous system. (Tr. 80). Although claimant testified that she took only methamphetamines, she tested positive for methamphetamines and amphetamines. Dr. Jacobsen explained that amphetamine is a metabolic product of methamphetamine. (Tr. 84). Amphetamines raise blood pressure and pulse, speed up processing and wakefulness, stimulate the emotional system and affect brain chemistry, stimulate the sensory system and impair visual perception and ability to handle tracking objects. (Tr. 81-82). Sleep is impaired and even if there is rest, it is agitated and not a restorative sleep. (Tr. 82). He explained that one-time use in a "drug-naive" person would cause impairment for 24 to 36 hours. (Id.) A "drug-naive" person is one who has not used amphetamines in the past or in the recent past. (Tr. 83).

Dr. Jacobsen explained that, after two days of methamphetamine use and three nights of sleep deprivation, claimant had three types of impairment on September 23, 1996: the continued effects of methamphetamine, the sub-acute withdrawal phase of methamphetamine and the effects of sleep deprivation. (Tr. 85). He explained that during the sub-acute withdrawal phase, the effects are depression, low energy, decreased judgment, decreased alertness, sleepiness and depression. (Tr. 85-

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[1] In light of our de novo review, we need not address claimant's argument that the ALJ erred by noting that his "own experience as a school bus and dump truck driver" entered into his interpretation of the facts. (Opinion and Order at 3 n.2).

[2] In light of Dr. Jacobsen's qualifications, we reject claimant's contention that he is not an "expert."

86). That phase starts to occur very soon after the acute phase wears off. (Tr. 85). Sleep deprivation goes "hand in hand" with use of methamphetamines. (Tr. 86). He felt that claimant probably had the effects of low blood sugar because stimulants speed up metabolism, lower blood sugar and decrease the appetite. (Tr. 85). The effects of low blood sugar include fatigue, jitteriness and lack of awareness. (Tr. 86).

Dr. Jacobsen testified that, within a reasonable medical probability, after claimant's two and one-half day use of methamphetamines, on Monday morning, September 23, 1996, she would have been suffering from the continued effects of methamphetamine use, sub-acute withdrawal effects of methamphetamine use, sleep deprivation and low blood sugar. (Tr. 86). He concluded that, on the morning of the accident, claimant was significantly impaired from her use of methamphetamines and he believed that the major contributing cause of the accident was claimant's use of methamphetamines. (Tr. 87, 88). He explained that claimant's methamphetamine use caused lack of awareness, lack of alertness and lack of judgment (Tr. 88). Because claimant had used methamphetamines for two days and three nights, her impairment was significantly greater than with a one-time use. (Tr. 89). He felt that the fact that claimant took the corner was consistent with poor judgment, lack of awareness and lack of attention. (Tr. 90). Within a reasonable medical probability, Dr. Jacobsen felt that claimant was physically impaired and less capable of driving a truck on the day of the accident because of the methamphetamine use. (Tr. 91).

Although Dr. Jacobsen testified that "[t]here's no way I or anyone can know exactly what [claimant] did or what type of methamphetamine impairment caused the accident to happen" (Tr. 90), medical certainty is not required. Rather, a preponderance of evidence may be shown by medical probability. Robinson v. SAIF, 147 Or App 157, 160 (1997). Dr. Jacobsen persuasively stated his opinion in terms of reasonable medical probability.

Claimant contends that Dr. Jacobsen did not testify in any manner concerning the levels of the methamphetamine found by the testing. However, the degree of impairment is not the relevant inquiry. Ronald Martin, 47 Van Natta 473, 475 (1995). Rather, the issue is whether claimant was impaired by her consumption of a controlled substance and, if so, whether that impairment was the major contributing cause of the injury. In fact, Dr. Jacobsen did distinguish between a prescribed medical dose of methamphetamine and the abuse of the substance. (Tr. 80-83). Furthermore, we note that claimant's attorney objected to Dr. Jacobsen's discussion of dosages of methamphetamines. (Tr. 80).

Finally, we disagree with claimant's argument that Dr. Jacobsen's testimony was based on generalizations and is not specific to claimant. Dr. Jacobsen explained the general nature of impairments caused by methamphetamine use. However, he also examined the medical records, listened to claimant's testimony regarding her repeated use of methamphetamines over the weekend and testified that, on the morning of the accident, she was significantly impaired from her use of methamphetamines and the major contributing cause of the accident was her use of methamphetamines.

Based on Dr. Jacobsen's opinion, we conclude that the insurer has sustained its burden of proving that claimant's consumption of methamphetamines was the major contributing cause of the September 23, 1996 injury. See ORS 656.005(7)(b)(C).

ORDER

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

In the Matter of the Compensation of
PETER R. BALIUKONIS, Claimant
WCB Case Nos. 96-06855 & 96-04161
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established that his work activities for the employer were the major contributing cause of a right wrist/upper extremity tendinitis condition separate from his right wrist arthritis condition.

The employer argues, inter alia, that claimant has not established the existence of an occupational disease "by medical evidence supported by objective findings." See ORS 656.802(2)(d). We agree.

We assume (without deciding) for purposes of this analysis, that claimant has a right wrist tendinitis condition which is medically separable from his nonwork related right wrist arthritis condition. (See Ex. 31B). In addition, we note that there are undisputed objective right wrist findings, including swelling and reduced range of motion. (See Exs. 16, 17; see also Exs. 24, 29A) However, we find no evidence associating any of claimant's objective findings with the work-related condition as opposed to the noncompensable arthritis condition. Under these circumstances, we conclude that the claim for an occupational disease must fail. See Sharon D. Julien, 43 Van Natta 1841, 1843 (1991), aff'd mem 112 Or App 327 (1992) (Where symptoms of noncompensable migraine headaches were "congruent" with the claimed work related tension headaches, the claimant failed to establish the existence of an occupational disease by medical evidence supported by objective findings).

ORDER

The ALJ's order dated April 16, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's claim for a right wrist/upper extremity tendinitis condition is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID W. BLAIR, Claimant
WCB Case Nos. 97-00731 & 96-07756
ORDER ON REVIEW
Cole Cary & Wing, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral wrist overuse condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of the same condition. On review, the issues is compensability and, if the condition is compensable, responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, through page three.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for a number of employers during the pendency of this claim, including SAIF's insured and Liberty's insured. He developed recurring right wrist pain with activity in the fall of 1994 and similar left wrist pain by May 1995. Dr. Lantz provided conservative treatment.

The ALJ found claimant's bilateral wrist condition compensable, based on the opinion of Dr. Lantz. We disagree.

Dr. Lantz initially suspected that claimant had a right wrist ganglion cyst. (Ex. 14). In March 1995, Dr. Lantz found no left wrist ganglion cyst and suspected tendinitis. (Ex. 15). By May 25, 1995, no cyst was evident, but claimant's wrists remained symptomatic and he wore splints bilaterally. (Ex. 19A). On December 23, 1996, Dr. Lantz stated that his May 25, 1995 working diagnosis had been "recurrent synovitis of both wrists due to overuse in work activities." (Ex. 50B; see also Exs. 3, 13).

We do not find Dr. Lantz' ultimate conclusion persuasive because it is entirely unexplained. See Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 972 (1988) (Physician's opinion lacked persuasive force because it was unexplained); Somers v. SAIF, 77 Or App 259 (1986). Accordingly, in the absence of persuasive supporting medical evidence, we conclude that the claim must fail.

ORDER

The ALJ's order dated May 5, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
SHARON A. ELMORE, Claimant
WCB Case No. 97-02682
ORDER ON REVIEW
Gatti, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Michael Johnson's order that awarded claimant's attorney a fee of $2,200 for services at hearing. Claimant cross-requests review of the same issue, contending the award is inadequate. On review, the issue is attorney fees.

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

On January 11, 1997, claimant sustained a work injury while she was transporting a patient to bed as part of her duties as a licensed practical nurse. On March 17, 1997, SAIF accepted a resolved left shoulder strain and a resolved low back strain. However, on March 18, 1997, SAIF denied the problems claimant was experiencing at L4-5 and L5-S1, contending those problems were related to her preexisting lumbar laminectomy and discectomy.

Claimant obtained her former counsel, who requested a hearing on the denial. The hearing was scheduled for June 26, 1997. Subsequently, on April 16, 1997, claimant obtained her current counsel. No depositions were taken in preparation for hearing. The record consisted of 26 exhibits, three of which were supplemental exhibits submitted by claimant's counsel. Of these, one was a chart note from claimant's attending physician and two were letters generated by SAIF. Claimant's counsel generated no evidence in this case. On May 16, 1997, SAIF rescinded its partial denial and accepted claimant's recurrent L4-5 disc herniation. The only matter remaining unresolved was the amount of the attorney fee. Claimant's current counsel submitted a Statement of Services to the ALJ documenting six and a half hours of work on the case and requesting a $5,000 attorney fee award for services rendered in obtaining the pre-hearing rescission of the partial denial.

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

We adopt the ALJ's finding regarding the factors of: (1) the time devoted to the case; (2) the value of the interest involved; (3) the benefits secured for claimant; and (4) the risk that claimant's counsel's efforts may go uncompensated. We note that claimant stresses the importance of this last factor. However, like all of the other factors, including the time devoted to the case, the risk that claimant's counsel's efforts may go uncompensated is but one of the eight factors to be considered in determining a reasonable attorney fee.

We offer the following additional comments. Neither party contends that frivolous issues or defenses were asserted, nor would the record support such a contention. Given the fact that claimant had a preexisting L 4-5 disc condition for which she had undergone surgery, the issue of compensability of the recurrent L 4-5 disc condition was of moderate complexity. Furthermore, both attorneys are highly skilled. Finally, as to the nature of the proceedings, because the matter was resolved by a pre-hearing rescission of the partial denial, the case did not go to hearing on the merits.

After considering the factors listed in OAR 438-015-0010(4), we find $2,200 to be a reasonable attorney fee for claimant's counsel's efforts in getting the partial denial rescinded. In particular, we have considered 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 July 7, 1997 is affirmed.

In the Matter of the Compensation of
JEFFREY T. KNUDSON, Claimant
Own Motion No. 940439M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's September 18, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from July 11, 1994 through September 9, 1997. SAIF declared claimant medically stationary as of July 15, 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 September 18, 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).

Claimant's low back injury claim was reopened in July 1994. Since that time, claimant underwent two lumbar spine surgeries. By letter dated June 6, 1997, Dr. Salib, treating surgeon, noted that he had recommended referral to a chronic pain rehabilitation program in April 1997. Dr. Salib stated that, following completion of that program, claimant's condition would be considered "medically stable."

Claimant entered a chronic pain program on August 24, 1997. Dr. Bowar, M.D., treated claimant during his participation in that program. By September 12, 1997, claimant had completed the chronic pain program, although Dr. Bower recommended additional psychological counseling to help claimant cope with his limitations due to the back injury. (September 12, 1997 letter from Dr. Bower to Dr. Salib). Dr. Bowar also noted that follow up in "Aftercare" was planned. However, Dr. Bowar did not address claimant's medically stationary status.

Claimant has also been treating with Dr. Henrickson, M.D., and Dr. Trusheim, neurologist, regarding his compensable low back injury. In a July 16, 1997 chart note, Dr. Trusheim noted that claimant "is improving somewhat on the Amitriptyline." He also noted "for the purposes of work evaluation, etc., that [claimant] is essentially at his point of medical stability." However, Dr. Trusheim also stated that he "will be attempting to improve [claimant's] situation with manipulation of medications."

In a letter dated October 28, 1997, Dr. Henrickson noted that claimant had entered a chronic pain rehabilitation program on August 24, 1997, a six month follow-up program was recommended, and claimant continues to follow up with Dr. Bowar regarding this program. Dr. Henrickson opined that "it is reasonable to expect further material improvement from further medical therapy over the passage of time."

Although Dr. Salib stated that claimant would be medically stationary after completion of the chronic pain program, there is no evidence in the record that Dr. Salib saw claimant after completion of this program. Therefore, we find that Dr. Salib's statement established only that he predicted that claimant would be medically stationary after completion of the chronic pain program. A prediction regarding future medically stationary status is not sufficient to establish that claimant is medically stationary. See Volk v. SAIF, 73 Or App 643, 646 (1985); Edward B. Castro, 44 Van Natta 362 (1992).

SAIF argues that Dr. Trusheim's July 16, 1997 chart note establishes that claimant was medically stationary at claim closure. We disagree.

We note that the need for continuing medical treatment does not necessarily prove that claimant was not medically stationary at claim closure. See Maarefi v. SAIF, 69 Or App 527, 531 (1984). However, both Drs. Trusheim and Henrickson indicated that claimant's compensable condition would improve with treatment or the passage of time. In this regard, although Dr. Trusheim stated that claimant had essentially reached "medical stability," he also stated that claimant was improving with medication and he would be manipulating claimant's medications to try to further improve claimant's situation. We find that Dr. Trusheim's opinion, read as a whole, establishes there is a reasonable expectation of material improvement in claimant's condition with medical treatment. Dr. Henrickson's opinion supports this finding.

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
CHRIS C. CAMARA, Claimant
Own Motion No. 97-0489M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our October 28, 1997 Own Motion Order which reopened his 1982 right and left knee injury claim for the payment of temporary disability compensation. Specifically, claimant requests penalties for the insurer's allegedly untimely Own Motion Recommendation.

Inasmuch as claimant is raising the issue of penalties for the first time on reconsideration, we are not inclined to address that issue at this late date. See Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7, 13 (1994); Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). However, even if we were to address this issue, we would conclude that claimant is not entitled to a penalty. When a claim is under the Board's own motion jurisdiction, as this claim is, no compensation is due until the Board issues an order authorizing reopening of the claim. Therefore, prior to an order authorizing reopening, there are "no amounts then due" upon which to base a penalty. John D. McCollum, 44 Van Natta 2057 (1992). Under these circumstances, a penalty would not be warranted.

Accordingly, we withdraw our prior order. On reconsideration, as supplemented herein, we adhere to and republish our October 28, 1997 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS J. LUCAS, Claimant
WCB Case Nos. 97-04322, 96-04972, 96-09129 & 96-07773
ORDER DENYING MOTION TO LIFT STAY
Pozzi, Wilson, et al, Claimant Attorneys
Ronald Atwood & Associates, Defense Attorneys
Sather, Byerly, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Sedgwick James & Co. has requested review of Administrative Law Judge (ALJ) Otto's orders that: (1) set aside its denial of claimant's right wrist condition; (2) upheld denials of the same condition issued by Liberty Northwest/DR Mechanical, Portland General Electric Company, the SAIF Corporation, and Liberty Northwest/Advanced Piping, Inc.; and (3) awarded a $3,000 attorney fee. In its request, Sedgwick represented that compensation awarded by the ALJ's order would be stayed under ORS 656.313. Noting that the primary issue concerns which carrier will ultimately be responsible for the claim, claimant asserts that there "is no legitimate basis to delay further payment of [his] benefits." Consequently, claimant seeks a Board order "lifting the ORS 656.313 stay of compensation pending appeal." We deny the motion.

ORS 656.313(1)(a) provides that the filing of a request for Board review of an ALJ's order "stays payment of the compensation appealed," except for several specifically enumerated benefits. Subsection (1)(b) of the statute provides that the Board "shall expedite the review of appeals in which payment of the compensation has been stayed under this section." In accordance with the aforementioned statute, OAR 438-011-0005(4) states that an appellant's request for review should recite whether payment of compensation will be stayed under ORS 656.313. Furthermore, consistent with this statutory scheme, Board review of a case in which awarded compensation is being stayed will be expedited. OAR 438-011-0022(2).

Here, in seeking review of the ALJ's order, Sedgwick has recited that compensation granted by that order will be stayed. Consistent with that recitation, Sedgwick does not challenge claimant's representation that "pre-ALJ order" temporary disability has not been paid. In light of such circumstances, once the parties' briefing schedule has expired, review of this case will be expedited. See ORS 656.313(1)(b); OAR 438-011-0022(2).

Finally, claimant has neither cited, nor are we aware of, any authority that would empower us to "lift" a carrier's statutory entitlement to stay the payment of certain compensation pending appeal. In the absence of such authority, we decline to grant claimant's motion to lift the carrier's stay of compensation.[1]

Accordingly, the motion is denied. Enclosed with the parties' attorneys' copy of this order is a copy of the hearing transcript. The following briefing schedule has been implemented. Sedgwick James' appellant's brief must be filed within 21 days from the date of this order. The other carriers' and claimant's respondent's briefs must be filed within 21 days from the date of mailing of Sedgwick James' brief. Sedgwick James' reply brief must be filed within 14 days from the date of mailing of the respondents' briefs. Thereafter, this case will be docketed for expedited review.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we note that, although this proceeding did not arise pursuant to ORS 656.307, there is no statutory prohibition against the parties entering into a stipulation in which a particular carrier agrees to pay compensation to claimant pending appeal, provided that the ultimately responsible carrier reimburses that carrier for those benefits. Thus, if the parties could reach a mutually satisfactory agreement, the proposal could be presented for our consideration.

In the Matter of the Compensation of
DARAL T. MORROW, Claimant
WCB Case Nos. 96-06161 & 95-08182
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the self-insured employer's denial of claimant's current low back condition; and (2) affirmed an Order on Reconsideration awarding no unscheduled permanent disability. On review, the issues are compensability and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

In 1991, claimant was injured while working for a prior employer. The employer's insurer, the SAIF Corporation (SAIF), accepted a low back and right shoulder injury claim. In 1994, while working for Barrett Business Services (the employer), claimant sustained another low back injury. Both SAIF and the employer denied responsibility for this claim. The parties proceeded to a hearing over those denials.

Applying ORS 656.308(1), an ALJ found that claimant had sustained a "new compensable injury" because the major contributing cause of claimant's disability or need for treatment was the 1994 injury. Thus, the ALJ found the employer, rather than SAIF, responsible. On review, we agreed that claimant had proven that the 1994 injury was the major contributing cause of his need for treatment or disability and affirmed the ALJ's decision to place responsibility with the employer. Daral T. Morrow, 47 Van Natta 2030, on recon 47 Van Natta 2384 (1995). The Court of Appeals affirmed without opinion. Barrett Business Services v. Morrow, 142 Or App 311 (1996).

Meanwhile, in July 1995, the employer denied claimant's "current low back condition" on the basis that the major contributing cause of claimant's need for treatment or disability was the 1991 injury with SAIF, rather than the 1994 injury. Claimant requested a hearing to challenge the employer's denial. In August 1995, the employer issued a Notice of Closure that did not award permanent disability. A subsequent Order on Reconsideration awarded claimant 3 percent unscheduled permanent disability. The employer appealed the award of permanent disability made by the reconsideration order. The two appeals were consolidated for hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

Although phrased in terms of compensability, this case raises the issue of whether an employer that has been found responsible for providing benefits for a work-related condition pursuant to ORS 656.308(1) may avoid continuing responsibility for those benefits by asserting that the provision of such benefits are now the responsibility of a prior employer. In this regard, the employer's denial in this case was issued following its receipt of the medical opinion of Dr. Howard Geist, orthopedic surgeon. Dr. Geist opined that the major contributing cause of claimant's current need for treatment was his 1991 injury with SAIF's insured. In response, the employer denied claimant's current low back condition on the basis that claimant "suffer[ed] from a preexisting low back condition arising from the injury of 1991 which remains the major contributing cause of your current condition and disability." The employer advised claimant to file an aggravation claim with SAIF for benefits regarding his current condition.

The ALJ upheld the employer's denial. Although agreeing with claimant that "the law of the case" was that he had sustained a "new compensable injury" for which the employer was responsible, the ALJ further concluded that the employer's denial was procedurally valid under ORS 656.262(7)(b)[1]

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[1] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

and 656.262(6)(c).[2] Specifically, the ALJ found that the employer had accepted a "combined condition" by litigation order and, consequently, it could issue a denial of claimant's current condition under ORS 656.262(6)(c) before closing the claim. The ALJ further found that claimant failed to establish that the 1994 injury with the employer was the major contributing cause of his current condition. The ALJ concluded that claimant did not carry his burden of proving compensability of his current low back condition.

As the ALJ's order discussed, we have held that, pursuant to ORS 656.262(7)(b) and 656.262(6)(c), when a carrier has accepted a "combined condition," either voluntarily or by litigation order, that carrier may issue a denial before claim closure. E.g., Robin W. Spivey, 48 Van Natta 2363, 2364 (1996). Our decisions, however, have examined the application of the statutes only in the context of a preexisting noncompensable condition. We have not decided their effect under the facts presented here: that is, when responsibility for a condition previously has been assigned to a subsequent carrier pursuant to ORS 656.308(1) and that carrier denies continuing responsibility for benefits based on the allegation that the major contributing cause of the current condition has reverted to the prior compensable injury. We conclude that, under these facts, ORS 656.308(1) does not permit the later carrier to avoid continuing responsibility for compensable medical treatment or disability by shifting responsibility backward to the prior carrier.

In this regard, 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." (Emphasis added).

This statute operates together with ORS 656.005(7)(a) to assign responsibility when a compensable preexisting condition resulting from a prior injury combines with a subsequent accidental injury. SAIF v. Drews, 318 Or 1, 8-9 (1993).[3] If the subsequent accidental injury is found to be the major contributing cause of the ensuing disability or need for treatment, then the claimant is considered to have sustained a "new compensable injury" and responsibility shifts to the subsequent carrier. Id. at 9. If, however, the preexisting compensable condition is the major contributing cause of the "combined condition," then the first sentence of the statute applies and responsibility remains with the original carrier. Id.

As previously discussed, this analysis was applied during the prior litigation, resulting in the conclusion that claimant had sustained a "new compensable injury" for which the employer was responsible. The employer is not contending that claimant has sustained another "new compensable injury" to warrant shifting responsibility to another carrier. Nor is the employer contending that claimant's current need for treatment is not compensably related to his employment generally. Rather, the employer is arguing that responsibility for compensable treatment should revert to the original carrier. This assertion is inconsistent with the express language in ORS 656.308(1) that the 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." Therefore, we reject such argument.

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

> "An insurer's or self-insured employer's acceptance of a combined condition or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer 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."

[3] The version of ORS 656.308(1) that was interpreted by the Court in Drews was enacted in 1990. The current version of the statute remains identical except for the addition of the final sentence in the current version.

We find support for our conclusion in the final sentence of ORS 656.308(1). That sentence provides: "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." (Emphasis supplied.) The statute appears to codify the Court's holding in Drews, which addressed the initial assignment of responsibility among successive employers for multiple compensable injuries. The statute does not provide that the combined condition standards contained in ORS 656.005(7) may be used to shift responsibility for compensable medical treatment or disability backward from the responsible carrier to a prior carrier. To the contrary, the second sentence of the statute provides that "all further compensable medical services and disability" shall be processed by the responsible employer as a new injury claim. (Emphasis supplied.) Here, as previously noted, the employer does not contend that claimant's medical treatment and disability is not compensable.

Our conclusion is not changed by the provisions of ORS 656.262(6)(c) and 656.262(7)(b). The first provision relates to an "acceptance of a combined or consequential condition under ORS 656.005(7)" while the latter refers to "the accepted injury." ORS 656.308(1), however, speaks to a "new compensable injury," which, as the court in Drews explained, refers to a compensable preexisting condition that combines with a second compensable injury. We find that the absence of a reference to "new compensable injury" in ORS 656.262(6)(c) and (7)(b) further shows that the legislature did not intend for the statutes to apply in those situations where the carrier has accepted a "new compensable injury" pursuant to ORS 656.308(1).

Consequently, because the employer accepted a "new compensable injury" under ORS 656.308(1), the employer cannot avail itself of ORS 656.262(6)(c) and (7)(b) to shift responsibility backward for compensable medical treatment or disability. Rather, as provided in ORS 656.308(1), it remains responsible for future compensable treatment and disability unless claimant sustains a subsequent "new compensable injury." Thus, we conclude that the employer's denial is procedurally invalid and we set it aside on that basis.[4]

Claimant's attorney is entitled to an assessed fee for services at hearing.[5] ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 6, 1997 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the employer.

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[4] Our conclusion should not be interpreted to preclude a responsible employer or insurer from denying compensability of further medical treatment or disability under ORS 656.262(6)(c) and (7)(b) when the medical evidence establishes that the major contributing cause of a worker's current disability or treatment is a noncompensable preexisting condition rather than the "new compensable injury" for which the employer or insurer is responsible. Those are not the facts of this case, however.

[5] Claimant did not file an appellant's brief. Consequently, he is not entitled to an attorney fee on review. E.g., Shirley M. Brown, 40 Van Natta 879 (1988).

In the Matter of the Compensation of
GEORGE B. ORAZIO, Claimant
WCB Case No. 97-01840
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's termination of claimant's temporary disability benefits. On review, the issue is entitlement to temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, including the parties' stipulation.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury on November 4, 1996. Claimant was performing modified work at the time he was terminated on February 24, 1997, earning the same wage as he earned at the time of injury. Claimant was terminated for disciplinary reasons; specifically, for being late to work, for causing damage to employer's property, and for allegedly engaging in activities that jeopardized the safety of his co-workers. SAIF did not pay temporary disability benefits after claimant was terminated.

The ALJ held that SAIF properly terminated claimant's temporary disability benefits pursuant to ORS 656.325(5)(b) when claimant was discharged for disciplinary reasons. We agree that claimant is not entitled to temporary disability benefits after February 24, 1997, but we do so based on the following reasoning.

Our first task is to determine which provisions of the Workers' Compensation Law are applicable. Hewlett-Packard Co. v. Renalds, 132 Or App 288, 292 (1995). Subsequent to the ALJ's order, we held that ORS 656.325(5)(b)[1] applies in the context of temporary total disability. Jerilyn J. Hendrickson, 49 Van Natta 1208 (1997) (where the claimant was not entitled to temporary total disability benefits when she was fired for reasons unrelated to her claim, ORS 656.325(5)(b) does not apply).

Here, at the time of termination, claimant was performing modified work and earning the same wage he earned at the time of injury. Thus, claimant was not entitled to receive temporary total disability benefits, because he was not sustaining wage loss as a result of the compensable injury. See Cutright v. Weyerhaeuser Co., 299 Or 290, 295 (1985). Therefore, since claimant was not receiving (and was not entitled to receive) temporary total disability benefits at the time of termination, we hold that ORS 656.325(5)(b) does not apply in this case. Nevertheless, we find that claimant was not entitled to temporary disability benefits after he was discharged from employment.

Temporary disability benefits are intended to provide replacement for wages lost due to a compensable injury. Cutright, 299 Or at 296; Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991). Where a worker leaves work for reasons other than an inability to work as a result of the compensable injury, the worker is not entitled to temporary disability benefits. Noffsinger v. Yoncalla Timber Products, 88 Or App 118, 121 (1987); Bruce Conklin, 44 Van Natta 134 (1992); compare Peggy J. Baker, 49 Van Natta 40 (1997) (claimant terminated, at least in part, because of inability to perform regular work due to compensable injury).

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[1] ORS 656.325(5)(b) provides:

"If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 [temporary total disability] and commence payments pursuant to ORS 656.212 [temporary partial disability] 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."

Here, claimant left work on February 24, 1997, when he was discharged for disciplinary reasons. The record does not establish that claimant left work due to an inability to work as a result of his compensable injury. Therefore, claimant is not entitled to temporary disability benefits after February 24, 1997. See, e.g., Michael D. Wingo, 48 Van Natta 2477 (1996); Patricia K. Stodola, 48 Van Natta 613 (1996); Terri Link, 47 Van Natta 1711 (1995).

ORDER

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

In the Matter of the Compensation of
CHARLES W. PERKINS, Claimant
WCB Case No. 97-01190
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Hall and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that increased claimant's award of unscheduled permanent disability for a neck, low back, and brain injury from 3 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 12 percent (38.4 degrees). On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

Although SAIF requested Board review, claimant filed no brief on review. Consequently, there is no basis for awarding an assessed attorney fee on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated June 2, 1997 is affirmed.

In the Matter of the Compensation of
REGGIE D. REICHELT, Claimant
WCB Case Nos. 96-11370 & 96-08549
INTERIM ORDER OF DISMISSAL
Vick & Conroyd, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys
Jeff Gerner (Saif), Defense Attorney

On October 31, 1997, the Board received an October 29, 1997 letter from the attorney for the SAIF Corporation (Willamette Valley Christian School). The letter was addressed to a SAIF claims adjuster (at SAIF's Salem address) and to the "Board Review Committee" (at the Board's Salem address). On receipt of the letter, the Board acknowledged the letter as a request for review of Administrative Law Judge (ALJ) Michael Johnson's October 14, 1997 order that: (1) set aside SAIF's (Willamette Valley Christian School) denial of claimant's left shoulder condition; (2) set aside SAIF's denials (Superior Quality Construction Co.) of the same condition; and (3) awarded a $3,000 attorney fee to be equally paid by SAIF on behalf of the two employers.

On November 7, 1997, SAIF (Superior Quality Construction) mailed to the Board, by certified mail, its request for review of the ALJ's order.[1] On November 10, 1997, the Board received a letter from the attorney for SAIF/ Willamette Valley Christian School. Representing that the October 29, 1997 letter had been "inadvertently forwarded" to the Board, SAIF/Willamette Valley Christian School's attorney announced that the letter was not intended as a formal request for Board review.[2]

Based on the announcement from SAIF/Willamette Valley Christian School, we dismiss the request for review. Under such circumstances, SAIF/Superior Quality Construction is the appellant, while SAIF/Willamette Valley Christian School and claimant are the respondents. A hearing transcript has been ordered. On its receipt, copies will be distributed to the parties' attorneys and a briefing schedule will be implemented. Following completion of that schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] The opening sentence of the request states that SAIF's request is on behalf of "Willamette Valley Christian." However, a later portion of the request indicates that SAIF's request was submitted on behalf of its insured "Superior Quality Construction." Inasmuch as the request was signed by SAIF's counsel who appeared at the hearing on behalf of SAIF / Superior Quality Construction, we have interpreted SAIF's request for review as an appeal of the ALJ's order on behalf of Superior Quality Construction.

[2] SAIF/Willamette Valley Christian School also requests that all copies of its attorney's October 29, 1997 letter be returned. In support of its request, it relies on Goldsborough v. Eagle Crest Partners, Ltd., 314 Or 336 (1992). In Goldsborough, the Supreme Court held that, where a defendant's lawyer voluntarily gave a plaintiff a letter that was subject to the lawyer-client privilege and there was no evidence and no contention that the disclosure was mistaken, inadvertent, or unauthorized, there was sufficient evidence to support a trial court's ruling under OEC 104(1) that the defendant had waived its privilege. Based on its citation to Goldsborough, we understand SAIF/Willamette Valley Christian School to be asserting that its letter was mistakenly or inadvertently mailed to the Board and, as such, remains subject to the lawyer-client privilege.

We do not consider Goldsborough to be controlling. Goldsborough pertained to an allegedly "privileged" letter that was disclosed to another party during discovery procedures. Here, in contrast, the allegedly "privileged" letter was "filed" with the Board and acknowledged as a request for review of an ALJ's order. See OAR 438-005-0046(1). Regardless of the filing party's intentions, the indisputable fact remains that a document has been filed with the Board. Although the previously acknowledged request for review can be dismissed, it would be inappropriate for us to remove from the record any "filed" document. In light of such circumstances, we decline SAIF/Willamette Valley Christian School's request to return the previously filed October 29, 1997 letter from its counsel.

In the Matter of the Compensation of
HERBERT K. SHINN, Claimant
Own Motion No. 66-0117M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our October 6, 1997 Own Motion Order, as reconsidered on October 30, 1997. In those prior orders, we declined to authorize payment for medical services and temporary disability compensation for claimant's current right hip dislocation condition because the record contained no medical evidence as to the relationship between the current right hip condition and the compensable 1955 injury claim. Given this complete lack of medical evidence regarding causation, we were unable to conclude that claimant had established a causal relationship between his current condition and his compensable injury. However, we invited the parties to supplement the record with medical evidence regarding whether claimant's current right hip dislocation was causally related to the compensable injury.

In a letter dated November 3, 1997,[1] claimant explains that he is not seeking temporary disability compensation because he was back to normal function after his right hip dislocation was treated on February 13, 1997. Thus, claimant seeks only payment for the medical services related to the February 1997 hip dislocation. In addition, claimant requests clarification of our October 30, 1997 order on reconsideration. Specifically, claimant requests that we explain what would constitute medical evidence of a causal relationship between the current right hip condition (the February 1997 hip dislocation) and the 1955 work injury claim.[2] We consider claimant's request for clarification as a request for reconsideration of our prior orders and proceed with that reconsideration.

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). Nevertheless, claimant has the burden of proving that the requested medical services are compensably related to the compensable injury. ORS 656.266.

Medical evidence usually comes from one or more of the following sources: (1) a claimant's treating physician; (2) an examining physician, i.e. a physician who has not treated the claimant, but examines the claimant; or (3) a nontreating physician who performs a review of the medical record without examining the claimant.

However, here, as our prior orders found, the record contains no medical evidence regarding the causal relationship between claimant's current right hip and the compensable 1955 work injury. Therefore, we are unable to determine whether claimant's need for treatment is causally related to his compensable injury. Nevertheless, we again stress that, should the parties wish to supplement the record with medical evidence and opinion regarding whether claimant's current right hip dislocation was causally related to his original injury, they may do so provided that the additional evidence is filed within 30 days from the date of this order.

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[1] A copy of any document in an own motion proceeding directed to the Board must be simultaneously mailed to all other parties. OAR 438-012-0016. As it is unclear whether claimant mailed a copy of his November 3, 1997 letter to the SAIF Corporation, we are sending a copy of that letter with SAIF's copy of this order.

[2] To the extent that claimant is requesting legal advice, we are unable to grant that request. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, claimant may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97310
Telephone: 1-800-927-1271

Accordingly, our October 6, 1997 order, as reconsidered on October 30, 1997, is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order. We will reconsider this order if further evidence is forthcoming within 30 days after the date of this order.

IT IS SO ORDERED.

November 18, 1997 Cite as 49 Van Natta 1986 (1997)

In the Matter of the Compensation of
ROY A. SINGLETON, Claimant
Own Motion No. 97-0499M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right knee injury. Claimant's aggravation rights expired on October 14, 1987. SAIF opposes the authorization of temporary disability compensation (TTD) in this claim, contending that: (1) claimant was not in the work force at the time of disability; and (2) that the proposed surgery is not reasonable and necessary.

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

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

SAIF contends that claimant is retired and therefore not in the work force at the time of the current worsening requiring surgery. Claimant has not responded to SAIF's contention. Moreover, by order dated March 15, 1996, we denied authorization of temporary disability benefits to claimant on the basis that he had not established that he was in the work force at that time. There is no evidence which establishes that claimant has re-entered the work force since that time. While a prior finding that claimant was not in the work force does not irrevocably commit claimant to retirement for purposes of workers' compensation benefits, claimant has the burden of proving that he has re-entered the work force at the time of his current worsening. See Arthur R. Morris, 42 Van Natta 2820 (1990).

On this record, claimant has not established that he was in the work force at the time of his current disability. Accordingly, claimant's request for temporary disability benefits is denied. We will reconsider this order if claimant submits evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from a prospective employer, or a letter from a physician stating that a work search would be futile because of claimant's compensable condition for the time period in question.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDY B. BAKER, Claimant
WCB Case No. 96-09302
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's current right median neuropathy 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 following changes. In the second paragraph of the findings of fact on page 2, we change the date in the first sentence to "January 1995." On page 3, we change the second paragraph to read: "Claimant filed a claim for bilateral CTS in February 1995. (Tr. 4)."

CONCLUSIONS OF LAW AND OPINION

At hearing, the parties agreed that claimant's current right wrist/hand condition was due to an accepted right carpal tunnel syndrome (CTS) superimposed on a preexisting median neuropathy. The ALJ concluded that claimant's current condition was not compensable under either ORS 656.005(7)(a)(B) or ORS 656.802(2)(b). The ALJ also determined that SAIF's denial was not an invalid back-up denial of a previously accepted condition. However, the ALJ set aside SAIF's denial of claimant's current condition, reasoning that SAIF was barred by claim preclusion from denying current right median neuropathy. See Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996) (Messmer II); Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) (Messmer I).

Claim Preclusion

SAIF contends that the ALJ erred by deciding that Messmer I and Messmer II precluded its denial of claimant's current right hand condition. SAIF argues that this case is distinguishable from the Messmer decisions.

After the ALJ's order was issued, the 1997 legislature amended ORS 656.262(10). Or Laws 1997, ch. 605, § 1. 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." (Emphasis added).[1]

In Keith Topits, 49 Van Natta 1538 (1997), we concluded that the newly amended statute effectively overruled the Messmer decisions. We held that a carrier's failure to appeal a prior Order on Reconsideration permanent disability award based on an unaccepted condition did not preclude the carrier from subsequently contesting the compensability of the condition.

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[1] Section 2 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." Or Laws 1997, ch. 605, § 2. Thus, amended ORS 656.262(10) is fully retroactive and applies to this claim. See Bay Area Hospital v. Landers, 150 Or App 154, 157 (1997).

Here, the January 17, 1997 Order on Reconsideration awarded 19 percent permanent disability under claimant's accepted CTS claim. (Ex. 31). The award was based on findings of decreased right wrist motion and decreased sensation in the right fingers. (Id.) Dr. Dinneen, medical arbiter, had opined that the findings were at least equally due to claimant's preexisting neurologic/diabetic condition. (Ex. 27-2).

Even if we assume, without deciding, that the reconsideration order award included a range of motion value that was, in part, attributable to claimant's preexisting neuropathy, in light of the 1997 amendments to ORS 656.262(10), SAIF is not precluded from denying claimant's neuropathy condition. Consequently, we reverse the portion of the ALJ's order that set aside SAIF's denial on that basis.

Compensability - Merits

We adopt and affirm the ALJ's reasoning and conclusion concerning the merits of compensability, with the following change and supplementation.

On page 5, we delete the last paragraph and replace it with the following:

The only other medical opinion that supports compensability is from Dr. Green, who reported that claimant has "superimposed on possible polyneuropathy clearly symptomatic median neuropathy at the level of the wrist that is likely related to his occupational activities." (Ex. 26A). Dr. Green felt that claimant had bilateral carpal tunnel syndrome, the major cause of which was his work activity.

There is no evidence that Dr. Green examined claimant. Moreover, it is unclear whether he reviewed any other medical reports. Dr. Green did not discuss claimant's preexisting diabetes condition, which was important to Drs. Dickerson, Tsai, Coletti, Studt and Bufton in determining causation. (Exs. 16, 18, 24, 25, 28, 29). There is no indication that Dr. Green considered other possible causes of claimant's current condition. Furthermore, Dr. Green failed to discuss the details of claimant's work activities. For these reasons, we are not persuaded by Dr. Green's conclusory opinion.

Because there are no persuasive medical opinions in the record that support compensability under either ORS 656.005(7)(a)(B) or ORS 656.802(2)(b), we conclude that claimant has failed to meet his burden of proof.

Invalid Back-up Denial

We adopt and affirm the ALJ's reasoning and conclusion that SAIF's acceptance was limited to the right CTS diagnosis and its subsequent denial was not an invalid back-up denial of a previously accepted condition.

ORDER

The ALJ's order dated May 9, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that concluded SAIF was barred by claim preclusion from denying claimant's current right median neuropathy is reversed. SAIF's denial of claimant's current right median neuropathy is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

November 18, 1997 Cite as 49 Van Natta 1988 (1997)

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

On October 24, 1997, we withdrew our September 25, 1997 Order on Reconsideration that had republished our August 27, 1997 Order on Review that: (1) set aside the insurer's denial of claimant's aggravation claim for a low back condition; and (2) assessed a $500 attorney fee under ORS 656.382(1) for a discovery violation. We took this action in response to the insurer's announcement that the parties had settled their dispute.

The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders. Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The settlement further provides that claimant "withdraws all Requests for Hearing regarding these matters." Finally, the parties agree that this matter "shall be dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

November 19, 1997 Cite as 49 Van Natta 1989 (1997)

In the Matter of the Compensation of
MARGARET N. DONAHUE, Claimant
WCB Case No. C702788
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On October 29, 1997, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.[1]

The first and fourth pages of the proposed CDA provide that the total consideration due claimant is $6,000 and the total due claimant's attorney is $2,000 which equals a total consideration of $8,000. However, on page 3, line 5, the CDA provides for a total consideration of $4,200.50. The lone reference on page 3 to a consideration of $4,200.50 appears to be a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $8,000, minus a $2,000 attorney fee.

As clarified by this order, the agreement is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $2,000, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

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[1] The parties submitted only one set of postcards for the CDAs submitted in this claim (7823076B) and in claim number 7787413. Because this CDA is being approved by order, the postcard notification of approval will only be for claim number 7787413.

In the Matter of the Compensation of
RICK ELLINGSON, Claimant
WCB Case No. 97-00607
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant previously injured his low back in 1989, while working in Montana, and 1993, while working in California. In August 1996, while working in a photography studio in Oregon, claimant experienced a sudden onset of low back symptoms.

The ALJ found that claimant had a preexisting condition that combined with the August 1996 injury and so analyzed compensability under ORS 656.005(7)(a)(B). The ALJ further found the opinion of claimant's treating physician, Dr. Harris, most reliable and, based on that opinion, concluded that claimant carried his burden of proof. Although agreeing with the application of ORS 656.005(7)(a)(B), SAIF contends that the more reliable medical opinion shows that the preexisting condition is the major contributing cause of claimant's need for treatment and disability.

The record contains opinions from four physicians. Dr. Fuller, orthopedic surgeon, examined claimant on behalf of SAIF. Based on reports of MRIs conducted in January 1994 in California and in September 1996 in Oregon, Dr. Fuller found that claimant had preexisting degenerative disc disease at L5-S1. (Ex. 19-5). Dr. Fuller further found that the preexisting condition combined with the August 1996 work incident to result in a herniated disc and right-sided sciatica. (Id. at 6). Finally, Dr. Fuller concluded that the preexisting condition was the major contributing cause of claimant's need for treatment because the mechanism of injury was not sufficient to otherwise herniate a disc. (Id.)

At SAIF's request, Dr. Young, radiologist, compared the 1994 MRI scan with the 1996 MRI scan. Dr. Young found that the 1994 MRI showed a degenerative disc bulge at L5-S1 and that the 1996 MRI revealed a "mild progression of degenerative disc dehydration which is associated with further decrease in joint space at the L5-S1 level." (Ex. 22-2). Dr. Young concluded that claimant's preexisting degenerative disc disease at L5-S1 "seems to have been aggravated by his current injury of 08/27/96" but that the August 1996 injury was a "minor contributor" while the preexisting condition was the major contributing cause of the need for treatment and disability. (Id. at 3).

Dr. Harris, internal medicine specialist, diagnosed claimant with a herniated disc at L5-S1 and a low back strain. (Ex. 27-1). Dr. Harris identified claimant's "preexisting condition" as "a low back strain suffered in 1993" and, because claimant had fully recovered from that injury, Dr. Harris reported that such preexisting condition did not contribute to his need for treatment in 1996. (Id.) Dr. Harris disagreed with Dr. Young that the degenerative changes shown in the 1994 MRI was a significant factor, finding that such changes were too mild. (Id. at 2).

Finally, based on a 1994 medical journal article, Dr. Harris stated that it "is easy to over-interpret and over-read MRI changes in a scan," as well as "ill-advised to associate these abnormalities on MRI scan with 'disease.' For this reason I feel the MRI abnormalities are not only incidental findings but are also likely normal changes that occur in all of us and are not related to back pain or disease." (Id.)

The final opinion is from Dr. McWeeney, an orthopedic surgeon who initially treated claimant. Dr. McWeeney reported that "clearly [claimant] does have a pre-existing condition." (Ex. 28). Based on medical reports showing that claimant had radicular and neurologic symptoms in 1994, and Dr. Young's report, Dr. McWeeny found such evidence "would suggest that the major predominant problem is more likely than not to be the pre-existing condition." (Id.)

In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. See Weiland v. SAIF, 56 Or App 810 (1983). Here, we find persuasive reasons for not deferring to Dr. Harris' opinion. Dr. Harris characterized claimant's preexisting condition as the 1993 low back strain and disregarded any effect from degenerative disc disease. We find Dr. Harris' opinion unpersuasive in this regard. Dr. Harris based his opinion concerning the minimal effects of the degenerative disc disease on a "landmark article" published in the New England Journal of Medicine in 1994. We find such foundation less persuasive than Dr. Young's personal examination of the MRI scans; Dr. Young, as a radiologist, also has greater expertise in this regard than Dr. Harris. Additionally, Dr. Fuller and Dr. McWeeney, both orthopedic surgeons, agreed with Dr. Young's analysis.

Consequently, based on the more reliable opinions from Dr. Young, Dr. Fuller, and Dr. McWeeney, we conclude that claimant failed to prove that the major contributing cause of his need for treatment and disability is the compensable injury. ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated May 20, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

November 19, 1997 Cite as 49 Van Natta 1991 (1997)

In the Matter of the Compensation of
CAROL A. HEASTON, Claimant
WCB Case No. 96-08661
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) awarded claimant $557.13 in temporary total disability for the period of August 5, 1996 through September 9, 1996;[1] (2) awarded penalties and attorney fees based on the additional compensation made payable by the order ($15.48); and (3) assessed a 20 percent penalty based on the insurer's allegedly unreasonable refusal to pay compensation. On review, the issues are rate of temporary total disability, 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, age 31 at the time of hearing, worked for the employer as a gas station attendant clerk. She compensably injured her low back on November 14, 1995. At that time, she was working four days a week for the employer, at various hours and various days.

The insurer paid temporary disability compensation from November 15, 1995 through March 20, 1996. Claimant received no temporary disability compensation in the months following March 20, 1996.

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[1] The insurer conceded that claimant was entitled to five complete weeks of temporary total disability at a weekly rate of $108.33. The parties' dispute centered on the rate of disability for one additional day.

Claimant's low back condition worsened. On August 5, 1996, she was seen by Dr. Fredstrom, who released her from work. Claimant continued to treat with Dr. Fredstrom.

Beginning on September 10, 1996, the insurer resumed paying temporary total disability benefits to claimant. At that time, the insurer was using a payment week beginning on each Friday and continuing through the next Thursday.

The parties stipulated that claimant was entitled to temporary disability benefits for the period of August 5, 1996 through September 9, 1996. The parties further stipulated that claimant's weekly temporary total disability rate during this time was $108.33. The parties could not agree, however, on how to compute the amount of compensation due claimant for this 36-day time period.

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer conceded that claimant was entitled to at least five weeks of temporary total disability at a rate of $108.33 per week ($541.65). As the ALJ noted, the parties' dispute centered around the one extra day beyond those five weeks of disability.[2] Rejecting claimant's contention that she was entitled to one quarter of her weekly temporary total disability rate for that one day ($27.08), the ALJ determined that she was entitled to a proportionate amount of her weekly temporary total disability rate for every day of the work week she was disabled. Consequently, the ALJ awarded claimant an additional $15.48 (one-seventh of $108.33) for the additional day of total disability beyond the five week period. The ALJ also awarded an approved attorney fee and a penalty equivalent to 20 percent of the additional $15.48 in compensation.

On review, claimant again asserts that she is entitled to her "daily" rate of $27.08 for the extra day in dispute rather than the proportionate "one-seventh" amount awarded by the ALJ. We agree.

Pursuant to ORS 656.210(2)(a), a worker's weekly wage "shall be ascertained by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed." Because a weekly wage is determined based upon the number of days per week that the worker is regularly employed, it follows that a worker's "daily wage" should be the ascertained by dividing the weekly wage by the number of days in any seven-day period that the worker regularly works.

As claimant argues, when the insurer began paying claimant's temporary total disability effective September 10, 1996, she received $297.91 for the period of September 10, 1996 through September 26, 1996. According to the insurer's records, claimant was paid for 11 days of work during this 16 day period, based on a weekly rate of $108.33 and 4 days of work per week.[3] (Ex. 35). Had the insurer begun paying temporary total disability from August 5, 1996, the date claimant first became disabled, claimant would have been paid for a full eight weeks of time loss ($866.64) based on a four-day work week through September 26, 1996. Subtracting the amount paid on September 10, 1996 ($297.91) from the total time loss claimant was entitled to for that eight-week period ($866.64), leaves an unpaid balance of $568.73, an amount equal to $541.65 (the five full weeks of time loss, which the insurer conceded was due) *plus* $27.08 (claimant's "daily wage"). In other words, insofar as claimant's September 10, 1996 temporary disability check only paid compensation for three of the four days claimant was unable to work during the (calendar) week beginning on Sunday, September 8, we agree with claimant that she is entitled to be paid her "daily wage" of $27.08 for the additional day in dispute between August 5, 1996 and September 9, 1996.

Because the insurer conceded that claimant was entitled to at least $541.65 for five weeks of temporary total disability and the parties' dispute focused only upon the amount due for the one extra day beyond that five week period, we agree with the ALJ that the attorney fee and penalty should be based upon the additional compensation made payable by the litigation order, rather than the entire five weeks plus one day of temporary total disability. We further adopt and affirm the ALJ's decision to award a penalty equivalent to 20 percent of the additional compensation due as a result of the order. For the reasons expressed by the ALJ, that penalty assessment shall also include the compensation granted by this order.

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[2] August 5, 1995 was a Monday, as was September 9, 1996.

[3] As claimant notes, this translates to a "daily wage" of $27.08 for the four days claimant worked per week.

ORDER

The ALJ's order dated May 28, 1997 is modified in part and affirmed in part. In lieu of the ALJ's award of temporary total disability award of $557.37, claimant is awarded $568.73 for the period of August 5, 1996 through September 9, 1996. Claimant's counsel is awarded 25 percent of the additional compensation made payable by this order ($11.36), payable directly to claimant's counsel. However, the total "out-of-compensation" attorney fee awarded by the ALJ's order shall not exceed $3,800. The ALJ's penalty assessment is modified to include the additional temporary disability granted by this order. The remainder of the ALJ's order is affirmed.

November 19, 1997 Cite as 49 Van Natta 1993 (1997)

In the Matter of the Compensation of
TERRY R. HUFFMAN, Claimant
WCB Case No. 97-00076
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of claimant's low back and hernia condition. In his brief, claimant also contends that SAIF's denial was unreasonable and, thus, it should be assessed a penalty. SAIF responds that, because the penalty issue was not raised at hearing, that matter should not be considered on review. On review, the issues are compensability and, potentially, penalties.

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

Claimant contends that his need for treatment and disability was caused by an event at work on October 11, 1996 and, thus, he proved compensability. We agree with the ALJ that claimant failed to carry his burden of proof. Along with the ALJ's reasoning, we base this conclusion on the inconsistency between claimant's testimony and the history relied upon by claimant's treating physician, Dr. Rabie, the only physician who provided an opinion concerning causation.

Claimant testified that, before October 11, 1996, he felt a lot of muscle soreness from the heavy work. (Tr. 17). On October 11, 1996, claimant moved an engine with a cart; the engine slipped from the cart and claimant unsuccessfully attempted to prevent it from falling. (Id. at 18). After attempting to lift the engine alone, a coworker helped claimant lift the engine back onto the cart. (Id. at 19). According to claimant, following this incident, he felt the "same soreness" but, unlike past experience, the soreness persisted and progressively worsened. (Id. at 20, 24). Claimant conceded that, as of October 16, 1996, he "wasn't aware" that he had been "injured" on October 11 and he attributed his need for treatment to such event because it was the most "traumatic" that had occurred. (Id. at 29, 31).

Dr. Rabie, who saw claimant on November 4, 1996, recorded a history that claimant "sustained an injury on 10/11/96[.]" (Ex. 2-1). Dr. Rabie further noted that, "within the next several hours, and especially over the ensuing days, he started to develop severe low back discomfort[.]" (Id.)

Because claimant's testimony that he felt the "same" but persistent soreness following the incident is not consistent with Dr. Rabie's history that claimant felt "severe low back discomfort" within several hours and days, we find that Dr. Rabie based his opinion on an inaccurate history. Consequently, we find the opinion unreliable. See Somers v. SAIF, 77 Or App 259 (1986).

Finally, we need not decide the penalty issue, whether or not raised at hearing, because, having failed to prove compensability, there are no "amounts then due" upon which to base a penalty. See ORS 656.262(11)(a).

ORDER

The ALJ's order dated April 28, 1997 is affirmed.

In the Matter of the Compensation of
RONALD M. JAMES, Claimant
WCB Case Nos. 96-07440 & 96-05925
ORDER ON REVIEW
Welch, Bruun, 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) Lipton's order that declined to award an attorney fee pursuant to former ORS 656.386(1). On review, the issue is attorney fees.

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

The dispute in this case is limited to whether claimant has established entitlement to an attorney fee under former ORS 656.386(1)[1] for obtaining rescission of an alleged "de facto" denial of claimant's right knee pre-patellar bursitis condition. Relying on our decision in Jerome M. Baldock, 48 Van Natta 355, aff'd mem 143 Or App 360 (1996) (where there has been no refusal to pay compensation, no express denial of a claim, and no questioning of causation by the carrier, no "denied claim" has been established; therefore, no attorney fee may be awarded under former ORS 656.386(1)), the ALJ determined that there had been no "denied claim" as that term is defined in former ORS 656.386(1) that would support an attorney fee award.

We agree with the ALJ's reasoning and conclusions regarding his determination that there was no "denied claim" in this case; therefore, no attorney fee is allowed under former ORS 656.386(1). Jerome M. Baldock, 48 Van Natta at 356.

In addition, pursuant to ORS 656.262(6)(d),[2] a worker with an accepted claim is required to first present his written objections to the notice of acceptance to the carrier and allow 30 days for a response before the worker requests a hearing. Merely filing a hearing request alleging a "de facto" denial does not satisfy the "communication in writing" prerequisite in ORS 656.262(6)(d) because the communication must precede the hearing request. Shannon E. Jenkins, 48 Van Natta 1482 (1996), aff'd mem 149 Or App 436 (1997). Accordingly, under such circumstances, the worker is precluded from proceeding to hearing on the issue of "de facto" denial. Id. at 1484, 1486.

Here, claimant had an accepted claim for a contusion to the right patellar tendon. Claimant made no written communication to SAIF objecting to the fact that his right knee pre-patellar bursitis condition was not included in the Notice of Acceptance. Instead, on June 21, 1996, claimant requested a hearing alleging a "de facto" denial of that condition. On August 12, 1996, claimant submitted another

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[1] Former ORS 656.386(1) provides, in relevant part:

"In all cases involving denied claims where a claimant finally prevails against the denial * * * in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or the board shall allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed. 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 is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

[2] ORS 656.262(6)(d) was not amended by the 1997 legislature and provides:

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

request for hearing alleging a "de facto" denial of the same condition. That same date, claimant submitted a letter contending that the June 21, 1996 hearing request served as his "written communication" under ORS 656.262(6)(d) manifesting his objection to the scope of SAIF's Notice of Acceptance and the August 12, 1996 hearing request actually requested a hearing on the alleged "de facto" denial. On September 13, 1996, SAIF expanded its Notice of Acceptance to include the right knee pre-patellar bursitis condition.

We have previously rejected the contention that an initial hearing request alleging a "de facto" denial in a series of hearing requests making the same allegation satisfies the "written communication" requirement in ORS 656.262(6)(c). Carl L. Gruenberg, 49 Van Natta 750 (1997) (holding that none of a series of hearing requests alleging a "de facto" denial would satisfy ORS 656.262(6)(c); to hold otherwise would thwart the legislative intent of ORS 656.262(6)(c)). Furthermore, even if claimant's attorney's August 12, 1996 letter was "written communication," there is still no proof of a denied claim.

Finally, claimant cites Kimberly Quality Care v. Bowman, 148 Or App 292 (1997), in support of his argument that he is entitled to an assessed fee for services at hearing. We find Bowman distinguishable.

In Bowman, the court found that the employer's check-the-box notation on a hearing response form was an express denial of the unaccepted conditions on the ground that they were not related to the employment. Thus, the court found that there was a "denied claim" as defined in former ORS 656.386(1). In addition, the court found that the claimant's attorney was instrumental in obtaining an acceptance of the claim. Therefore, the court agreed that the claimant's attorney was entitled to an assessed fee under former ORS 656.386(1).

Here, for the reasons explained by the ALJ, there is no "denied claim" as defined in former ORS 656.386(1). Unlike Bowman, the record contains no "Response to Issues" wherein SAIF indicated it was denying the unaccepted condition on the ground it was not related to employment. Moreover, there is no other evidence that SAIF ever denied the unaccepted condition. Thus, there is no "denied claim" that would support an assessed attorney fee under former ORS 656.386(1).

Alternatively, claimant argues that he is entitled to an assessed attorney fee for services at hearing pursuant to amended ORS 656.386(1)(b)(B), which expands the definition of a "denied claim" for purposes of an attorney fee award under former ORS 656.386(1) to include: "[a] claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262(6)(d), which the insurer or self-insured employer does not respond to within 30 days[.]" HB 2971, 69th Leg., Reg. Session, § 3 (July 25, 1997). However, the amendments to ORS 656.386(1) do not apply retroactively. Stephenson v. Meyer, 150 Or App 300, 304 n.3 (1997) (noting that the 1997 amendments to ORS 656.386(1) were not made retroactive).

In this regard, we note that HB 2971 contains only four sections. Sections 1 and 3 provide the amendments to ORS 656.262 and ORS 656.386, respectively. Section 4 contains an emergency clause and declares that the Act takes effect on its passage. Section 2, which immediately follows the amendments to ORS 656.262, provides:

> "Notwithstanding any other provision of the 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."

Given the placement of Section 2 immediately after the amendments to ORS 656.262 and its specific reference only to the amendments to ORS 656.262, we find that the retroactivity provision applies only to the amendments to ORS 656.262. Furthermore, there is no similar retroactivity provision referring to or following the amendments to ORS 656.386. This contextual analysis provides further support for the court's statement that the 1997 amendments to ORS 656.386(1) are not retroactive. Stephenson v. Meyer, 150 Or App at 304 n.3. Thus, amended ORS 656.386(1)(b)(B) does not support claimant's request for an assessed attorney fee.

ORDER

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

In the Matter of the Compensation of
LINELL V. KOENIG, Claimant
WCB Case No. 96-06311
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial of claimant's claim for a left knee (chondromalacia) condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's arguments on review.

Claimant alleges that she injured her left knee in November 1995, which subsequently developed into a chondromalacia condition requiring medical treatment, while working as a waitress/bartender for the employer, a restaurant. The ALJ concluded that claimant failed to prove that her injury occurred in the course and scope of employment, because she failed to produce witnesses to corroborate the alleged incident.

Claimant makes three arguments on review: (1) the ALJ did not find her not credible[1] and there is no basis in the record to find her not credible; (2) her claim should be found compensable because her testimony regarding her injury was supported by the medical records; and (3) there is no legal authority requiring corroboration of her testimony.

Claimant asserts that, at about 1:00 pm on or about November 15, 1995, she slipped and fell on both knees, harder on the left, while getting ashtrays from the dishwashing area of the restaurant. Claimant lost no time from work until she sought medical treatment for her left knee on April 30, 1996, at which time Dr. Patee reported that claimant complained of pain in the medial aspect of her left knee for about six months, and that she may have fallen at work on her knees about five months previously. (Ex. 2). On May 6, 1996, claimant filed a claim in which she reported that the owners of the restaurant, Richard and Ann Marie Horton, and a co-worker, Ginger Reed, witnessed the slip and fall incident. (Ex. 5).

Claimant cites Barbara Cooper-Townsend, 47 Van Natta 2381 (1995) for the proposition that there is no basis in the record to find her not credible. We find Cooper-Townsend to be inapposite. There, the employer sought to impeach the claimant's credibility regarding her employment history after she stopped working for the employer. We rejected the employer's credibility argument because there was no showing that the claimant's work history since her exposure with this employer was material or relevant to the compensability or vocational issues presented.

Here, in contrast, where it is claimant's burden under ORS 656.266 to prove the compensability of her claim by a preponderance of the evidence, corroboration of the circumstances of her injury is both material and relevant to the compensability issue, particularly in light of the employers' countervailing testimony. While claimant is correct, that no statute, administrative rule, or Board case "requires" a claimant to bring corroborating witnesses to establish the facts of an injury, a claimant must nevertheless carry the burden of proving her claim. In some cases, corroborating witnesses are helpful in order to do so. In the present case, we do not find that claimant has met her burden of proof in the remainder of the record, since the persuasiveness of the medical opinions regarding claimant's chondromalacia

[1] We agree that the ALJ did not make credibility findings based on demeanor. Thus, we perform our own evaluation based on the entire record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

condition turn on claimant's establishment of an injury to her knee at work. E.g., Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). 77 Or App 259 (1986).[2]

Finally, in Roberts v. SAIF, 18 Or App 590, 593 (1974), the claimant testified that he reported an injury to a fellow worker and his supervisor. 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 who, he claimed, witnessed his injury, or to place any reason in the record why the co-worker was not called.

In this case, as in Roberts, claimant identified witnesses who could corroborate her testimony regarding the circumstances of her injury. Both Mr. and Mrs. Horton, co-owners of the business, testified that they did not recall seeing claimant fall, nor had claimant reported hurting her knee at work prior to her seeking medical treatment. (Tr. 9, 15, 16, 21). The third witness, Ms. Reed, was not produced at hearing, nor was there any explanation provided as to why she was not called. Thus, like the ALJ, we construe the failure to call her 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 she sustained a work-related injury.

ORDER

The ALJ's order dated May 5, 1997 is affirmed.

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[2] Claimant also cites Herbert Lawrence, 47 Van Natta 1716 (1995), for the proposition that we should find claimant's claim compensable based on the record as a whole, since claimant's testimony regarding the mechanism of her injury and the development of chondromalacia is supported by the medical record. Claimant's reliance on Lawrence is also misplaced. In Lawrence, the claimant testified that he was injured on October 8, 1992, and that he reported his injury to his wife and the employer the day after it occurred. Unlike the present case, we found the claimant's testimony regarding his work injury was generally consistent with the testimony of the witnesses as well as the history he reported to his doctor. Here, we lack the corroboration of the circumstances of injury that were present in Lawrence.

November 19, 1997 Cite as 49 Van Natta 1997 (1997)

In the Matter of the Compensation of
CHERYL A. SHAPLEY, Claimant
WCB Case No. C702827
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Peter O. Hansen, Claimant Attorney
Safeco Legal, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On November 6, 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.

Number 20 on page 3 of the CDA provides:

> "The parties herein stipulate and agree that claimant's right ring finger tuft, right hand abrasion, cervical strain, thoracic strain is ready for closure as claimant has reached medically stationary status. Additionally, the parties agree that based upon the medical report of Dr. Eric Long and treating physician Dr. Wymore that claimant has suffered permanent restrictions in her ability to lift, a loss of repetitive use and a loss of range of motion. The parties agree that her condition is permanent in nature."

We do not interpret this language as closing the claim or granting claimant an award of permanent disability[1]. 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 or possibly, as a measure to ensure claimant's eventual eligibility as a "preferred worker" under the Re-employment Assistance Program. Ronald A. Compton, 49 Van Natta 1530 (1997); Jon T. Strebe, 48 Van Natta 2102 (1996).

Based on this interpretation, 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, (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.

November 19, 1997 Cite as 49 Van Natta 1998 (1997)

In the Matter of the Compensation of
ALEX S. WARDEN, Claimant
WCB Case No. 96-03913
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) declined to consider premature closure and medically stationary date issues because claimant's request for hearing from an Order on Reconsideration was filed untimely; (2) upheld the insurer's denial of claimant's claim for bilateral plantar fascitis; and (3) upheld the insurer's denial of claimant's aggravation claim relating to a compensable electric shock injury. On review, the issues are timeliness of appeal from an Order on Reconsideration, compensability, and aggravation.

We adopt and affirm the ALJ's order, with the following supplementation to address claimant's concerns on review.

At hearing, claimant asserted that his claim had been prematurely closed and that he was not medically stationary on June 15, 1994. The issues of premature claim closure and the correct medically stationary date are issues related to claim closure. In other words, those issues were addressed in the July 21, 1994 Determination Order and the March 30, 1995 Order on Reconsideration. (Exs. 60, 64). In order to have a hearing on those issues, claimant would have had to request a hearing from the Order on Reconsideration.

Claimant had one day after March 30, 1995 to request a hearing on the Order on Reconsideration.[1] Claimant did not request a hearing by March 31, 1995. Therefore, claimant did not timely appeal the Order on Reconsideration, and the premature closure and medically stationary date

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[1] The Order on Reconsideration included the following statement:

"Any party to the claim has the right to request a hearing for a period of 180 days from the date of the Determination Order. The period of time from Jan. 17, 1995 to Mar. 30, 1995 is not included in the 180 days. A hearing request must be sent in writing to the workers' compensation Board, 2250 McGilchrist St. S.E. Salem, Oregon 97310." (Ex. 64-2).

January 16, 1995 was the 179th day after the Determination Order issued. Therefore, claimant had only one day to request a hearing after the Order on Reconsideration issued on March 30, 1995.

issues cannot be considered. In other words, because claimant did not timely appeal the Order on Reconsideration, the order became final by operation of law, making the determinations regarding claim closure and the medically stationary date final as well.

Claimant requested a hearing on April 19, 1996 (received by the Board on April 23, 1996) stating, "I am requesting a comp hearing with the Workers' Compensation Board in regards to my accident which took place 12/14/93." (Administrative Record). If we were to consider claimant's April 1996 letter to be a hearing request from the Order on Reconsideration, we would still have to find that claimant's hearing request was late because it was made long after the time to appeal the Order on Reconsideration had expired. Therefore, the ALJ properly refused to consider the issues of premature closure and medically stationary date.

Claimant asserts that he was not properly represented by his counsel in regard to claim closure and appeal of the Order on Reconsideration. The Workers' Compensation Board cannot consider any matter related to claimant's allegedly improper representation by his attorney. This is a matter that must be raised before a different forum, not the Workers' Compensation Board.

Claimant also objected that the insurer incorrectly sent claimant's file to an attorney who was not representing claimant. In June 1996, the insurer apparently believed that a particular attorney was representing claimant. (See Administrative Record). It properly sent the packet of exhibits for the July 22, 1996 hearing to that attorney. The rules governing hearings before the Hearings Division of the Workers' Compensation Board required the insurer to send hearing exhibits to claimant, or to claimant's counsel if claimant was represented. See OAR 438-005-0046(2)(a); 438-007-0018(1). The insurer acted correctly in June 1996, based on the information it had at that time.

Claimant also expressed concern about whether the documents he submitted became part of the record, and whether those documents were considered in reaching a decision in his case. The ALJ admitted into the record all the documents claimant offered at hearing. (Tr. 49). Those documents were included in the exhibit packet that was sent to the Board when claimant requested review. Consistent with our de novo review of ALJs' decisions, we have reviewed and considered all the documents submitted by claimant, as well as the exhibits submitted by the insurer, prior to making our decision.

Finally, claimant invited the Board to review his claim in its entirety, not just the two issues addressed by the ALJ. Generally, our review is limited to those issues that were raised at the hearing. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991); Gunther H. Jacobi, 41 Van Natta 1031, 1032 (1989); see also Fister v. South Hills Health Care, 149 Or App 214, 218-19 (1997) (Board's own decisions establish the rule that it will consider only issues raised at hearing). We have considered claimant's attempt to raise the issues of premature claim closure and medically stationary date at the hearing. However, as explained above, we agree with the ALJ that those issues cannot be considered - either at hearing or before the Board - because claimant did not timely appeal the Order on Reconsideration. We have also considered the compensability (bilateral plantar fascitis condition) and aggravation issues addressed by the ALJ. Although we have reviewed all the documents and testimony in the record, our decision is limited to the specific issues addressed by the ALJ.

ORDER

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

In the Matter of the Compensation of
MAUREEN E. BRADLEY, Claimant
WCB Case No. 96-03019
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
VavRosky, 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) Hoguet's order that increased claimant's scheduled permanent disability award to 14 percent (21 degrees) for loss of use or function of each forearm, whereas an Order on Reconsideration awarded only 6 percent (9 degrees) scheduled permanent disability for the right forearm and 5 percent (7.5 degrees) scheduled permanent disability for the left forearm. In her respondent's brief, claimant asserts that if we find the ALJ erred in awarding scheduled permanent disability based on her loss of grip strength, we must also address whether the employer's denial of her aggravation claim should be set aside. On review, the issues are extent of scheduled permanent disability and, alternatively, aggravation. We reverse.

FINDINGS OF FACT

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

In September 1994, claimant made a claim for bilateral carpal tunnel syndrome claim arising out of her work as a proof operator for the employer. The claim was accepted and, in November 1994, Dr. Ordonez performed right carpal tunnel release surgery. In May 1995, Dr. Layman became claimant's attending physician.

Dr. Layman performed a closing exam on August 25, 1995 and reported, among other things, impairment related to decreased grip strength, which he graded 4/5 and ascribed to median nerve impairment. The claim was closed by a December 1, 1995 Determination Order, which awarded 14 percent scheduled permanent disability for each forearm (9 percent for loss of strength and 5 percent for a chronic condition).

Both claimant and the employer requested reconsideration. Dr. Brown performed a medical arbiter examination in February 1996. Based on Dr. Brown's findings, a March 14, 1996 Order on Reconsideration reduced claimant's scheduled permanent disability awards to 6 percent for the right forearm and 5 percent for the left forearm.

Claimant returned to Dr. Layman in July 1996 complaining of an exacerbation of her hand symptoms. He filed an aggravation claim on her behalf, which the employer denied on September 6, 1996.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Disability

In awarding 14 percent scheduled permanent disability for each forearm, the ALJ found that a preponderance of the medical opinion established a different level of impairment from that found by the medical arbiter. Specifically, the ALJ found Dr. Layman's opinion concerning claimant's loss of grip strength more persuasive and better documented than those of the medical arbiter.

On review, the employer challenges the ALJ's finding that Dr. Layman's grip strength measurements were "better documented" than the arbiter's and argues that claimant has failed to prove a loss of grip strength related to her accepted carpal tunnel syndrome by a preponderance of the evidence. We agree with the employer.

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. Former

OAR 436-35-007(9) (WCD Admin. Order No. 6-1992). 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).

In this case, we find that the medical arbiter provided the most persuasive opinion addressing claimant's permanent impairment. Although he did not document the specific grip test results (as did Dr. Layman), it is apparent from his report that Dr. Brown tested the muscle power in claimant's hands and fingers. In finding 5/5 muscle power of the shoulders, arms, and all hand muscles, the arbiter specifically noted "there is no weakness of the thenar or intrinsic muscles of the hands." (Ex. 27-3). The arbiter considered these findings to be valid. Because claimant's permanent disability is rated at the time of the March 14, 1996 reconsideration order, Dr. Brown's February 20, 1996 evaluation of claimant's permanent impairment is more probative than that of Dr. Layman, who last measured claimant's grip strength in August 1995, two months prior to his October 16, 1995 closing report.[1]

Aggravation

As noted above, claimant argues that in the event we conclude that claimant is not entitled to an award of scheduled permanent disability for loss of grip strength, we must also address whether she experienced a compensable aggravation.

Pursuant to ORS 656.273(1), claimant must prove an "actual worsening" of her compensable condition "[a]fter the last award or arrangement of compensation." Therefore, in this case, claimant must prove that her compensable condition actually worsened since the last arrangement of compensation, which is the March 1996 Order on Reconsideration. As the court explained in SAIF v. Walker, 145 Or App 294, 305 (1996), rev allowed 325 Or 367 (1997), an "actual worsening" may be established by direct medical evidence of a pathological worsening. 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. Id.

Here, both Dr. Layman and Dr. Denkas have opined that claimant has not suffered from any clinical worsening of her bilateral carpal tunnel syndrome. Both doctors noted that claimant's nerve conduction studies had improved from May 1995 to June 1996, and reported that her symptom presentation in July 1996 represented a "waxing and waning" of her symptoms but no increase in objective pathology. (Exs. 34, 37). In his deposition, Dr. Denkas testified that, although he found some weakness in claimant's right hand in his July 1996 examination, the weakness was likely subjective and not necessarily related to her accepted carpal tunnel syndrome. (Ex. 38).

On this record, we find no persuasive medical evidence of an actual worsening of claimant's bilateral carpal tunnel syndrome after her last arrangement of compensation in March 1996. Consequently, claimant has not proven a compensable aggravation and the employer's denial must stand.

ORDER

The ALJ's order dated April 28, 1997 is reversed in part and affirmed in part. The March 14, 1996 Order on Reconsideration is affirmed. The remainder of the ALJ's order is affirmed.

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[1] A medical arbiter having examined a claimant closer in time to the reconsideration order is not always decisive. See, e.g., Charlene L. Vinci, 47 Van Natta 1919, 1920 (1995) (attending physician more persuasive than medical arbiter). In this case, however, given the six month gap between Dr. Layman's closing examination (in which he found 4/5 grip strength) and Dr. Brown's arbiter examination (finding no weakness), we are persuaded that claimant's grip strength improved between the time she last saw Dr. Layman to the time of the medical arbiter's examination in February 1996. Consequently, we conclude that the medical arbiter's report is more probative on the issue of grip strength. See Kyle L. Ellis, 49 Van Natta 557 (1997).

In the Matter of the Compensation of
LARRY W. BURKE, Claimant
WCB Case Nos. 96-08283, 95-13502, 96-03539 & 96-03937
ORDER ON RECONSIDERATION
Charles L. Lisle, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys
Lane, Powell, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our October 24, 1997 Order on Review that did not award an assessed attorney fee under ORS 656.382(2).[1] Specifically, claimant alleges that although the SAIF Corporation did not challenge the compensability of claimant's condition on review, the compensability issue was potentially at risk by virtue of the Board's de novo review of the ALJ's order, and therefore his attorney is entitled to an assessed fee. Claimant asserts that, under the circumstances of this case, an attorney fee of $1,500 is reasonable.

Both SAIF/Lemax and SAIF/Willamina Lumber submitted responses to claimant's request for reconsideration. SAIF/Willamina took no position regarding claimant's entitlement to an attorney fee on review, but argued that the requested fee should be reduced because, as a practical matter, the compensability issue was not raised on review and was not addressed in the Board's order. SAIF/Lemax similarly argued that, to the extent claimant was theoretically entitled to an attorney fee because compensability was potentially at risk, a reasonable attorney fee should not exceed $500 because the appeal turned on a determination of responsibility only.

For the reasons set forth below, we find that, pursuant to court and Board precedent, claimant is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the potential compensability issue. We further find that a fee of $500 is reasonable in this case.

Relying on cases such as Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252- 53 (1992), mod on recon, 119 Or App 447 (1993) and International Paper Co. v. Riggs, 114 Or App 203 (1992), we have often found that, where both compensability and responsibility are addressed by the ALJ, the compensability of the claimant's condition remains at risk by virtue of the Board's de novo review authority of the ALJ's order, even if responsibility is the only issue addressed in the Board's order. See, e.g., Paul R. Huddleston, 48 Van Natta 4 (1996); Joseph R. Flores, 45 Van Natta 2151 (1993). In such circumstances, we have held that claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by the carrier that is responsible for the claimant's condition. See, e.g., Francisco J. DeLacerda, 49 Van Natta 777 (1997); Charles R. Morgan, 48 Van Natta 841, on recon 48 Van Natta 960 (1996). In this case, because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the potential compensability issue, even though the issue was not argued 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 $500, payable by SAIF/Lemax. We note that claimant's respondent's brief, while providing an excellent discussion regarding the applicable responsibility law, did not address the compensability issue. Consequently, the brief does not represent the time devoted to the compensability issue on review. Rather, in awarding an attorney fee, we have particularly considered the complexity of the compensability issue, the nature of the proceedings, the value of the interest involved, the benefit secured for claimant and the risk that claimant's counsel might go uncompensated.

Finally, claimant is not entitled to an attorney fee for his counsel's services on reconsideration, as the request for reconsideration was limited to the attorney fee issue. See Conrid J. Paxton, 48 Van Natta 1045 (1996).

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[1] Our prior order affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the denial of the SAIF Corporation (on behalf of Lemax General Contractors) of claimant's occupational disease claim for a bilateral hearing loss condition; and (2) upheld the responsibility denials of Liberty Northwest/Snow Mountain Pine, SAIF/Willamina Lumber Company and Liberty Northwest/Willamina Lumber Company for the same condition.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our October 24, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 20, 1997 Cite as 49 Van Natta 2003 (1997)

In the Matter of the Compensation of
KENNETH V. JENNINGS, Claimant
WCB Case No. 97-02183
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that affirmed an Order on Reconsideration awarding 7 percent (10.5 degrees) scheduled permanent disability for the loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability.

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

The employer argues on review that a chronic condition award for loss of repetitive use of the hand is not appropriate where the only accepted condition involves the distal phalanx of the index finger. The employer contends that, absent a separate condition of the hand, an award for loss of use of the hand is inappropriate. We disagree.

Generally, a worker is entitled to a disability rating for permanent impairment that was caused by the compensable injury, including the compensable condition, a consequential condition and direct medical sequelae. OAR 436-035-0007(1). A disability rating is appropriate where loss of use of a particular body part results from a compensable injury, even though the particular body part may not have sustained injury. See Foster v. SAIF, 259 Or 86 (1971); Winfried H. Seidel, 49 Van Natta 1167, on recon 49 Van Natta 1545 (1997); Alvena M. Peterson, 47 Van Natta 1331 (1995).

Here, claimant sustained an injury to the distal phalanx of his left index finger that resulted in loss of sensation in the volar aspect of the index finger. The medical arbiter found that, because of this condition, claimant had sustained some limitation in the ability to repetitively use his left hand.[1] (Ex. 7-5). We find that this medical evidence is sufficient to establish at least partial loss of ability to repetitively use the hand, resulting from claimant's compensable index finger injury. Compare Kim S. Anderson, 48 Van Natta 1876, 1876 (1996) (medical evidence failed to establish inability to repetitively use arm, as distinguished from shoulder). Thus, we agree with the ALJ that claimant is entitled to a chronic condition award for the left hand. OAR 436-035-0010(5)(c).

When there are impairment findings in two or more body parts in an extremity, the impairment findings in the distal body part must be converted to a value in the most proximal body part. OAR 436-035-0007(16). Here, there are impairment findings in the left index finger, as well as in the left hand. Therefore, it is appropriate to convert the impairment findings in the finger to a value in the next most proximal part, the hand. Consequently, we agree with the ALJ that claimant is entitled to 7 percent permanent disability for loss of use or function of the left hand. See OAR 436-035-0070(4); 436-035-0007(14) through (17).

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[1] We agree with the ALJ's determination that impairment should be established by the medical arbiter in this case, because a preponderance of medical opinion does not establish a different level of impairment than established by the medical arbiter. OAR 436-035-0007(13).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 29, 1997 is affirmed. Claimant is awarded an attorney fee of $800 for his counsel's services on review, payable by the self-insured employer.

In the Matter of the Compensation of
DORIS M. MILLER, Claimant
WCB Case No. 97-00624
ORDER ON REVIEW
Bennett, Hartman, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's denial of her injury claim for a left hip fracture. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the third sentence of the second paragraph on page 2, we change the reference to a "semi-public road" to refer to a "public road." In the third paragraph on page 2, we change the last sentence to read: "Unless an employee is known to the personnel office, any employees who elect to go to the personnel office must first show an official name tag before they can receive their paychecks." In the fourth paragraph on page 2, we change the fifth sentence to read: "In November, the plant safety committee was concerned about the width of the corner and the mud that employees tracked into the personnel office, so efforts were begun to correct the difficulty." In the last paragraph on page 2, we add the following sentence after the fifth sentence: "Claimant testified that it was rather dark and hard to see."

CONCLUSIONS OF LAW AND OPINION

Claimant, age 69 at hearing, started working for the employer in 1990. She sustained a left hip fracture on December 27, 1996, when she slipped on her way to the personnel office to obtain her paycheck. Claimant contends that her injury occurred in the course and scope of her employment. For the following reasons, we agree.

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) "arising 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.

We first examine the time, place and circumstances of the injury. 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.[1] Fred Meyer, Inc. v. Hayes, 325 Or 592, 598 (1997). "In the course of" employment also includes a reasonable period of time after work for the worker to leave the employer's premises. Id. Activities that are "reasonably incidental" to employment may include personal activities, such as a telephone call home or a brief visit with a coworker - so long as the conduct bears some reasonable relationship to the employment and is expressly or impliedly allowed by the employer. Id. at 598-99; see generally 2 Larson's Worker's Compensation Law §§ 21.60 to 21.64 (rebound ed 1997).

On the date she was injured, claimant worked a shift from 11:00 p.m. until 7:00 a.m. She had finished her shift and was walking directly to the personnel office to obtain her paycheck. She testified that she fell approximately five to ten minutes after her shift ended. (Tr. 17, 25). Claimant was not paid for her time to pick up her paycheck. Nevertheless, we find that claimant's injury occurred during a reasonable interval after working hours, while she was on the premises engaged in an activity reasonably incidental to work.

Claimant had a legitimate reason for remaining on the employer's premises a few minutes after her shift ended. She went directly to pick up her paycheck and it was her understanding that was the only method by which she could receive her paycheck. (Tr. 19, 22). Claimant's activity in picking up her paycheck was expressly allowed by the employer (Ex. 13, Tr. 46), and it was reasonably incidental to her employment. In addition, her injury occurred during a reasonable interval after work. Considering the short length of the interval after claimant's usual working hours, her legitimate need to remain on the premises and the fact that her activity at the time of injury was reasonably incidental to her employment, we conclude that the timing of her injury occurred in the course of her employment. See Hayes, 325 Or at 598-99; Jackie J. Freeny, 43 Van Natta 1363 (1991).

Next, we consider the place of claimant's injury. There is no dispute that the injury occurred on the employer's premises. Nevertheless, the insurer argues that claimant was not on the actual part of the premises where she performed her work or in an area through which she needed to travel to get to such premises. The insurer does not contend, however, that claimant was injured in a location where she was not authorized to be present. The insurer cites no authority that establishes that an injury is only compensable if it occurs at the exact location where the employee performs his or her work. Because claimant was injured on the employer's premises, we conclude that the place of the injury was in the course of her employment. Compare Barbara M. Lapies, 48 Van Natta 2317 (1996) (employer's office where the claimant was injured was in another location, and was independent from, her work with the copy and duplicating business; employer did not control the area where the claimant fell).

We also conclude that the circumstances of claimant's injury were in the course of her employment. On December 27, 1996, claimant's shift ended at approximately 7:00 a.m. (Tr. 11). She went directly from her job station to the personnel office to get her paycheck. (Tr. 12, 17). She was injured when she slipped and fell on her way to the personnel office. Claimant did not know, and had never been advised, that she could obtain her paycheck by other means, such as direct deposit or through the mail. (Tr. 19, 21-22). She believed she was required to show her identification card at the personnel office to receive her paycheck. (Tr. 22). Claimant's identification card included her photograph and stated, in part: "Paychecks are distributed at the Personnel Office on Friday of each week. This I.D. must be presented before check will be handed out." (Ex. 13). Her routine was to go to the personnel office each Friday, present her identification card and receive her paycheck. (Tr. 22). Claimant understood that Friday was the only day she could obtain her paycheck. (Tr. 18). We conclude that the time, place and circumstances of claimant's injury were "in the course of employment."

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[1] The Court described this 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." Hayes, 325 Or at 599 (quoting 2 Larson's Worker's Compensation Law § 21.60(a) at 5-45 to 5-46; footnotes omitted).

Furthermore, we conclude that claimant's injury "arose" out of her employment. An injury is deemed to "arise out of" employment if the risk of injury results from the nature of the work or the injury "originates from some risk to which the work environment exposes the worker." Hayes, 325 Or at 601 (the claimant's employment exposed her to risk of assault where she was required to park in poorly lit, "fringe" area of employer's parking lot). A claimant need not prove that he or she was exposed to any "peculiar" or "increased" risk by the employment. Id.

After claimant's shift ended on December 27, 1996, she walked directly from one building on the employer's premises to another building where the personnel office was located. She walked on a sidewalk maintained by the employer. Claimant testified that it was "pourin' down rain" and cloudy. (Tr. 18). It was rather dark. The lights on the corner of the building were not bright and it was hard to see because of a tree that made a shadow. (Id.) Claimant was doing a "normal walk" and not rushing, but she was trying to avoid getting wet. (Tr. 12, 18). She testified that when she came around the corner, her left foot went down further than she anticipated and she fell over, landing on her hip and shoulder. (Tr. 12). She explained that there was a "dip" in the cement and her foot went down further than she expected. (Tr. 23).

In an earlier statement to the employer, claimant said that there was a crack in the cement outside the personnel office. (Ex. 6-4). She said that there "was kind of a dip in there, and my foot just turned and then I went on over." (Id.) The cement was not level where she lost her footing. (Id.) At hearing, claimant testified as to the accuracy of her previous statement. (Tr. 65).

Before claimant's injury, the employer had authorized repair of the sidewalk where claimant was injured. A purchase order dated December 4, 1996 was authorized for "sidewalk repair." (Ex. 14). Ms. Hendricks, a member of the employer's health and safety staff, testified that the sidewalk repair was authorized in order to widen the sidewalk and the curve. (Tr. 44, 52-53). Employees were cutting the corners and would occasionally step into the mud. (Tr. 44). Ms. Hendricks felt there was a "wearing away" of the sidewalk and she explained there was a "crumbling away" of part of the expansion joint. (Tr. 53). However, Ms. Hendricks testified that the sidewalk changes were not made because of claimant's fall. (Tr. 43, 53). The sidewalk was repaired on February 18, 1997. (Ex. 14; Tr. 61).

We conclude that claimant's left hip injury resulted from a risk associated with her work environment. The employer maintained the sidewalk where claimant fell. Compare Barbara M. Lapies, 48 Van Natta at 2318 (there was no evidence employer controlled the area where the claimant fell or that it was responsible for cleaning debris). Claimant explained that there was a "dip" in the cement and her foot went down further than she expected and she fell. (Tr. 23). It was raining heavily at the time and it was rather dark and hard to see. (Tr. 18). Under these circumstances, we conclude that claimant's injury originated from a risk to which her work environment exposed her. See Hayes, 325 Or at 601-02.

Because both prongs of the compensability test have been established, we conclude that the relationship between claimant's injury and her employment is sufficient and her left hip fracture 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 27, 1997 is reversed. The insurer's denial of claimant's left hip injury 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 $5,000, payable by the insurer.

In the Matter of the Compensation of
RENA L. ROSE, Claimant
WCB Case No. 96-08552
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that increased claimant's scheduled permanent disability award from 8 percent (12 degrees) for loss of use or function of claimant's right wrist (forearm), as awarded by an Order on Reconsideration, to 12 percent (23.04 degrees) for loss of use or function of claimant's right arm. 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 awarded claimant 12 percent[1] scheduled permanent disability for loss of use or function of claimant's right arm, which included a 5 percent chronic condition impairment award for the right hand/forearm. The insurer challenges only the ALJ's award of 5 percent chronic condition impairment regarding the right hand/forearm. Specifically, the insurer argues that the ALJ erred in combining the opinions of Dr. Pons, attending physician, and Dr. Rand, medical arbiter, to conclude that claimant has a chronic condition impairment regarding her right hand/forearm. We need not address the insurer's argument as to whether a combination of opinions from an attending physician and a medical arbiter may satisfy claimant's burden of proof, because we find that the opinions of Drs. Pons and Rand do not establish entitlement to a chronic condition impairment, whether those opinions are considered separately or in combination.

The extent of scheduled permanent disability is evaluated as of the date of the Order on Reconsideration, applying the standards effective as of the date of the Determination Order or Notice of Closure. ORS 656.283(7); 656.295(5); OAR 436-035-0003(2). Here, the claim was closed by a June 24, 1996 Notice of Closure. Therefore, the applicable standards are found at WCD Admin. Order 96-051.

Claimant has the burden of proving the extent of her permanent disability. ORS 656.266. ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." Furthermore, with the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure or other physicians with whom the attending physician agrees. ORS 656.245(2)(b)(B); Roseburg Forest Products v. Owen, 129 Or App 442 (1995); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994); Dennis E. Conner, 43 Van Natta 2799 (1991).

Former OAR 436-035-0010 provides, in relevant part:

> "(5) 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:
>
> "* * * * *

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[1] In reaching this total, the ALJ converted the right hand/forearm impairment values for loss of range of motion (4 percent) and chronic condition (5 percent) to a right "arm" value of 8 percent, which he combined with the right "arm" value for loss of range of motion (4 percent) for a total scheduled permanent disability award for loss of use or function of the right "arm" of 12 percent. OAR 436-035-0090.

"(c) Forearm (below elbow/hand/wrist)[.]"

Responding to a question regarding whether claimant was significantly limited in the ability to repetitively use the hand, wrist/forearm due to a chronic condition resulting from the accepted condition of right carpal tunnel syndrome, Dr. Rand stated that "claimant may have some difficulty in repetitive use of her hand, particularly more forceful repetitive use or grasp, or motions requiring prolonged flexion of her wrist, in performance of her duties, due to the diagnosed accepted condition of right carpal tunnel syndrome." (Ex. 18-4) (emphasis added).

However, because Dr. Rand's opinion is stated in terms of possibility, rather than medical probability, and because his opinion is not couched in terms indicating a significant limitation, we do not find his opinion persuasive evidence that claimant "is significantly limited" in the repetitive use of her right hand/wrist. Gormley v. SAIF, 52 Or App 1055 (1981); Boyd K. Belden, 49 Van Natta 59, 63 (1997).

Furthermore, in his closing exam, Dr. Pons stated: "I feel [claimant] has no disability related to her carpal tunnels. I would certainly advise that she continue wearing her splints if she uses her hands in any repetitive manner." (Ex. 13-2). Dr. Pons' recommendation of continued use of splints with repetitive use, without more, does not establish that claimant is significantly limited in the repetitive use of her right hand/wrist. In this regard, Dr. Pons' does not explain the reason for this recommendation. We have previously held that a restriction on repetitive use to prevent reinjury or an increase in symptoms does not constitute persuasive evidence of a chronic condition impairment. See David A. Kamp, 46 Van Natta 389, 390 (1994) (work limitations were imposed to avoid likelihood of reinjury; no other medical evidence established that claimant had partially lost his ability to use his neck and right shoulder repetitively); Kathleen L. Hofrichter, 45 Van Natta 2368, 2369 (1993), aff'd mem Hofrichter v. Hazelwood Farms Bakeries, 129 Or App 304 (1994) (physician's recommendation that claimant avoid certain motions at work in order to prevent an increase in symptoms was insufficient to establish permanent and chronic impairment of the back).

We recognize that the use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986); Austin v. SAIF, 48 Or App 7 (1980). However, given the problems with the opinions of Drs. Rand and Pons, as discussed above, we do not find that those opinions, alone or in combination, satisfy claimant's burden of proof. Accordingly, we find that claimant has failed to establish entitlement to a chronic condition award. Therefore, claimant's impairment is limited to her loss of range of motion, which results in 8 percent scheduled permanent disability for loss of use or function of the right arm.

Inasmuch as claimant's compensation has been reduced on review, she is not entitled to an attorney fee pursuant to ORS 656.382(2).

ORDER

The ALJ's April 30, 1997 order, as supplemented on May 1, 1997, is modified. In lieu of the ALJ's and Order on Reconsideration's scheduled permanent disability awards, claimant is awarded 8 percent (15.36 degrees) scheduled permanent disability for loss of use or function of the right arm. Claimant's attorney fee shall be adjusted accordingly.

In the Matter of the Compensation of
BRIAN K. LUTZ, Claimant
Own Motion No. 94-0392M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant, pro se, requests review of the insurer's May 6, 1997 Notice of Closure which closed his claim without an award of temporary disability compensation. The insurer declared claimant medically stationary as of May 5, 1997. Claimant appears to contend that he is entitled to additional benefits as he plans to have hernia repair surgery in the future.

Pursuant to OAR 438-012-0060(1), claimant had 60 days from the mailing date of the insurer's Notice of Closure in which to filed a request for review, or 180 days from that mailing dated if he could establish "good cause" for failing to file the request within 60 days. Here, the 60th day after the mailing date of insurer's May 6, 1997 Notice of Closure was July 7, 1997. Claimant's request for review, dated, September 18, 1997, was received by the Board on October 8, 1997. Consequently, claimant's request for review is untimely unless good cause is established.

In his request for review, claimant indicated that in late April 1997, he left for a 16 week sabbatical throughout Canada and Alaska. He further indicated that he just recently returned prior to the date of his September 16, 1997 letter. Claimant's assertion is unrebutted. Inasmuch the Notice of Closure issued on May 6, 1997, it appears that it was sent while claimant was in Canada and Alaska and the 60-day period ran while claimant remained out-of-state. Under these circumstances, we find that claimant has established good cause for his failure to appeal the May 6, 1997 Notice of Closure within 60 days. We now proceed to the merits.

Pursuant to OAR 438-012-0055, claims reopened pursuant to ORS 656.278 may be closed either when medical reports indicate to the insurer that claimant's condition has become medically stationary or when a Claims Disposition Agreement (CDA) has been approved by the Board in which claimant releases his right to further payment of temporary disability compensation.

Here, the most recent medical evidence is an October 18, 1995 report from Dr. Sheppard, which indicates that claimant was not medically stationary. There is no further medical evidence which suggests that claimant became medically stationary. It appears from the insurer's April 21, 1997 letter, that the May 6, 1997 Notice of Closure was based on claimant's failure to seek medical treatment. While the Department does have rules that allow such closure under ORS 656.268, there are no similar provisions for closure of an Own Motion claim pursuant to ORS 656.278. See OAR 436-030-0020(3)(b). Rather, as noted, claim closure of a claim reopened under ORS 656.278 can only occur when a claimant is medically stationary or when a CDA extinguishes a claimant's right to further temporary disability compensation.[1]

On this record, there is no evidence which suggests that claimant's condition was medically stationary as of May 6, 1997, the date the insurer issued its Notice of Closure. Consequently, we find that claim closure was premature and set aside the insurer's May 5, 1997 Notice of Closure. Claimant's claim is to remain open until claim closure is appropriate under OAR 438-012-0055. In reaching this conclusion, we note that the May 6, 1997 Notice of Closure did not award temporary disability benefits. Claimant does not contest this portion of the Notice of Closure. Therefore, this order does not require the insurer to immediately commence the payment of temporary disability benefits. However, claimant does assert that he plans to undergo surgery . If claimant is hospitalized or undergoes surgery while this claim remains open, payment of temporary disability benefits is authorized from the date of the hospitalization/surgery to continue until such benefits can be lawfully terminated.

IT IS SO ORDERED.

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[1] There has been no CDA filed with or approved by the Board with regard to this claim.

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

On October 20, 1997, we abated our September 18, 1997 Order on Reconsideration in which we denied the self-insured employer's request for en banc review and adhered to our previous decision setting aside the employer's current condition denial. We took this action to consider the employer's renewed request for en banc review. Having received claimant's response, we proceed with our reconsideration.

The employer directed its request for reconsideration/en banc review to Board Chair Hall, who did not participate in review of this case, asking him to "personally direct" that the Board review this case en banc. In response, we emphasize that the act or decision of any two members shall be deemed the act or decision of the Board. ORS 656.718(3); Brian W. Andrews, 48 Van Natta 2532 (1996). There is no statutory or case law authority that gives a member who did not participate in review of a case the power to "personally direct" en banc review. Whether a case is reviewed en banc is a matter solely within our own discretion. E.g., Ralph L. Witt, 45 Van Natta 449 (1993).

As explained in the decision cited in our first reconsideration order, Andrew D. Kirkpatrick, 48 Van Natta 1789 (1996), each case which is subject to the Board's review undergoes an appraisal regarding whether the dispute presents a potentially significant issue. This case was no exception and was determined by the reviewing members of the panel not to satisfy the criteria for potential significance. Claimant's subsequent requests for en banc review do not automatically require the participation of the entire Board membership. To the contrary, a decision of a panel shall be by a majority of the panel. ORS 656.718(3). In this particular case, that majority has rejected, and continues to reject, claimant's request for en banc review for the reason previously expressed.[1]

Claimant's attorney is entitled to an assessed fee for services on reconsideration. ORS 656.382(2). This award is in addition to the award granted for claimant's counsel's prior services at hearing and 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 the second reconsideration is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to the employer's motion for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as modified herein, we republish our July 18, 1997 order, as reconsidered on September 18, 1997. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] The employer asserts that our decision will have a widespread impact on the workers' compensation system and requires disavowal of prior Board case law. We disagree. First, our decision is in accordance with our decision in Katherine A. Wood, 48 Van Natta 2196 (1996). Second, this decision is limited to this limited set of facts where the current condition is the same as the one previously denied and later judged to be compensable. Moreover, given our alternative finding that, even if the employer was not precluded from denying claimant's current condition, claimant has sustained her burden of proof, we specifically reject the employer's evaluation of the significance of this case.

In the Matter of the Compensation of
ROB R. HARTLEY, Claimant
WCB Case No. 97-01468
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Bock and Moller.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Schultz' order that set aside its denial of claimant's left knee injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On December 30, 1996, claimant worked for the employer setting up bleachers in Portland's Memorial Coliseum. Claimant felt a "twinge" in his left knee while he was exerting pressure against the bleachers with his legs and back. He proceeded to repair chairs around the perimeter of the basketball court.

Some of claimant's co-workers were shooting baskets on the court and a loose basketball bounced toward claimant. He picked it up and took a set shot at the basket from about the "three point" line. The ball bounced off the rim and came back to claimant. He dribbled the ball toward the basket, attempted a lay-in shot, and his left knee gave way completely.

Surgery was performed that evening to repair claimant's ruptured left patellar tendon.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant credibly testified that his left knee injury occurred while he was working, rather than while he was shooting the basketball. Further finding that Dr. Graham had an accurate history regarding claimant's activities at the time of injury, the ALJ concluded that the claim was compensable, based on Dr. Graham's opinion. We disagree.

Dr. Graham, treating surgeon, opined that claimant sustained a partial tendon tear while pushing against the bleacher section and a complete tear while shooting the basketball. (Ex. 12-1). He indicated that the bleacher incident was the primary cause of claimant's ruptured tendon "provided that events occurred as described by [claimant]." (Ex. 12-2).

The central issue in this case is the accuracy and reliability of claimant's reporting to Dr. Graham. The ALJ found claimant to be a credible witness based on his demeanor. We generally defer to the ALJ's demeanor-based credibility finding. See International Paper Co. v. McElroy, 101 Or App 61 (1990). However, we are in as good a position as the ALJ to evaluate the credibility of a witness based on an objective review of the substance of the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Davies v. Hanel Lumber Co., 67 Or App 35 (1984); Timothy D. McCune, 47 Van Natta 438 (1995). Inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible. See Gail A. Albro, 48 Van Natta 41, 42 (1996); Angelo L. Radich, 45 Van Natta 45 (1993). Where a claimant's reporting is inconsistent or incomplete, a medical opinion based on that reporting is unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) ("[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."); James D. Shirk, 41 Van Natta 90, 93 (1989) (A physician's opinion based on a patient's history is only as reliable as the history is accurate).

Claimant testified that his left knee "exploded" under him when he attempted the lay-in shot on December 30, 1996. (Tr. 17). Yet, he apparently did not mention the basketball incident to Dr. Graham for over a month. (See Exs. 3A, 5, 10; see also Ex. 4). To the contrary, claimant initially attributed his knee "give-way" to the bleacher incident alone. (Ex. 3A). When claimant did tell Dr. Graham how and

when his knee gave way, Dr. Graham understood that claimant had "simply tossed the basketball up with [] a slight jump[,]" a relatively insignificant move.[1] (Exs. 10, 12). Moreover, we note that Dr. Graham mistakenly believed that the bleacher incident caused pain and swelling, and that claimant was unable to straighten his knee after pushing against the bleacher, whereas the remainder of the record indicates that claimant's knee swelled after the basketball incident, not before. (See Exs. 3A, 5-1).

Under these circumstances, we cannot say that Dr. Graham had an accurate history regarding the onset of claimant's left knee symptoms or the relationship between claimant's activities and his symptoms on December 30, 1996. Consequently, we decline to rely on Dr. Graham's causation opinion and conclude that the claim must fail for lack of persuasive medical evidence.

ORDER

The ALJ's order dated June 3, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[1] We further note the inconsistency between Dr. Graham's impression (based on claimant's reporting) that claimant made a "slight jump" before his left knee collapsed, and his later impression (based on claimant's attorney's representation) that claimant's feet never left the floor. (Compare Exs. 10, 11-1). These discrepancies raise little doubt standing alone. However, when considered along with claimant's failure to report the basketball incident to Dr. Graham (or to Dr. Fahey, emergency room physician), we cannot say that the medical opinions are based on complete and accurate histories. See Somers v. SAIF, 77 Or App 259 (1986).

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

On November 13, 1997, we issued an Order on Remand that set aside the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome condition. Noting that our decision issued prior to the expiration of the supplemental briefing schedule and announcing that the parties have resolved their dispute, the employer seeks abatement of our decision to await the submission of an executed agreement.

In light of the employer's announcement, we withdraw our November 13, 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 fully apprised of any future developments regarding this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAUL D. JOHANSEN, Claimant
WCB Case No. 96-05209
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order that: (1) awarded temporary disability benefits beginning May 9, 1995 until termination was allowed by law; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recite the relevant facts.

Claimant sustained a compensable injury on October 19, 1993. The claim was accepted by SAIF as a nondisabling acute low back strain. Claimant did not contest that classification.

Claimant continued to experience low back pain and in May 1994, a disc herniation at L4-5 was discovered. On May 9, 1995, Dr. Martinson reported that claimant had slight increased low back pain since foot surgery six weeks previously. Dr. Martinson stated that claimant's foot had been in a cast and that claimant had significant foot pain. Claimant was not medically stationary and permanent impairment was undetermined. Dr. Martinson released claimant for modified work from May 9, 1995 to May 25, 1995, which was to consist of sedentary desk work only. (Exs. 27; 28).

On June 13, 1995, more than one year after claimant's October 1993 injury, claimant's attorney wrote SAIF stating, in part: "The SAIF Notice of Claim Acceptance issued November 9, 1993 only provides for SAIF's acceptance of a condition identified as 'Acute Low Back Strain.' At this time, [claimant] makes additional claim for his herniated nucleus pulposus at L4-5. Please respond at your earliest convenience." On August 24, 1995, SAIF accepted the L4-5 disc herniation as part of the 1993 claim.

Claimant requested a hearing seeking temporary disability benefits. At hearing, claimant sought temporary disability for periods in 1993 and 1994. Claimant also sought temporary disability beginning in May 1995. The ALJ found that claimant was not entitled to temporary disability before May 1995 because his claim then remained in nondisabling status. Claimant does not challenge this portion of the ALJ's opinion.

However, the ALJ found that on May 9, 1995, Dr. Martinson authorized temporary disability as a result of claimant's L4-5 herniated disc, which was subsequently accepted by SAIF as part of the 1993 injury claim. The ALJ found that SAIF did not comply with ORS 656.262(6)(b)(B) when it accepted claimant's "new medical condition claim" but did not specify whether the claim was disabling or nondisabling. The ALJ concluded that claimant was entitled to temporary disability from May 9, 1995 until termination was allowed by law. The ALJ also assessed a penalty for SAIF's failure to comply with ORS 656.262(6)(b)(B).

On review, SAIF contends that by requesting temporary disability benefits, claimant is asserting that his 1993 nondisabling injury has become disabling and that under ORS 656.277, because more than one year has passed since the date of injury, claimant's claim for reclassification must be made pursuant to ORS 656.273 as an aggravation claim. SAIF asserts that no claim for an aggravation was made and that the claim should remain in nondisabling status. Because the injury remains nondisabling, SAIF argues that it is not currently required to pay temporary disability benefits in the claim.

Claimant argues that when SAIF accepted his "new medical condition claim" for an L4-5 disc herniation pursuant to ORS 656.262(7)(a), SAIF was obligated to include the information in its acceptance required by ORS 656.262(6)(b)(A) through (E),[1] including advising claimant whether the claim was considered disabling or nondisabling. For the following reasons, we agree with SAIF that in order to receive temporary disability benefits in his nondisabling injury claim, claimant's claim must be brought as a claim for aggravation.

Under ORS 656.277(2): "A claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation." (Emphasis added). ORS 656.277 refers to the "date of injury."

Since claimant is seeking temporary disability benefits for the 1993 nondisabling injury, he is essentially asserting that his nondisabling injury has become disabling. Because more than one year has passed since the date of injury, in order to have the claim reclassified, claimant must establish an aggravation claim under ORS 656.273. ORS 656.277(2).

Contrary to claimant's arguments, ORS 656.262(7)(a) contains no requirement that the 1993 injury claim be reclassified upon acceptance of a new medical condition stemming from that injury.[2] Rather, ORS 656.262(7)(a) pertains to the amendment of an existing notice of acceptance to include a new medical condition. The statute does not pertain to entitlement to benefits.[3] We conclude that the initial 1993 injury claim was accepted as a nondisabling injury and remains so unless claimant seeks reclassification under the procedures set out in ORS 656.277.

In reaching this conclusion, we find amended ORS 656.262(7)(c) to be inapplicable to this claim. That statute provides in pertinent part: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." (Emphasis added).

According to ORS 656.262(7)(c), if a new condition is accepted after claim closure, the insurer is required to reopen the claim for processing of the newly accepted condition. The statute is directed at claims that have been "closed," in other words, disabling claims. Here, however, the claim was not previously closed because it was nondisabling. Thus, by its terms, the statute is not applicable.

We now turn to the question of whether Dr. Martinson's May 9, 1995 chart note constitutes an aggravation claim. We conclude that it does not. A claim for an aggravation is established by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury. ORS 656.273(3).[4]

To establish an entitlement to procedural temporary disability under ORS 656.273(6), the employer must receive notice or knowledge of a medically verified inability to work resulting from a compensable worsening pursuant to ORS 656.273(1).

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[1] Since the parties briefed this case, the 1997 legislature has added a new subsection, subsection (F), to ORS 656.262(6)(b).

[2] Were we to interpret ORS 656.262(7)(a) as requiring a carrier to classify a new condition stemming from a previously accepted and classified claim, we would be circumventing ORS 656.277. There is no indication that the legislature intended that ORS 656.262(7)(a) be used as an alternative means to obtain reclassification of a claim. Claimant argues that the claim for an L4-5 condition is "unclassified." To the contrary, the L4-5 condition has been accepted as part of the 1993 claim which is classified as nondisabling until such time as claimant obtains reclassification of the claim under ORS 656.277.

[3] In this regard, an improper amendment to an existing notice of acceptance might give rise to a penalty under ORS 656.262(11).

[4] Amended ORS 656.273(3) also requires that an aggravation claim be made in a form and format prescribed by the director. However, where, as here, the aggravation claim was filed prior to the enactment of amended ORS 656.273(3) and before the existence of the Director's aggravation claim filing form, we have declined to retroactively apply the form requirement. Rick A. Webb, 47 Van Natta 1550 (1995).

Here, Dr. Martinson's May 9, 1995 report states that claimant reported a "slight increased low back pain especially since his foot surgery." Claimant "continued" to have tenderness in his paravertebral muscles and was unable to perform range of motion secondary to his need for partial weight-bearing only.[5] We are not persuaded that a slight increase in pain with tenderness in the paravertebral muscles constitutes prima facie evidence of an actual worsening attributable to the compensable injury. See SAIF v. Walker, 145 Or App 294 (1996) (The "actual worsening" standard of ORS 656.273 requires evidence that the condition has pathologically worsened). Under such circumstances, we find that the May 9, 1995 medical report is not a claim for an aggravation and is insufficient to trigger the payment of interim compensation.

We emphasize that claimant has a means of obtaining reclassification of his claim under ORS 656.277. Thus, we are not holding that claimant may not obtain reclassification or that his claim is not disabling. However, the exclusive statutory means of obtaining reclassification is through ORS 656.277. Because the claim remains nondisabling, there is no requirement at this time that temporary disability be paid. To hold otherwise would circumvent the statutory procedure for reclassification set out in ORS 656.277. Once claimant files an aggravation claim in accordance with ORS 656.273, interim compensation would be payable under ORS 656.273(6) no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the compensable worsening. If claimant establishes an aggravation of his 1993 injury, his claim would then be considered disabling. See Jean B. Rogers, 48 Van Natta 1307 (1996) (acceptance of an aggravation claim made pursuant to ORS 656.277(2) constitutes a determination that the aggravation claim is disabling).

Because we have concluded that SAIF is not required to pay temporary disability until claimant obtains reclassification of his claim, we reverse the ALJ's award of a penalty pursuant to ORS 656.262(11).

ORDER

The ALJ's order dated September 23, 1996 is reversed.

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[5] Although a decrease in range of motion can be an objective finding under ORS 656.005(19), the inability to perform range of motion is attributable to claimant's foot condition which is not part of the accepted claim.

Board Chair Hall and Board Member Biehl dissenting.

We believe that "new medical condition" claims are a new type of "claim" which are to be processed in the same manner as any other new claim. Consequently, we believe that the filing of a "new medical condition" claim triggers the carrier's duty to pay interim compensation and to issue a notice of acceptance that classifies the "new medical condition" claim as disabling or nondisabling. Because we disagree with the majority's analysis, we offer this dissent.

ORS 656.262(7)(a)[1] creates a new type of claim, a "new medical condition" claim. A new medical condition claim is a "claim" within the meaning of ORS 656.005(6) and ORS 656.262(6). In addition, under the unambiguous terms of ORS 656.262(7)(a), a "new medical condition" claim is separate and distinct from an "aggravation" claim. Indeed, the statute sets forth separate and distinct claim filing requirements for "new medical condition" claims which, unlike aggravation claims, may be initiated "at any time."

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

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." (Emphasis added).

A "claim" is defined by ORS 656.005(6) as a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge. ORS 656.003 provides that: [e]xcept where the context otherwise requires, the definitions given in this chapter govern its construction." ORS 656.003 calls for the use of the definitions given in ORS chapter 656, unless:

> "the context - - including the structure and purpose of the workers' compensation scheme as a whole - - demonstrates that the use of that given definition would be inappropriate, because the result of such use would conflict with one or more aspects of that structure or purpose." Astleford v. SAIF, 319 Or 225, 233 (1994); see also SAIF v. Allen, 320 Or 192, 203 (1994).

Here, we find nothing in the context of ORS 656.262(7)(a) that requires that we apply a definition of the term "claim" that is different from the definition specified by ORS 656.005(6). That "new medical condition" claims are to be processed in the manner of other new claims is further supported by the language of ORS 656.262(7)(a) which requires the insurer to provide "written notice of acceptance or denial" of the claim within 90 days of the insurer's receipt of the claim. See ORS 656.262(6)(a) (which also requires the insurer to provide written notice of acceptance or denial of an initial claim within 90 days).

Based on the text and context of ORS 656.262(7)(a), we are persuaded that the general definition of a "claim" in ORS 656.005(6) is applicable to new medical condition claims in ORS 656.262(7)(a), and that the requirements of ORS 656.262(6) for processing "claims" apply equally to claims for "new medical conditions." Thus, it follows that when a new medical condition claim is accepted under ORS 656.262(7)(a), the notice of acceptance must meet all of the requirements for a claim acceptance set out in ORS 656.262(6)(b), including advising the claimant whether the claim is considered disabling or nondisabling. ORS 656.262(6)(b)(B). Moreover, like any other new claim, the filing of a new medical condition claim would trigger the payment of interim compensation under ORS 656.262(4)(a).[2]

The majority of the Board concludes that claimant is, in essence, reclassifying the 1993 claim as disabling and that such a claim must be made as a claim for aggravation pursuant to ORS 656.277. We respectfully disagree. Contrary to the majority's conclusions regarding "reclassification," this case involves the initial acceptance and processing of a "new medical condition claim" on its own merits. Thus, ORS 656.277 is inapplicable because it pertains to reclassification, whereas the present case involves not reclassification, but the initial classification of a newly accepted new medical condition claim. Further, ORS 656.262(7)(a) provides that a "new medical condition" claim may be initiated "at any time." The reclassification of nondisabling injuries, on the other hand, is provided for in ORS 656.277 with separate time parameters and procedures, including a link to ORS 656.273 aggravation claims. The reclassification of nondisabling injuries is not statutorily linked to the filing of "new medical condition" claims. Because an aggravation claim is a different type of claim, ORS 656.273 is inapplicable to a "new medical condition" claim. Accordingly, we reject the conclusion that claimant must establish an "aggravation" of the originally accepted condition in order to process a "new medical condition" claim.

Because we believe that claimant's new medical condition claim should be processed in the same manner as any other new claim, and because we believe that procedural temporary disability benefits should be paid, we respectfully dissent from the majority's decision.

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[2] That statute provides, in part: "The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation."

In the Matter of the Compensation of
TIMOTHY A. RAGLAND, Claimant
WCB Case No. 96-06463
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact through page 2.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of relevant facts.

Claimant worked for the employer at its lumber mill for about six years before the investigation and two-day suspension leading to this claim.

In 1992, claimant was diagnosed as suffering from Post Traumatic Stress Disorder (PTSD) as a result of an off-work hunting accident and its sequelae.

When claimant reported for work on April 2, 1996, he was interviewed by an investigator concerning drug use, buying, and selling at the employer's plant. (See Ex. 20). Claimant was one of about 20 employees who were interviewed and suspended from working as part of the investigation. Claimant missed two work shifts before he was reinstated with pay for lost work time. (He was one of three employees who were not terminated as a result of the investigation).

Claimant felt stressed, anxious, nauseous, shaky, and faint during and after the interview and suspension. He felt as though all the bad things in his life came together all at once.[1] (Tr. 78, 80, 88-91).

Claimant sought treatment from Mr. De Smet, a psychologist who had been providing marriage counseling for claimant and his wife for two or three weeks before the work incident. He began treating with Dr. Fiallos, psychiatrist, on April 22, 1996.

The ALJ upheld the employer's denial of claimant's claim for a psychological condition (acute stress disorder or PTSD), reasoning that claimant failed to establish that he has a mental or emotional disorder that is generally recognized in the medical or psychological community.[2] ORS 656.802(3)(c). We reach the same result, based on the following reasoning.

Claimant bears the burden of establishing, among other things, that work conditions not otherwise statutorily excluded were the major contributing cause of his psychological condition. ORS 656.802(2)(a) and (3). There must be clear and convincing evidence that the condition arose out of and in the course of employment. ORS 656.802(3)(d). Considering claimant's prior PTSD condition (and its contribution to his current problems), we find that the causation issue is a complex medical question which must be resolved by medical evidence. See Uris v. Compensation Department, 247 Or 420 (1967).

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[1] Claimant felt humiliated by the investigation and suspected that his co-workers thought he was a "snitch." He also feared that relatives of the hunting accident victim would "jump" him. (See Tr. 80-81).

[2] We need not determine whether claimant's diagnosis is "generally recognized" under the statute because, even it is, we find the medical evidence insufficient to carry claimant's burden.

The medical evidence regarding causation is provided by Dr. Fiallos, treating psychiatrist.[3] Dr. Fiallos initially found that claimant's psychological problem had "been brought on by what he claims to be a wrongful suspension from his duties. This action precipitated the development of his present condition since he already had a predisposing factor of a very traumatic experience in his life which occurred around three years prior." (Ex. 6) (emphasis added).

On July 12, 1996, Dr. Fiallos stated that he had "made it very clear that [claimant] is suffering from an Acute Stress Disorder which was brought on as a direct consequence of the manner in which certain situations were dealt with by [the employer]. . . .Due to his previous unfortunate life experience and the most recent incident at the plant he has been left quite vulnerable emotionally." (Ex. 9) (emphasis added).

On September 3, 1996, Dr. Fiallos wrote that the work events "precipitated" claimant's emotional disorder. (Ex. 14-1). On November 26, 1996, Dr. Fiallos opined:

> "I am [] aware that [claimant] had been diagnosed in the past with Post Traumatic Stress Disorder. However, it is my opinion that the precipitating event which caused [claimant's] decompensation and need for treatment was the incident which occurred at his place of employment and, of these two conditions, it is the latter which I consider to be the major contributing cause of his Acute Stress Disorder and exacerbation of his Post Traumatic Stress Disorder." (Ex. 17-1) (emphasis added).

Dr. Fiallos repeatedly referred to the work incident as the event precipitating claimant's current problems. Although he acknowledged claimant's previous unfortunate life experience as a "predisposing factor," Dr. Fiallos nonetheless concluded that the work incident was the major contributing cause of claimant's current problems, without further explanation. In our view, Dr. Fiallos' ultimate opinion is insufficient to carry claimant's burden because it fails to adequately weigh claimant's noncompensable predisposition even though it is identified as a contributor. See McGarrah v. SAIF, 296 Or 145, 166 (1983) ("[T]he worker must prove that employment conditions, when compared to non-employment conditions, were the 'major contributing cause' of the mental disorder.") (emphasis added). Under these circumstances, we cannot say that clear and convincing evidence establishes that claimant's current condition arose out of and in the course of employment. ORS 656.802(3)(d). Consequently, the claim must fail.

ORDER

The ALJ's order dated April 16, 1997 is affirmed.

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[3] We also note that psychologist De Smet commented on April 19, 1996 that the claimed work events "precipitated and aggravated a severe emotional/psychological trauma that [claimant] experienced a few years ago." (Ex. 3A).

In the Matter of the Compensation of
VERONICA M. STRACKBEIN, Claimant
WCB Case No. 96-08239
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Galton's order that set aside its denial of claimant's injury claim for post-concussive syndrome (PCS). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On September 3, 1985, claimant was compensably injured in a motor vehicle accident (MVA), an injury that SAIF accepted as a cervical and lumbar strain. (Ex. 30). The claim was initially closed on April 27, 1987 by Determination Order that awarded no permanent disability. However, a September 22, 1987 stipulation awarded claimant 15 percent unscheduled permanent disability. (Ex. 64).

Claimant consulted Dr. Mirka, a neuro-otologist, in May 1987 for symptoms of dizziness and imbalance. Dr. Mirka diagnosed a probable inner ear concussion syndrome. (Ex. 57). After experiencing cognitive, memory and concentration difficulties, claimant sought treatment in May 1990 from a neuropsychiatrist, Dr. Erickson, who diagnosed an adjustment reaction with anxiety and depression; moderate impairment of recent memory and new learning; and cannabis dependence. (Ex. 81). Dr. Erickson attributed claimant's cognitive and memory deficits to a post-concussive syndrome (PCS) related to the 1985 MVA. (Ex. 86A).

In the meantime, the claim had been reopened in November 1989. It was reclosed in August 1990 by Determination Order that awarded only temporary disability. (Ex. 85). That closure was set aside in October 1992 by a prior ALJ who held that the inner ear concussion syndrome and adjustment reaction with anxiety and depression were compensable components of the 1985 claim. (Ex. 107). The prior ALJ, however, found that any visual dependence, memory loss, concentration or cognitive difficulties related to marijuana use and/or noncompensable psychological conditions were not compensable aspects of the claim. (Ex. 107-13). In addition, the prior ALJ found several ear disorders (perilymph fistual, endolymphatic hydrops, BPPN/BPPV, tinnitus) were not compensable components of the claim. The prior ALJ's order was not appealed and became final.

In October 1992, an osteopath, Dr. Tobin, became claimant's attending physician. Dr. Tobin began aggressive osteopathic manipulation of claimant's cranium for a closed head injury related to the September 1985 MVA. (Ex. 108B). The claim was eventually reclosed by Determination Order on November 16, 1995 with no award of permanent disability. Claimant requested reconsideration for which a panel of medical arbiters was appointed. On April 2, 1996, an Order on Reconsideration issued affirming the Determination Order. (Ex. 128). Claimant requested a hearing seeking an award of permanent total disability (PTD). (WCB # 96-03694).

On May 17, 1996, claimant requested that SAIF accept claimant's PCS diagnosed by Dr. Tobin. (Ex. 128A). SAIF denied the condition on August 15, 1996 on the grounds that claimant did not have the alleged PCS condition, but that, if she did, it was not due to the compensable 1985 injury. (Ex. 130). Claimant requested a hearing from the denial. (WCB # 96-08239). Subsequently, in a September 9, 1996 order in WCB # 96-03694, ALJ Herman awarded claimant permanent total disability (PTD). (Ex. 131).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial of claimant's alleged PCS. In doing so, the ALJ found that SAIF's denial was a denial of a condition previously determined compensable by the prior ALJ in 1992 and of a condition which was a basis for claimant's PTD award in WCB # 96-03694. Alternatively, the ALJ concluded that, on the merits, the compensable 1985 MVA was the major contributing cause of claimant's PCS.

On review, SAIF requests that we take administrative notice of our order in WCB # 96-03694 in which we reversed ALJ Herman's order finding claimant to be PTD and in which we determined that claimant's current disability, including symptoms allegedly due to PCS, were not related to the compensable 1985 injury. SAIF asserts that our order in that case requires reversal of ALJ Galton's order in this case. For the following reasons, we agree.

To begin, we may take administrative notice of our own orders. Groshong v. Montgomery Ward Co., 73 Or App 103 (1985); Lloyd G. Crowley, 43 Van Natta 1416 (1991). Therefore, we grant SAIF's request that we take administrative notice of our order in WCB # 96-03694. Veronica M. Strackbein, 49 Van Natta 880, on recon 49 Van Natta 1511 (1997). In that case we stated:

> "Inasmuch as claimant's current claim for permanent total disability is based on a post-concussion syndrome due to an alleged head injury, and because we are not persuaded that the symptoms allegedly related to that condition are "due to" the compensable injury, we do not find that claimant's disability is related to the compensable injury." 49 Van Natta at 883 n. 3.

On reconsideration, we adhered to our previous conclusion that claimant's current disability, including the alleged PCS condition, was not related to her compensable 1985 injury. 49 Van Natta at 1512. Therefore, we agree with SAIF that our decision in WCB # 96-03694 creates new "law of the case," which includes our determination that claimant's PCS is not related to claimant's compensable 1985 injury.

Claimant contends, however, that it would be inappropriate to determine the compensability of her PCS condition in the context of the extent of disability hearing with its more limited record. Claimant's contention notwithstanding, our review in WCB # 96-03694 preceded our review in this case. We agree with SAIF that, had our order in WCB # 96-03694 become final prior to our review in this case, there would be no question that it would constitute the "law of the case." Moreover, ALJ Galton agreed with the reasoning in ALJ Herman's order in finding claimant's PCS to be compensable. Under such circumstances, we do not find it inappropriate to rely on our order in that case in reversing ALJ's Galton's order here.[1]

In conclusion, in accordance with our decision in WCB # 96-03694, we find that claimant's PCS condition is not compensable. Because the ALJ concluded otherwise, we reverse his decision.

ORDER

The ALJ's order dated May 20, 1997 is reversed in part and affirmed in part. That portion which set aside SAIF's denial is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[1] Even if we decided this on the merits, we would still conclude that claimant failed to prove the compensability of her PCS conditon. The only medical evidence in this case that we did not consider in WCB # 96-03694 was provided by Dr. Hryekewicz (Ex. 128B), Dr. White (Ex. 133), Dr. Binder (Ex. 134), and Dr. Scott (Ex. 136). Although claimant in this case also relies on the medical evidence from Drs. Tobin and Erickson, we continue to find those opinions unpersuasive for the reasons explained in our order in WCB # 96-03694. Moreover, we find the opinions of Drs. Hryekewicz and Dr. Scott (the only other physicians to support compensability) to be unpersuasive because they are conclusory and do not adequately account for claimant's noncompensable psychological conditions. Somers v. SAIF, 77 Or App 259 (1986). Thus, we would conclude that claimant's compensable 1985 accident was not a material contributing cause of her PCS conditon. Accordingly, even if we considered the merits of the PCS claim, we would not find that condition to be compensable.

In the Matter of the Compensation of
FRANCISCO E. VARGAS, Claimant
WCB Case No. 96-06947
ORDER ON REVIEW
Allen, Stortz, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the insurer's denial of his claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant is a 38 year old male who has worked for the employer since about 1993. On April 3, 1996, claimant was working as a lumber grader. He developed a sudden onset of low back pain while stretching and bending towards his right to pull a six foot length of 2 x 6 lumber. Four or five days after the incident at work, claimant developed numbness down his left leg; subsequently, he developed an ache in his left leg. He also developed left groin and testicle pain. Claimant left work. A MRI scan of April 17, 1996 showed a focal disc protrusion in the midline, more evident on the left side, that impinged against the thecal sac and a smaller disc protrusion at L5-S1, with preexisting degenerative changes anteriorly at these two levels. On May 24, 1996, the claim was accepted as disabling for a low back strain, left.

Claimant had a prior compensable low back strain at a different employer with a date of injury of December 3, 1990. The claim was closed in March 1991 with an award of temporary disability only. Between 1991 and claimant's injury in April 1996, claimant performed medium to heavy work without pain or other back symptoms.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had failed to establish that his L4-5 and L5-S1 disc condition was compensable. We agree.

Claimant's claim is for an industrial injury. Therefore, in order to establish that his low back disc condition is compensable, he must show that the April 3, 1996 work incident is a material contributing cause of his claimed condition. ORS 656.005(7)(a). However, if claimant has a preexisting condition which combines with his industrial injury, he must establish that the work injury is the major contributing cause of his disability or need for medical treatment of the combined condition. ORS 656.005(7)(a)(B); SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997).

Regardless of whether claimant's claim is subject to the "material" or "major" contributing cause standard, we find that claimant has not established that his condition is compensable based on the following reasoning.

The only physician to squarely address causation is Dr. McQueen who opined that claimant's work injury was the major cause of the disc protrusions. (Exs. 18, 19A, 20). We are not persuaded by Dr. McQueen's opinion. To begin, Dr. McQueen offers no explanation for his conclusion that claimant's disc protrusions are causally related to the work injury. Moreover, Dr. McQueen is a family practitioner, and not a specialist. Neither Dr. Malos, a neurosurgeon, nor Dr. Andersen, a rehabilitation specialist, related claimant's disc protrusions to the work injury.[1] (Ex. 14, 19-16). Claimant was

[1] Neither Dr. Malos nor Dr. Andersen offered a definitive opinion on causation. (Exs. 14, 19-16). While both physicians indicated that it was "possible" that the disc protrusions were the result of claimant's work injury, a mere "possibility" is not sufficient to carry claimant's burden of proof. See Gormley v. SAIF, 52 Or App 1055 (1981) (medical opinion must be stated in terms of reasonable medical probability, not mere possibility).

referred to both of these physicians by Dr. McQueen. Under these circumstances, claimant has not established that his disc protrusion condition is causally related to the work injury. Accordingly, we agree with the ALJ that the insurer's denial must be sustained.

ORDER

The ALJ's order dated May 12, 1997 is affirmed.

In the Matter of the Compensation of
SIRIJEET S. JOHNSON, Claimant
Own Motion No. 96-0236M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's September 26, 1997 Notice of Closure which closed his left knee injury claim with an award of temporary disability compensation from May 22, 1996 through September 22, 1997. The insurer declared claimant medically stationary as of September 22, 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 September 26, 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 7, 1997 letter, we requested the insurer to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on October 15, 1997; however, no further response has been received from claimant. Therefore, we proceed with our review.

In support of their positions, both claimant and the insurer rely on a September 15, 1997 letter from Dr. Blum, claimant's treating orthopedist. In that letter, Dr. Blum stated that claimant had increased pain with walking, jogging, riding a stationary bicycle, and going up and down stairs and recommended quadriceps exercises to keep the knee joint strong. However, Dr. Blum did not recommend further medical treatment. Instead, Dr. Blum stated that he did not suggest additional surgery and recommended that claimant "accept the condition of his knee as it is without embarking on more surgery at this time." Dr. Blum also stated that:

> "my advice to [claimant] is to keep his knee strong and not plan on any surgery in the immediate future. I would say that his condition is relatively stable. I do not expect it to improve any further in the coming months or year. Based on the fact that he has had cartilage damage, even though there has been an attempt at restoration of cartilage, I would anticipate gradual deterioration of his knee with the passage of time. I expect that he will eventually have degenerative arthritis in his knee and may require some type of surgery in the future."

Claimant argues that Dr. Blum's statements that his knee is "relatively stable," his statements regarding claimant's continued discomfort, and his statement that he does not expect any improvement over the next months or year establish that claimant's knee condition was not medically stationary at claim closure. We disagree.

As noted above, "medically stationary" is a legal term defined by statute as meaning there is no reasonable expectation of further material improvement from medical treatment or the passage of time. ORS 656.005(17). Therefore, the fact that claimant continues to have discomfort in his knee does not

mean that the knee condition is not medically stationary. Instead, the relevant inquiry focuses on whether there is a reasonable expectation of material improvement. In addition, any confusion caused by Dr. Blum's use of the term "relatively stable" was cleared up by his statement that he does not expect any further improvement in the coming months or year. Contrary to claimant's argument, rather than proving claimant was not medically stationary, this last statement supports a finding that claimant's knee condition was medically stationary at claim closure.

We find that Dr. Blum's unrebutted medical opinion establishes that claimant's compensable left knee condition was medically stationary at claim closure, i.e., there is no reasonable expectation of further material improvement from medical treatment or the passage of time. ORS 656.005(17). Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's September 26, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL D. LATHROP, Claimant
Own Motion No. 97-0194M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 23, 1997 Own Motion Order Reviewing Carrier Closure that modified the SAIF Corporation's July 31, 1997 Notice of Closure. Specifically, our prior order awarded claimant additional temporary partial disability (TPD) from May 7, 1997 through June 20, 1997, and affirmed SAIF's Notice of Closure in all other aspects. In his request for reconsideration, claimant argues that SAIF miscalculated his TPD rate when it notified him that he was not due any TPD compensation for the period of May 7, 1997 through June 20, 1997. Claimant also requests that we confirm that his temporary total disability (TTD) rate is $243.65 per week, the rate of TTD paid by SAIF.

On October 21, 1997, we abated our prior order to allow SAIF 14 days to respond to claimant's motion. That period has passed without receipt of any response from SAIF. Therefore, we proceed with our reconsideration.

Claimant has the burden of proof regarding this temporary disability issue. ORS 656.266. In arguing that SAIF miscalculated his TPD rate as zero, claimant argues that the TPD rate should include annual increases in benefits as does the TTD rate. In support of this argument, claimant notes that ORS 656.212(2) indicates that TPD should be "a portion of temporary total benefits." Claimant further argues that a straight calculation of own motion TPD benefits under OAR 436-060-0030(2), without a provision for annual increases in TPD benefits, creates an injustice.[1] To address this alleged injustice, claimant requests that we "direct the [Workers' Compensation Department (WCD)] to formulate a rule governing TPD in Own Motion cases which will allow the same increases for TPD benefits as are mandated for TTD benefits." We decline to grant this request on the following grounds.

First, the Board in its own motion authority has sole jurisdiction over claims, like claimant's claim, for which aggravation rights have expired. ORS 656.273(4); 656.278. Thus, the WCD has no jurisdiction to adopt any rules affecting claims that are within the Board's own motion jurisdiction. However, in the interest of administrative efficiency, we apply WCD rules in determining the rates of TTD and TPD regarding own motion claims. Second, as explained below, the rules governing calculation of TPD rates comply with statutory and case law.

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[1] We note that claimant's argument that TPD rates that do not include annual salary increases creates an injustice for own motion claims could also apply to TPD rates for claims still within their aggravation rights where the claimants have received wage increases since their date of injury. Under those circumstances, the TPD rate is also based on the at-injury wage, without consideration of increases in the average weekly wage or individual salary increases since the date of injury. However, as discussed later, the legislature has determined that TPD is calculated using the at-injury wage.

Prior to its amendment in 1995, former ORS 656.212 provided that TPD is to be based on "that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury." Relying on the statute, the court in Stone v. Whittier Wood Products, 116 Or App 427 (1992), rev'd on recon 124 Or App 117 (1993), rev den 318 Or 459 (1994), held that TPD must be measured by loss of earning power "at any kind of work," not just the job held at injury. 124 Or App at 122. Thus, claimant's argument against a strict reliance on the at-injury wage to calculate TPD may have had merit under former ORS 656.212 and Stone.

However, the Legislature amended ORS 656.212 in 1995.[2] Or Laws 1995, ch 332, Sec. 16 (SB 369, Sec. 16). Amended ORS 656.212 provides, in part:

> "When the disability is or becomes partial only and is temporary in character:
>
> "* * * * *
>
> "(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive for an aggregate period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary disability pursuant to ORS 656.210."

ORS 656.210(2)(b)(A) provides that "[t]he benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury."[3] Consequently, under amended ORS 656.212, a worker's TPD rate is calculated based on a comparison of a claimant's wage at modified employment with his at-injury wage. Accordingly, in Lonnie L. Dysinger, 47 Van Natta 2282 (1995), we held that, to the extent that Stone held otherwise, it was no longer good law.

Amended ORS 656.212 applies here, because claimant's own motion claim was reopened on April 22, 1997, after the June 7, 1995 effective date of the amendments in Senate Bill 369. Thus, the calculation of claimant's TPD rate is based on a comparison of claimant's wage at modified employment with his at-injury wage. In a letter dated September 25, 1997, SAIF stated that claimant's at-injury wage was $110.00 per week. Claimant does not dispute that figure. Claimant's modified work paid $168.00 per week.[4] Because claimant's modified work paid more than his at-injury wage, his TPD rate is zero.[5] ORS 656.212(2); OAR 436-060-0030(2). Accordingly, SAIF correctly calculated claimant's TPD rate as zero.

We proceed to address claimant's request that we confirm that his TTD rate is $243.65, the TTD rate paid by SAIF. Because claimant was injured before July 1, 1973, the "average weekly wage" is not used in calculating his TTD benefits. ORS 656.202(2); 656.211; WCD Bulletin 111 (Rev.), June 7, 1996. Instead, claimant's TTD rate is calculated using the "Retroactive Program Benefits Schedule." WCD Bulletin 295, September 13, 1996. Applying that schedule, claimant's TTD rate is $243.65, the rate paid by SAIF.[6]

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[2] Neither ORS 656.210 (the TTD statute) nor 656.212 (the TPD statute) were amended during the 1997 legislative session. See HB 2971, 69th Leg., Reg. Session (July 25, 1997).

[3] This provision was not amended in 1995 or thereafter.

[4] Claimant's modified work consisted of 4 hours work per day, five days per week, at $8.40 per hour. (4 x 5 x $8.40 = $168.00).

[5] Any injustice claimant perceives in this TPD rate must be addressed to the legislature. We are without authority to change the requirements of ORS 656.212(2) by rule or to order the Department to do so, as claimant requests.

[6] Under the "Retroactive Program Benefits Schedule," the amount of claimant's weekly TTD benefits is the lesser of $395.55 (80% of the July 1, 1995 "average weekly wage") or the figure calculated using the following formula: multiply 66.67 percent of claimant's weekly wage at-injury ($110.00) by the conversion factor for the year of injury (claimant was injured on 4/9/73; injuries occurring from 7/1/72 through 6/30/73 have a conversion factor of 3.32240). (66.67% x $110.00 x 3.32240 = $243.65). Thus, claimant's weekly TTD rate is $243.65.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 23, 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
TRUDY A. POLING-LLOYD, Claimant
WCB Case No. 97-00647
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests, and the self-insured employer cross-requests, review of Administrative Law Judge (ALJ) Howell's order that awarded 9 percent (13.5 degrees) scheduled permanent disability bilaterally for loss of use or function of the hands, whereas an Order on Reconsideration awarded no permanent disability. On review, the issue is extent of scheduled permanent disability.

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

At hearing and on review, the employer argues that claimant is not entitled to any scheduled permanent disability. Specifically, the employer argues that Dr. Kho, the medical arbiter, did not indicate that the loss of two point sensory discrimination is "due to" the compensable bilateral carpal tunnel syndrome. We disagree.

If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe those findings as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550 (1997). However, where the medical arbiter relates the claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not considered persuasive evidence of injury-related impairment. Julie A. Widby, 46 Van Natta 1065 (1994). Here, neither the treating physician, Dr. Worland, nor the medical arbiter related claimant's impairment to causes other than the compensable injury. Furthermore, sensory discrimination loss in the fingers is consistent with claimant's compensable injury. Therefore, like the ALJ, we find that claimant has established the impairment was "due to" the injury.

The employer also argues that Dr. Kho's two point sensory discrimination findings do not meet the requirement that a worker's impairment must be established by medical evidence that is supported by objective medical findings. ORS 656.283(7); 656.726(3)(f)(B). In this regard , the employer argues that the 2-point discrimination findings do not meet the requirements of ORS 656.005(19). We disagree.

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 Tony D. Houck, 48 Van Natta 2443 (1996), aff'd mem Atlas Bolt & Screw v. Houck, 151 Or App 200 (1997), we noted that "range of motion" findings were specifically included as an example of "objective findings" even though range of motion is based on a worker's subjective responses. Id at 2448. We further concluded in Houck, that the listing of "reproducible, measurable or observable" regarding subjective responses to physical examinations was in the disjunctive, rather than the conjunctive. Thus, meeting one of these conditions would be sufficient to establish "objective findings."

Here, we find that claimant's subjective response to the two-point discrimination test constitutes a measurable subjective response to a physical examination. Former OAR 436-035-0110(1)(a). Therefore, the two-point discrimination test results are objective findings of impairment.

The employer also argues that Dr. Kho's two-point discrimination findings are not valid. In making this argument, the employer relies on Dr. Kho's statement that the "sensation impairment of the upper extremities was felt odd." (Ex. 36-4). However, Dr. Kho stated that the findings were valid. Id. Furthermore, former OAR 436-035-0007(27) provides that a physician's determination that impairment findings are invalid must provide "a written opinion, based on sound medical principles, explaining why the findings are invalid." See Justeen L. Parker, 49 Van Natta 334 (1997) (finding that the medical arbiter's mere statement that the claimant's range of motion (ROM) findings were "invalid" did not meet the requirements of former OAR 436-035-0007(27), Board considered the arbiter's ROM findings in determining the claimant's impairment). We do not find Dr. Kho's statement that the sensation findings were "odd" meets the requirements under former OAR 436-035-0007(27) that findings of "invalidity" be explained in a written opinion, based on sound medical principles. In addition, Dr. Kho explicitly stated the findings were valid. Therefore, based on Dr. Kho's opinion, we find that claimant has established valid objective findings of impairment due to the work injury.

Finally, claimant argues that she is entitled to a rating of 2-point discrimination loss for the whole of each finger, even though Dr. Kho did not indicate the location of the loss of sensation on each finger. We disagree. See Gary L. Waldrupe, 42 Van Natta 2623 (1990) (where there was no indication in medical report as to the location of loss of sensation on the digits, the claimant established "less than normal" sensation for 1/2 the distal phalanx of each digit tested).

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

ORDER

The ALJ's order dated May 7, 1997 is affirmed. For services on review, claimant's attorney is awarded a fee of $750, payable by the self-insured employer.

In the Matter of the Compensation of
SUSAN R. FOSTER, Claimant
WCB Case No. 96-08981
ORDER ON REVIEW
Jeff Carter, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) upheld the insurer's denial of claimant's aggravation claim for an accepted low back condition; (2) did not award interim compensation; (3) declined to award penalties/attorney fees for failure to pay interim compensation; and (4) declined to award penalties/attorney fees for failure to timely accept or deny the claim. On review, the issues are aggravation, interim compensation, penalties and attorney fees.

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

The ALJ concluded that claimant had not perfected an aggravation claim under former ORS 656.273(3). On review, claimant assumes that the ALJ came to that conclusion on the basis that Dr. Bogard's chart notes did not accompany the Department's aggravation claim forms. Claimant asserts that Dr. Bogard's chart notes accompanied the Department's aggravation claim forms, as the insurer acknowledged receipt of the chart notes in its January 31, 1996 letter to Dr. Bogard. Thus, she argues, because she perfected an aggravation claim, she is entitled to interim compensation and penalties/attorney fees for unreasonable claims processing. We disagree.

ORS 656.273(3)[1] provides:

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

Assuming without deciding that the chart notes actually accompanied the aggravation claim forms, we nevertheless conclude that the chart notes are legally insufficient to establish that claimant perfected an aggravation claim.

The chart notes[2] from claimant's attending physician fail to establish by written medical evidence supported by objective findings that claimant suffered a worsened condition attributable to her compensable injury. The notes document claimant's low back and radicular pain and incontinence and indicate that the pain started after a long drive. The notes also report that claimant had a history of two low back surgeries. However, the notes do not establish that claimant's symptoms are due to her prior compensable injury. Moreover, the report does not address whether the symptoms represent a worsening of claimant's compensable condition. Consequently, we conclude that the September 20 and October 4, 1995 notices were not legally sufficient under ORS 656.273 to perfect an aggravation claim.

Claimant's entitlement to interim compensation depends upon whether the insurer received notice or knowledge of a medically verified inability to work in a medical report which satisfies the requirements of the above-quoted statute (and thus constitutes prima facie evidence in the form of objective findings that claimant's compensable condition has worsened). See ORS 656.273(6).[3] Moreover, until such time as claimant properly filed an aggravation claim, the insurer was under no obligation to issue a denial. See ORS 656.273(3), (6); Lloyd S. Abraham, 46 Van Natta 939 (1994); Herman M. Carlson, 43 Van Natta 963 (1991), aff'd Carlson v. Valley Mechanical, 115 Or App 371 (1992).

ORDER

The ALJ's order dated June 5, 1997 is affirmed.

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[1] Claimant cites a prior version of ORS 656.273(3), which sets forth a different standard for establishing an aggravation than the statute as amended in 1995. The prior version of the statute provides: "A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation."

[2] The chart notes state in relevant part:

"[Claimant is] still having severe low back pain, h/o two surgeries to low back. This started after she drove back from Reno. It is going down her leg, rt buttocks, & rt leg. She's having some bladder probs w/it. Has had effusion of all three lower lumbar vertebrae.

"* * * *

"A: 1) Low back pain w/acute exacerbation & radiculopathy down rt leg. 2) Incontinence."

And:

"A: Low back pain w/radicular pain.

"P: Get MRI of low back. Depending on results, we will either send her to a neurosurgeon or physical therapy."

[3] ORS 656.273(6) provides:

"A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening under subsection (1) of this section."

In the Matter of the Compensation of
TRACIE L. MARTIN, Claimant
WCB Case No. 94-12729
SECOND ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

The self-insured employer requests reconsideration of our October 30, 1997 Order on Remand. In that order, we relied on the opinion of claimant's attending physician, Dr. Warren, to conclude that claimant had established entitlement to an award of permanent disability for her left forearm. On reconsideration, the employer argues that we erred in finding that claimant had established permanent disability. We proceed with our reconsideration.

First, the employer argues that we raised the issue, sua sponte, of whether the opinions of examining physician, Dr. Radecki, had been ratified by Dr. Warren. We disagree.

We did not raise a "new issue" when we noted that Dr. Radecki's findings could not be considered in rating claimant's impairment. The requirement that we rely only on the findings of an attending physician (or findings that have been ratified by an attending physician) in rating a claimant's permanent disability is statutory. ORS 656.245(2)(b)(B); see also, Koitzsch v. Liberty Northwest Insurance Corp., 125 Or App 666, 670 (1994). The statute does not give us discretion to choose whether or not to rely on findings of a non-attending physician or non-medical arbiter in rating a claimant's permanent disability. We have addressed only the issue of the extent of claimant's scheduled permanent disability which was the issue raised and litigated by the parties.

The employer also argues that there is no evidence concerning which documents were contained in the reconsideration record. If an evidentiary objection to "extra-reconsideration" evidence is not made at hearing, the Board may not exclude such evidence on review. Fister v. South Hills Healthcare, 149 Or App 214 (1997). Thus, even assuming any of the evidence in this record was not part of the Director's "reconsideration record," that evidence may not be excluded. In any case, based on the Appellate Unit's explanatory notes regarding the Order on Reconsideration, Dr. Warren's findings (which we relied on) were contained in the reconsideration record.

Contrary to the employer's arguments, there is no evidence in this record that Dr. Warren ever ratified Dr. Radecki's conclusions regarding claimant's impairment. If such evidence existed, the employer could have submitted that evidence at hearing so that we could have considered it. The lack of such evidence in the record does not support remand. The record, as it exists, is not insufficiently developed and no explanation is given why the evidence (if it exists) was not obtainable with due diligence at the time of hearing. Thus, remand is not warranted. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (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).

The employer next asserts that it is inconsistent that the Board initially found that there was no evidence of the permanency of claimant's impairment findings, but concluded on remand that a preponderance of the evidence established that claimant's disability was permanent. What the employer has not noted is that, in reversing our prior order, the court disagreed with our initial conclusion that there was no evidence of the permanency of claimant's impairment and remanded this matter to us for reconsideration. On reconsideration, we explained why we reconsidered our decision and found that the record supported an award of permanent disability. We are not prohibited from reviewing the record and reconsidering our opinion on remand. See Kevin P. Silveira, 47 Van Natta 2354, 2357 n. 3 (1995); see also Dung T. Nguyen, 42 Van Natta 2625 (1990). In fact, the court has expressly directed us to reconsider the record and our initial decision.

The remainder of the employer's arguments have been adequately addressed in our October 30, 1997 order and will not be addressed further.

Accordingly, our October 30, 1997 order is withdrawn. On reconsideration, as supplemented herein, we republish our October 30, 1997 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
WILLIAM T. SHIELDS, Claimant
WCB Case No. 97-00952
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) awarded temporary total disability benefits from September 10, 1996, to October 28, 1996; and (2) assessed a penalty for allegedly unreasonable claims processing and refusal to pay temporary disability compensation. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the first sentence of the second paragraph on page 3. We do not adopt the first three findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a fare inspector and road supervisor for Tri-Met. His job required extensive reading and driving. Claimant was qualified to perform his job only when wearing corrective lenses. (Ex. 20). On September 10, 1996, when inspecting a park-and-ride location, claimant was hit in the face and head by an assailant. The assault destroyed claimant's corrective lenses. When he arrived home, claimant's wife called his regular family physician, Dr. Roddy, M.D. On September 11, 1996, claimant went to an optician to get his glasses replaced. (Ex. 7A). On September 12, 1996, Dr. Roddy signed a time loss authorization slip for claimant, taking him off work until his eyeglasses were replaced. (Ex. 5). Claimant provided the time loss authorization form to the employer.

The time loss authorization from Dr. Roddy was received by the claims administrator on September 25, 1996. (Id.) No time loss was paid.

On December 9, 1996, the employer accepted claimant's cervical strain and injury to prosthetic appliance (eyeglasses) as a nondisabling injury. (Ex. 15).

The ALJ concluded that Dr. Roddy was claimant's attending physician and could therefore authorize temporary disability compensation. On review, the employer contends that Dr. Fladoos was claimant's attending physician during the period he was seeking time loss.[1] We agree with the employer.

Only an attending physician can authorize payment of temporary disability compensation. ORS 656.245(2)(b)(B) (formerly 656.245(3)(b)(B)); see First Interstate v. Morris, 132 Or App 98 (1994); Food Services of America v. Ewen, 130 Or App 297 (1994). Moreover, an attending physician may not delegate "time loss" authority. See Francisco J. Delacerda, 46 Van Natta 1021 (1994). ORS 656.005(12)(b) provides, in part: "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 * * * ." Whether a physician qualifies as an "attending physician" is a question of fact. See Christine Sutton, 45 Van Natta 192, 193 (1993); Paula J. Gilman, 44 Van Natta 2539 (1992).

In this case, claimant had treated with Dr. Fladoos in August 1996. (Ex. 1). Dr. Fladoos treated claimant for cervical, upper back, mid back and shoulder pain due to the compensable injury from September 11, 1996 through January 1997. (Exs. 1, 2, 16, 17, 19). Claimant filled out a Form 801, in which he indicated that Dr. Fladoos was his attending physician. (Ex. 3). Moreover, Dr. Fladoos identified himself as claimant's attending physician on a palliative care request form that he submitted to the Department on March 5, 1997. (Ex. 19).

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[1] The employer asserts that, as a member of an MCO, Dr. Fladoos was not limited by ORS 656.005(12)(b) and could, therefore, be the attending physician and authorize temporary disability in excess of 30 days. Claimant does not dispute the employer's assertion.

Claimant testified that he considered Dr. Roddy to be his attending physician, that Dr. Roddy told him to see Dr. Fladoos, and that he (claimant) saw Dr. Roddy about a week or 10 days after the injury. (Tr. 17). However, although Dr. Fladoos, who suspected a concussion syndrome, recommended that claimant "continue" to treat with Dr. Roddy for his headaches and dizziness (Ex. 14), and claimant indicated on an Occupational Injury Report and a claim report that Dr. Roddy was his regular doctor, there is no medical evidence that he actually treated with Dr. Roddy until November 11, 1996. (Ex. 11-2; Tr. 80).

After our review of the entire record, we find that Dr. Fladoos was primarily responsible for claimant's treatment and, accordingly, was claimant's attending physician, not Dr. Roddy, the physician who took claimant off work. Dr. Fladoos did not authorize the payment of temporary disability benefits. Therefore, the employer had no obligation to pay temporary disability during the contested period (September 10, 1996 through October 28, 1996).

Having found that claimant is not procedurally entitled to time loss benefits for the time period in issue, we also reverse that portion of the order awarding a penalty based on the employer's allegedly unreasonable claims processing.

ORDER

The ALJ's order dated May 12, 1997 is reversed in part and affirmed in part. That portion of the order requiring payment of temporary total disability benefits for the period from September 10, 1996, to October 28, 1996, is reversed. The related attorney fee is reversed. The penalty assessed for unreasonable claims processing is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
GLENDA BLACKWELDER, Claimant
WCB Case No. TP-97008
THIRD PARTY DISTRIBUTION ORDER
Cobb & Woodworth, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement.[1] See ORS 656.593(3). Specifically, the dispute concerns the amount of costs claimant's attorney may recover and claimant's share of the settlement proceeds. We conclude that claimant's attorney may recover costs of $501.96, and that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

Claimant was compensably injured on July 10, 1995, when the vehicle she was driving was rear-ended by another vehicle driven by Robert West. Liberty Northwest, the paying agency, accepted claimant's accident-related injuries. The claim was closed by a Determination Order issued December 21, 1995, which awarded temporary disability only. Claimant did not challenge this order, which became final by operation of law.

In March 1996, claimant retained an attorney to recover damages incurred as a result of her July 10, 1995 automobile accident. She continued to experience neck and back symptoms as well as memory and concentration problems, which she related to the accident. In April 1996, claimant was examined by Dr. Phipps, a neurologist, to rule out a possible closed head injury.

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[1] Believing that Liberty had not approved the third party settlement, claimant also petitioned Board for approval of the compromise pursuant to ORS 656.587. In its response to claimant's petition, however, Liberty acknowledges that it approved the settlement. Thus, the dispute is limited to what constitutes a "just and proper" distribution of proceeds.

Although Mr. West's liability for the July 10, 1995 accident was not seriously disputed, his insurer did challenge the nature and extent of claimant's damage claims because claimant had a history of prior treatment to the same body parts as well as post-injury medical reports suggesting significant functional overlay.

At some point in late May or early June 1997, claimant and the third party insurer agreed to settle claimant's third party claim for $7,500. On June 4, 1997, the third party insurer issued a check in the amount of $7,500 in the names of claimant and her husband, her attorneys and Liberty Northwest. Because Liberty had not approved of the settlement and proposed distribution of proceeds as of early July 1997, claimant's counsel filed a complaint on claimant's behalf against the third party to protect claimant's rights.[2] Liberty subsequently approved the settlement, but not claimant's proposed distribution of proceeds.

A post-closure audit of claimant's claim established that Liberty has paid compensation totaling $7,554.06, consisting of $7,054.06 in medical benefits and $500 in temporary disability.[3]

Claimant's attorneys claim $654.03 in incurred costs in connection with claimant's third party claim. Liberty objects to a portion of those costs ($325.41), asserting that such costs were not reasonable and necessary to the litigation as they were incurred after claimant's counsel received the settlement check.[4]

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The paying agency has a lien against the worker's cause of action, which lien shall be preferred to all claims except the cost of recovering such damages. ORS 656.580(2). The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury allegedly as a result of the negligence of a third person, Mr. West. The claim was accepted by Liberty, which provided compensation in excess of $7,500. Liberty is therefore a paying agency under ORS 656.576. When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable.

Because claimant settled her third party claim and Liberty ultimately approved the settlement, the distribution of proceeds is governed by ORS 656.593(3). Liberty is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that claimant receives at least the amount to which she is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). The amounts referred to in ORS 656.593(1) and (2) pertain to attorney fees, litigation expenses, and claimant's statutory 1/3 share of the balance. Because the parties cannot agree as to what constitutes a "just and proper distribution," the conflict shall be resolved by the Board.

In determining a "just and proper" distribution, we judge each case based on its own merits. Urness v. Liberty Northwest, 130 Or App 454, 458 (1994). Since "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party

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[2] Pursuant to ORS 12.110, the statute of limitations on claimant's third party action would have run on July 10, 1997, two years from the date of injury.

[3] Claimant asserts that the Determination Order awarded temporary disability at an improper rate (a rate which did not account for her non-cash compensation as an apartment complex manager) and therefore her temporary disability compensation was substantially less than it should have been. Claimant concedes, however, that she did not timely appeal the order.

[4] Claimant's counsel incurred costs of $173.43 in July 1997 related to the filing of the complaint, and $152.07 related to a "Jay Sample Investigation" in August 1997.

judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. Id. Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination is based on the merits of the case.[5] Id.

In this case, both sides agree that claimant's counsel shall be paid the statutory 1/3 share of attorney fees ($2,500). As noted above, however, the parties dispute the amount of litigation costs that may be recovered. Liberty asserts that only those costs incurred prior to settlement ($328.62) may be reimbursed, and objects to those costs incurred subsequent to claimant's receipt of the settlement check ($325.41). Claimant responds that these later costs were incurred to protect claimant's third party claim, because Liberty did not immediately approve the settlement and/or distribution of proceeds.

Claimant is entitled to reimbursement from the third party recovery for previously unreimbursed costs which are reasonably and necessarily incurred during the litigation of the third party action. See Thomas Lund, 41 Van Natta 1352 (1989); OAR 438-015-0005(6). Claimant's counsel has adequately explained why he incurred costs of $173.34 in July 1997. Although the settlement check was received in June, Liberty had yet to approve the settlement by early July, necessitating the filing of a complaint in circuit court to preserve claimant's right of action before the statute of limitations expired. Claimant has not, however, addressed how the $152.07 incurred in August 1997 was reasonably and necessarily incurred in pursuit of the third party action.[6] Consequently, we conclude that claimant's counsel is entitled to recover from the third party settlement costs in the amount of $501.96.[7]

Under the statutory formula, claimant is entitled to receive at least 1/3 of the *balance* of the recovery. See ORS 656.593(1)(b). Claimant argues, however, that it is "just and proper" for her to receive at least 1/3 of the gross settlement ($2,500) because: (1) Liberty received a windfall due to its erroneous processing of claimant's temporary disability compensation; and (2) a significant portion of the medical bills paid by Liberty were for diagnostic purposes rather than for treatment of claimant's accident-related injuries. Liberty, on the other hand, asserts a "just and proper" distribution should follow the third party judgment scheme (ORS 656.593(1)): claimant should be paid one-third of the balance and it should recover the remaining two-thirds as partial reimbursement for its $7,554.06 lien.

In reaching our determination regarding a "just and proper" distribution, we judge this case based on its own merits and not on an inapplicable statutory distribution scheme. In other words, in exercising our statutory authority under ORS 656.593(3), we do not arbitrarily adhere to the specific distribution scheme set forth in ORS 656.593(1). However, an examination of the components of compensation which are subject to reimbursement from a third party judgment under section (1)(c) provides some general guidance to us in determining what portion of the remaining balance of claimant's third party settlement would be "just and proper" for Liberty to receive in partial satisfaction of its lien.

Pursuant to ORS 656.593(1)(c), the paying agency shall be paid and retain the balance of a third party recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8). Where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. Norman H. Perkins, 47 Van Natta 488, 490 (1995); Jack S. Vogel, 47 Van Natta 406 (1995).

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[5] Indeed, even though claimant's proposed distribution differs from the statutory formula (in that she is seeking 1/3 of the gross settlement amount rather than 1/3 of the balance after payment of costs and attorney fees), she asserts that it "closely parallels" the distribution of proceeds set forth in ORS 656.593(1).

[6] The record also does not establish whether this August 1997 cost bill reflects services incurred prior to Liberty's approval of the settlement.

[7] This includes costs of $328.62 incurred pre-settlement, and the $173.34 incurred in July 1997 related to the filing of the complaint.

Here, claimant does not contest Liberty's assertion that it incurred the $7,054.06 in medical expenses and $500 in temporary disability in processing claimant's injury claim. Rather, as noted above, claimant argues that Liberty's share of the settlement proceeds should be reduced (thereby increasing claimant's recovery) because Liberty miscalculated her temporary disability benefits and also because it sought additional medical opinions (concerning claimant's psychological and closed head injury symptoms) which tended to hinder her third party case.[8]

We are unpersuaded by claimant's arguments. First, to the extent Liberty made an error in calculating claimant's temporary disability benefits, claimant's remedy was to seek reconsideration of the December 21, 1995 Determination Order. Claimant's belated, collateral attack on the wage rate determined by this final order does not provide a legitimate basis for reducing Liberty's share of the third party proceeds.[9]

Second, although claimant argues that not all of the medical bills paid by Liberty would have been awarded to her by a jury on the third party claim, a claimant's "special damages" is not the standard for determining the paying agency's right to reimbursement from the third party recovery. As discussed above, it is "just and proper" for a paying agency to receive reimbursement for its expenditures for compensation. In this regard, "compensation" includes all benefits (including diagnostic medical services) provided for the compensable injury.[10] See ORS 656.005(8); see also Robert E. Greer, 43 Van Natta 650 (1991) (recovery of actual claim costs are not contingent upon the success or failure of a particular service; our inquiry is confined to whether paying agency has actually incurred expenses for compensation provided to the worker who has received a third party recovery).

We have in the past rejected arguments that it would be more equitable to order a distribution that results in a claimant receiving a larger portion of a third party settlement by reducing a paying agency's unchallenged lien for claim costs. See, e.g., Santos King, 47 Van Natta 2026, 2027 (1995); Gerald L. Davidson, 42 Van Natta 1211 (1990). We have also previously ruled that the liability risks present in a third party action are of no consequence in determining a "just and proper" distribution of settlement proceeds. See Delores M. Shute, 41 Van Natta 1458 (1989). In reaching such a conclusion, we have reasoned that such liability risks properly rest with the worker who is pursuing the action and have no logical correlation to the amount of a paying agency's lien. Id.

Consequently, in this case, we find that it is "just and proper" for Liberty to recover the balance of settlement proceeds remaining after distribution of attorney fees, litigation expenses, and claimant's statutory one-third share of the balance. Indeed, even under this scheme, Liberty will recover less than one-half of its undisputed costs incurred in processing this claim ($7,554.06) and even less than the $3,335 which claimant concedes was incurred for treatment of her compensable injuries. The third party settlement shall be distributed consistent with the statutory formula of ORS 656.593(1) as follows:

$ 7,500.00	(total recovery)
-$ 2,500.00	(less 1/3 attorney fee)
-$ 501.96	(less reasonable and necessary litigation costs)
$ 4,498.04	(balance of proceeds)
-$ 1,499.34	(less 1/3 share to claimant)
$ 2,998.70	(remaining balance to Liberty)

[8] Specifically, claimant argues that, under her attorney's analysis, less than half of her medical bills ($3,335) were attributable to the accident. The remaining medical bills (for services related to diagnosing her psychological symptoms) may not have been awarded by a jury, had the third party case gone to trial.

[9] Finality attaches to uncontested closure orders, barring future litigation of any issue determined by the order. See, e.g., Hammon Stage Line v. Stinson, 123 Or App 418, 423 (1993); Rex A. Howard, 46 Van Natta 1265, 1266 (1994).

[10] Claimant does not challenge any specific cost incurred by Liberty, nor does she assert that certain expenditures are not properly included in the carrier's lien. See, e.g., David G. Payne, 43 Van Natta 918 (1991) (expenditures for "claim evaluation" reports are analogous to litigation reports and, as such, are not properly included in a paying agency's lien against a third party). Rather, claimant argues only that "a large portion" of the medical bills were incurred "in an attempt to diagnose and sort out the psychological and closed-head injury symptoms." Such diagnostic medical services constitute "compensation" under ORS 656.005(8). See, e.g., Brooks v. D & R Timber, 55 Or App 688 (1982) (diagnostic medical services are considered compensable when the services are reasonable and necessary in order to determine whether a causal relationship exists between a compensable condition and a current condition).

Claimant's attorney is directed to distribute the proceeds of the third party settlement in the manner detailed above.

IT IS SO ORDERED.

November 28, 1997 Cite as 49 Van Natta 2034 (1997)

In the Matter of the Compensation of
KAREN L. GALLIMORE, Claimant
WCB Case No. 96-07968
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's occupational disease claim for a C6-7 disc condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's occupational disease claim for a C6-7 disc condition was compensable. We agree that claimant's occupational disease claim is compensable, based on the following reasoning.

Our first task as a fact finder is to determine the appropriate legal standard for evaluating the compensability of this claim. Daniel S. Field, 47 Van Natta 1457, 1458 (1995) (citing Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995)). This is an occupational disease claim for a mental stress-caused physical condition. ORS 656.802(1)(b) provides that a "mental disorder" includes any physical disorder caused by mental stress. Claimant's physical disorder was caused, at least in part, by factors related to mental stress. (See Ex. 16). Therefore, claimant must establish compensability under ORS 656.802(3), the statute pertaining to "mental disorders." Karen Hudson, 48 Van Natta 113, 114 (1996).

ORS 656.802(3) sets forth the criteria for finding a "mental disorder" compensable:

> "(a) The employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation[.]
>
> "(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

When a claimant has a mental stress-caused physical disorder, a diagnosis of a physical condition that is generally recognized in the medical community satisfies the statutory requirement for a "diagnosis of a mental or emotional disorder" in ORS 656.802(3)(c). Christine Falconer, 48 Van Natta 1545, 1547 (1996). Here, claimant has a diagnosis that is generally recognized in the medical community: a herniated disc at C6-7. (Exs. 11, 12, 16). Therefore, claimant has met the requirement of ORS 656.802(3)(c).

Claimant testified regarding the stressful environment at work in about May 1996. She described having office management responsibilities for which she had no training, working long hours with too few staff people to perform the required work, and working several hours every day when she simultaneously used a telephone (without a headset) and computer, causing her to tilt her left shoulder and head to cradle the telephone receiver between her ear and shoulder. (Tr. 8-9, 14-17, 19). Claimant also testified that she experienced unusual stress at work in May 1996 because her supervisor required her to enter false Social Security claims for illegal aliens. (Ex. 15, Tr. 21-22). We find claimant's testimony to be clear and consistent with the documentary record. We find no basis to disagree with the ALJ's finding that claimant was a credible witness. (Opinion and Order at 5). Therefore, based on claimant's uncontradicted testimony, as well as the history found in the documentary record, we find that the employment conditions that produced her disorder existed in a real and objective sense. ORS 656.802(3)(a).

We further find that the source of claimant's "unusual" stress in May 1996 was an employment condition that is not generally inherent in every working situation. Specifically, claimant was required to file false Social Security claims for illegal aliens. (Exs. 15, 16). Claimant was concerned that her employer would be closed down by the INS (Immigration and Naturalization Service). (Ex. 17-2). Claimant tried to discuss her concerns with superiors, but she was threatened with retaliation if she brought up her concerns again. (Tr. 21-22). Such conditions we do not find to be generally inherent in every working situation. Therefore, claimant has met the requirement of ORS 656.802(3)(b).

Finally, we find that claimant established by clear and convincing evidence that her disorder arose out of and in the course of employment. ORS 656.802(3)(d).

Dr. Peterson, claimant's treating physician, opined that claimant's disorder was due to work conditions. (Exs. 15A, 16). Specifically, Dr. Peterson believed, based on the history he obtained from claimant, that the combination of physical activity at work and the unusual mental stress claimant experienced at work was the major contributing cause of her neck and upper extremity complaints. (Ex. 16). Dr. Peterson has the advantage of treating claimant in 1995 for a similar problem. (Ex. 1). In addition, he obtained a complete history of claimant's work conditions related to her current problem. (Exs. 15, 15A, 16). We find Dr. Peterson's opinion to be clear and well-founded. Somers v. SAIF, 77 Or App 259, 263 (1986).

By contrast, the contrary opinions of Drs. Rosenbaum and Smith are more generalized and not specifically focused on this worker's history. (See Exs. 17, 18). Dr. Rosenbaum acknowledged that claimant's work activity could cause a cervical disc protrusion or onset of radiculopathy, but he then concluded without adequate explanation that it did not do so in this case. (Ex. 17-4). Dr. Smith's opinion was not based on any detailed knowledge of claimant's work conditions. (Ex. 18-1). Therefore, we find the opinions of Drs. Rosenbaum and Smith unpersuasive.

We also find that claimant's clear, uncontradicted testimony establishes that her disorder was caused by work conditions. Accordingly, relying on Dr. Peterson's opinion and claimant's testimony, we find that there is clear and convincing evidence that claimant's disorder arose out of and in the course of her employment. ORS 656.802(3)(d).

Claimant has established all the elements necessary to prove a compensable claim under ORS 656.802(3). Therefore, we conclude that claimant's C6-7 condition is compensable.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 30, 1997 is affirmed. Claimant's counsel is awarded an attorney fee of $1,000 for his services on review, to be paid by the self-insured employer.

Board Member Moller dissenting.

I agree with the majority that this claim should be analyzed as a mental disorder claim under ORS 656.802(3). However, I believe claimant failed to meet her burden of proof under that statute. Furthermore, even if the claim were analyzed as a physical occupational disease claim under ORS 656.802(2)(b), I would still find the claim not compensable. Therefore, I respectfully dissent.

The majority correctly sets forth the criteria for finding a mental disorder claim compensable. ORS 656.802(3). I disagree, however, that claimant proved all the elements of her claim. Specifically, I do not find that there is clear and convincing evidence that claimant's mental disorder arose out of and in the course of her employment. ORS 656.802(3)(d).

Only Dr. Peterson opined that claimant's condition, a herniated disc at C6-7, was related to her work. Dr. Peterson's opinion, however, is completely conclusory. Dr. Peterson simply relied on claimant's explanation of why she considered her neck pain to be an on-the-job injury to conclude that her condition was work-related. (Exs. 8, 15, 15A). He provided no medical explanation or analysis of how the stress claimant experienced at work caused a herniated disc. (See Ex. 16). Dr. Peterson's opinion is particularly lacking in light of his prior treatment of claimant for similar complaints which were not related to work. (See Ex. 1). Consequently, I do not find Dr. Peterson's opinion persuasive.

In contrast to Dr. Peterson's opinion, Drs. Rosenbaum and Smith both opined that claimant's herniated disc was not work-related. (Exs. 17, 18). Dr. Rosenbaum observed that psychological stress would not cause a cervical disc protrusion. He also considered that claimant had spontaneously developed cervical radiculopathy one year earlier, unrelated to any work activity. Under such circumstances, he concluded there was no relationship between claimant's work activity and her C6-7 herniated disc condition. (Ex. 17-4). Dr. Smith agreed there was no evidence that claimant's 1996 cervical disc protrusion was related to work activity. He suggested that claimant may have had a small protrusion in July 1995 that responded to conservative measures. He believed that the disc protrusion worsened to the point that claimant required surgery in 1996, but he believed the worsening was consistent with the natural history of a protruded disc, rather than caused by her work activity. (Ex. 18).

Considering Dr. Peterson's conclusory, unpersuasive opinion in support of compensability, as well as the contrary opinions of Drs. Rosenbaum and Smith, I cannot conclude that there is clear and convincing evidence establishing that claimant's disorder arose out of and in the course of her employment.

Furthermore, I am not persuaded that the work conditions that allegedly caused claimant's disorder are not generally inherent in every working situation. ORS 656.802(3)(b). I agree that the filing of false Social Security claims is not a condition that is generally inherent in every working situation. However, claimant also cited other stressors (limited training, long hours, inadequate staffing, and working with a telephone and computer simultaneously) which I believe are generally inherent in every working situation. Considering that claimant claimed that **all** her work stressors allegedly caused her disorder, it was incumbent upon claimant to prove that **all** the allegedly stressful work conditions were not generally inherent in every working situation. I find that claimant failed to do so.

Therefore, I conclude that claimant failed to prove a mental disorder claim under ORS 656.802(3).

Moreover, even if claimant only needed to prove a physical occupational disease claim, as the ALJ found, I would still conclude that she failed to carry her burden of proof.

There is no dispute that claimant would be required to prove a physical occupational disease claim 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."

Dr. Peterson's conclusory opinion, particularly in light of the contrary opinions of Drs. Rosenbaum and Smith, simply fails to carry claimant's burden. Therefore, I would find that claimant failed to establish a compensable occupational disease under ORS 656.802(2)(b).

Accordingly, I would reverse the ALJ's order and uphold the employer's denial. Therefore, I dissent.

November 28, 1997 Cite as 49 Van Natta 2037 (1997)

In the Matter of the Compensation of
RACHEL KAY, Claimant
WCB Case No. 96-01616
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Galton's order that upheld the self-insured employer's denial of her claim for a necrotic fibroid condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has worked for the employer as a special education teacher for approximately 17 years. In mid-1992, claimant was seen by Dr. Goldberg, her family physician, who noted increased uterine size and benign uterine fibroids. Because of these findings, claimant was referred to Dr. Leigh, OB/GYN, who recommended that claimant's uterine size and fibroids be monitored and noted that a hysterectomy could be a treatment option in the future. Dr. Leigh continued to follow claimant's condition through 1993. In February 1994, claimant was examined by Dr. Goetsch, OB/GYN, Dr. Leigh's partner. Dr. Goetsch followed claimant's condition throughout 1994 and 1995.

On October 19, 1995, claimant participated in a parent/teacher meeting to discuss an individualized education program. The meeting took place in a small room and claimant sat in a "child's chair" which was lower to the ground than an "adult chair." The meeting lasted approximately 3-1/2 hours and claimant remained seated the entire time. The manner in which claimant sat in the child's chair caused her thighs to be drawn up close to her abdomen. After the meeting concluded, claimant stood up and felt immediate abdominal pain. During the evening, claimant's abdominal pain intensified. She reported to work the following day, but left at 10:00 a.m., to seek chiropractic treatment.

The next day, claimant contacted Dr. Goldberg, who prescribed pain medication. On October 22, 1995, claimant sought emergency room treatment for her abdominal pain. The following day, claimant was seen by Dr. Goetsch, who diagnosed an infarcted uterine fibroid and recommended surgery. On October 24, 1995, Dr. Goetsch performed a total abdominal hysterectomy and umbilical hernia repair. Thereafter, claimant filed an 801 Form alleging that her infarcted fibroid condition was related to her work activities on October, 19, 1995. By letter dated December 15, 1995, the employer denied claimant's claim.

On March 7, 1996, Dr. Casperson, OB/GYN, conducted a records review at the request of the employer. On April 19, 1997, Dr. Schrinksy, OB/GYN, conducted a records review at the request of the employer.

FINDINGS OF ULTIMATE FACT

Claimant's work activities on October 19, 1995 were the major contributing cause of her necrotic uterine fibroid condition and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not credible and concluded that she had failed to establish that her infarcted uterine fibroid condition was compensable. We disagree.

The initial question presented on review is claimant's credibility. Based on her demeanor at hearing, as well as the substance of her testimony, the ALJ concluded that claimant was not credible. Although we generally defer to an ALJ's demeanor-based credibility finding, we decline to do so in this case. As explained below, we find claimant's testimony regarding her work activity on October 19, 1995 is consistent, unrebutted, and supported by the contemporaneous medical documentation. We, therefore, give the ALJ's credibility finding little weight. See Erck v. Brown Oldsmobile, 311 Or App 519, 528 (1991); Davies v. Hamel Lumber Co., 67 Or App 35 (1984); Steve L. Nelson, 43 Van Natta 1053 (1991), aff'd mem 113 Or App 474 (1992).

To begin, there is no dispute that claimant participated in a lengthy at-work meeting on October 19, 1995. Similarly, there is no dispute that claimant sat in a "child's chair" throughout the course of that meeting. Moreover, the contemporaneous medical evidence confirms the work activities. The October 22, 1995 emergency room intake form stated that claimant had pain since a 3-1/2 hour meeting during which she sat in a child's chair. (Ex. 8A). The emergency room physician's reports stated that claimant "believes the pain came on after [she] had been seated in a small chair that she felt constricted in and sat in it for approximately 3-1/2 hours for a meeting." (Ex. 10).

Dr. Goetsch's October 24, 1995 reports indicated that claimant experienced abdominal pain after sitting in a cramped position in a small chair for several hours. (Exs. 13, 14, 16). In a November 17, 1995 827 Form, claimant indicated that she first noticed abdominal pain after she sat for 3-1/2 hours in a position cramping her abdomen on a small child size chair. (Ex. 19). The November 30, 1995 employer-prepared 801 Form's description of the accident reported that claimant "stated [she] was seated in a small chair for about 3-1/2 hours in Individual Education Plan and when she stood up she was in pain." (Ex. 21). In a February 1, 1996 report, Dr. Goetsch indicated claimant had been sitting in a cramped position in a child's chair which required the knees to be drawn up in front of the abdomen. (Ex. 23). Finally, in her deposition, Dr. Goetsch described claimant's position in the chair as being "flexed and scrunched up." (Ex. 28-20).[1]

In addition, contrary to the ALJ's finding, claimant did not testify that sitting in the "child's chair" did not require her to draw her knees up to her abdomen. Rather, claimant testified that her sitting position required her to draw her knees up to her abdomen. (Tr. 41-42). Finally, the ALJ noted that claimant's testimony regarding being asymptomatic prior to October 19, 1995 was contradicted by the medical record. To the contrary, the medical record only indicates that claimant had experienced prior back pain (not pelvic pain) and specifically supports claimant's testimony that she did not experience prior pelvic symptoms. (Exs. 1-2, 3A, 11).

In light of the above, we conclude that claimant's testimony is credible with regard to her work activities on October 19, 1995. To the extent that her testimony regarding whether she discussed a possible surgery in 1992 with her physicians was not consistent, such inconsistencies relate to a collateral matter and are not sufficient to detract from claimant's testimony regarding her 1995 work activities. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

Although claimant's credible testimony establishes legal causation, she must still prove medical causation.[2] In this regard, the medical evidence is in agreement that claimant's fibroid condition preexisted the October 19, 1995 work activities and that both the preexisting condition and the work

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[1] Unlike the ALJ, we do not consider Dr. Goetsch's use of the non-medical terms "flexed and scrunched up" to mean anything different than what Dr. Goetsch had previously described, i.e., claimant was in a cramped position in a small chair for a lengthy amount of time.

[2] We agree with the ALJ's conclusion that claimant's "injury" occurred in the course and scope of her employment. The sitting activity on October 19, 1995 occurred during claimant's work shift while she was performing her job duties. Moreover, we consider sitting in a "child's chair" for a lengthy amount of time to be a risk of claimant's employment. Contrary to the employer's argument, the fact that claimant had a preexisting fibroid condition, although relevant to medical causation, does not take claimant out of the course and scope of her employment.

activity contributed to claimant's need for treatment. (Exs. 23-25). Therefore, in order to establish compensability, claimant must prove that her work activities on October 19, 1995 were the major contributing cause of her need for medical treatment or disability for her combined condition. ORS 656.005(7)(a)(B); SAIF v. Nehl, 148 Or App 101, recon 104 Or App 309 (1997). Determination of the major contributing cause involves evaluating the relative contribution of different cause 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 dismissed 320 Or 416 (1995).

Dr. Goetsch reported that claimant's position in the child's chair for an extended period of time caused a lack of blood flow to her fibroid causing it to infarct and necrose which necessitated the hysterectomy. (Ex. 23). Dr. Goetsch explained that claimant's fibroids had been asymptomatic for years and that it was medically probable that the cramped position in which claimant was sitting was the major cause of the necrotic fibroid tumor and need for surgery. (Ex. 26-9). In her deposition, Dr. Goetsch acknowledged that a hysterectomy would not have been necessary if claimant did not have uterine fibroids, but continued to opine that the major cause of the necrosed fibroid and need for surgery was claimant's work activities on October 19, 1995. (Ex. 28-25, 32).

Dr. Schrinksy, who performed a records review at the request of the employer, also acknowledged that the preexisting fibroid and claimant's work activities were both necessary to cause the infarction of the fibroid. (Ex. 25-2). Dr. Schrinksy concluded that "sitting in a chair for a prolonged period of time in the presence of a large pelvic mass probably was a significant causative factor in the need for surgery (somewhere over 51%)." (Ex. 25-3).

Conversely, Dr. Casperson, who also performed a records review at the request of the employer, opined that while sitting in a cramped position may have precipitated the infarction, the presence of the fibroids were per se, the necessary cause of claimant's need for surgery. (Ex. 24-3). Dr. Casperson concluded that it was simply a "fortuitous situation" that the infarction occurred while claimant was sitting in the chair at work. (Id.)

When medical opinion is divided, the opinion of the treating physician is generally accorded deference, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons to discount the opinion of Dr. Goetsch. Moreover, we are not persuaded by the contrary opinion of Dr. Casperson. Dr. Casperson acknowledged that the size of claimant's uterus did not indicate that the fibroid would infarct. (Ex. 24-3). In addition, he acknowledged that claimant's work activities may have been a factor in the infarction. (Id.). However, Dr. Casperson then concluded that since claimant had a large uterus, sitting in a chair could not cause an infarction. On this basis, Dr. Casperson concluded that claimant's fibroids caused the need for treatment and her work activities were merely "fortuitous." (Id.). We find Dr. Casperson's opinion inconsistent and lacking in analysis and, therefore, not persuasive.

Based on the well-reasoned opinion of Dr. Goetsch, as supported by the opinion of Dr. Schrinsky, claimant has established that her work activities on October 19, 1995, were the major contributing cause of her necrosed fibroid and need for surgery. See ORS 656.005(7)(a)(B). Accordingly, the employer's denial must be 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 $4,000, 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 brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 16, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the self-insured employer's denial is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is award a reasonable assessed attorney fee of $4,000, payable by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
NANCY L. KUEHL, Claimant
WCB Case No. 97-00665
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a current low back condition; (2) upheld the insurer's "de facto" denial of claimant's claim for an August 26, 1996 new low back injury; (3) found that claimant's May 12, 1996 injury claim was not prematurely closed; and (4) declined to award temporary disability benefits for periods after August 5, 1996. On review, the issues are compensability, premature closure, and temporary disability.

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

The second sentence in the second full paragraph on page three is corrected to read: "Even though earlier reports had mentioned other incidents after May 1996, the first mention of any further incident in August 1996 was in January 1997 (exhibit 68C)."

In addition, we agree with the ALJ that claimant has not established that her May 12, 1996 compensable injury and/or the claimed August 26, 1996 incident are the major contributing cause of her current low back condition or her need for treatment for that condition.[1] See SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309, 312 (1997); Jesse M. Wright, 49 Van Natta 1118, on recon 1498, 1499 (1997) (Physician's "precipitating cause" analysis insufficient to establish that the work injury was the major contributing cause of the claimant's combined condition).

ORDER

The ALJ's order dated May 12, 1997 is affirmed.

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[1] We acknowledge claimant's contention that the insurer's September 17, 1996 rescission of its September 5, 1996 Notice of Closure constituted an acceptance of claimant's then current condition because its "acceptance includes the diseases contributing to the condition," citing Georgia Pacific v. Piwowar, 305 Or 494 (1988) and Emmert v. City of Klamath Falls, 135 Or App 209 (1995). Appellant's Brief, p. 6. However, Piwowar and Emmert were cases where the employers were deemed to have accepted underlying conditions when they accepted symptoms of those conditions (without limiting their acceptances in any manner). Here, in contrast, the insurer expressly limited its August 14, 1996 acceptance to a "lumbosacral strain." (Ex. 40). See Boise Cascade Corp. v. Katzenbach, 104 Or App 732, 735 (1990), rev den 311 Or 261 (1991) (Carrier's acceptance of a "strain" is not an acceptance of the worker's underlying condition). Nothing about the insurer's subsequent conduct persuades us that it accepted more than a strain.

In the Matter of the Compensation of
TERRELL G. LEE, Claimant
WCB Case No. 96-07978
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) found that the insurer's denial was limited to claimant's medical services for his accepted low back strain condition; and (2) dismissed his hearing requests from the insurer's denial for lack of jurisdiction. Should we determine that the Hearings Division has jurisdiction over this dispute, claimant seeks remand to the ALJ. On review, the issues are jurisdiction, remand and compensability. We reverse the ALJ's order, reinstate claimant's hearing requests, deny the motion to remand, and uphold the insurer's denial.

FINDINGS OF FACT

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

Claimant compensably injured his low back on February 20, 1995 while pushing a load of veneer. In March 1995, the insurer accepted a nondisabling acute lumbosacral strain. The claim was later reclassified as disabling on July 16, 1996. At the time of his compensable injury, claimant had preexisting asymptomatic congenital stenosis.

Claimant sought regular treatment for persistent low back pain and spasm between February 1995 and September 1995. On September 5, 1995, he was released for work with moderately increased activities as tolerated. Shortly thereafter, claimant was taken off work for a prolonged period for treatment of an unrelated kidney condition.

In January 1996, claimant returned to Dr. Hansen with complaints of continued, chronic low back pain. Dr. Rasmussen assumed claimant's treatment in February 1996. Dr. Rasmussen provided conservative care for claimant's persistent symptoms the first half of 1996.

On April 17, 1996, claimant experienced an acute exacerbation of his symptoms after lifting a heavy load of veneer and Dr. Rasmussen referred him to Dr. Karasek, a spinal specialist. Dr. Karasek first examined claimant on April 30, 1996. He suggested epidural steroids for diagnostic and possible therapeutic purposes. Dr. Karasek then performed facet and nerve root blocks with injections in May and June 1996.

While at work on June 21, 1996, claimant felt a sharp, incapacitating jolt of pain in his low back which radiated down his legs. He was transported by ambulance to the emergency room. Claimant then sought follow up treatment with Dr. Karasek, who referred him to Dr. Hacker, a neurosurgeon. Dr. Hacker evaluated claimant on July 23, 1996. Dr. Hacker diagnosed soft tissue injury with spinal stenosis and mild radicular distribution parasthesias.

Two days later, on July 25, 1996, claimant was examined by Dr. Anderson at the insurer's request. Dr. Anderson diagnosed lumbar strain and sprain, possible partial tear of the annulus of one of the lumbar discs and preexisting spinal stenosis. In November 1996, Dr. Young, a board-certified radiologist, performed a records review at the insurer's request.

On August 14, 1996, the insurer issued a partial denial of claimant's continued need for treatment and/or disability asserting that his current condition was due to his preexisting stenosis rather than the accepted lumbosacral strain.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Relying on SAIF v. Shipley, 147 Or App 26, rev allowed 326 Or 57 (1997), and Randy R. Kacalek, 49 Van Natta 475, on recon 49 Van Natta 1121 (1997), the ALJ concluded that the Hearings Division lacked jurisdiction because the parties' dispute involved only medical services. On review, both the insurer and claimant argue that these cases are distinguishable and that the compensability of claimant's current condition was properly before the Hearings Division for adjudication. We agree with the parties.

As set forth in the ALJ's order, the Shipley court held that, pursuant to ORS 656.245(6), the Board and Hearings Division lack jurisdiction to consider disputes that concern only the compensability of medical services.[1] In Shipley, the claimant received medical treatment for an off-the-job injury to his knee five years after closure of his compensable knee injury claim. The carrier denied that the claimant experienced a worsening of his compensable condition and declined to reopen the claim. The Hearings Division and Board assumed jurisdiction over the matter and determined that the claimant's medical services were compensably related to his accepted injury. On appeal, the carrier argued that the Board lacked jurisdiction because the case involved only a claim for medical benefits on a previously accepted claim. The claimant contended that, because the carrier denied the compensability of his current condition and need for treatment, it also denied the compensability of the "underlying claim" as described in ORS 656.245(6).

The court rejected the claimant's contention and agreed with the carrier that the Board lacked jurisdiction over the dispute. The court noted that the claimant never sought benefits for an aggravation of his accepted injury, nor did he seek to establish the compensability of a "new consequential condition." Rather, the court reasoned that the claimant sought only treatment of his current condition, contending that the treatment was compensable because it was materially related to his accepted injury. The court concluded that, because the dispute concerned only the compensability of medical services under ORS 656.245, the case was subject to the exclusive jurisdiction of the Director under ORS 656.245(6).

Similarly, in Randy R. Kacalek, we dismissed the claimant's request for hearing for lack of jurisdiction. We observed that the claimant was seeking medical treatment of his current condition in the absence of a denial of the accepted claim. As in Shipley, by the time the case went to hearing, the sole issue was whether the claimant's need for treatment for his current condition was related to his compensable injury. The claimant was not asserting a claim for a new, unaccepted condition, as is claimant in this case.

Unlike the claimants in Shipley and Kacalek (who sought only treatment and did not seek to establish the compensability of a new condition), claimant in this case is asserting the compensability of a new medical condition, i.e., a combined condition involving his preexisting stenosis and his accepted lumbosacral strain, as well as the compensability of his current need for treatment of that condition. Therefore, the dispute in this case goes beyond a medical services dispute on a previously accepted claim. Although part of the benefits potentially flowing from a resolution of this dispute in claimant's favor would include medical treatment for his current condition, the claim is not limited to just medical benefits for his previous strain condition. Rather, the dispute concerns claimant's claim for his new combined condition that gave rise to the need for those services. Therefore, the insurer's denial is a denial of the underlying claim and, as such, the Hearings Division retains jurisdiction to resolve the dispute. See, e.g., Jacqueline J. Rossi, 49 Van Natta 1844 (1997) (Board retained jurisdiction pursuant to ORS 656.246(6) where claimant's claim for right knee surgery was tied to a claim for compensability of the combined condition giving rise to that claimed treatment); Charles Bertucci, 49 Van Natta 1833 (1997) (Board retained jurisdiction where claimant's claim for hearing aids was tied to a claim for the compensability of a new condition: his "post-retirement" hearing loss). Consequently, the Board retains jurisdiction over the medical services/compensability dispute in this case.

Remand

As noted above, claimant argues that the claim should be remanded to the ALJ for a decision in the merits. Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding.

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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."

In this case, we find no compelling reason to remand. Although the ALJ ultimately determined that the Hearings Division lacked jurisdiction, she did so after a complete record had been submitted and the parties had litigated the compensability of claimant's current combined condition at hearing. Because the evidence on compensability has been sufficiently developed, and our review is de novo, we decline claimant's request for remand.

Compensability

As discussed above, claimant seeks to establish the compensability of his current combined condition. Pursuant to ORS 656.005(7)(a)(B), claimant must establish that his compensable injury is the major contributing cause of the disability of his combined condition or the major contributing cause of the need for treatment of the combined condition. In other words, claimant must show that his compensable injury, the accepted lumbosacral strain, contributed more to his current disability or need for treatment than all other causes or exposures combined. See Dietz v. Ramuda, 130 Or App 397, rev dismissed 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of different causes and explain why the work exposure or injury contributes more to the claimed condition than all other causes or exposures combined).

Where, as here, the medical evidence concerning causation is divided, 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, the opinions of claimant's treating physicians are divided. While both Dr. Karasek and Dr. Rasmussen agree that claimant's compensable injury caused a worsening of his preexisting spinal stenosis,[2] only Dr. Rasmussen has opined that claimant's February 20, 1995 work injury was the major contributing cause of claimant's current condition and need for treatment. Dr. Karasek, a spinal specialist, has essentially agreed with Dr. Anderson's and Dr. Young's determination that claimant's preexisting, noncompensable spinal stenosis is the major contributing cause of his current condition.

Dr. Karasek began treating claimant in April 1996, on referral from Dr. Rasmussen. In early August 1996, Dr. Karasek concurred with Dr. Anderson's assessment that claimant's spinal stenosis was the greater contributing cause to claimant's condition at that time. (Ex. 24). A few weeks later, Dr. Karasek reported that he could not determine which factor was contributing more to claimant's current need for treatment, the compensable injury or the preexisting stenosis. (Ex. 26A). In a subsequent "check the box" report, Dr. Karasek opined that claimant's February 20, 1996 injury caused an objective worsening of claimant's low back condition, as reflected by claimant's limited range of motion and spasms in the paravertebral muscles, but he agreed that the preexisting spinal stenosis was the major cause of claimant's current low back pain. (Ex. 28).

In response to the same "check the box" letter, Dr. Rasmussen indicated he did not agree with the IME report, and that it was his opinion that claimant's February 20, 1995 compensable injury was the major cause of claimant's current combined condition. Dr. Rasmussen noted only that "irritation of spinal joints--facets--seemed a major cause of pain--more than the stenosis." (Ex. 29).

In contrast to Dr. Karasek's and Dr. Rasmussen's conclusory, "check the box" reports, Dr. Young, a radiologist, who reviewed claimant's medical records at the employer's request, provided a reasoned explanation for claimant's current condition. Dr. Young reported that claimant's compensable injury may have been the precipitating event, the "last straw" leading to claimant's low back symptoms, but the major cause of claimant's ongoing disability was his preexisting condition, including the congenital narrowing of the spinal canal and degenerative disc disease. (Ex. 30). He explained that claimant's imaging studies showed no evidence of nerve root irritation and no objective findings of radiculopathy, indicating that the compensable injury was probably not a significant event and did not cause any neurological impairment. Based on the absence of any findings of neurological impairment, Dr. Young concluded that the compensable injury was not the major cause of claimant's current need for treatment. Id. Dr. Young stated that the compensable injury was only a small event, an additional event of wear and tear in the aging and degenerative processes in claimant's low back. Id. at 18.

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[2] Dr. Young, on the other hand, opined that claimant's compensable injury did not cause a pathological worsening of his preexisting condition. (Ex. 27).

Because Dr. Rasmussen's opinion is lacking in reasoning and explanation, we give it little weight. See, e.g., Marta I. Gomez, 46 Van Natta 1654 (1994) (Board gives the least weight to conclusory, poorly analyzed opinions, such as unexplained, conclusory "check-the- box" reports). Given the opinions of Drs. Karasek and Anderson, read in conjunction with the well-developed opinion of Dr. Young (which all identify claimant's preexisting stenosis as the major cause of his current disability and need for treatment), we find that claimant has failed to establish the compensability of his current condition under ORS 656.007(7)(a)(B). We therefore uphold the employer's current condition denial.

ORDER

The ALJ's order dated May 8, 1997 is reversed. Claimant's request for hearing is reinstated. The employer's current condition denial is reinstated and upheld.

November 28, 1997 Cite as 49 Van Natta 2044 (1997)

In the Matter of the Compensation of
STEVEN J. LASSEIGNE, Claimant
WCB Case No. C702718
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

The cover letter from the SAIF Corporation, accompanying the CDA states: "The signature line for DCBS is in error. Please ignore and process in the normal course." In addition, the CDA contains a signature block for the Director of the Department of Consumer and Business Services which has been deleted by interlineation.

On page 4, however, the agreement provides, "[t]his Claim Disposition Agreement has qualified for reimbursement or may be eligible for reimbursement from the Workers' Benefit Fund, approval by the Director of the Department of Consumer and Business Services (or the Director's authorized representative) of this Claim Disposition Agreement is a condition precedent to the settlement of this claim. Absent such approval, the settlement is void."

In light of this apparent inconsistency, we have reached the following conclusion regarding the parties' intentions. Although the parties apparently included the Director's signature line in error, they neglected to delete the paragraph on page 4 of the agreement providing that the settlement is void without the approval of the Director. Because it is evident that this paragraph was included in error, we interpret the agreement as if the paragraph on page 4 had been deleted.

As clarified by this order, the agreement is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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
DANA K. MOORE, Claimant
WCB Case No. 97-00134
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that increased claimant's unscheduled permanent disability for a cervical condition from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration,[1] to 33 percent (105.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

On October 25, 1994, claimant, a welder, compensably injured her neck and upper back. Claimant's treating physician was Dr. Linehan. On May 17, 1995, SAIF accepted a claim for a contusion, strain of upper shoulder girdle and cervical strain. (Ex. 15).

On September 8, 1995, SAIF sent claimant a letter indicating that she had not seen Dr. Linehan since August 11, 1995. (Ex. 21). SAIF indicated that if claimant did not seek further medical treatment within 14 days, it would close the claim. (Id.) On October 10, 1995, SAIF requested administrative closure of the claim due to claimant's lack of response to the September 8, 1995 letter. (Ex. 22). A Determination Order dated October 27, 1995 awarded temporary disability benefits, but no permanent disability. (Ex. 24). Claimant requested reconsideration, asserting, among other things, that the claim was prematurely closed. (Ex. 27).

On December 7, 1995, claimant was examined by Dr. Parsons for neck and left arm pain. (Ex. 29). A CT scan showed a disc protrusion at C5-6, which Dr. Parson felt was compatible with claimant's left sided radiculopathy. (Ex. 30). On December 20, 1995, Dr. Parsons performed a cervical laminectomy at C5-6. (Ex. 35). SAIF reopened the claim for a C5-6 disc herniation. (Ex. 38).

A medical arbiter examination was scheduled for January 19, 1996. (Ex. 42, 43). Because of claimant's recent cervical surgery, SAIF requested cancellation of the examination and asked that the reconsideration order be determined based on the record developed at the time of the October 27, 1995 Determination Order. (Exs. 45, 46). Claimant requested postponement and the arbiter's examination was postponed until her condition could be accurately evaluated. (Exs. 48, 49).

On February 27, 1996, Dr. Parsons reported that claimant's degree of numbness and weakness seemed to be out of proportion to the other physical findings. (Ex. 51). He was concerned about her use of prescription pain medication. (Id.) In May and June 1996, Dr. Parsons again expressed his concern about claimant's use of prescription pain medication. (Exs. 54, 55). On June 18, 1996, he reported that claimant was medically stationary and had some permanent physical impairment. (Ex. 55-2). He noted that it was difficult to determine the extent of claimant's impairment based on a rather diffuse weakness of her left shoulder and arm and he requested the assistance of an independent medical examination to determine the extent of her impairment. (Id.)

A physical capacity evaluation was performed on July 3, 1996, which placed claimant in the light/medium range of work. (Ex. 61). Claimant's work at injury had been heavy. Dr. Parsons concurred with the findings of the July 3, 1996 physical capacity evaluation. (Ex. 63). He did not feel claimant could return to her regular work as a welder. (Id.)

On August 13, 1996, claimant was examined by Dr. Farris, on behalf of SAIF. Dr. Farris reported that claimant had marked functional behavior and there were no objective findings. (Ex. 65-5). Claimant had marked give-way weakness in a non-anatomical fashion and marked sensory loss in a non-anatomical distribution. (Id.) Dr. Farris reported that range of motion was variable and felt to be non-anatomical, but under the volition of claimant. (Id.) He concluded that claimant's functional overlay was to the degree that an accurate assessment of her current condition could not be performed. (Ex. 65-8).

[1] At hearing, SAIF conceded that the adaptability factor used in the reconsideration process was inaccurate and claimant was actually entitled to the 20 percent awarded by the October 9, 1996 Notice of Closure.

Dr. Parsons was asked to comment on Dr. Farris' report and the July 3, 1996 physical capacity examination. Dr. Parsons considered all measurements of cervical motion, sensory loss, and motor weakness to be invalid for rating claimant's permanent impairment. (Ex. 68).

On September 11, 1996, SAIF notified the Appellate Review Unit that it was appropriate to schedule an arbiter's examination as part of the reconsideration process of the October 27, 1995 Determination Order. (Ex. 67). On November 15, 1996, claimant was examined by Drs. Martens, Thomas and Bell. (Ex. 75). The arbiter panel reported that claimant had a limited and partial loss of ability to repetitively use the cervical spine due to the injury and the December 1995 cervical laminectomy. (Ex. 75-3). The panel reported cervical range of motion findings and determined that muscle strength testing was probably invalid. (Exs. 75-3, -4).

On December 6, 1996, an Order of Reconsideration issued, affirming the October 27, 1995 Determination Order in all respects. (Ex. 80). The Appellate Reviewer noted that there was not a preponderance of medical opinion in the record, including the arbiter examination, to establish that any permanent impairment existed at the time the claim was administratively closed on October 27, 1995. (Ex. 80-2).

On October 9, 1996, a Notice of Closure issued, awarding claimant 20 percent unscheduled permanent disability. (Ex. 70). Claimant requested reconsideration. (Ex. 76). A medical arbiter examination was scheduled for January 31, 1997. (Exs. 81, 84, 85). In the meantime, claimant reported to Dr. Parsons that she had fallen and broken her scapula. (Ex. 86). On February 6, 1997, the Appellate Review Unit concluded that, because of claimant's new injury, a medical arbiter examination was not appropriate at the time. (Ex. 87). SAIF did not consent to a postponement of the arbiter examination and the exam was cancelled. (Ex. 88-1). On February 14, 1997, an Order of Reconsideration issued regarding the October 9, 1996 Notice of Closure. (Ex. 88). Claimant was awarded 12 percent unscheduled permanent disability.[2] (Ex. 88

Claimant requested a hearing on the December 6, 1996 Order on Reconsideration, raising issues of premature closure, penalties and attorney fees. She also requested a hearing on the February 14, 1997 Order on Reconsideration, raising issues of scheduled and unscheduled disability, permanent disability, penalties and attomey fees.

CONCLUSIONS OF LAW AND OPINION

December 6, 1996 Order on Reconsideration

We adopt and affirm the ALJ's reasoning and conclusion that claimant's claim was appropriately closed by the October 27, 1995 Determination Order.

February 14, 1997 Order on Reconsideration

Based on the November 15, 1995 medical arbiter examination, the ALJ concluded that claimant was entitled to 33 percent unscheduled permanent disability. The ALJ reasoned that, although the arbiter examination was a result of reconsideration of the first closure, the examination focused on claimant's impairment at the time of the examination, which occurred after the second closure.

SAIF agrees that claimant is entitled to 20 percent unscheduled permanent disability as awarded by the October 9, 1996 Notice of Closure. SAIF contends, however, that the ALJ erred by awarding an additional 13 percent impairment based on decreased cervical ranges of motion. SAIF argues that the ALJ erred by relying on the medical arbiter panel's examination from the first closure to rate disability from the second closure.

To be entitled to permanent disability compensation for her cervical condition, claimant must establish that the impairment is due to her compensable condition. ORS 656.214(5). OAR 436-035-0007(13) (WCD Admin. Order 96-051) provides:

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[2] At hearing, SAIF conceded claimant was actually entitled to the 20 percent awarded by the Notice of Closure.

> "Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0080 except where a preponderance of medical opinion establishes a different level of impairment pursuant to ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence." (Emphasis added).

Here, a medical arbiter was not "used" on reconsideration of the October 9, 1996 Notice of Closure. Although an arbiter panel's examination was scheduled, it was determined that the examination would not be appropriate because claimant had sustained a new injury. (Ex. 87). SAIF did not consent to a postponement of the arbiter examination. (Ex. 88-1). Therefore, the record developed at the time of the October 9, 1996 closure constituted the record on reconsideration. (Id.) Because a medical arbiter was not "used" for the second closure, the February 14, 1997 Order of Reconsideration did not rely on any arbiter's examination for its impairment findings.[3] (Ex. 88).

OAR 436-035-0007(13) provides that impairment is established by the attending physician, except where a preponderance of medical opinion establishes a different level of impairment. Claimant's attending physician was Dr. Parsons, who performed a cervical laminectomy at C5-6 on December 20, 1995. On February 27, 1996, two months after surgery, Dr. Parsons reported that claimant's degree of numbness and weakness seemed to be out of proportion to the other physical findings. (Ex. 51). He was concerned about her use of prescription pain medication. (Id.) In May and June 1996, Dr. Parsons again expressed his concern about claimant's use of prescription pain medication. (Exs. 54, 55). On June 18, 1996, he reported that claimant was medically stationary and had some permanent physical impairment. (Ex. 55-2). He noted that it was difficult to determine the extent of claimant's impairment based on a rather diffuse weakness of her left shoulder and arm and he requested the assistance of an independent medical examination to determine the extent of her impairment. (Id.)

A physical capacity evaluation was performed on July 3, 1996, which placed claimant in the light/medium range of work. (Ex. 61). Claimant's work at injury had been heavy. The evaluators reported:

> "Pain behaviors were favoring her left hand in all handling activities, holding and rubbing her left wrist, forearm and shoulder, and holding the back of her neck. During lift and carry the worker appeared to struggle to reach her maximum load, indicating good effort. However, three out of five tests for worker reliability were abnormal, indicating mixed reliability during this evaluation. Pain rating indicated common levels of pain up to the 'highest imaginable.' On repetitive grip strength testing five of ten coefficients of variation were abnormal, indicating less than maximum voluntary effort with grip strength test. Borg scale rating of perceived exertion indicated exaggerated reporting of exertion compared to her body's physiologic response. Despite mixed reliability measures, given the worker's efforts with the lift test, this is felt to be an accurate reflection of this worker's physical capacities." (Ex. 61-1).

Dr. Parsons concurred with the findings of the July 3, 1996 physical capacity evaluation. (Ex. 63). He did not feel claimant could return to her regular work as a welder. (Id.)

On August 13, 1996, claimant was examined by Dr. Farris, on behalf of SAIF. Dr. Farris reported that claimant had marked functional behavior and there were no objective findings. (Ex. 65-5). Claimant had marked give-way weakness in a non-anatomical fashion and marked sensory loss in a

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[3] The only medical arbiter's examination in the record was in connection with the reconsideration of the first closure, the October 27, 1995 Determination Order, which awarded only temporary disability benefits. (Ex. 24). When claimant requested reconsideration of that determination order, she asserted, among other things, that the claim was prematurely closed and her condition was not medically stationary. (Ex. 27). On December 6, 1996, an Order of Reconsideration issued, affirming the October 27, 1995 Determination Order in all respects. (Ex. 80). The Appellate Reviewer noted that there was not a preponderance of medical opinion in the record, including the arbiter examination, to establish that any permanent impairment existed at the time the claim was administratively closed on October 27,1995. (Ex. 80-2).

non-anatomical distribution. (Id.). Dr. Farris reported that range of motion was variable and felt to be non-anatomical, but under the volition of claimant. (Id.) He concluded that claimant's functional overlay was to the degree that an accurate assessment of her current condition could not be performed. (Ex. 65-8).

Dr. Parsons was asked to comment on Dr. Farris' report and the July 3, 1996 physical capacity examination. Dr. Parsons responded:

> "The range of motion of the cervical spine as measured at the August 13, 1996 IME and the July 3, 1996 PCE are as accurate as possible considering the subjective responses under the volition of the worker. The variability of the ranges are non-anatomical and are not valid for rating purposes. This is also true of the findings of sensory loss and motor weakness in [claimant's] left upper extremity. Due to the patient's functional overlay, the presence of any sensory loss or motor weakness cannot be determined. If the patient does have any permanent injury of the left C6 nerve root, one might expect some numbness in the left thumb and index finger, and possibly a mild weakness of grip with her left hand. Objectively, we can not determine if in fact she has any impairment whatsoever. I therefore consider all measurements of cervical motion, sensory loss, and motor weakness to be invalid for rating her permanent impairment. It remains unknown if [claimant] has any impairment or not." (Ex. 68).

For the purpose of rating disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter, if any, may be considered. See ORS 656.245(2)(b)(B), 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442, 445, rev den 320 Or 271 (1994); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). We rely on the most thorough, complete, and well-reasoned evaluation of thd claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994). In addition, absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

After considering the medical evidence, we find no persuasive reason not to rely on the complete, well-reasoned opinion of claimant's attending physician, Dr. Parsons. Dr. Parsons had the benefit of comparing his past examinations of claimant. He reported two months after surgery that claimant's degree of numbness and weakness was out of proportion to her other physical findings. (Ex. 51). In his September 19, 1996 report, Dr. Parsons explained why he did not believe that claimant's measurements of cervical motion, sensory loss, and motor weakness were valid. (Ex. 68). Based on Dr. Parsons' opinion, we conclude that claimant's cervical range of motion findings are invalid and are insufficient for rating her permanent disability. Although claimant relies on the November 15, 1995 medical arbiter panel's opinion to establish impairment, there is no evidence that Dr. Parsons' concurred with those findings. As we discussed earlier, there was no medical arbiter "used" on reconsideration of the October 9, 1996 Notice of Closure. See OAR 436-035-0007(13). Therefore, we conclude that claimant is not entitled to an award for reduced cervical range of motion. We reinstate the 20 percent unscheduled permanent disability as awarded by the October 9, 1996 Notice of Closure.

Alternatively, even if we consider the arbiter panel's November 15, 1995 examination to rate disability from the second closure, we are not persuaded by claimant's argument that she is entitled to 33 percent unscheduled permanent disability.

On November 15, 1995, the medical arbiter panel reported that claimant's range of motion of the cervical spine was: flexion 30 degrees, extension 24 degrees, lateral reflexes right 30 degrees and left 32 degrees, right rotation 44 degrees and left 40 degrees. (Ex. 75-3). Although the panel determined that claimant's muscle strength testing was probably invalid (Ex. 75-4), it made no comments regarding claimant's range of motion findings.

Dr. Farris examined claimant on August 13, 1996 and reported that claimant had marked functional behavior and no objective findings. (Ex. 65-5). He concluded that claimant's functional overlay was to the degree that an accurate assessment of her current condition could not be performed. (Ex. 65-8).

Claimant's attending physician, Dr. Parsons, reported that he considered all measurements of cervical motion, sensory loss, and motor weakness to be invalid for rating claimant's permanent impairment. (Ex. 68).

After considering the medical evidence, we conclude that Dr. Parsons provided the most thorough, complete, and well-reasoned evaluation of the claimant's impairment. As we discussed earlier, Dr. Parsons had more contact with claimant and had the benefit of comparing his past examinations of claimant. He reported two months after surgery that claimant's degree of numbness and weakness was out of proportion to her other physical findings. (Ex. 51). In his September 19, 1996 report, Dr. Parsons explained why he did not believe that claimant's measurements of cervical motion, sensory loss, and motor weakness were valid. (Ex. 68). Dr. Parsons agreed with Dr. Farris' conclusion that the cervical ranges of motion were non-anatomical and were not valid for rating purposes. On the other hand, the medical arbiter panel examined claimant on one occasion and did not explain whether or not claimant's cervical range of motion findings were valid. In light of Dr. Parsons' past experience with claimant and his conclusion that the cervical range of motion findings were invalid, we defer to Dr. Parsons' opinion and conclude that the cervical range of motion findings are insufficient for rating claimant's permanent disability.

ORDER

The ALJ's order dated May 19, 1997 is modified. In lieu of the ALJ's award and in addition to the February 14, 1997 Order of Reconsideration award of 12 percent (38.4 degrees) unscheduled permanent disability, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, for a total award of 20 percent (64 degrees) unscheduled permanent disability for her cervical condition. Claimant's counsel's out-of-compensation attorney fee from this award shall be adjusted accordingly.

November 28, 1997 Cite as 49 Van Natta 2049 (1997)

In the Matter of the Compensation of
GARRY L. STEFFY, Claimant
WCB Case No. 96-07420
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the insurer's denial of claimant's aggravation claim for a right shoulder injury. On review, the issue is aggravation.

We adopt and affirm the ALJ's order with the following supplementation. We do not adopt the following statement: "Dr. Deming has expressed opinions on both sides of the issue."

Claimant contends that he proved a compensable aggravation of his accepted right shoulder condition. According to claimant, he proved a "pathological worsening" of his accepted condition with evidence that his treating physician increased his work restrictions and he exhibited decreased range of motion. The ALJ found that the evidence showed only that claimant "experienced increased symptoms which required further treatment and temporary activity restrictions," and, because such a showing was not enough to prove a compensable aggravation, upheld the denial.

In order to prove a compensable aggravation, claimant must establish an "actual worsening." ORS 656.273(1). In SAIF v. Walker, 145 Or App 294, 305 (1996), rev allowed 325 Or 367 (1997), the court interpreted the "actual worsening" language in ORS 656.273(1) to require direct medical evidence that a condition has worsened. 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. 145 Or App at 305. 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.

Here, the record contains two opinions concerning the "actual worsening" issue. Examining orthopedic surgeon, Dr. Neumann, found that claimant had not sustained a "worsening" and that his symptoms represented a "waxing-and-waning" of his condition. (Ex. 57).

Claimant's treating surgeon, Dr. Deming, first reported to claimant's attorney that claimant's sweeping work "aggravated his symptoms" and that claimant was put on light duty. (Ex. 74). Dr. Deming further stated that, in June 1996, claimant could not abduct his shoulder beyond 90 degrees, a decrease from March 1995, when claimant abducted to 170 degrees. (Id.). Dr. Deming then concurred with a "check-the-box" report from the insurer's counsel stating that there had been no actual worsening of the right shoulder condition and, based on claimant's past history, he would expect claimant's symptoms to wax and wane. (Ex. 77-1A). Dr. Deming also agreed that he could not say that the waxing and waning of symptoms was greater than would be expected from claimant's previous award of 11 percent permanent disability. (Ex. 77-2).

Dr. Deming was then deposed. Dr. Deming reiterated that, based on claimant's history, he would expect claimant to "have some worsening occasionally." (Ex. 78-14). Dr. Deming also indicated that he agreed with Dr. Neumann's report stating that claimant had experienced a waxing and waning of his condition and that a MRI performed in October 1996 did not reveal an "actual worsening" of claimant's condition. (Id. at 24). Finally, although agreeing that there had been a "worsening," (id. at 28), Dr. Deming stated that there was "no actual evidence that there's a worsening of the disease process," and agreed that claimant had sustained only a "symptomatic worsening" or "worsening of symptoms," (id. at 33).

We agree with the ALJ that claimant failed to prove an "actual worsening." There is no evidence of a pathological worsening of the underlying condition. Furthermore, although Dr. Neumann and Dr. Deming agreed that claimant's condition had symptomatically worsened, there was no expert evidence that such worsening is of such a degree that the condition worsened; rather, both physicians agree that claimant's symptoms reflect a "waxing and waning" of his condition.

Finally, we note claimant's reliance on Marcum v. City of Hermiston, 149 Or App 392 (1997), in asserting that claimant's reduced range of motion proves a compensable aggravation. As noted by claimant, the issue in Marcum was whether claimant's "worsened" knee condition was in major part caused by an off-work incident. Because the court was not directly deciding whether claimant proved an "actual worsening," we find the case distinguishable. Moreover, we emphasize that our order is not holding that reduced range of motion always, or never, constitutes an "actual worsening." Rather, consistent with the approach in Walker, such a finding is considered, as well as any other relevant factors, in deciding whether there is expert medical evidence of a pathological worsening or that symptoms have increased to the point that it can be said that the condition has worsened. Here, as discussed above, the expert medical opinions fail to carry claimant's burden of proof.

ORDER

The ALJ's order dated April 18, 1997 is affirmed.

In the Matter of the Compensation of
RICKEY A. STEVENS, Claimant
WCB Case No. 96-00962
ORDER ON RECONSIDERATION (REMANDING)
Emmons, Kropp et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Claimant requested reconsideration of that portion of our September 11, 1997 order that denied claimant's request for remand and upheld the SAIF Corporation's denial. Specifically, claimant contends that remand is appropriate for two reasons: (1) to take the testimony of two witnesses who failed to appear for the second day of hearing; and (2) to have a hearing on the merits, including the Administrative Law Judge's (ALJ's) assessment of credibility.

In order to consider claimant's motion, we withdrew our prior order on October 10, 1997. SAIF has submitted a response. We now address claimant's motion.

We begin with a recap of the procedural posture of the case. Claimant filed a request for hearing on SAIF's denial of his low back injury claim. The hearing convened on April 17, 1996, at the Santiam Correctional Institution in Salem, Oregon. At the commencement of the hearing, claimant requested a continuance because two alleged eyewitnesses, Mr. and Mrs. Reed, were not permitted to enter the correctional facility. The motion was granted by the ALJ.

The hearing was reconvened on December 4, 1996, at the Workers' Compensation Board hearing rooms in Salem, Oregon. Mr. and Mrs. Reed failed to appear. Claimant requested a continuance to allow their testimony, to which SAIF objected. The ALJ declined to continue the hearing, although he agreed to admit the Reeds' testimonies, provided that they appeared by the time of closing arguments.

In his order, the ALJ dismissed claimant's hearing request on the basis that it was untimely filed. On review, we reversed the order of dismissal, reinstated claimant's hearing request, denied claimant's request for remand, and found the claim not compensable. Claimant requested reconsideration of those portions of our order denying remand and upholding SAIF's denial for the reasons stated above.

On review, the insurer argued that claimant was not credible and asserted that he failed to prove that his injury occurred as alleged, and that claimant's failure to produce the alleged witnesses to the incident should be construed against him. In response, claimant moved for remand to the ALJ, as the ALJ made no findings (including an assessment of the witnesses' credibility) relative to the merits of the compensability issue.

We have previously declared that "[c]redibility is always potentially at issue in a compensability case." Jeffrey M. Fisher, 46 Van Natta 729, 730 (1994). In this case, credibility is directly at issue, since the insurer has specifically challenged claimant's credibility in regard to whether the injury occurred as claimant alleged. The compensability issue (including an evaluation of the witnesses' credibility) was before the ALJ at hearing and exhibits were admitted and testimony was given concerning that issue. However, as the ALJ dismissed claimant's request for hearing as untimely filed, he did not make findings concerning the witnesses' credibility or evaluate the evidence concerning the compensability issue. Inasmuch as claimant's (and the other witnesses') credibility is a central issue in this case, and is reasonably likely to affect the outcome of the case, we remand to ALJ Michael Johnson for reconsideration. See ORS 656.295(5); Neil W. Walker, 45 Van Natta 1597, 1598 (1993) (where the ALJ did not make credibility findings and did not evaluate evidence concerning occupational disease issue, remand was appropriate); Refugio Guzman, 39 Van Natta 808 (1987) (same).

On reconsideration, claimant also requested remand for the taking of testimony from Mr. and Mrs. Reed. Claimant contends that he stated the reasons why the witnesses were not called at hearing, and requested a continuance, which the ALJ denied. (Tr. 13). SAIF opposes remand. However, because we are already remanding the case to the ALJ, the ALJ shall proceed as follows.

We review an ALJ's "continuance" ruling for abuse of discretion. E.g., Herbert Gray, 49 Van Natta 714 (1997). Therefore, if the ALJ declines to reopen the record for the taking of the Reeds' testimonies on remand, then he shall supplement his reasoning in regard to his "continuance" ruling sufficient for us to review for abuse of discretion, should the ALJ's final order eventually be appealed. The ALJ shall also evaluate the credibility of the witnesses who have already testified and issue an order on the compensability issue.

Conversely, if the ALJ reopens the record for the taking of the Reeds' testimonies, then he shall evaluate the credibility of those additional witnesses, as well as that of the prior witnesses, and issue an order on the compensability issue.

Accordingly, on reconsideration of our September 13, 1997 order, we republish our prior conclusion that claimant's hearing request was timely. In addition, we vacate the ALJ's order dated January 24, 1997. This matter is remanded to ALJ Michael Johnson with instructions to issue a final, appealable order on remand in accordance with our instructions above.

On reconsideration, as modified herein, we adhere to and republish our September 13, 1997 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LANCE J. THOMPSON, Claimant
WCB Case No. C702835
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Black, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On November 6, 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 2, number 7, the agreement provides;

> "The claim was accepted as disabling. As such, the May 16, 1996 Notice of Acceptance also constitutes claim closure." (Emphasis added).

According to the Department's records, it appears that this claim was accepted as nondisabling rather than disabling. Thus, the statement on page 2 of the CDA is likely a typographical error. In any case, whether the claim has been accepted as disabling or nondisabling, a notice of acceptance does not constitute closure of a claim. Thus, we interpret the CDA as providing that the claim has never been closed. Accordingly, we find that the agreement satisfies OAR 438-009-0022(4)(b) (CDA must give a date of the first claim closure, if any).

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.

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
ERIC A. FRANCIS, Claimant
WCB Case No. 96-05021
ORDER ON REVIEW
Black, Chapman, et al, 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) Stephen Brown's order that awarded claimant temporary total disability benefits. On review, the issue is entitlement to temporary total disability. We reverse.

FINDINGS OF FACT

On November 7, 1995, claimant injured his left knee while in the course and scope of his employment. SAIF accepted claimant's injury as a disabling left knee strain. As a result of his compensable injury, claimant underwent surgery and was released from work. Claimant was paid temporary total disability benefits until April 19, 1996, at which time he returned to modified work with the employer. Claimant's benefits were reduced to temporary partial disability. Inasmuch as claimant's wage at the modified job was the same as his at-injury wage, claimant's rate of temporary partial disability benefits was zero.

On May 2, 1996, claimant was terminated by the employer for reasons unrelated to his compensable injury. At the time of claimant's termination, the employer had an "early return to work" policy in effect.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's "temporary employment had been terminated" pursuant to former OAR 436-060-0030(4) and therefore concluded that claimant was entitled to temporary total disability benefits. We disagree.

As a preliminary matter, we note that this dispute does not involve claimant's entitlement to temporary partial disability benefits. That is, there is no dispute that claimant has some injury-related limitations which restrict him to modified work. Rather, the issue here is whether claimant is entitled to receive temporary total disability benefits following his termination.[1]

Former OAR 436-060-0030(4) provides that temporary partial disability benefits will be paid at the rate of full temporary total disability benefits where a claimant is performing modified work and "a modified job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure." (Emphasis supplied).

It is clear from the context of the rule that the emphasized portion is an example, as are layoffs or plant closures, of a modified job offer being withdrawn or no longer existing. Moreover, the language of the rule, as well as the examples given, all involve circumstances within the control of the employer and not the injured worker. Based on the language and the context, we find that "termination of temporary employment" refers to the termination of the temporary employment itself and not a termination of a claimant from the temporary employment. See also Bradley S. Parker, 48 Van Natta 160, 161 (1996) (The claimant entitled to temporary total disability benefits under former OAR 436-60-030(11) where the claimant did not return to regular work following temporary work that lasted only a few days).

Under these circumstances, claimant did not suffer "a termination of temporary employment" that would entitle him to temporary total disability benefits pursuant to former OAR 436-060-0030(4).

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[1] We agree with the ALJ that ORS 656.325(5)(b) does not apply to this dispute. That provision applies where a carrier is seeking to reduce temporary total disability to temporary partial disability. As noted above, this dispute inolves claimant's request to increase his temporary disability benefits from partial to total.

Rather, claimant returned to modified work with the employer on April 9, 1996 and was terminated by the employer on May 2, 1996 for reasons unrelated to his compensable injury. Consequently, claimant is not entitled to temporary total disability benefits.[2] See Patricia K. Stodola, 48 Van Natta 613 (1996) (Carrier not obligated to pay temporary disability benefits where a claimant terminated from modified work for reasons unrelated to the compensable injury).

In reaching this conclusion, we disagree with the ALJ's statement that former OAR 436-060-0030(8) "evinces a legislative intent to restrict the holding" in Safeway Stores v. Owsley, 91 Or App 475 (1988). Both the former and current versions of the administrative rule contain language stating that termination from a modified job for violation of work rules or other disciplinary reasons would not be considered withdrawal of a job offer. See former OAR 436-060-0030(11)(b); current OAR 436-060-0030(8). However, the deletion of this language does not necessarily lead to the conclusion that the Department, assuming it had the authority, intended to grant temporary total disability benefits to an injured worker who left work for reasons unrelated to the compensable injury.

Temporary disability benefits are designed to compensate an injured worker for lost wages or diminished earning capacity that is attributable to the compensable injury. See Dawes v. Summers, 118 Or App 15 (1993); Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987), rev den 305 Or 102 (1988). Conversely, where an injured worker has lost wages, either in whole or in part, for reasons unrelated to the compensable injury, he/she is not entitled to temporary disability benefits. See Michael D. Wingo, 48 Van Natta 2477 (1996); Stodala, 48 Van Natta at 614.

The mere fact that the applicable version of the rule does not administratively equate termination of modified work for disciplinary reasons with refusal of wage earning employment does not relieve claimant of his burden of establishing that his lost wages or diminished earning capacity is attributable to the compensable injury. That is particularly true where, as here, the unrebutted evidence establishes that claimant's termination was due to "poor attitude and lack of respect" for his supervisor when asked to perform certain tasks. (Ex. 22).

Inasmuch as claimant has not established that he suffered additional lost wages or diminished earning capacity attributable to the compensable injury, he is not entitled to temporary disability benefits.

ORDER

The ALJ's order dated October 4, 1996 is reversed. The ALJ's award of temporary total disability benefits as of May 1, 1996 is reversed. The ALJ's award of an "out-of-compensation" attorney fee is also reversed.

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[2] As we stated earlier, because claimant had not been released to his regular work at the time of his termination, he remained entitled to temporary partial disability benefits. However, those benefits were properly computed at "zero" because his wage for performing the modified work was the same as his at-injury wage.

December 4, 1997 Cite as 49 Van Natta 2054 (1997)

In the Matter of the Compensation of
CORRINE BIRRER, Claimant
Own Motion No. 97-0466M
OWN MOTION ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Argonaut Insurance Co., Insurance Carrier

Claimant requests reconsideration of our November 6, 1997 Own Motion Order, in which we declined to award a penalty for the insurer's failure to pay temporary disability benefits because, prior to an Own Motion Order authorizing reopening, there are no "amounts then due" upon which to base a penalty.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANE L. ZACHARY, Claimant
WCB Case No. 96-02574
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
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 insurer's denial of her claim for a bilateral shoulder condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

In 1987, claimant began working for the employer as an editor. Her job duties included making written corrections on documents by hand and then entering those corrections into a computer. In mid-1994, claimant assumed a coordinator's position. As a coordinator, claimant hand-logged projects into the log book and distributed work to editors. In May 1995, claimant applied for and received the position of trainer. As a trainer, claimant was involved in teaching new employees about cataloging and editing rules. In performing her work duties, claimant used a computer keyboard to check the employee's editing work.

In late December 1995, claimant sought treatment from Dr. Kaeshe, M.D., for bilateral shoulder pain. X-rays of the right shoulder revealed calcific densities in the rotator cuff. Thereafter, she was treated by Dr. Lorish, M.D. Claimant filed an 801 Form alleging that her bilateral shoulder condition was related to her work activities. By letter dated February 13, 1996, the insurer denied claimant's claim on the basis that her work activities were not the major contributing cause of her condition or need for medical treatment.

On April 8, 1996, claimant was examined by Dr. Duff, orthopedist, at the request of the insurer. On April 16, 1996, claimant was examined by Dr. Wong, M.D., who diagnosed bilateral shoulder overuse syndrome. Thereafter, Dr. Wong became claimant's attending physician.

Claimant has preexisting calcific tendinitis in her shoulders. The preexisting condition combined with her bilateral overuse syndrome.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had not established that her bilateral shoulder condition was compensable. We agree.

Claimant's claim is for an occupational disease. The medical evidence is in agreement that both her preexisting calcific condition and her overuse syndrome contribute to her need for medical treatment. (Exs. 11, 12, 15, 16-8, 16-14). While claimant has a "combined" condition, her claim is not based on a worsening of her preexisting condition; therefore, ORS 656.802(2)(b) does not apply. See Ron L. Merwin, 49 Van Natta 1801 (1997) (ORS 656.802(2)(b) not applicable where the claimant's theory of compensability is not based on a worsening of the preexisting condition).

However, because claimant has a "combined" condition, in order to establish that her condition is compensable, claimant must show that her work activities were the major contributing cause of her

disability or need for treatment for the combined condition. ORS 656.802(2)(c); Richard E. Johnson, 49 Van Natta 282 (1997); John H. Davila, 48 Van Natta 769 (1996).[1]

Because both the preexisting calcific condition and the overuse syndrome contribute to claimant's condition, the issue of the causal relationship between her combined condition and the work activities is a complex medical question. Thus, while claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. See Barnett v. SAIF, 122 Or App 279 (1993).

The only physician who supports a major causal relationship is Dr. Wong. In his initial report, Dr. Wong indicated that claimant's work activities were the major contributing cause of her need for medical treatment. (Ex. 8). Dr. Wong's opinion was based in part on his conclusion that claimant did not have a preexisting condition. (Id.). In a subsequent opinion, Dr. Wong acknowledged the fact that claimant did have a preexisting condition, which was contributing to claimant's shoulder symptoms. (Ex. 15). However, Dr. Wong opined that claimant's work activities were the major contributing cause of, and precipitated, claimant's need for treatment for her overuse syndrome. (Id.). In his deposition, Dr. Wong indicated that claimant had a preexisting condition and a work condition that resulted in overuse syndrome. (Ex. 16-14). These two conditions combined, but Dr. Wong continued to opine that the main contributing cause of claimant's need for treatment was the work condition. (Id.).

We do not find Dr. Wong's opinion sufficient to carry claimant's burden of proof. While he agreed that claimant has a "combined condition," Dr. Wong does not state that the work activities were the major contributing cause of the need for treatment for the combined condition. Rather, Dr. Wong indicates that claimant's work activities were the major cause of her need for treatment only for the bilateral overuse syndrome. (Ex. 15, 16-14). Under these circumstances, claimant has not established that her work activities were the major contributing cause of her disability or need for medical treatment for her combined shoulder condition. Accordingly, the insurer's denial must be upheld.

ORDER

The ALJ's order dated May 9, 1997 is affirmed.

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[1] We note that claimant contends that her "symptoms are the condition" and therefore she has established compensability under the court's decision in Teledyne Wah Chang v. Vorderstasse, 104 Or App 498. We disagree. While Dr. Wong did agree with this proposition at one point in his deposition, he later agreed that the symptoms and the condition were different. (Ex. 16-11, 16-13). Moreover, assuming Dr. Wong's opinion supports claimant's contention, Dr. Wong does not explain which condition (the calcific tendinitis or the overuse syndrome) is equated with claimant's symptoms. Consequently, we are not persuaded by claimant's contention.

In the Matter of the Compensation of
LOGAN A. ADAMS, Claimant
WCB Case No. 96-07974
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that dismissed his requests for hearing, concerning the compensability of his claim for medical services, for lack of jurisdiction. On review, the issues are jurisdiction and compensability of medical services. We reverse the ALJ's order, reinstate claimant's request for hearing, and set aside the SAIF Corporation's denial.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Relying on SAIF v. Shipley, 147 Or App 26, rev allowed 326 Or 57 (1997), the ALJ concluded that since claimant's request for hearing concerned only medical services, the Hearings Division lacked jurisdiction over the dispute. For the reasons set forth below, we disagree.

Subsequent to the ALJ's order, we issued our Order on Reconsideration in Jacqueline J. Rossi, 49 Van Natta 1844 (1997). In Rossi, we held that the Hearings Division had jurisdiction over a medical services dispute where the claimant was seeking to establish the compensability of a new "combined" condition under ORS 656.005(7)(a)(B). We distinguished this situation from the court's decision in Shipley, where the claimant sought only medical services for a compensable condition, reasoning that because the dispute concerned the compensability of a new condition it necessarily involved the denial of an "underlying claim." See also Charles Bertucci, on recon 49 Van Natta 1833 (1997) (Hearings Division has jurisdiction over medical services dispute where claimant seeking to establish compensability of a new condition under ORS 656.802).

Here, as in Rossi, claimant is seeking to establish the compensability of a "combined" condition, *i.e.*, the accepted low back strain and the degenerative disc disease.[1] Thus, although the dispute concerns a claim for medical services, the claim is also for the degenerative disc condition that gave rise to the need for those services. Therefore, SAIF's formal denial is a denial of the underlying claim. Pursuant to ORS 656.245(6), the Hearings Division retains jurisdiction over the medical services/compensability dispute in this case which necessarily involved a formal denial of the compensability of the underlying claim, *i.e.*, a denial of the claim for the underlying condition that gave rise to the need for treatment. Rossi, 49 Van Natta at 1845. For these reasons, we reinstate claimant's request for hearing and proceed to the merits.

Compensability/Medical Services

As a preliminary matter, claimant, in his appellant brief, assumes that if the ALJ's decision on jurisdiction was reversed, the matter would be remanded to the ALJ for a decision on the merits. We disagree.

The Board may remand a matter to an ALJ if it is determined that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). The initial hearing in this matter took place in November 1996, some four months prior to the court's decision in Shipley. The parties indicated that compensability was at issue and that they were prepared to proceed on that issue. (Day 1 Tr. 4-6). Thereafter, a continued telephonic proceeding took place on March 31, 1997. Two exhibits were admitted into evidence and the parties again agreed that compensability was at issue. (Day 2 Tr. 1). Based on this, we conclude that the parties believed that compensability was at issue and prepared their cases accordingly. Therefore, we do not find that the record has been improperly, incompletely or otherwise insufficiently developed. Consequently, we find no compelling reason to remand this matter to the ALJ, and proceed with our *de novo* review of the record.

In order to decide whether claimant's current need for medical services is causally related to his 1976 compensable injury, it must first be determined what is encompassed by SAIF's acceptance.

Claim acceptance is an act through which the carrier acknowledges responsibility for the claim and obligates itself to provide the benefits due under law. Gene C. Dalton, 43 Van Natta 1191 (1991). Acceptance of a claim may be accomplished by checking the appropriate options on an 801 Form. U. S. Bakery v. Duval, 86 Or App 120 (1987). Whether an acceptance has occurred is a question of fact. SAIF v. Tull, 113 Or App 449 (1992).

Here, there is no formal acceptance in the record. On the 801 Form, claimant listed his condition as "pulled muscle, back-left and right." (Ex. 1). In the portion of the 801 Form designated for insurer, the option for acceptance is checked, however, the form is neither signed nor dated. (Id.).

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[1] In the alternative, claimant alleges that the degenerative disc disease is part of his accepted condition. Assuming claimant is correct, then SAIF's denial would constitute a denial of his original "underlying claim" and the Hearings Division would also retain jurisdiction on this basis.

Under such circumstances, it cannot be said that SAIF acknowledged responsibility for claimant's claim by virtue of the 801 Form. Therefore, the 801 Form does not establish what condition was accepted by SAIF.

The record as a whole establishes that claimant's accepted condition includes lumbar spondylosis and lumbar degenerative disc disease. In this regard, the August 26, 1976 initial physician's report, from Dr. Pfeiffer, D.C., indicated that claimant was being treated "on the basis of a mild sprain lumbosacral region with a moderately algesiogenic pain upon movement and aggravating preexisting L5 disc scelerosing and possible spondylosis." (Ex. 2). In an attached x-ray report, Dr. Pfeiffer indicated that the lumbar spine had moderate scelerosing at L5; marked hypertrophic formation on the left lateral margins of L1-2; probable facet syndrome at L5-S1 which moderate encroachment. (Ex. 3). In a December 23, 1976 report to SAIF, Dr. Smith indicated that claimant's condition was an acute lumbosacral strain superimposed on a chronically degenerated lumbosacral disc and lumbar spine. (Ex. 5).

In September 1977, claimant underwent a laminectomy at L3-4. (Ex. 19). In May 1978, claimant underwent a second surgical procedure consisting of a laminectomy at L4-5 and L5-S1. (Ex. 29). The post-operative diagnosis after each of these surgeries included lumbar spondylosis and degenerative disc disease. (Exs. 19, 29). In May 1981, claimant underwent a third laminectomy at L3-5 and again the diagnosis was lumbar spondylosis and degenerative disc disease. (Ex. 49). In August 1984, claimant underwent a laminectomy and foraminotomy L4-5 and L5-S. (Ex. 86). All of the above surgeries were authorized by SAIF as a part of claimant's accepted 1976 injury claim.

Considering the record as a whole, we conclude that SAIF has accepted claimant's degenerative spine disease. We now turn to the merits of claimant's current condition.

SAIF's July 19, 1996 letter denies claimant's current condition, which it describes as degenerative disc disease, disc scolerosing, and possible spondylosis, on the basis that those conditions are unrelated to claimant's accepted injury. (Ex. 126). Dr. Williams, who performed a records review at the request of SAIF, explained that spondylosis, degenerative disc disease, disc scolerosis and facet disease were all terms describing various aspects of claimant's degenerative spine disease. (Ex. 129-14). Dr. Williams' attributed claimant's current need for treatment to claimant's degenerative spine disease. (Ex. 127, 129). The only other medical opinion comes from Dr. Kendrick, who has treated claimant since 1980 and reported that claimant's current need for treatment was due to the 1976 compensable injury. (Ex. 128A).

Because we have concluded that SAIF's acceptance includes claimant's degenerative spine disease, it necessarily follows that claimant's current need for treatment is due to his accepted condition.[2] Consequently, SAIF's denial must be 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 $2,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate brief), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 28, 1997 is reversed. Claimant's request for hearing is reinstated. The SAIF Corporation's denial, dated July 19, 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 counsel is awarded a reasonable assessed fee of $2,500, payable by SAIF.

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[2] To the extent that claimant's degenerative spine condition preexisted his 1976 injury, that condition is a compensable condition and does not constitute a preexisting condition for the purposes of ORS 656.005(7)(a)(B). See Pepsi Cola Bottling Co. v. Walton, 147 Or App 698 (1997). Consequently, the "major contributing cause" standard set forth in ORS 656.005(7)(a)(B) is not applicable.

In the Matter of the Compensation of
LOGAN A. ADAMS, Claimant
WCB Case No. 96-0373M
OWN MOTION ORDER
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable lumbosacral injury claim. Claimant's aggravation rights on that claim expired on April 26, 1984.

On July 29, 1996, SAIF denied the compensability of claimant's current degenerative disc disease, disc scolerosing and possible spondylosis conditions. In addition, SAIF opposed reopening the claim on the ground that claimant was not in the work force at the time of disability. Claimant requested a hearing. (WCB Case No. 96-07974). On October 1, 1996, the Board consolidated the own motion matter with the pending litigation. The Board requested the Administrative Law Judge (ALJ) to take evidence and provide a recommendation as to whether claimant was in the work force at the time of disability, if claimant's current condition was found compensable.

By Opinion and Order dated April 28, 1997, ALJ Hazelett upheld SAIF's July 29, 1996 denial. The ALJ also issued a recommendation regarding the work force issue, noting that the parties stipulated at hearing that claimant was working part time in 1996 before and at the time of the request for authorization for medical services. Claimant requested Board review of ALJ Hazelett's order, and, by an order issued on today's date, the Board reversed ALJ Hazelett's order and set aside SAIF's July 29, 1996 denial.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On April 30, 1996, Dr. Kendrick, claimant's treating physician, recommended low back surgery. On May 8, 1996, Dr. Kendrick performed a decompressive redo laminectomy, L2-3, L3-4, to relieve claimant's disc complaints. Thus, we are persuaded that claimant's compensable injury worsened requiring surgery. In addition, given the parties stipulation regarding the work force issue, we find that claimant was in the work force at the time of his disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Accordingly, we authorize the reopening of claimant's 1976 injury claim to provide temporary disability compensation beginning the date claimant was hospitalized for the proposed 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
JEFFREY P. CONNOR, Claimant
Own Motion No. 97-0511M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on November 15, 1990. SAIF 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.

It is undisputed that claimant's compensable condition requires surgery. Specifically, on August 13, 1997, Dr. Kirkpatrick, claimant's treating physician, requested authorization for a lumbar diskectomy at L4-5. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant responds that he was and remains self-employed as a general contractor and submits supporting documentation. This documentation includes, among other things: copies of tax returns for 1995 and 1996, current registration with the Construction Contractors Board, a current commercial liability insurance certificate, confirmation of current bank accounts under the name of his construction firm, a Yellow Page advertisement for his construction firm, a January 1997 construction contract with a customer, and copies of invoices for his firm showing supplies purchased and payments made from March 1997 through June 1997. We are persuaded by this evidence that claimant is engaged in regular gainful employment and remains in the work force.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
EFREN QUINTERO, Claimant
Own Motion No. 97-0288M
OWN MOTION ORDER ON RECONSIDERATION
Robert E. Nelson, Claimant Attorney
David L. Bussman, Defense Attorney

Claimant requested reconsideration of our October 6, 1997 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability. On October 28, 1997, we abated our prior order to allow the insurer time to respond to claimant's motion. We have received the insurer's response and proceed with our reconsideration.

There is no dispute that claimant's compensable low back injury worsened, requiring surgery, which was performed on June 23, 1997. The sole issue is whether claimant was in the work force at the time of disability.

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).

Based on medical opinions from Dr. Aversano, claimant's long-time treating physician, and Dr. Neuwelt, claimant's treating surgeon, we determined in our prior order that claimant was unable to work due to the compensable injury at the time of disability. We adhere to and republish our reasoning and conclusions regarding that determination.

Furthermore, nothing the insurer has submitted on reconsideration persuades us that we should change that determination. Specifically, the insurer makes two arguments regarding claimant's ability to work. First, the insurer argues that, as late as 1990, claimant's low back condition was sufficiently recovered to play volleyball. However, the medical records show that this isolated attempt at playing volleyball resulted in increased pain. (Physical therapy chart note dated August 15, 1990). More importantly, the relevant inquiry is whether claimant is in the work force at the time of disability, i.e., the date of his surgery. Fred Vioen, 48 Van Natta 2110 (1996); John R. Johanson, 46 Van Natta 2463 (1994). Thus, the fact that claimant attempted to play volleyball in 1990 is not relevant to his work force status as of June 23, 1997, the date of his surgery.

Second, the insurer argues that a statement in a November 7, 1996 chart note from Dr. Nilaver, M.D., indicates that claimant was not incapable of working at that time. Specifically, Dr. Nilaver stated that, although claimant had a disc herniation at L5-S1 on the left side that was displacing the left S1 nerve root posteriorly, claimant "was apparently doing quite well until approximately two weeks ago he lifted a bag of groceries and started experiencing excruciating, radiating pain down into his left lower extremity." (Chart note dated November 7, 1996). We do not find that this statement supports a finding that claimant was able to work. In the first place, Dr. Nilaver's statement that claimant was doing "quite well" was made in relation to the fact that claimant had a disc herniation that was displacing a nerve root. Dr. Nilaver gave no opinion regarding claimant's ability to work. Second, as claimant's long-time treating physician, Dr. Aversano is in a better position to render an opinion regarding claimant's ability to work. Dr. Aversano opined that claimant was unable to work due to the compensable low back injury, which he also stated was the reason claimant was receiving social security benefits. Therefore, we continue to find that claimant was unable to work due to the compensable injury at the time of disability.

However, pursuant to the Dawkins rationale, if a claimant is not working at the time of disability, in order to be considered a member of the work force, the claimant must establish both that he was willing to work and unable to work at that time. See Stephen v. Oregon Shipyards, 115 Or App 521 (1992); Arthur R. Morris, 42 Van Natta 2820 (1990). On reconsideration, claimant submits an affidavit swearing that he was willing to work but for his inability to do so because of the compensable

work injury. In addition, claimant's affidavit states that he has applied for jobs within his physical capabilities, but his inability to read, write or use a computer prevented him from being hired and his physical limitations prevented him from returning to farm labor, the only trade he has experience in. Finally, claimant submits a handwritten letter making the same affirmations.

On this record, we find that claimant has established that he is willing to work, although his low back injury rendered him unable to work at the time of disability and made efforts to find work futile.

Accordingly, on reconsideration, and in lieu of our October 6, 1997 Own Motion Order, we hold as follows. We authorize the reopening of claimant's claim to provide temporary total disability compensation beginning June 23, 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.

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.

The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 2, 1997 Cite as 49 Van Natta 2062 (1997)

In the Matter of the Compensation of
KATHLEEN McKAY, Claimant
WCB Case No. C702771
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Neil W. Jones, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On October 31, 1997, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b); Jeanne P. Morgan, 47 Van Natta 1062 (1995).

The first page of the agreement has been amended and initialed by claimant to provide for a waiver of the "30-day" waiting period. In addition to the amendment of the agreement, claimant submitted a letter requesting the Board to waive the "30-day" cooling-off period. Nonetheless, because claimant is unrepresented, the Board is without statutory authority to waive the 30-day statutory period and has thus, allowed the "cooling-off period" to expire before considering the agreement for approval.

We conclude 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.

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
MURIEL E. DEXTER, Claimant
Own Motion No. 97-0409M
OWN MOTION ORDER
Employers Insurance of Wausau, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable low back injury. Claimant's aggravation rights expired on March 17, 1985. 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.

It is undisputed that claimant's compensable condition requires surgery. Specifically, on August 4, 1997, Dr. Silver, claimant's attending physician, recommended decompression at L3-L4 and removal of the previously installed pedical screws at L4 and L5. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

The insurer contends that claimant was not in the work force at the time of the current disability. Claimant responds that she is self-employed as a baby-sitter and submits supporting documentation. This documentation includes: (1) a notarized letter from Ms. Hill, the mother of the child claimant baby-sits, verifying that claimant has earned wages caring for her child from January 1, 1997 through October 1, 1997 and indicating that she had requested preparation of a 1099 form from her bookkeeper to verify claimant's 1997 wages, the last payment of which was made on November 1, 1997; (2) a statement from Mr. Owens, of Woko Automated Bookkeeping, stating that, at the request of Ms. Hill, he prepared a 1099 form which represents claimant's earnings for 1997; (3) a 1099 form stating claimant's income for 1997; and (4) a federal income tax "Schedule C (Form 1040) Profit and Loss Statement" using that 1099 form to calculate claimant's net profit in 1997 from her baby-sitting work. We are persuaded by this evidence that claimant is engaged in regular gainful employment and remains in the work force.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD A. KRASNESKI, Claimant
Own Motion No. 96-0509M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
G. Duff Bloom, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 21, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from November 25, 1996 through March 9, 1997. SAIF declared claimant medically stationary as of July 25, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

Pursuant to OAR 438-012-0055, claims reopened pursuant to ORS 656.278 may be closed either when medical reports indicate to the insurer that claimant's condition has become medically stationary or when a Claims Disposition Agreement (CDA) has been approved by the Board in which claimant releases his right to further payment of temporary disability benefits.

Here, the most recent medical evidence is a July 21, 1997 report from Dr. Teal. In that report, Dr. Teal notes that claimant had missed his last two scheduled appointments. Dr. Teal further indicated that it was "undetermined" whether claimant was medically stationary at that time. It appears from SAIF's July 25, 1997 letter to claimant, that the August 21, 1997 Notice of Closure is based on claimant's failure to seek medical treatment. While the Department does have rules that allow such closure pursuant to ORS 656.268, there are no similar provisions for closure of an Own Motion claim pursuant to ORS 656.278. See OAR 436-030-0020(3)(b). Rather, as noted above, claim closure of a claim reopened under ORS 656.278 can only occur when a claimant is medically stationary or when a CDA extinguishes claimant's right to further temporary disability compensation.[1]

On this record, there is no medical evidence which suggests that claimant's condition was medically stationary as of August 21, 1997, the date SAIF issued its Notice of Closure. Consequently, we find that claim closure was premature and set aside SAIF's August 21, 1997 Notice of Closure. Claimant's claim is to remain opened until claim closure is appropriate under OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of any increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the SAIF Corporation directly to claimant's attorney. See OAR 438-105-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] There has been no CDA filed with or approved by the Board with regard to this claim.

In the Matter of the Compensation of
TIMOTHY W. STONE, Claimant
WCB Case No. 97-06478
INTERIM ORDER OF DISMISSAL
Bischoff, et al, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

On September 25, 1997, the Board received the SAIF Corporation's request for review of Administrative Law Judge (ALJ) Tenenbaum's "September 8, 1997" order. Because the caption of SAIF's request referred to "WCB Case No. 97-06478," SAIF's appeal was acknowledged as pertaining to this case. In fact, ALJ Tenenbaum's order in this case (which upheld SAIF's denial of a bilateral wrist condition and a right foot plantar fascitis/bone spur condition) issued on September 18, 1997, whereas ALJ Tenenbaum's September 8, 1997 order (which granted permanent total disability) pertained to WCB Case No. 97-03891.

SAIF has provided notification of its clerical error. Noting that its request for review concerned the ALJ's September 8, 1997 order, SAIF seeks acknowledgment of its appeal in WCB Case No. 97-03891. Consistent with SAIF's recent announcement, a letter acknowledging its request in WCB Case No. 97-03891 is being processed.[1]

In light of such circumstances, we dismiss SAIF's "request for review" insofar as it pertains to ALJ Tenenbaum's order in this case. Because claimant has previously requested Board review of ALJ Tenenbaum's September 18, 1997 order in this case, we retain jurisdiction. Consequently, this order is interim and will be incorporated into our final, appealable order.

As a result of this decision, claimant is now the appellant and SAIF is the respondent. Furthermore, the briefing schedule shall be revised as follows.

Claimant's appellant's brief shall now be due within 21 days from the date of this order. SAIF's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of SAIF's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] In the event that a question arises regarding the Board's appellate review authority in WCB Case No. 97-03891, the parties may wish to address the effect, if any, the following cases have on such an issue: Dorothy I. Adams, 48 Van Natta 2190 (1996); Alton D. Simons, 48 Van Natta 860 (1996); Terry L. Starnes, 48 Van Natta 790 (1996).

In the Matter of the Compensation of
CIRILA DOMINGUEZ, Claimant
WCB Case No. 97-02067
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's syncopal (fainting) episode claim. On review, the issue is compensability.

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

Claimant fainted at work and was subsequently diagnosed with a concussion. The record contains only one opinion concerning causation. Dr. Boyle, who treated claimant at the hospital, stated:

> "[Claimant] suffered a fainting spell resulting in a concussion. Fainting is a common problem that can easily result from standing for long periods of time. She had no other medical problems that could have caused it, so I would conclude that the fainting was almost certainly a result of the work she was doing, and her head injury (concussion) was a direct result of her fainting." (Ex. 7).

We disagree with SAIF that Dr. Boyle's understanding that claimant had "no other medical problems" was inaccurate because claimant was suffering from the flu on the day she fainted. The record shows that claimant had recovered from her recent illness when she fainted. (Tr. 12). Dr. Boyle also provided an affirmative work-related cause for claimant's fainting episode. Consequently, we agree with the ALJ that claimant carried her burden of proof. See ORS 656.266; Ruben G. Rothe, 45 Van Natta 369 (1993).[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by 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 June 5, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

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[1] In Rothe, we held that the enactment of ORS 656.266 "effectively overruled" the holding in Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), that an unexplained or idiopathic fall is compensable if it occurs at work while the worker is performing regular duties. Because the statute provides that compensability is not established "merely by disproving other possible explanations of how the injury or disease occurred," we held that the worker must show an affirmative work-related cause of the injury or disease. Consequently, although discussed by the ALJ, we find the Russ case to have little relevance to our decision here.

In the Matter of the Compensation of
RONALD C. FULLER, Claimant
WCB Case No. 96-04233
ORDER ON REVIEW (REMANDING)
Pozzi, Wilson, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) denied SAIF's motion to postpone the hearing and compel claimant's attendance at a medical examination; and (2) set aside its denial of claimant's aggravation claim for a low back condition. On review, the issues are the propriety of the ALJ's preliminary ruling and aggravation. We vacate and remand.

FINDINGS OF FACT

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

Claimant has an accepted claim for cervical, thoracic, and lumbar strains and L5-S1 herniation. In March 1996, claimant's treating physician filed a claim for aggravation. On April 25, 1996, SAIF denied the claim.

Between the issuance of the denial and the convening of the hearing, SAIF notified claimant of an appointment with an examining physician. Claimant refused to attend the examination. SAIF then moved the ALJ to postpone the hearing until claimant attended the examination. The ALJ denied the motion.

CONCLUSIONS OF LAW AND OPINION

In denying the motion to postpone, the ALJ found that ORS 656.325(1)(a) and 656.262(14) did not require claimant's attendance at an examination SAIF scheduled after the issuing its denial. Instead, relying on ORS 656.012(3), the ALJ found that "impartiality and balance" weighed on the side of not requiring claimant to submit to "a post-denial examination the purpose of which is to bolster the insurer's case in litigation, not to facilitate insurer's carrying out of its claims processing responsibilities."

SAIF asserts that the ALJ erred in denying its motion to postpone the hearing until claimant attended the examination with a physician chosen by SAIF.[1] Based on the following reasoning, we vacate and remand.

Although there is no express statutory requirement that a claimant attend a post-denial insurer-arranged medical examination (IME), there is likewise no express statutory provision with regard to postponements (or dismissals) of hearings. Rather, the authority to "make and declare all rules which are reasonably required in the performance of [our] duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings" is delegated by statute to the Board. ORS 656.726(4). Pursuant to that broad delegation, it is our obligation to interpret our procedural rules -- including our rule addressing postponement of hearings -- in a manner that "is consistent with * * * the purpose of the relevant statutes." Mershon v. Oregonian Publishing, 96 Or App 223, 226 rev den 308 Or 315 (1989).

As further discussed below, in our prior decisions addressing our postponement rule, in which we have found an obligation on the part of a claimant to attend a post-denial IME, we have relied in part on the legislative directives set forth in ORS 656.012 ("to provide a fair and just administrative system * * * that reduces litigation and eliminates the adversary nature of the compensation system to the greatest extent practicable") and ORS 656.283(7) (to conduct hearings "in any manner that will achieve substantial justice"). Consistent with those policy directives, our rule relating to disclosure of claims information provides that the Board's express policy is "to promote the full and complete disclosure of all facts and opinion pertaining to the claim[.]" OAR 438-007-0015(5). In its review of our application of

[1] The Department also submitted a brief providing its position concerning this issue. Pursuant to ORS 656.726(3)(h), the Department is authorized to participate in any proceeding before the Hearings Division, Board, or Court of Appeals which the Director determines involves a matter that affects or could affect the discharge of the Director's duties. Since this case involves such a matter, we accept the Department's brief and consider it on review.

our dismissal rule, the Mershon court looked to precisely those standards to determine whether we have acted consistently with the purposes of the relevant statutes. Mershon, 96 Or App at 226.

In Mershon, the court addressed our interpretation of our dismissal rule that provided for dismissal of a request for hearing "for want of prosecution." Former OAR 438-06-085. The claimant in Mershon had instructed his physician to refuse to meet with the employer unless claimant's attorney was also present. Prior to the scheduled hearing, a referee had issued three orders directing the claimant to allow the employer "full, complete and private access" to claimant's physician. The claimant refused to comply with those orders. Subsequently, the referee dismissed the hearing request for "want of prosecution" under former OAR 438-06-085. We affirmed, reasoning that the employer's access to medical information held by the claimant's physician should be unrestricted and that the claimant had improperly interfered with that access, thereby justifying dismissal.

Initially on review, the court reversed our decision based on its conclusion that our dismissal rule "is not a sanction for a failure to comply with discovery." 94 Or App at 129. The court further discussed the potential role to be played by former OAR 436-10-030, which allowed for a physician's release of information relevant to the claim. The court initially interpreted the department's rule as authorizing -- but not requiring -- the disclosure of medical information. Absent such a requirement, the court reasoned that conventional methods of discovery (such as depositions and interrogatories) should be used to enforce discovery rather than interpreting our dismissal rule to apply to the facts before it. On reconsideration, however, the court concluded that it had not accorded a proper degree of deference to our interpretation of our dismissal rule and the department's medical release rule. The court held that our interpretations were consistent with the wording of the rules and the purpose of the statutes and our rules "favoring full and expeditious disclosure of information." 96 Or App at 226-27. The court concluded that our application of the dismissal rule to the facts was appropriate and it affirmed our order.

Notably, neither a statute nor the department's rule expressly addressed, let alone required, a claimant to permit an employer "full, complete and private access" to the claimant's physician. Nevertheless, given the policies expressed in ORS 656.012, ORS 656.283(7), our administrative rule providing for full and complete disclosure, and the department's rule concerning release of medical information, the court affirmed the application of our dismissal rule to the facts in Mershon. Those same policies apply in the context of a postponement request under our postponement rule. In other words, our authority in this regard is inherent.

The Oregon Supreme Court said as much in its decision six decades ago in Carnine v. Tibbetts, 158 Or 21, 29-30 (1937):

> "Most of the judiciary recognizes that if a court is powerless to require a plaintiff to submit himself to a physical examination to the end that the truth as to the nature, effect and possible duration of his injuries may be ascertained, the administration of justice becomes tinged with partiality. The plaintiff, by filing suit, has made his injuries the subject of judicial investigation, but retains the power to stop that investigation at the point where a discovery of actual facts would do him harm. Under such circumstances courts may be made instruments of the most gross injustice. The object for which courts are instituted may be defeated. If the plaintiff's claim is meritorious; if he suffered the injuries of which he complains and on account of which he prosecutes his action, what has he to fear from the most rigid examination? If his claim is such as the court should enforce, it could only be strengthened by additional proof."

The Court's reasoning is reflected in our rule of procedure, OAR 438-007-0005(5), which provides the ALJ with the authority to "appoint a medical or vocational expert to examine the claimant and to file a report with the [ALJ]." This rule is not founded upon any express statutory authority but rather flows from our rule providing for full and complete disclosure of facts and opinion and the more general legislative directive that hearings be conducted "in any manner that will achieve substantial justice."

This is not an issue of first impression before the Board. We first found the failure of an injured worker to attend a post-denial IME to be grounds to postpone a hearing in Victoria Napier, 34 Van Natta 1042 (1982). In Napier, the ALJ concluded that the hearing should be continued until such time as the claimant submitted to an insurer-arranged medical examination. On appeal, the claimant argued that she was not obligated to attend the medical examination under former ORS 656.325(1). That statute provided, in relevant part, that:

> "Any worker entitled to received compensation under ORS 656.001 to 656.794 is required, if requested by the director, the insurer or the self-insured employer to submitted to a medical examination at a time and place reasonably convenient for the worker and as may be provided by the rules of the director. . . If the worker refuses to submit to any such examination, the rights of the worker shall be suspended with the consent of the director until the examination has taken place. . ."[2]

The claimant contended that she was not a "worker entitled to receive compensation" as described in former ORS 656.325(1) because her claim had been denied. Citing former ORS 656.012(2)(b), we rejected the claimant's argument as "fallacious." We concluded that permitting an injured worker who is seeking to establish entitlement to benefits under the Workers' Compensation Law to refuse to allow the carrier "access to the most relevant information, information about claimant's medical condition" would amount to "unacceptable gamesmanship in a dispute resolution system with the declared objective of minimizing the adversary nature of workers' compensation cases." Napier, 34 Van Natta at 1043.[3]

Four years later, we again required an injured worker to attend a post-denial IME. In Myron E. Blake, 39 Van Natta 144 (1987), the insurer contended the ALJ erred in granting the claimant's motion to quash the insurer's request for a medical examination after its denial had been issued. Sitting en banc, we reversed the ALJ and remanded the matter with directions to instruct the claimant to attend the IME. We expressly found that Napier continued to be good law. We reasoned that:

> "Permitting independent medical examinations after a denial of compensation is consistent with the Workers' Compensation Act's policy, '[T]o provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable. ORS 656.012(2)(b). We do not consider preventing an insurer from obtaining meaningful and relevant evidence concerning a contested denial to be either fair or just.
>
> "ORS 656.325(1) must be read in light of the Workers' Compensation Act's explicit and implicit statutory policy of providing a forum for the just and fair administration of claims. When viewed in this manner, the first six words of the statute are ambiguous and are subject to statutory construction within the context of the entire Act. See Newell v. Taylor, 212 Or 522 (1958). Considering ORS 656.325(1) within this context, we conclude that it applies to claimants seeking compensation as well as those receiving its benefits. In pursuing a claim, the claimant proceeds on the premise that he is entitled to compensation. This contention is sufficient to require the claimant to submit to an examination within the limits of the statutes and rules.
>
> "Thus, for the above reasons we adhere to our previous decision in Napier, supra."

The issue in both Napier and Blake was whether the matter should be postponed until the claimant attended an IME. One year after our decision in Blake, the Court of Appeals examined ORS 656.325(1) in the context of a case involving the dismissal of a claimant's hearing request. In Ring v. Paper Distribution Services, 90 Or App 148 (1988), the Board had affirmed an ALJ's order that dismissed the claimant's request for hearing on the basis that the claimant had failed to attend an insurer-arranged medical examination as required by former ORS 656.325(1). The Court of Appeals reversed, reasoning that because the claimant's claim was in denied status, the sanctions provided by former ORS 656.325(1) (regarding suspension of compensation) were not applicable. Id. Therefore, the court concluded that former ORS 656.325(1) did not itself authorize the dismissal of the claimant's request for hearing. Id. In reaching this conclusion, the court commented that the claimant's failure to attend the medical examination may have caused an unjustified delay which would warrant dismissal under the Board's practice and procedure rules (former OAR 438-06-071). However, the court concluded that such an issue was for the ALJ to determine in the first instance. Id.

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[2] The emphasized language of former ORS 656.325(1) has remained unchanged and is now found in ORS 656.325(1)(a).

[3] As further discussed *infra*, the Court of Appeals echoed this same sentiment concerning the policies underlying the law in Ring v. Paper Distribution Services, Inc., 90 Or App 148, 150 (1988), when it agreed with the employer that "a claimant should not be allowed to reap the benefits of the workers' compensation system without the modest level of cooperation that [ORS 656.325] requires[.]" The cooperation provided for in the statute is attendance at a reasonably scheduled IME.

In Ring, the most expeditious disposition of the case would have been for the court to simply state that the entire statute was inapplicable because the claimant was not "entitled to receive compensation" because the claim had been denied. However, the court neither stated that a claimant's obligation to attend an IME under ORS 656.325(1) did not apply to a denied claim nor that a claimant's failure to attend a properly scheduled IME could not justify the dismissal of the claimant's hearing request under the Board's "dismissal" rule. To the contrary, the court agreed that "a claimant should not be allowed to reap the benefits of the workers' compensation system without the modest level of cooperation that the statute requires." Further, the court volunteered that the claimant's failure to attend the post-denial IME might support dismissal under our administrative rule. In this context, the court's expression of the policy inherent in ORS 656.325(1) could not be more clearly stated.

We addressed the impact of Ring in the context of a request for a postponement in David M. Foote, 45 Van Natta 270 (1993). The issue in Foote, as in the earlier decisions in Napier and Blake, was whether the matter should be postponed to allow the insurer to obtain a medical examination. In Foote, we held that the claimant's failure to attend a post-denial IME was contrary to the statutory directive of achieving substantial justice. Foote, 45 Van Natta at 271. We reasoned that when a claimant fails to attend IMEs -- thus preventing the carrier from obtaining medical evidence concerning causation -- "the actions of [the] claimant have prevented any semblance of substantial justice in the resolution of the claim." In order to "accomplish the objective of achieving substantial justice" required under ORS 656.283(7), we remanded the case to the ALJ for entry of an interim order requiring the claimant to attend the IME. We further directed the ALJ to reconsider the carrier's motion to dismiss if the claimant failed to attend the examination. 45 Van Natta at 272.

In John A. Zurfluh, 47 Van Natta 1408 (1995), we affirmed an ALJ's dismissal of the claimant's request for hearing on the basis that the claimant's failure to attend three scheduled IMEs caused an unjustified delay of the hearing by preventing the insurer from preparing its case. We relied on former OAR 438-06-071(1),[4] which provided that a request for hearing may be dismissed if the party requesting the hearing had engaged in conduct that resulted in an unjustified delay in the hearing of more than 60 days, and the language in Ring that it "may be that [the] claimant's refusal to cooperate caused an unjustified delay in prosecution that would warrant dismissal of the claim pursuant" to the rule.

In Gary E. Frazier, 47 Van Natta 1313, on recon, 47 Van Natta 1401, second recon, 47 Van Natta 1508 (1995), we reversed an ALJ's order that had dismissed the claimant's request for hearing on the basis that the claimant's failure to attend two scheduled insurer-arranged medical examinations constituted an unjustified delay under former OAR 438-06-071. In doing so, we concluded that the claimant's reasons for failing to attend the examinations were justified. Frazier, 47 Van Natta at 1314. In reaching this conclusion, we noted both in our original order and in the second reconsideration order, that neither former ORS 656.325(1) nor current ORS 656.325(1)(a) were applicable because since the claimant's claim had been denied, there was "no compensation to suspend." Id,. at 1314 n. 1; 47 Van Natta at 1508.

Both the court's decision in Ring and our decision in Frazier indicate that where a claim has been denied, there is no compensation to be paid and thus the sanctions permitted by ORS 656.325(1), i.e., suspension of compensation by the Director, are not applicable. However, as acknowledged by the Ring court, the failure of a claimant to attend a medical examination could result in dismissal if it constitutes an unjustified delay under the Board's dismissal rules.

The ALJ considered our prior decisions in Napier and Blake, but concluded that those decisions were no longer dispositive in light of subsequent statutory amendments. Specifically, in 1995, the legislature amended ORS 656.262, the claims processing statute, by adding ORS 656.262(14) which provides, in relevant part:

> "(14) Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition." [The statute proceeds to provide sanctions against a recalcitrant attorney if the attorney's unwillingness or unavailability is unreasonable.]

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[4] Renumbered OAR 438-006-0071(1).

By its terms, ORS 656.262(14) requires injured workers to cooperate and assist carriers "in the investigation of claims for compensation" and imposes a like obligation on an injured worker's attorney, if any, to reasonably cooperate in such investigation. However, the new provision does not clearly indicate the scope of its application. The ALJ concluded that this new provision applied only to pre-denial investigation of claims. We need not decide whether ORS 656.262(14) is limited to pre-denial cooperation because, even if it is so limited, we do not find that the amended statute affects the precedential authority of our earlier decisions.

When the legislature met in 1995 to discuss and adopt ORS 656.262(14), our precedent unequivocally provided that an injured worker was required to attend reasonably scheduled post-denial IMEs. We had determined that failure to attend such IMEs could result in postponement of the hearing and, potentially, dismissal of the hearing request. In Ring, the court had also noted that our rules might provide for the ultimate sanction of dismissal. Consequently, we decline to interpret the adoption of ORS 656.262(14), whether or not limited to pre-denial conduct, as evidencing a legislative intent to alter our existing precedent as it relates to post-denial attendance at reasonably scheduled IMEs.

Relying on ORS 656.012(3), the ALJ also determined that a claimant should not be further burdened with the obligation of submitting to a "post-denial examination" for the purpose of bolstering the carrier's litigation case, rather than facilitating the carrier's claim processing obligations. As previously noted, this conclusion is directly contrary to our analysis for the last fifteen years. See e.g. Napier, 34 Van Natta at 1044 (where we held that the policy concerns inherent in this issue so strongly weighed in favor of allowing post-denial IMEs that we concluded that an ALJ not only had the "authority" to postpone a hearing for the failure of a claimant to submit to an IME, but that the ALJ, assuming a finding of due diligence, had "the duty to suspend proceedings unless and until the claimant submits to an examination." (Emphasis in original)).

In sum, consistent with "the modest level of cooperation" required by ORS 656.325(1), the statutory policy directive of ORS 656.012 that we provide a "fair and just administrative system," and in the interests of achieving substantial justice under ORS 656.283(7), we continue to adhere to the Board's long-standing holding that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing under our applicable administrative rule. Because the ALJ denied SAIF's motion to postpone the hearing, we vacate the ALJ's order and remand this case to ALJ Tenenbaum.

Accordingly, the ALJ's orders dated August 29, 1996 and July 5, 1996 are vacated. This matter is remanded to ALJ Tenenbaum for further proceedings consistent with this order. Under these circumstances, the rescheduling of a hearing will presumably be conducted following claimant's attendance at a reasonably scheduled medical examination arranged by SAIF. In this regard, we note that claimant's failure to attend the insurer-arranged medical examination was based on his position that he was not statutorily required to attend pursuant to ORS 656.325(1). Inasmuch as no other objection to the examination was apparently raised, we do not find it necessary to have the ALJ take further evidence with regard to whether a postponement should be granted. In other words, under the particular facts of this case, there is no need for the ALJ to decide whether SAIF exercised due diligence under OAR 438-006-0081(4)[5] in order to be granted a postponement. Compare Sarah A. Strayer, 49 Van Natta 244 (1997) (record concerning dismissal of hearing request, for failure to attend a "post-denial" insurer-arranged medical examination, was incompletely developed where no documentary evidence, testimony, or stipulation of parties was admitted in record).

These further proceedings may proceed in any manner that the ALJ deems achieves substantial justice. Following the completion of the rescheduled hearing and the closure of the record, the ALJ shall issue a final appealable order addressing the matters that remain at issue.

IT IS SO ORDERED.

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[5] OAR 438-006-0081(4) provides that incomplete case preparation is not grounds for a postponement unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence.

In the Matter of the Compensation of
MARGARET S. MORGAN, Claimant
WCB Case No. 96-10923
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our November 6, 1997 Order on Review, in which we affirmed that portion of the Administrative Law Judge's (ALJ's) order which declined to award unscheduled permanent disability beyond that granted by a Notice of Closure and affirmed by an Order on Reconsideration. Requesting en banc review, claimant contends that our finding that claimant returned to "regular work" cannot be reconciled with our decision in George O. Hamlin, 46 Van Natta 491 (1994). The self-insured employer has responded, asserting that we have adequately explained the distinction between our decision and the Hamlin decision, the employer argues that reconsideration is unnecessary. For the following reasons, we deny claimant's request for en banc review, and adhere to our prior decision.

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 this is not a case of first impression having a widespread impact on the workers' compensation system, and because it does not require disavowal of prior Board case law, claimant's request for en banc review is denied.

In our original order, we determined that claimant had returned to her "regular work," even though extensive work modifications were made to her work site, because the record did not establish that there had been any change in claimant's job duties. In reaching this conclusion, we distinguished several cases including Hamlin. In Hamlin, we held that the claimant did not return to his "regular" job when he returned to former bus driver job, but could no longer operate manual steering buses. Although claimant asserts that this case is indistinguishable from Hamlin, on further consideration, we continue to find that this case differs from Hamlin.

In contrast to Hamlin, where the claimant's job duties were modified (i.e, the claimant could no longer perform that aspect of his pre-injury duties that concerned the operation of manual steering buses), in this case, the record does not establish a change in claimant's job duties from that which she performed prior to her injury. Therefore, we continue to conclude that claimant returned to her "regular work" and, thus, that her unscheduled permanent disability was properly based entirely on permanent impairment.

Accordingly, we withdraw our November 6, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our November 6, 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
KATHRYN L. OWENS, Claimant
WCB Case No. CV-97001
CRIME VICTIM ORDER OF DISMISSAL (REMANDING)

Applicant requested Board review of the Department of Justice's June 6, 1997 Order on Reconsideration denying her claim for benefits, on behalf of her children, under the Compensation Act for Victims of Crime. In presenting her written position in support of her request for review, applicant has referred to information and submitted documents not contained in the record considered by the Department.

We granted the Department an opportunity to respond to applicant's letter, noting that applicant referred to evidence that was not contained in the record previously considered by the Department and, thus, applicant's statements could be interpreted as a request for remand to the Department for consideration of additional evidence. In response, the Department conceded that applicant's letter contained references to additional evidence not previously considered and that, if applicant provided the cited evidence to the Department, it "would be willing to issue a second order on reconsideration."

Based on the Department's response, we dismiss applicant's request for Board review and remand this matter to the Department to reconsider its prior decision in light of the additional information that applicant apparently is willing to provide. See Georgia Cole, 47 Van Natta 2339 (1995). In the event that applicant is dissatisfied with the Department's eventual reconsideration order, she may request Board review of that decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIO F. TORRES, Claimant
WCB Case No. 95-04348
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) admitted Exhibits 37 and 38 into evidence; (2) upheld the self-insured employer's compensability and responsibility denials of his C6-7 herniated disk condition; (3) declined to assess a penalty or penalty-related fee for the employer's allegedly unreasonable compensability denial; (4) declined to assess a penalty or penalty-related fee for the employer's allegedly unreasonable responsibility denial; and (5) declined to award an extraordinary attorney fee. On review, the issues are evidence, compensability, responsibility, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant has been employed as a deputy sheriff since July 1984. In addition to his patrol duties, he is a self-defense instructor and SWAT team member. His job duties require him to be in good physical condition; his training involves strenuous physical activity. His off-the-job activities include racquetball, aerobics and running.

Claimant has sustained previous injuries during his employment with employer. Although the employer is currently self-insured, it was previously insured by SAIF. In September 1984, claimant was injured when he hit his head on a tree limb. (Ex. 1). He was diagnosed with a head laceration and also sustained an injury to his right eye. (Exs. 2, 4, 5). SAIF, on behalf of the employer, accepted a head laceration and "foreign body right eye." (Ex. 6). In July 1987, claimant was diagnosed with a mild concussion as a result of an injury in self-defense class. (Ex. 7). SAIF accepted a mild concussion. (Ex. 9). In April 1993, claimant was injured when he tried to subdue a drunk, who attempted to choke him. (Ex. 11). Claimant was diagnosed with "[a]brasions to anterior neck." (Id.)

On January 31, 1995, claimant sought treatment from Dr. Jackson. (Tr. 16). Claimant described a one month history of increasing pain over the right side of his upper back. (Exs. 10, 13). He had pain shooting down his right arm, with numbness and tingling. Claimant did not recall a specific injury, although he said that symptoms were worse when playing racquetball. (Id.) An x-ray report on January 31, 1995 showed mild, congenital central spinal stenosis. (Ex. 12). A February 2, 1995 cervical MRI showed a large right posterolateral disk protrusion of C6-7 intervertebral disk with extension of the protruded disk into the right C6-7 intervertebral neural foramen and significant compression of the right side of the cord. (Ex. 14). The MRI also showed mild, congenital central spinal stenosis, which increased the significance of the C6-7 protrusion. (Id.) Claimant was referred to Dr. Kirkpatrick, a neurosurgeon.

On February 9, 1995, Dr. Kirkpatrick examined claimant and reported that his condition began in December 1994 without a particular injury. (Ex. 18). Claimant began to notice pain in the right neck and scapular area and it slowly got progressively worse. Dr. Kirkpatrick noted that claimant worked as a sheriff's deputy and was routinely placed in situations of high physical stress. He diagnosed right C6-7 disk hernation with severe right C7 radiculopathy and recommended surgery. (Ex. 18-2). On February 27, 1995, Dr. Kirkpatrick performed a C6-7 anterior diskectomy, foraminotomy and interbody fusion. (Ex. 22). Claimant was released for full duty work on June 1, 1995. (Ex. 28-2).

Claimant signed an "801" form on February 6, 1995, indicating that his shoulder pain was due to his work activities. (Ex. 17). On February 21, 1995, the employer issued a compensability denial on the basis that claimant's neck and right arm problems did not arise out of or in the course and scope of his employment. (Ex. 20). On December 1, 1995, the employer issued a responsibility denial, asserting that claimant's condition may be related to a prior work exposure or to an accepted, compensable injury previously suffered while the employer was insured with SAIF. (Ex. 31).

On March 20, 1996, Dr. Zivin performed a records review on behalf of the employer. (Ex. 32).

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that the ALJ erred by admitting Exhibits 37 and 38 into evidence. The ALJ determined that the matters addressed by Exhibits 37 and 38 addressed a new inquiry. Claimant contends that the exhibits should not have been admitted because Dr. Kirkpatrick's January 31, 1997 rebuttal report (Ex. 36) did not raise any new issues of compensability or causation. The employer contends that, rather than providing a rebuttal report as anticipated, Dr. Kirkpatrick changed his definition of a herniated disk.

We need not address claimant's evidentiary argument because, even if we disregard Exhibits 37 and 38, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused his discretion by admitting Exhibits 37 and 38. See Jose L. Duran, 47 Van Natta 449 (1995); Larry D. Poor, 46 Van Natta 2451 (1994).

Compensability

Claimant has been employed as a deputy sheriff since 1984. In addition to his patrol duties, he is a self-defense instructor and a SWAT team member. In December 1994, claimant developed right upper back pain. He was diagnosed with right C6-7 disk hernation with severe right C7 radiculopathy and recommended surgery. (Ex. 18-2). On February 27, 1995, Dr. Kirkpatrick performed a C6-7 anterior diskectomy, foraminotomy and interbody fusion. (Ex. 22).

On February 21, 1995, the employer denied the claim on the basis that his neck and right arm problems did not arise out of or in the course and scope of his employment. (Ex. 20). On December 1, 1995, the employer issued a responsibility denial, asserting that his condition could be related to a prior work exposure or to a previous compensable injury. (Ex. 31). Claimant requested a hearing on both denials. Based on Dr. Zivin's opinion, the ALJ concluded that claimant failed to prove medical causation.

On review, claimant contends that Dr. Kirkpatrick's opinion establishes that his work activities were the major contributing cause of his C6-7 disk herniation. He argues that the claim is compensable as an injury or an occupational disease.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's C6-7 disk herniation 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).

The onset of claimant's symptoms in this case did not correspond to a specific "event." Claimant could not recall a specific incident prior to seeking treatment in January 1995. (Tr. 19-20). He testified that in December 1994, he initially had discomfort in a very small area. (Tr. 32). The pain became more nagging and noticeable and covered a larger area. (Id.) Claimant's "801" form signed on February 6, 1995 referred to the date of onset as December 1994 and he indicated that he initially had pain in his right shoulder that gradually got worse and spread to his right arm. (Ex. 17). The medical reports are consistent with that characterization. (Exs. 10, 13, 18).

Claimant's symptoms arose gradually and he was unable to identify a specific event that precipitated the onset of his symptoms. Thus, we conclude that claimant's cervical claim more properly relates to an ongoing condition with a gradual onset rather than an "event." Thus, we conclude that it is most appropriately characterized as an occupational disease.

Under ORS 656.802(2)(a), claimant must establish that his employment conditions were the major contributing cause of his C6-7 herniated disk condition. If the occupational disease claim is based on the 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).

There are two medical opinions on causation. Claimant contends that we should defer to the opinion of his treating physician, Dr. Kirkpatrick, who opined that claimant's work activities were the major contributing cause of claimant's C6-7 disk herniation with severe right C7 radiculopathy. (Exs. 21, 22, 29, 30, 33, 36). In contrast, the employer relies on the opinion of Dr. Zivin, who concluded that claimant's preexisting degenerative cervical condition was the major contributing cause of his disk herniation and need for surgery. (Ex. 32-3).

Both Dr. Kirkpatrick and Dr. Zivin believed that the herniation had occurred within six months before February 1995. (Exs. 30-17, 30-20, 32-1). They both agreed that claimant's symptoms arose gradually, without any specific injury or incident. (Exs. 18, 32-2). Both physicians agreed that claimant had preexisting congenital cervical spinal canal stenosis. (Exs. 29, 32-1). Dr. Zivin did not refer to claimant's stenosis as a cause of his cervical condition. (Exs. 32, 34, 38). Similarly, Dr. Kirkpatrick did not feel claimant's cervical stenosis had any effect on the onset of the herniation. (Ex. 30-21). He testified that stenosis does not contribute to causing a herniated disk, but it could contribute to symptoms that may arise after the disk has herniated. (Ex. 30-6).

Dr. Kirkpatrick and Dr. Zivin disagreed, however, as to whether or not claimant had preexisting cervical degenerative disk disease and whether claimant's herniation was caused by the degenerative condition.

On March 20, 1996, Dr. Zivin, a neurologist, performed a records review. He reported that claimant had degenerative disk disease in the cervical spine before December 1, 1994. (Ex. 32-1). He reached that conclusion based on the February 2, 1995 cervical MRI, "which reveals a C5-6 narrowing of the disk space and over growth of the end plates with associated bony compromise at the neural foramina, particularly on the left; at C6-7 there is similar bony end plate hypertrophy, narrowing of the disk with a herniation of the disk material along the midline and towards the right lateral recess and into the neural foramen; there is some impingement upon the right side of the cord by this lesion." (Id.) Dr. Zivin also noted claimant had congenital cervical spinal canal stenosis. (Id.) He concluded that claimant had "[m]ulti-level degenerative changes[.]" (Id.) Dr. Zivin concluded that claimant's preexisting degenerative cervical condition was the major contributing cause of his disk herniation and need for surgery. (Ex. 32-3).

Dr. Kirkpatrick reviewed Dr. Zivin's report and questioned whether claimant had any intrinsic degenerative disease. (Ex. 33). He felt that, if claimant had some degree of intrinsic degenerative disease, it was only a minor factor. (Id.) He believed that claimant's work was the major contributing cause of his cervical problems. (Id.)

In a deposition on August 27, 1996, Dr. Kirkpatrick explained that he disagreed with Dr. Zivin's conclusion that claimant had degenerative disk disease in the cervical spine before December 1994. (Ex. 35-23). Dr. Kirkpatrick testified that he had personally reviewed the January 31, 1995 x-ray report and the February 2, 1995 cervical MRI. (Ex. 35-20). He found no indication of any degeneration or disk space narrowing in the x-ray report. (Ex. 35-22, -23). Dr. Kirkpatrick found no mention of loss of height, degeneration of the disk or disk space narrowing in the MRI report. (Ex. 35-22). Based on his review, he agreed with Dr. Ballantyne's analysis of the MRI. (Id.) Dr. Kirkpatrick felt that, had there been a significant degenerative process, Dr. Ballantyne likely would have commented on it in the MRI report. (Ex. 35-21).

The January 31, 1995 x-ray report showed mild, congenital central spinal stenosis. (Ex. 12). Regarding the February 2, 1995 cervical MRI, Dr. Ballantyne reported that claimant had a large right posterolateral disk protrusion of C6-7 intervertebral disk with extension of the protruded disk into the right C6-7 intervertebral neural foramen and significant compression of the right side of the cord. (Ex. 14). The MRI also showed mild, congenital central spinal stenosis, which increased the significant of the C6-7 protrusion, as well as a moderately large cavernous hemangioma of T1 that was unlikely to be of any clinical significance. (Id.) There was no description or discussion of any degenerative disk disease in the MRI report.

Dr. Kirkpatrick explained why he disagreed with Dr. Zivin's conclusion that claimant had preexisting degenerative disk disease:

> "Well, among other things it's quite significant in that last plain film report you were just alluding from January 31 of '95, that this is felt to be a normal, fairly normal cervical spine series except for the loss of lordosis and a slightly diminutive canal as they describe it.
>
> "When a person has chronic cervical disease, whether it's traumatic or degenerative, if there is such a thing, a pure degeneration, the disks invariably narrow in their height, you can see it in the plain films.
>
> "If you have a person with a pinched nerve presentation and a disk hernation, yet the plain films don't show any loss of space, that ipso facto means this is an acute process that is a disk injury, disk hernation rather than some chronic wearing down or chronic grinding down of the disk space from degeneration." (Ex. 35-23, -24).

Dr. Kirkpatrick testified that, if there had been bony compromise at the neuro foramina, it would have been very easily seen on plain x-rays. (Ex. 35-24). Instead, the January 31, 1995 x-ray report stated that the "intervertebral neural foramina are patent and symmetrical." (Ex. 12). Unlike Dr. Zivin, Dr. Kirkpatrick found no evidence in the MRI of overgrowth of the end plates with associated bony compromise at the neuro foramina. (Ex. 35-24). Dr. Kirkpatrick disagreed with Dr. Zivin's conclusion that claimant had multi level degenerative changes. (Ex. 35-24, -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). Here, we find no persuasive reason not to rely on Dr. Kirkpatrick's opinion.

In light of the January 31, 1995 x-ray report, the February 2, 1995 cervical MRI report and Dr. Kirkpatrick's deposition testimony, we are not persuaded by Dr. Zivin's report that claimant had degenerative disk disease in the cervical spine before December 1, 1994. There was no description or discussion of any degenerative disk disease in the x-ray report or the MRI report. Moreover, we are persuaded by Dr. Kirkpatrick's deposition testimony that claimant did not have preexisting cervical degenerative disk disease.

Because we do not agree with Dr. Zivin's conclusion that claimant had degenerative disk disease in the cervical spine before December 1994, we are not persuaded by his conclusion that claimant's preexisting degenerative cervical condition was the major contributing cause of his disk herniation and need for surgery. (Ex. 32-3). Furthermore, Dr. Zivin's discussion of causation focuses in large part on his understanding of degenerative changes and the aging process generally. (Exs. 32, 34). Because Dr. Zivin did not adequately focus on claimant's particular circumstances, we give less weight to his conclusions. See, e.g., Sueyen A. Yang, 48 Van Natta 1626 (1996).

In contrast, we are most persuaded by Dr. Kirkpatrick's opinion because it is well-reasoned and based on accurate and complete information. Dr. Kirkpatrick first examined claimant on February 9, 1995 and noted that claimant's job routinely placed him in situations of high physical stress. (Ex. 18). On February 24, 1995, Dr. Kirkpatrick opined that a cumulation of claimant's various duties, including the SWAT team and a self-defense course, were the cause of his cervical condition. (Ex. 21). Dr. Kirkpatrick felt that claimant's "very physical work requirements have contributed at least 51% to his present condition." (Id.)

In a later report, Dr. Kirkpatrick described claimant's work activities. Dr. Kirkpatrick explained that, as a patrol deputy, claimant had to be in top physical condition. (Ex. 25). Claimant ran, performed aerobics and played racquetball to stay in shape. Dr. Kirkpatrick explained that claimant was a self-defense instructor, which involved hard physical fighting and wrestling. (Id.) Claimant also volunteered for the SWAT team and stayed in shape for that by doing sit ups, pull ups and running. (Id.)

In a June 26, 1995 report, Dr. Kirkpatrick reported that claimant's work activities were the major contributing cause of his C6-7 disk herniation with severe right C7 radiculopathy. (Ex. 29). Although claimant had preexisting congenital central spinal stenosis, Dr. Kirkpatrick believed that the C6-7 disk herniation was the major contributing cause of claimant's disability and need for treatment. (Id.)

In a deposition on October 12, 1995, Dr. Kirkpatrick adhered to his opinion that claimant's work activities were the major cause of his herniated disk. (Ex. 30-26). He was familiar with claimant's work activities and was aware that claimant was in repeated situations of high physical stress. (Ex. 30-13, -14, -23). He felt that repetitive minor traumas at work caused claimant's herniated disk. (Ex. 30-15, -16). Dr. Kirkpatrick was not aware of any off-the-job physical activities that caused claimant's herniated disk. (Ex. 30-25). In an earlier report, he had referred to claimant's off-work activities, including running, aerobics and racquetball. (Ex. 25). Dr. Kirkpatrick doubted that playing racquetball could cause a herniated disk. (Ex. 30-26, -27).

Because Dr. Kirkpatrick's opinion is well-reasoned and based on accurate and complete information, we find it persuasive. Furthermore, as claimant's treating physician and surgeon, Dr. Kirkpatrick was in a superior position to render an opinion concerning causation of claimant's C6-7 herniated disk. Based on Dr. Kirkpatrick's opinion, we conclude that claimant's work activities were the major contributing cause of his C6-7 herniated disk condition. See ORS 656.802(2)(a).

Responsibility

Claimant has worked for the employer since July 1984. As discussed earlier, both Dr. Kirkpatrick and Dr. Zivin believed that claimant's C6-7 herniation had occurred within six months before February 1995, while claimant was working for the employer. (Exs. 30-16, -17, 30-20, 32-1). Based on Dr. Kirkpatrick's opinion, we are persuaded that claimant's work activities with the employer were the major contributing cause of his C6-7 herniated disk condition. There is no medical evidence establishing that another carrier was responsible for claimant's condition. Consequently, we assign responsibility for claimant's herniated disk condition to the employer.

Penalty - Compensability Denial

Claimant contends that he is entitled to penalties for the employer's allegedly unreasonable compensability denial. He argues that the employer's denial was issued without adequate investigation.

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).

Claimant signed an "801" form on February 6, 1995, indicating that his right shoulder pain was due to his work activities. (Ex. 17). The employer's claims manager testified that the "801" form was received on February 9, 1995. (Tr. 46). On February 21, 1995, the employer issued a denial of the claim on the basis that claimant's neck and right arm problems did not arise out of or in the course and scope of his employment. (Ex. 20). The denial letter indicated that Dr. Kirkpatrick's records had been reviewed and the claim had been discussed with claimant and the employer. (Id.)

At the time the employer issued its denial, it had a February 9, 1995 report from Dr. Kirkpatrick stating that claimant had right C6-7 disk herniation with severe right C7 radiculopathy. (Ex. 18). Dr. Kirkpatrick indicated that no specific injury had been involved, but claimant's work routinely placed him in situations of high physical stress. (Id.) Dr. Kirkpatrick requested authorization to perform surgery. (Ex. 19). At the time it issued the denial, the employer also had a copy of the February 2, 1995 cervical MRI that showed, among other things, mild, congenital central spinal stenosis. (Ex. 14)

The employer's claims manager testified that, at the time she issued the denial, she felt she had good enough reason to deny the claim. (Tr. 42). She said that there was no specific injury that caused claimant's problem. (Id.) She was aware that herniated discs could occur as part of the normal, aging process. The claims manager could not recall whether she had inquired with Dr. Jackson or Dr. Kirkpatrick as to whether claimant's condition was work-related. (Tr. 41). There is no evidence in the record of such an inquiry.

We find that the aforementioned exhibits that were available to the employer when it issued its denial did not raise a legitimate doubt as to its liability for claimant's neck condition. The remaining exhibits are either stamped with receipt dates after February 21, 1995 or bear receipt date stamps that are illegible.[1] Although the cervical MRI indicated that claimant had congenital stenosis in the cervical spine, the employer did not have any medical opinion which evaluated the relative contributions of the preexisting stenosis condition and claimant's work activities to his subsequent disability and need for treatment. The only medical opinion the employer had in its possession was from Dr. Kirkpatrick, which indicated that although no specific injury had been involved, claimant's work routinely placed him in situations of high physical stress. (Ex. 18). Furthermore, we are not persuaded by the employer's argument that it had an initial report that claimant had degenerative changes. As we discussed earlier, the February 1995 cervical MRI did not refer to degenerative disk disease. Finally, the claims manager could not recall whether she had requested further information from Dr. Kirkpatrick or Dr. Jackson as to whether claimant's condition was work-related. (Tr. 41). At a minimum, the lack of information available to the employer should have prompted further investigation before issuance of its denial. See, e.g., David A. Lee, 48 Van Natta 2420 (1997).

Notwithstanding the limited information available to the employer, it elected to issue its denial 12 days after it received claimant's "801" form. In light of the fact that carriers are allowed 90 days in which to investigate a claim prior to issuing an acceptance or denial of a claim, see ORS 656.262(6)(a), we find that the employer's denial in this case was hasty and issued without adequate investigation or information. Therefore, based on the information available to the employer at the time of its denial, we conclude that its denial was unreasonable. The employer shall be assessed a 25 percent penalty based on compensation due at the time of hearing as a result of this order, payable in equal shares to claimant and his attorney. See ORS 656.262(11)(a).

Penalty - Responsibility Denial

Claimant also contends that he is entitled to penalties for the employer's allegedly unreasonable responsibility denial. He asserts that there was no evidence in the record implicating prior periods of work exposure or prior accepted injuries.

On December 1, 1995, the employer issued a responsibility denial, asserting that claimant's condition could be related to a prior work exposure or to an accepted, compensable injury previously suffered while the employer was insured with SAIF. (Ex. 31).

Although the employer's claims manager who testified at hearing did not sign the responsibility denial letter, she testified that the denial was based on Dr. Kirkpatrick's deposition testimony in which he indicated that claimant had previous injuries with the employer. (Tr. 44). The claims manager "thought it'd be a good idea to maybe bring these people in just in case." (Id.)

Contrary to the claims manager's testimony, Dr. Kirkpatrick's October 12, 1995 deposition testimony did not attribute claimant's herniated disk to a compensable injury previously suffered at employer while it was insured with SAIF or another carrier. Dr. Kirkpatrick testified that claimant's cervical disk herniation had occurred within six months from the time he first examined him in February 1995. (Ex. 30-16, -17, -20). Dr. Kirkpatrick was asked about the April 1993 emergency room chart note that indicated claimant was injured when trying to subdue a drunk, who tried to choke him. (Exs. 11, 30-24). Claimant was diagnosed with "[a]brasions to anterior neck." (Ex. 11). Dr. Kirkpatrick did not believe that the April 1993 incident caused claimant's herniated disk condition. (Ex. 30-28). He noted that, although there was apparently some trauma to the neck, there were no neurological symptoms mentioned. (Ex. 30-29).

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[1] Although the claims manager initially testified that she thought she had a copy of Dr. Jackson's January 31, 1995 report (Exs. 10, 13) at the time the denial was issued, she subsequently acknowledged that she did not know whether she had that report when the denial was issued. (Tr. 46-48). There is no evidence on Exhibit 10 or 13 that the employer had received Dr. Jackson's January 31, 1995 report at the time the denial was issued. In light of the claim's manager's ambivalent testimony, we are not persuaded that the employer had received Dr. Jackson's January 31, 1995 report (Exs. 10, 13) at the time the denial was issued.

Although claimant did have previous injuries, there were no medical opinions at the time the employer issued its denial (or thereafter) that attributed claimant's herniated disk to any previous injury. In September 1984, claimant filed a claim for a cut on his head that occurred when he hit his head on a tree limb. (Ex. 1). He was diagnosed with a head laceration. (Ex. 2). Claimant also sustained an injury to his right eye. (Exs. 4, 5). SAIF, on behalf of the employer, accepted a head laceration and "foreign body right eye." (Ex. 6). In July 1987, claimant was diagnosed with a mild concussion as a result of an injury in self-defense class. (Ex. 7). SAIF accepted a mild concussion. (Ex. 9). As noted earlier, the only other injury in the record was the neck abrasions, which occurred April 1993. (Ex. 11).

The mere fact that claimant had prior work injuries, without more, does not provide a legitimate basis for the employer's responsibility denial. We find no evidence in the record that, at the time the employer issued its denial, claimant's herniated disk could be related to a previous work exposure or to an injury previously suffered with the employer while it was insured with SAIF or any other carrier. We are not persuaded that the employer had a legitimate doubt as to its responsibility at the time it issued the responsibility denial on December 1, 1995. Therefore, based on the information available to the employer at the time of its denial, we conclude that its responsibility denial was unreasonable.

There are amounts due, but we have already assessed a penalty on those amounts pursuant to ORS 656.262(11). We cannot assess another penalty on the same amount of compensation. 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., Oliver v. Norstar, Inc., 116 Or App 333, 336 (1992). Accordingly, since the employer's conduct constituted separate acts of unreasonable resistance to the payment of compensation, relating to different factual bases, claimant is entitled to a penalty-related attorney fee assessed 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 employer's unreasonable responsibility denial is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Attorney Fees - ORS 656.386(1)

Claimant requests an attorney fee of $10,500 for services at hearing and on Board review. Under ORS 656.386(1), a claimant is entitled to an attorney fee in cases involving denied claims where a claimant prevails finally on review. Under ORS 656.308(2)(d), a claimant may also be entitled to an attorney fee for prevailing against a responsibility denial, which is separate from and in addition to the attorney fee awarded for finally prevailing over a compensability denial under ORS 656.386(1). Paul R. Huddleston, 48 Van Natta 4, 9, on recon 48 Van Natta 203 (1996).

We determine the amount of claimant's counsel's attorney fee for services at hearing and 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.

Our review of the record reveals the following information. The primary issue in dispute was the employer's compensability denial of claimant's C6-7 herniated disk condition. Forty exhibits were received into evidence, at least three of which were generated by claimant's counsel. Two depositions were taken: one consisted of 29 pages of transcript; one consisted of 25 pages of transcript. The hearing transcript consists of 53 pages. Claimant testified on his own behalf and one witness testified for the employer. Claimant's counsel submitted a statement of services indicating that she spent approximately 70 hours on the case.

The compensability issue presents factual and medical questions of a complexity similar to those generally submitted for Board consideration. The value of the compensability issue is high, as claimant stands to gain substantial benefits, including substantial medical expenses, extensive time loss from work, and a potential award of permanent disability compensation. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering these factors, we agree that an above-average attorney fee award is appropriate for services rendered at hearing and on review regarding the compensability issue. Specifically, we conclude that $8,500 is a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review. Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee or penalty 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).

Attorney Fees - ORS 656.308(2)(d)

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

Under ORS 656.308(2)(d), an attorney fee shall not exceed $1,000 at hearing and on review, absent a showing of extraordinary circumstances. ORS 656.308(2)(d); Liberty Northwest Ins. Corp. v. Gordineer, 150 Or App 136, 141-42 (1997); Paul R. Huddleston, 48 Van Natta at 10.

Although claimant's attorney's arguments regarding the responsibility issue were successful and, as noted above, the value of the claim was above average proportions, the complexity of the responsibility issue itself was of below average complexity. The parties did not focus on the responsibility dispute and, as noted earlier, there is no medical evidence that another carrier was responsible for claimant's condition. Consequently, claimant has not demonstrated extraordinary circumstances to justify an attorney fee greater than the $1,000 cap. Accordingly, after considering the factors set forth in OAR 438-015-0010(4), we award $1,000 for claimant's attorney's services at hearing and on Board review, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the responsibility issue (as represented by the hearing record and claimant's respondent's brief), the nature of the proceeding, and the value of the interest involved.

ORDER

The ALJ's order dated March 8, 1997 is reversed. The self-insured employer's denial of claimant's C6-7 herniated disk condition is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded $8,500 under ORS 656.386(1), payable by the self-insured employer. For services at hearing and on review regarding the responsibility issue, claimant's attorney is awarded $1,000 under ORS 656.308(2)(d), payable by the self-insured employer. That portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable compensability denial is reversed. Claimant is awarded a 25 percent penalty under ORS 656.262(11), to be based on the amounts then due at hearing as a result of this order, to be shared equally by claimant and his attorney. That portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable responsibility denial is reversed. For its unreasonable responsibility denial, the employer is assessed an attorney fee of $1,000 under ORS 656.382(1), to be paid to claimant's attorney.

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

On November 21, 1997, we withdrew our November 13, 1997 Order on Remand that set aside the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. We took this action in response to the employer's announcement that the parties had resolved their dispute and would be submitting a proposed settlement for our consideration. The parties have now submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders.

Pursuant to the settlement, the parties agree that claimant's claim "shall remain in denied status." The settlement further provides that claimant's "request for hearing, and thus the pending Board review, shall be dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONNA BABCOCK, Claimant
WCB Case Nos. 96-11143 & 96-09902
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Zimmerman, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Baker's order that set aside its current condition denial of claimant's left knee condition. On review, the issue is propriety of the current condition denial.

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

Through its initial acceptance and a subsequent amended acceptance, the insurer ultimately accepted a disabling left knee strain and medial meniscus tear. (Exs. 7, 17). Claimant did not claim, and the insurer did not accept, any preexisting degenerative left knee condition or any combined condition. On November 7, 1996, the insurer issued a preclosure denial denying claimant's current condition, without qualification, based on its assertion that Dr. Zirschky, claimant's treating surgeon, reported that the major cause of claimant's current need for treatment and/or disability was her preexisting left knee degenerative conditions. (Ex. 25). On November 12, 1996, the insurer issued a Notice of Closure closing the claim and awarding temporary disability and 5 percent scheduled permanent disability for claimant's surgery regarding the compensable medial meniscus tear. (Ex. 26).

We agree with the ALJ that the insurer's preclosure denial is not procedurally proper under ORS 656.262(7)(b), which provides: "[O]nce a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed." We have interpreted ORS 656.262(7)(b) as applying only where the accepted condition, whether voluntary or by litigation, is a combined condition. Robin W. Spivey, 48 Van Natta 2363 (1996); Elizabeth B. Berntsen, 48 Van Natta 1219 (1996). Thus, determining the applicability of ORS 656.262(7)(b) depends on whether the carrier accepted a combined condition, it does not depend on whether the current condition actually is a combined condition. Fe D. Delariarte, 48 Van Natta 2485 (1996), on recon 49 Van Natta 39 (1997).

Here, there is no evidence that the accepted condition is a combined condition. To the contrary, the insurer accepted a disabling left knee strain and medial meniscus tear. Thus, as the ALJ found, by its terms, ORS 656.262(7)(b) does not apply to the present claim.

The insurer also argues that its denial is appropriate under Charles L. Wallace, 49 Van Natta 52, on recon 49 Van Natta 472 (1997), and Zora A. Ransom, 46 Van Natta 1287 (1994). Claimant contends that this argument should not be considered because it is an untimely attempt to amend the denial. Claimant also contends that, since the written denial framed the issue for hearing, this alternative basis for denying the claim should not be considered on review. We agree with claimant's contentions.

In Wallace and Ransom, we upheld preclosure denials of conditions that were separable from the accepted conditions. Thus, in effect, Wallace and Ransom applied the court's holding in Guerrero v. Stayton Canning Company, 92 Or App 209, 212-13 (1988), that a carrier "may not issue a partial denial of a previously accepted inseparable condition while the claim is in open status." However, here, the insurer's denial was not based on a separable condition; instead, the denial was based on a combined condition.

We have previously held that a carrier may not deny a claim on one basis, proceed to hearing on that basis and then, during closing arguments, raise a new basis for denial. See Jefferson S. Case, 44 Van Natta 1007 (1992); Ricardo Aguas, 42 Van Natta 2783 (1990), aff'd 109 Or App 220 (1991). Moreover, while a carrier is not precluded from amending its denial at hearing, extrinsic evidence may not be used to interpret the express language of a denial. SAIF v. Ledin, 149 Or App 94 (1997) Gregg Muldrow, 49 Van Natta 1866 (1997). However, the carrier did not attempt to amend its denial at hearing. Instead, on review, it attempts to use extrinsic evidence in the form of its argument regarding Wallace and Ransom to interpret the express language of its denial. For these reasons, we are not inclined to address the insurer's arguments regarding Wallace and Ransom.

In any event, we do not find those arguments persuasive. Whereas Wallace and Ransom involved preclosure denials that denied separable conditions, the express language of the denial in the present case addresses claimant's current condition as a combined condition. Thus, by its express terms, the denial does not deny a separable condition. Accordingly, we do not find the reasoning in Wallace and Ransom applicable to the present case.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, 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.

ORDER

The ALJ's order dated April 25, 1997 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
GRACIELA NARVAEZ, Claimant
WCB Case No. C702940
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Craine & Love, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On November 21, 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.

An attorney fee may be approved by the Board in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of any amount of the proceeds in excess of $12,500. See OAR 438-015-0052(1). Under extraordinary circumstances, a fee may be approved in excess of this calculation. Id.

Here, the CDA provides for a total consideration of $1,683.84, with $1,250 of this amount going to claimant's attorney as a fee, and the remaining $433.84 being paid to claimant as agreement proceeds.[1] Thus, the attorney fee exceeds the maximum allowed by the rule, absent extraordinary circumstances. However, accompanying the CDA, claimant and her counsel have submitted an "Extraordinary Attorney Fee Petition and Order" which provides a description of extraordinary circumstances justifying the excessive attorney fee.

In light of the CDA's reference to an "excess" attorney fee and claimant's submission of a petition for an "extraordinary attorney fee," we interpret the petition as being a part of the CDA. Under such circumstances, as interpreted herein, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Board. Moreover, after considering the description of claimant's attorney's efforts on behalf of claimant regarding the CDA, we find that extraordinary circumstances exist to justify the proposed attorney fee of $1,250. See OAR 438-015-0052(1). Accordingly, the CDA, including the extraordinary attorney fee petition, is approved. ORS 656.236(1); OAR 438-015-0052(1).

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[1] The CDA expressly provides that "claimant's attorney shall be paid a fee, in excess of allowable by statute, of $1,250.00, payable out of the proceeds, and not in addition thereto."

In the event that our interpretation of the CDA conflicts with the parties' intentions, the parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order.

IT IS SO ORDERED.

December 8, 1997 Cite as 49 Van Natta 2085 (1997)

In the Matter of the Compensation of
AGUSTIN F. VALLE, Claimant
WCB Case No. 97-01711
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the SAIF Corporation's denial of claimant's back, neck and shoulder injury claim; and (2) declined to assess penalties or attorney fees against SAIF for an allegedly unreasonable denial. In its respondent's brief, SAIF contends that the claim was untimely filed. On review, the issues are timeliness of the claim, compensability, penalties and attorney fees.

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

On December 16, 1996, claimant filed a claim for alleged injuries to his back, neck, and right shoulder as a result of a motor vehicle accident on April 15, 1996, when a small car struck the company bus in which he and other coworkers were being transported. The ALJ upheld SAIF's denial in part because of the testimony of SAIF's accident reconstruction expert, who testified that the impact of the collision would have caused claimant to move in the opposite direction from that to which claimant testified.

Claimant contends that his testimony establishes that his injury occurred not as the result of the impact of the collision, but rather as the result of the braking of the company bus. Noting the expert's testimony that she did not investigate the braking aspect of the accident, claimant asserts that the expert's testimony does not rule out his having sustained an injury as a consequence of the April 1996 incident. For the following reasons, we disagree with claimant's assertion.

On redirect examination, claimant testified that, when the bus driver braked, this caused him to slide in his seat and strike the window on the left side of the bus. (Tr. 101). Claimant had earlier testified on cross-examination, however:

> "When Ambrosio [the bus driver] hit the brakes--the bus brake, he braked dryly. When Ambrosio hit the brakes I wasn't expecting that accident and I was sitting as I am now with my arms crossed. And it threw me across the seat and it injured me mostly in my back." (Tr. 15, emphasis supplied).

From this testimony, it is unclear to what claimant was referring (the braking or the accident) when he used the word "it." However, claimant then testified: "I was sitting on the seat and with the impact I slid across and hit the side of the bus. And that's how the accident happened." (Tr. 15, emphasis added).

We conclude from claimant's testimony on cross-examination that claimant's movement allegedly occurred from the impact of the collision, not the braking. The description in the medical reports of the mechanism of injury also supports this conclusion. Claimant stated on the form 801 that: "While in the bus carrying other workers, the bus was struck by another car. I was thrown up against the side of the bus." (Ex. 1). In a January 17, 1997 chart note, Dr. Foglesong recorded a history that: "He [claimant] was on a school bus being transported on the job when the school bus was struck from the side. He was thrown sideways and injured his sides and back." (Ex. 3).

Based on our review of the record, both claimant's testimony and the description of the accident in the medical reports, we conclude that the ALJ properly relied on the testimony of SAIF's expert who assumed that claimant's injuries allegedly occurred as a result of the collision, not as consequence of braking. Inasmuch as claimant does not contest the validity of the expert's findings as to the likely affect of a collision, and because we, too, consider those findings to be persuasive, we conclude that the SAIF's expert's testimony supports the ALJ's conclusion that claimant failed to sustain his burden of proof. Moreover, we agree for the other reasons the ALJ cited that claimant did not sustain a compensable injury as alleged. Accordingly, we determine that the ALJ properly upheld SAIF's denial.[1]

ORDER

The ALJ's order dated June 18, 1997 is affirmed.

[1] Given our disposition of this case, we need not address the issue of whether claimant timely filed his claim.

In the Matter of the Compensation of
KEN T. DYER, Claimant
WCB Case No. 97-01666
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests, and claimant cross-requests, review of Administrative Law Judge (ALJ) Stephen D. Brown's order that directed it to recalculate claimant's temporary disability rate on the basis of an average weekly wage of $683.02. On review, the issue is rate of temporary disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except finding (3). In lieu of the ALJ's finding (3), we make the following finding of fact:

During the 52 weeks preceding claimant's October 1, 1996 injury, he earned a gross income of $27,938.32. (Ex. 2A-5).

CONCLUSIONS OF LAW AND OPINION

The rate of temporary disability benefits is based on a worker's wage at the time of injury. ORS 656.210(1), (2)(b)(A). For workers whose remuneration is not based solely on daily or weekly wages, the Director of the Department of Consumer and Business Services (Director) may prescribe rules for establishing the worker's weekly wage. ORS 656.210(2)(c).

At the time of claimant's injury on October 1, 1996, former OAR 436-060-0025 (WCD Admin. Order 96-053) provided, in material 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 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. * * *."

The parties do not dispute that claimant's weekly wage should be determined under the above-cited rule. However, the parties dispute whether "extended gaps" existed in the 52 weeks preceding claimant's injury.

In Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), the court rejected an interpretation of the phrase "extended gaps" in former OAR 436-60-025(5)(a)[1] that required a change in employment for the "extended gaps" exception to apply. The court did not otherwise define the phrase "extended gaps," but explained simply that it would be improper to require more than a hiatus in employment to establish an "extended gap." 144 Or App at 161-62.

On remand, we held that 16-1/2 weeks[2] of unemployment in a 26-week period constituted "extended gaps." Earin J. Hadley, 49 Van Natta 1101, 1103 (1997). Finding no guidance for a definition of "extended gaps" in the Director's rules or rule adoption documents, we turned to the dictionary, which defines "extended" as "drawn out in length *** esp. in length of time[.]" Webster's Third New Int'l Dictionary 804 (unabridged ed. 1993). 49 Van Natta at 1102. We reasoned that whether a gap in employment is "drawn out in length" depends on the particular circumstances of each case. We noted, however, that, pursuant to the court's instructions, we would not consider whether a change in the work relationship had occurred in determining whether there was an "extended gap" in employment. Under the circumstances of the Hadley case, we concluded that an unemployment period that represents approximately 63.4 percent of a 26-week period is "drawn out in length." Id. at 1103. Alternatively, we held that 7-1/2 weeks of unemployment in a 12-week period would also constitute an "extended gap." Id.

Here, claimant had 12 weeks of unemployment during the 52-week period preceding his injury. The periods of unemployment consisted of one week in October 1995, three weeks in November 1995 (two of which were consecutive weeks), two non-consecutive weeks in December 1995, and a six-week period of unemployment from the last week in January 1996 through March 9, 1996. Considering that claimant was unemployed for nearly three months of the year preceding his injury, or 23 percent of 52 weeks, we conclude that claimant's periods of unemployment constituted "extended gaps" within the meaning of former OAR 436-060-0025(5)(a).

Accordingly, we conclude that claimant's temporary disability rate should be calculated based on "the actual weeks of employment with the employer at injury up to the previous 52 weeks." Former OAR 436-060-0025(5)(a). The insurer contends that this phrase should include all 52 weeks preceding the injury, regardless of whether claimant actually worked during those weeks. We disagree. We find that the plain meaning of "actual weeks of employment" refers only to those weeks when claimant was actually **employed**; that is, earning remuneration for services performed for the employer. We find that this interpretation is consistent with the administrative rule and the statutory scheme, which is based on providing fair, adequate and reasonable income benefits to an injured worker. See ORS 656.012(2)(a)[3]; Thomas R. Hellingson, 49 Van Natta 1562, 1564 (1997) (only weeks when the claimant earned wages included in "actual weeks" under wage earning agreement); Randell R. Brood, 48 Van Natta 1783 (1996) ("extended gap" excluded from "actual weeks" under wage earning agreement).

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[1] Former OAR 436-60-025(5)(a) provided:

"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."

[2] The periods of unemployment in the 26 weeks preceding the claimant's injury consisted of nearly three weeks in December 1993, the first three weeks of January 1994, the three weeks between February 19 and March 10, 1994, and the 7-1/2 week period between March 15 and May 6, 1994.

[3] ORS 656.012(2)(a) provides that the objectives of the Workers' Compensation Law are, among others:

"To 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[.]"

Here, claimant was actually employed 40 weeks during the 52-week period preceding his injury. (See Ex. 2A). During this period, he earned gross wages of $27,938.32.[4] (Ex. 2A-5). Therefore, claimant's temporary disability rate should be calculated on the basis of an average weekly wage of $698.46 ($27,938.32 divided by 40 weeks). The ALJ's order is modified accordingly.

Because our order may result in increased compensation and claimant requested Board review, claimant's attorney is entitled to an "out-of-compensation" attorney fee. ORS 656.386(2); OAR 438-015-0055(1). Consequently, claimant's counsel is awarded a fee equal to 25 percent of any 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.

Because the insurer requested review and the compensation awarded to claimant was not disallowed or reduced 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 $500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 11, 1997 is modified. In lieu of the temporary disability rate determined by the ALJ, the insurer is ordered to pay temporary disability benefits based on an average weekly wage of $698.46. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, payable directly to claimant's counsel. However, the total "out-of-compensation" attorney fee awarded by the ALJ's order and this order shall not exceed $3,800. In addition, claimant's attorney is awarded a $500 attorney fee for services on review, payable by the insurer.

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[4] The insurer contends that claimant's gross wage was actually $26,794.68 ($27,938.32 minus $1,143), because the employer paid the $1,143 directly to claimant's union, not to claimant. (See Ex. 2A-5; Reply Brief at 1). Claimant explained that, as part of the wages paid under the union contract, the employer paid claimant one dollar for every hour worked. That amount was then deducted from claimant's pay and paid directly to the union, which in turn disbursed it to employees. (Tr. 10). Based on claimant's explanation, as well as the payroll records provided by the employer, we find that the one dollar per hour paid by the employer was properly included in claimant's gross wages. Therefore, we conclude that claimant's gross wage was $27,938.32.

In the Matter of the Compensation of
MARIA S. ESCALANTE, Claimant
WCB Case No. 97-02681
ORDER ON REVIEW
Maureen McCormmach, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for patellofemoral syndrome of the right knee. On review, the issue is compensability.

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

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[1] Claimant submitted a "Respondent's Reply" brief in response to the employer's Reply. The employer moved to strike this brief, asserting that it was not an authorized submission. We agree. The Board rules make no provision for a surreply brief of the respondent and we have not otherwise authorized the filing of such a brief in this case. See OAR 438-011-0020(2). We therefore grant the employer's motion to strike and do not consider claimant's "Respondent's Reply" brief. See Raymond T. Cox, Jr., 47 Van Natta 1628 (1995).

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 June 24, 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
WILLIAM W. GROVE, Claimant
WCB Case No. C702834
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Jensen, Fadeley, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On January 12, 1996, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b). This rule requires that the first page of the CDA contain a "statement indicating whether or not the parties are waiving the "30-day" approval period of ORS 656.236(1)(a)(C) as permitted by ORS 656.236(1)(b)."

The first page of the agreement has been amended and initialed to provide that the parties do not wish to waive the "30-day" cooling off period. However, the body of the document on page 5, lines 4-5, has not been amended and continues to request a waiver of the 30-day statutory period. It appears the parties' intent was to allow the "cooling-off period" to expire and then to seek Board approval and that the "waiver" language was left in the agreement inadvertently. Thus, we do not interpret the agreement as attempting to waive the 30 day period.

We conclude 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.

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
TINA HENRY, Claimant
WCB Case No. C702038
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Cole, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On August 13, 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 the parties agreed pursuant to ORS 656.236 to settle claimant's claim for compensation and payments of any kind due or claimed, except compensable medical services, for a total sum of $0.00. The self-insured employer agreed not to seek reimbursement for time loss benefits and medical and other expenses paid subsequent to September 30, 1996.[1]

On August 19, 1997, we wrote the parties noting that the total consideration for claimant's relinquishment of her "non-medical" benefits was the self-insured employer's agreement not to seek reimbursement for time loss benefits, medical and other expenses paid to claimant subsequent to September 30, 1996, which were allegedly attributable to a noncompensable condition. We further noted that it appeared that claimant's temporary disability award had become final. We requested the parties' positions regarding the effect on the CDA, if any, of Timothy W. Moore, 44 Van Natta 2060 (1992) (where an overpayment has apparently been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the CDA). In addition, we indicated we would consider any additional information or supplementation of the CDA the parties wished to provide.

On November 13, 1997, we received the parties' amended CDA. The amended CDA provided, in part, that "the consideration * * * for this Claim Disposition Agreement is a forbearance by [the employer] of its lawful entitlement to seek damages for fraud/misrepresentation in civil proceedings * * * ." The amended agreement provided for no monetary consideration in addition to the employer's forbearance of its civil cause of action. Because the amended agreement made reference to enclosed documents, but those documents were not enclosed, we wrote the parties on November 20, 1997, and requested that they provide the missing documents. Having received the referenced documents, we proceed with our review of the amended CDA.

In Laura A. Groves, 49 Van Natta 1938 (1997), we held that an employer's forbearance of a right to pursue a civil action against a claimant could constitute valid consideration for a CDA. See also Marriage of DeCair, 131 Or App 413, 418 (1994); Reid Strutt, Inc. v. Wagner, 65 Or App 475, 479 (1983).

Here, as in Groves, the employer has agreed not to assert its right to a civil cause of action against claimant in exchange for claimant's release of her rights to "non-medical service" workers' compensation benefits. Accordingly, here, as in Groves, we find that claimant's release of rights under the CDA is for valuable consideration and we conclude that the CDA meets the standard for approval under ORS 656.236(1)(a).

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.

IT IS SO ORDERED.

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[1] The agreement indicated that the employer had developed evidence that claimant's medical condition related to the injury was, in all probability, medically stationary and unrelated to the accepted claim on or about September 30, 1996 and that claimant subsequently received medical and time loss benefits to which she was not legally entitled.

In the Matter of the Compensation of
WILLIAM B. NOLAN, Claimant
WCB Case No. 97-00749
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to award an attorney fee under ORS 656.386(1); and (2) declined to award a penalty for allegedly unreasonable processing of claimant's cervical, thoracic and lumbar strain/sprain conditions. On review, the issues are attorney fees and penalties. We affirm.

FINDINGS OF FACT

Claimant was involved in a motor vehicle accident on May 29, 1996 while employed by the employer. On June 27, 1996, he made a claim for injury to his lower/upper back and neck. He sought medical treatment on July 11, 1996 and was diagnosed with a trapezius strain and lumbar radiculopathy without objective neurologic findings.

Claimant was examined by Dr. Fuller at SAIF's request on September 12, 1996. Dr. Fuller found no evidence of objective findings. On September 18, 1996, SAIF denied claimant's claim for a trapezius strain and right shoulder sprain/strain. Thereafter, on September 23, 1996, claimant's counsel wrote to SAIF indicating that unless he heard back from the carrier within 10 days, he would presume that the September 18, 1996 denial also denied claimant's cervical, thoracic and lumbar conditions.

Sometime thereafter, claimant's counsel requested a hearing and the parties entered into negotiations. The negotiations resulted in SAIF's November 5, 1996 acceptance of claimant's trapezius strain and right shoulder sprain/strain as a nondisabling injury, dismissal of claimant's request for hearing and a Stipulation and Order approved by the ALJ on March 6, 1997. In addition to setting forth SAIF's acceptance of the trapezius strain and right shoulder sprain/strain, the stipulation also provided as follows:

> "The parties further agree that nothing in this stipulation shall preclude the claimant from making a claim in the future for other conditions not accepted in this stipulation, nor shall it preclude SAIF Corporation from accepting or denying other conditions in the future if claimed by claimant."

The stipulation further awarded claimant's counsel a fee of $1,500 for prevailing on a denied claim.

Meanwhile, on November 7, 1996, claimant's counsel wrote to SAIF confirming the stipulated agreement. The letter notes, among other things, that SAIF will rescind its denial of claimant's right shoulder and trapezius strain/sprain, issue an acceptance of those conditions and that claimant's counsel will receive an attorney fee of $1,500. The letter further confirms as follows:

> "[I]t was agreed between the parties that [claimant] will preserve his right to pursue a claim for benefits for the cervical, thoracic and lumbar conditions set forth in my September 23, 1996 letter. Nothing in our stipulation including any 'raised or raisable' language will prevent [claimant] from requesting further clarification of the acceptance to include these conditions."

On January 23, 1997, claimant filed a new request for hearing alleging a "de facto" denial of his cervical, thoracic and lumbar conditions and seeking penalties for unreasonable denial and failure to process. On February 18, 1997, SAIF wrote to claimant's counsel advising that claimant had not provided the written notice required by ORS 656.262(6)(d) or 656.262(7)(a) before requesting a hearing on a "de facto" denial. SAIF further asserted that, because the statutory provisions require notice after an acceptance has been issued, claimant's counsel's September 23, 1996 letter (received well before the November 5, 1996 Notice of Acceptance) did not satisfy the statutory requirement.

By letter dated March 21, 1997, SAIF amended the Notice of Acceptance to include acceptance of a cervical, thoracic and lumbar sprain/strain. The parties went to hearing regarding the disputed penalty and attorney fee issues only.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant asserted that he was entitled to an assessed attorney fee for his counsel's efforts in obtaining rescission of the denial of his cervical, thoracic and lumbar conditions and penalties arising out of SAIF's allegedly unreasonable processing of the claim. The ALJ found that: (1) claimant's counsel had not been "instrumental in the acceptance" of those conditions; (2) the cervical, thoracic and lumbar conditions were not expressly denied at the time of the January 23, 1997 request for hearing; and (3) SAIF's claim processing was reasonable and penalties were not appropriate.

On review, claimant again argues that he is entitled to an attorney fee pursuant to ORS 656.386(1) because there was an express denial of these conditions at the time of his request for hearing as well as a penalty under ORS 656.382(1) due to SAIF's alleged failure to timely process the claim. Like the ALJ, we find to the contrary.

Pursuant to ORS 656.386(1), a claimant's counsel is entitled to an attorney fee "in such cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. Under the law in effect at the time of claimant's claim,[1] a "denied claim" was defined as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation."[2]

As the ALJ found, at the time of claimant's first request for hearing (prior to November 5, 1996), claimant's claim was in denied status. By virtue of the parties' stipulated agreement, however, SAIF agreed to accept certain conditions (the trapezius strain and right shoulder sprain/strain) and to preserve claimant's right to pursue a claim for other conditions not accepted by the stipulation (such as the cervical, thoracic and lumbar strains) at a later time. As the ALJ found, the stipulation "essentially wiped the slate clean regarding the balance of the conditions claimed and denied." Consequently, there were no conditions which were denied at the time of claimant's January 1997 request for hearing.

This interpretation of the parties' stipulated agreement is supported by claimant's counsel's November 7, 1996 confirmation letter to SAIF. As set forth above, the letter notes that the parties agreed to "preserve" claimant's right to pursue a claim for benefits for his cervical, thoracic and lumbar conditions. The letter also confirms that "[n]othing in our stipulation will prevent [claimant] from requesting further clarification of the acceptance to include these conditions." Had claimant's cervical, thoracic and lumbar conditions been in denied status as a result of the parties' stipulation, there would have been no need to preserve claimant's right to "pursue a claim" for these conditions.

On this record, we find no evidence that, at any time subsequent to the parties' stipulated agreement, SAIF expressly denied the compensability of claimant's cervical, thoracic or lumbar conditions. Therefore, under these circumstances, no "denied claim" has been established and no attorney fee is warranted under ORS 656.386(1). See Michael Galbraith, 48 Van Natta 351 (1996) (no "denied claim" where carrier paid all benefits for the compensable condition and did not expressly contend the condition was not compensable).

Furthermore, given our determination that the stipulation "wiped the slate clean" and preserved claimant's right to reassert his claim for a cervical, thoracic and lumbar condition, we agree with the ALJ that SAIF was under no duty to continue processing the conditions claimed in claimant's counsel's

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[1] ORS 656.386(1) was amended by the 1997 Legislature, but the revisions that went into effect on July 25, 1997 were not made retroactive and are therefore not applicable to this case. See Stephenson v. Meyer, 150 Or App 300, 304 n.3 (1997) (noting that the 1997 revisions to ORS 656.386(1) were not made retroactive).

[2] Under the new law, a "denied claim" now includes, among other things, a claim for a condition omitted from the notice of acceptance, made pursuant to ORS 656.262(6)(d), to which the carrier does not respond within 30 days. Amended ORS 656.386(1)(b)(B).

September 23, 1996 letter. Because the stipulation allowed claimant to raise these other claimed conditions at a later time, claimant was required to request formal written acceptance of these conditions before requesting a hearing. See ORS 656.262(7)(a); 656.262(6)(d). Even assuming that claimant's request for hearing could be construed as a request for acceptance of these conditions,[3] SAIF's March 21, 1997 acceptance of the cervical, thoracic and lumbar conditions was timely and did not constitute unreasonable claims processing.

ORDER

The ALJ's order dated April 25, 1997 is affirmed.

[3] We have specifically held that a hearing request concerning an unaccepted condition does not satisfy ORS 656.262(7)(a)'s requirement that a claimant first "clearly request formal written acceptance" of the condition. See Diane S. Hill, 48 Van Natta 2351 (1996), aff'd mem Hill v. Stuart Andersons, 149 Or App 496 (1997).

In the Matter of the Compensation of
DEBRA L. RIDENOUR, Claimant
WCB Case No. 97-0267M
OWN MOTION ORDER ON RECONSIDERATION (VACATING PRIOR ORDER)
Black, Chapman, et al, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration our November 10, 1997 Order on Reconsideration. Specifically, SAIF contends that we were without authority to issue the November 10, 1997 Order on Reconsideration as it was issued more than thirty (30) days from our October 3, 1997 Own Motion Order.

Pursuant to OAR 438-012-0065(2), an Own Motion Order becomes final within 30 days from the date it is issued or 60 days after the mailing date if good cause is shown. In conjunction with this provision, OAR 438-012-0065(3) allows the Board, under extraordinary circumstances, to "on its own motion, reconsider any prior Board order."

Here, as SAIF points out, there was no showing of good cause or extraordinary circumstances, which would allow reconsideration of our October 3, 1997 Own Motion Order. See OAR 438-012-0065(2) & (3). Moreover, the record does not otherwise contain any evidence which establishes good cause or extraordinary circumstances.[1] Consequently, we conclude that claimant's request for reconsideration should have been denied.

Accordingly, on reconsideration, we withdraw our November 10, 1997 Order on Reconsideration. In lieu of that order ,we deny claimant's request for reconsideration.

IT IS SO ORDERED.

[1] Although the current grounds for claimant's request for reconsideration does not constitute good cause or extraordinary circumstances, this conclusion does not preclude us from subsequently reconsidering our prior order should the situation described in our November 10, 1997 order eventually occur. In this regard, we further note that our Order on Reconsideration essentially informed claimant of this possible situation when we declined to hold the case in abeyance pending judicial review. Should the situation described in our November 10, 1997 order arise, we will then address our authority to modify our October 3, 1997 order. In doing so, we will consider whether such points and authorities as ORS 656.278(1) and SAIF v. Reddekopp, 137 Or App 102 rev den 322 Or 360 (1995) warrant the modification of our prior order.

In the Matter of the Compensation of
PAUL M. JORDAN, Claimant
Own Motion No. 97-0252M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Black, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our June 17, 1997 Own Motion Order, as reconsidered on October 6, 1997, in which we declined to reopen his 1984 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of his current disability. With his reconsideration request, claimant submits additional evidence regarding the work force issue.

On November 6, 1997, we abated our October 6, 1997 Own Motion Order on Reconsideration, and allowed the SAIF Corporation 14 days in which to file a response to claimant's motion. We have received SAIF's response and proceed with our reconsideration.

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

On February 12, 1997, claimant underwent a left L3-4 laminotomy and removal of free fragment disk rupture performed by Dr. Purtzer. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

SAIF contends that claimant has not provided evidence that he was in the work force at the time of the current disability. Claimant contends that "although [he] was not in the work force at the time of his worsening, he was willing to work and to seek work would be absolutely futile." Claimant has the burden of proof on this issue. ORS 656.266. Because claimant was not actually working or looking for work at the time of disability, he must provide persuasive evidence that he was willing to work, but unable to work because of his compensable condition for the period in question. Dawkins v. Pacific Motor Trucking, 308 Or at 258.

Claimant submits a copy of an October 24, 1997 letter in which Dr. Purtzer agreed with the following statement:

> "Do you believe that [claimant], at the time of his last surgery and through the present, was totally restricted from any kind of work activity and that it was medically futile for him to even look for work from the time of his surgery forward due to the worsened condition since he would have had frequent, unpredictable periods of absenteeism (more than 2 days a month), the need to lie down on a frequent and unpredictable basis, and has a very fragile spine with multiple surgeries and associated pain?" (Emphasis on original).

This statement has the same problem as an earlier statement to which Dr. Purtzer agreed. Specifically, in a June 18, 1997 letter, Dr. Purtzer agreed with the statement that, because of claimant's 5 low back surgeries and 2 neck surgeries, it was futile for him to look for work "right now."[1] Both

[1] As we noted in our prior reconsideration, claimant sustained a compensable injury to his low back. There is no evidence in the record that claimant's cervical condition is compensable. Therefore, claimant's cervical condition is not relevant to our inquiry.

statements relate to claimant's ability to work from the time of his February 1997 surgery and thereafter, which is not the "time of disability." See Weyerhaeuser v. Kepford, 100 Or App at 410. In other words, there is no dispute that claimant would be unable to work at the time he underwent surgery and during any recovery period following the surgery. However, the dispositive question is whether claimant was unable to work due to the compensable injury at the relevant time; i.e., whether claimant was in the work force at the time of current disability - before entering the hospital for surgery. See John B. Shaw, Sr., 48 Van Natta 2427, 2428 n.1 (1996) (Board rejected the claimant's argument that, because it was futile for him to seek work after his surgery, he had established that he was in the work force at the time of current disability).

Claimant also submits a November 5, 1997 letter from Mr. Potocki, a vocational consultant, in which he addresses "the issue of whether or not it would be futile from a vocational perspective for [claimant] to look for work at present." After reviewing Dr. Purtzer's June 18, 1997 and October 23, 1997 opinions, as discussed above, Mr. Potocki opined that it would not be feasible for claimant to seek employment. Mr. Potocki's opinion is unpersuasive for the same reasons that Dr. Purtzer's opinions are unpersuasive. Namely, Mr. Potocki's opinion deals with claimant's inability to seek work "at present," i.e., after the February 1997 surgery. As such, it does not address the relevant issue; that is, whether claimant was in the work force at the time of disability - before entering the hospital for surgery.

In addition, the record shows that Dr. Purtzer also performed an earlier compensable low back surgery. On September 25, 1995, Dr. Purtzer found claimant medically stationary regarding that surgery. At that time, as a result of claimant's physical capacities evaluation, Dr. Purtzer found claimant capable of light duty work with limitations on working below waist level. Dr. Purtzer concluded that claimant could return to work within those physical capacities. After that date, there is no evidence in the record that claimant was released from work or that claimant sought work within his physical capacity.

Finally, claimant submits an affidavit stating that he is willing to work, although he cannot look for work due to his disabling back condition. Claimant also states that he was totally disabled and on Social Security Disability even before he underwent his fifth workers' compensation related back surgery on February 12, 1997. However, as we explained in our prior reconsideration of this matter, receipt of Social Security Disability benefits, without more, does not establish inability to work due to a compensable injury. See Bobbi J. Blakely, 49 Van Natta 463 (1997); Lowell D. Armon, 48 Van Natta 2416 (1996).

A claimant's eligibility for Social Security Disability 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, a claimant's entitlement to Social Security Disability benefits is not persuasive evidence that he is disabled due to the compensable injury unless the claimant can establish the disability as compensable. Robert E. Carper, 48 Van Natta 1160 (1996); Kenneth C. Felton, 48 Van Natta 725 (1996). Here, claimant has not attempted to establish that his Social Security Disability benefits are due to his compensable low back condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 17, 1997 order, as reconsidered on October 6, 1997, in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY D. OSBERG, Claimant
WCB Case No. 97-02227
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of responsibility for claimant's left knee conditions. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant, a 37 year-old auto parts worker, sustained a twisting injury to his left knee while working for SAIF's insured on February 6, 1997. At that time, claimant had a history of left knee injuries and related surgeries, including a compensable 1988 injury with a prior employer that was also insured by SAIF. As a result of these prior injuries and surgeries, claimant sustained significant left knee damage, including degeneration in both the lateral and medial menisci, reactive synovitis in the medial joint, chondromalacia of the undersurface of the patella, and tibial plateau chondritis.

These preexisting conditions caused claimant to experience ongoing left knee pain and instability. In late January 1997, claimant's treating orthopedic surgeon, Dr. Brett, requested authorization for arthroscopic debridement to relieve these ongoing left knee symptoms. The subsequent injury on February 6, 1997 caused further instability and excruciating left knee pain. Dr. Brett performed arthroscopic surgery on March 4, 1997.

Claimant filed a new injury claim for his current left knee condition based on the February 1997 injury. SAIF issued a formal responsibility denial of the claim on March 12, 1997. A March 26, 1997 Board Own Motion Order reopened claimant's 1988 injury claim for processing of his current left knee condition and related surgery.

ULTIMATE FINDINGS OF FACT

Claimant's current left knee symptoms are attributable to a worsening of his preexisting degenerative conditions and a new tear in the lateral meniscus. Claimant's current condition is the result of a combining of the February 1997 twisting injury and the preexisting left knee damage. Claimant's torn lateral meniscus and worsened degenerative conditions involved the same conditions processed as part of the 1988 injury claim.

CONCLUSIONS OF LAW AND OPINION

In determining responsibility for claimant's current left knee condition, the ALJ analyzed the worsened, preexisting degenerative conditions separately from the new lateral meniscus tear. The ALJ determined responsibility for the worsened degenerative conditions under ORS 656.308(1), which shifts responsibility if the new injury is the major contributing cause of the disability or need for treatment of the current condition. ORS 656.308(1) and 656.005(7)(a)(B); SAIF v. Drews, 318 Or 1 (1993). The ALJ determined responsibility for the new lateral meniscus tear under the less rigorous "independent contribution" standard discussed in Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). The ALJ further concluded that Dr. Brett's unrebutted medical opinion satisfied both legal standards and persuasively established that SAIF was responsible for the new lateral meniscus tear and the worsened degenerative conditions under the 1997 injury claim.

On review, SAIF argues that ORS 656.308(1) is applicable to the new lateral meniscus tear as well as the worsened degenerative conditions. SAIF further contends that Dr. Brett's opinion does not establish that the 1997 injury is the major contributing cause of claimant's left knee condition, as distinct from the precipitating cause. We agree.

Responsibility must be analyzed under ORS 656.308(1) if claimant's current left knee condition involves the same condition previously processed as part of the 1988 injury claim. See Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993); Armand J. DeRosset, 45 Van Natta 1058 (1993). The ALJ concluded that the lateral meniscus tear was not subject to ORS 656.308(1) because Dr. Brett opined that the tear occurred at the time of the 1997 injury. However, Dr. Brett also explained that the tear in 1997 was due, in part, to the preexisting lateral meniscus degeneration that was processed under the 1988 claim. Consequently, we are persuaded that the new lateral meniscus tear involved the same degenerative condition processed as part of the 1988 claim and should be analyzed under ORS 656.308(1).

We are further persuaded that Dr. Brett's opinion is not a sufficient basis for shifting responsibility under ORS 656.308(1). To satisfy the major contributing cause standard incorporated in that provision, claimant must prove that the 1997 injury is the primary cause of the disability or need for treatment for his left knee condition, as distinct from the precipitating cause. Robinson v. SAIF, 147 Or App 157 (1997); Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). This causation issue involves complex medical questions that must be resolved with expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993).

Here, Dr. Brett has never opined that the February 1997 injury is the major contributing cause of claimant's worsened degenerative conditions, as distinct from the new lateral meniscus tear. Dr. Brett did initially indicate in his deposition testimony that the 1997 injury was the major contributing cause of the torn lateral meniscus. In that same deposition, however, he explained that his opinion was based on the temporal relationship between the tear and the injury, and he described the contribution of the injury as a precipitating cause. In light of these remarks, we are not persuaded that Dr. Brett understood that the major contributing cause standard is not satisfied unless the 1997 injury is the primary contributing factor, as distinct from the precipitating cause. Accordingly, we conclude that Dr. Brett's opinion does not satisfy the legal standard for shifting responsibility under ORS 656.308(1).[1]

ORDER

The ALJ's order dated July 18, 1997, as corrected and republished on July 29, 1997, is reversed. The SAIF Corporation's denial of claimant's left knee condition is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[1] In reaching this decision, we reject claimant's argument that "major contributing cause" means "immediate" cause of the current need for treatment. Claimant relies on SAIF v. Nehl, 148 Or App 101 (1997), in which the court held 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." On reconsideration, the court withdrew that language and concluded 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." 149 Or App 309 (1997).

In the Matter of the Compensation of
ROBERT D. SULLENGER, Claimant
WCB Case No. 97-00833
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for claimant's cervical and thoracic spine conditions. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 18, 1997 is affirmed.

Board Chair Hall dissenting.

The medical arbiter in this case found claimant's reduced range of motion findings to be valid. Nonetheless, the majority declines to rely on these findings because the arbiter opined that claimant's range of motion had essentially returned to "normal" for him as an individual.

We are required to rate impairment findings which are valid according to the American Medical Association standards for validity as adopted by the Director's rules for rating permanent disability. Moreover, we have previously noted that a physician's "statement that range of motion was 'normal' did not constitute an opinion concerning causation and is contrary to the legal standards" (i.e., the aforementioned rules for rating permanent disability). Scott Campbell, 49 Van Natta 143, n.1 (1997). In other words, the purported "normalcy" of lost range of motion is not a proper basis for rejecting valid range of motion findings. Accordingly, because the majority's failure to rate claimant's valid lost range of motion is contrary to law, I must respectfully dissent

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In the Matter of the Compensation of
DUSTIN L. CROMPTON, Claimant
Own Motion No. 970523M
OWN MOTION ORDER
Glen J. Lasken, Claimant Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable disabling lumbar disc protrusion, left L4-5, injury. Claimant's aggravation rights expired on August 22, 1996. The employer, through Sedgwick James, its processing agent, recommends that we deny authorizing the payment of temporary disability compensation. However, the employer provides no basis for this recommendation.

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). Claimant has the burden of proof on this issue. ORS 656.266. Where a claimant meets his burden of proof, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

Claimant, through his attorney, submits a July 16, 1997 letter from Dr. Treible, claimant's treating surgeon. Dr. Treible notes that claimant sustained a L4-5 lumbar disc herniation as a result of his December 1990 work injury and underwent surgery for that condition in 1991 and 1993. Dr. Treible states that, since March 1997, he has been treating claimant for a recurrent L4-5 disc herniation, which resulted from claimant's initial work injury. This treatment consisted of excision of the recurrent L4-5 disc herniation on March 12, 1997. Subsequently, claimant sustained a reherniation of the L4-5 disc that required a repeat lumbar discectomy on April 22, 1997, at which time a lumbar fusion was also performed.

While the Board in its own motion authority does not have jurisdiction over issues regarding causation or appropriateness of treatment issues, here there does not appear to be any dispute regarding those issues. ORS 656.245; 656.327; Charles C. Day, 49 Van Natta 511 (1997); Bonnie L. Turnbull, 49 Van Natta 139, on recon 49 Van Natta 470 (1997). In this regard, the employer answered "unknown" to all questions on its "Carrier's Own Motion Recommendation" form that inquired as to its positions regarding causation, responsibility and appropriateness of claimant's surgery. In addition, although the employer submitted voluminous copies of medical records and other information, those copies referred to claimant's treatment/condition for the period from 1991 through 1993. Therefore, none of the material submitted by the employer is relevant to claimant's current condition, which resulted in low back surgeries in March and April of 1997.

On this record, we find that the employer did not contest either compensability of claimant's current condition or appropriateness of the treatment for that condition. Therefore, based on Dr. Treible's unrebutted opinion, we find that claimant has met his burden of proving a worsening of the compensable low back injury that required surgery. ORS 656.278(1)(a).

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). Here, claimant must prove that he was in the work force on March 12, 1997, when his low back condition worsened requiring surgery. A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proving he was in the work force at the time of disability. ORS 656.266.

Dr. Treible stated that claimant was unable to participate in regular work activities from the time of his initial evaluation of claimant on March 11, 1997. For the same reasons as discussed above, we find that the employer did not contest the work force issue. Specifically, the employer responded "unknown" to the inquiry on the "Carrier's Own Motion Recommendation" form as to its position regarding the work force issue. Thus, Dr. Treible's unrebutted opinion establishes that claimant was unable to work due to the compensable injury at the time of his disability.

However, that is not the end of our inquiry regarding the work force issue. As stated above, claimant must also establish that he was willing to work, although unable to work due to the compensable injury. Dawkins v. Pacific Motor Trucking, 308 Or at 258. Dr. Treible's statements regarding claimant's inability to work do not establish claimant's willingness to work. Furthermore, the record contains no affidavit from claimant regarding his willingness to work, nor does it contain any other evidence that would establish claimant's willingness to work or that claimant was working before his compensable injury rendered him unable to work. Therefore, on this record, claimant has failed to establish the required work force element.

Accordingly, claimant's request for temporary disability compensation is denied. 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.

Finally, claimant requests that we assess a penalty for the employer's untimely own motion recommendation. Own motion claims must first be directed to and processed by the carrier. OAR 438-012-0020(1). A carrier has 90 days after receiving an own motion claim to submit to the Board a written recommendation as to whether the claim should be reopened or denied. OAR 438-012-0030(1).

Here, claimant's attorney submitted Dr. Treible's July 16, 1997 letter to Sedgwick James via a cover letter dated July 24, 1997. In addition, by letter dated August 6, 1997, claimant's attorney sent a letter to Sedgwick James formally requesting reopening of claimant's own motion claim. Sedgwick James submitted its "recommendation" to the Board on a form dated November 13, 1997.

However, even if we should find that Sedgwick James' recommendation was untimely filed, we are unable to award penalties under the facts of this case. When a claim is under own motion jurisdiction, no compensation is due until the Board issues an order authorizing reopening of the claim. Therefore, prior to such an order, there are no "amounts then due" upon which to base a penalty under ORS 656.262(11). Debra D. Robinson, 49 Van Natta 786 (1997); John D. McCollum, 44 Van Natta 2057 (1992); Thomas L. Abel, 44 Van Natta 1039, on recon 44 Van Natta 1189 (1992). Here, the alleged unreasonable conduct occurred prior to any order authorizing reopening of claimant's claim. In fact, to date, we have not authorized reopening claimant's claim. Therefore, there are no amounts "then due" upon which to base a penalty. Accordingly, we deny claimant's request to assess a penalty.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD D. DAVIS, Claimant
WCB Case No. 97-01045
ORDER ON REVIEW
Daniel J. Denorch, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) reduced claimant's scheduled permanent disability for loss of use or function of the left arm from 5 percent (9.6 degrees), as awarded by an Order on Reconsideration, to zero; and (2) declined to address claimant's contentions concerning compensability, penalties, and attorney fees. On review, the issues are extent of scheduled permanent disability and, potentially, compensability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

Claimant has an accepted claim for "left elbow contusion." The self-insured employer issued a Notice of Closure awarding only temporary disability. Pursuant to ORS 656.268(16)[1] and OAR 436-035-0010(2),[2] the Order on Reconsideration found that claimant's epicondylitis condition was a "sequela" of the compensable injury and awarded 5 percent scheduled permanent disability for that condition.

The ALJ reasoned that, because epicondylitis was not an accepted condition, the award was "in error." The ALJ concluded that, in the absence of evidence showing impairment from the accepted condition, claimant failed to prove entitlement to scheduled permanent disability.

Under ORS 656.268(16), if the persuasive medical evidence supports a conclusion that a condition is a "direct medical sequelae" to the original accepted condition, then disability from that condition is rated if it has not been specifically denied. See Richard D. Worton, 49 Van Natta 1849 (1997). Consequently, even though the employer accepted only left elbow contusion, if other conditions are "direct medical sequelae," then impairment from such conditions is rated since the employer did not issue any denial.

Here, shortly after the October 1995 injury, claimant's treating physician, Dr. Browning, diagnosed left elbow bursitis "secondary to contusion" and left lateral epicondylitis, "a sequela of the 10/26/95 injury." (Ex. 10A). Dr. Browning later indicated that the bursitis was "trauma induced" from the October 1995 injury. (Ex. 14).

Dr. Tilson, another treating physician, also diagnosed "traumatic olecranon bursitis" and "traumatic lateral epicondylitis." (Ex. 16-2). Dr. Tilson further reported that the bursitis condition was "resolved." (Id.) Dr. Peacock, who also treated claimant, agreed that bursitis was "resolved." (Ex. 19).

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[1] ORS 656.268(16) provides:

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

[2] That rule states:

"Scheduled disability is rated on the permanent loss of use or function of a body part due to a compensable, consequential, combined condition (pursuant to these rules) and any direct medical sequelae. * * *"

Dr. Browning then reported that the October 1995 injury "was sufficiently severe to cause a traumatic olecranon bursitis immediately" and "also directly responsible for initiating a subsequent lateral epicondylitis[.]" (Ex. 21). In subsequent chartnotes, Dr. Browning continued to indicate that the epicondylitis condition was secondary to the injury. (Exs. 32, 33B).

Examining orthopedic surgeon, Dr. Tesar, diagnosed, in part, "olecranon bursitis, by history, resolved" and "lateral epicondylitis, by history." (Ex. 37-71). He felt the olecranon bursitis condition "certainly" was related to the industrial injury. (Id. at 72). With regard to epicondylitis, Dr. Tesar discussed claimant's prior symptoms of such condition, finding that he had recovered from his previous condition by the mid-1980's. (Id.) According to Dr. Tesar, the lateral epicondylitis condition was "related to the industrial injury, and the industrial injury was the major cause for" the condition. (Id.)

In a subsequent chartnote, Dr. Browning stated that Dr. Tesar had declared the "olecranon bursitis to be work related" and the "left lateral epicondylitis to be non-work related (pre-existing or prior predisposition)." (Ex. 35). Dr. Browning then reported: "I expressed [in] a letter to the insurance carrier at one point that I felt the left lateral epicondylitis was a direct sequela of the elbow contusion however I ultimately concurred with Dr. Tesar and Dr. Don Tilson who felt the lateral epicondylitis was not work caused." (Id.)

Dr. Peterson, neurologist, performed a medical arbiter examination. Although noting that left lateral epicondylitis was not an accepted condition, Dr. Peterson reported that the condition "arises from the accepted condition of left elbow contusion and is significantly limiting [claimant's] ability to repetitively use the left elbow and arm." (Ex. 35C-6).

We first find that, because the record shows that the bursitis condition has resolved and there is an absence of any evidence showing that such condition resulted in impairment, claimant is not entitled to permanent disability for this condition, whether or not it is a "direct medical sequela" of the accepted injury.

We come to a different conclusion with regard to left lateral epicondylitis. First, based on Dr. Peterson's report, we find that such condition is a "direct medical sequela" of the original accepted condition. The only contrary opinion is Dr. Browning's ultimate opinion that she "concurred" with Dr. Tesar and Dr. Tilson, who she thought had decided the epicondylitis condition was not work related. Because Dr. Browning based her changed opinion on an inaccurate understanding of Dr. Tesar's and Dr. Tilson's opinions, we find her last statement concerning causation to be unreliable.

Having found that the left lateral epicondylitis condition is a "direct medical sequela" of the original accepted injury, we further find that, based on Dr. Peterson's report, such condition significantly limits claimant from repetitively using the left elbow and arm. Consequently, claimant is entitled to 5 percent scheduled permanent disability. ORS 656.268(16), OAR 436-035-0010(2).

Claimant's counsel is entitled to 25 percent of any increased compensation created by our order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055. 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), aff'd on other grounds Volk v. America West Airlines, 135 Or App 565 (1995), rev den 322 Or 645 (1996).

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). After considering the factors set forth 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 $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Compensability, Penalties, and Attorney Fees

In written arguments to the ALJ, claimant asserted that the bursitis and epicondylitis conditions were "de facto" denied, and that such denials were unreasonable, warranting the assessment of penalties and attorney fees. The ALJ declined to address the issues on the basis that they were not

raised until closing arguments. On review, claimant challenges this conclusion, arguing that, because the hearing was "on the record," "counsel's written arguments were also pleadings framing the issues and delineating the evidence."

Whether or not claimant timely raised the issues before the ALJ, we find that the ALJ properly declined to address them. Under ORS 656.262(6)(d), the worker "first must communicate in writing to the [carrier] the worker's objections" to a notice of acceptance concerning a condition that has been incorrectly omitted or any other deficiency; if such an action is not taken, the worker may not allege a "de facto" denial of a condition at any hearing or other proceeding. See Shannon E. Jenkins, 48 Van Natta 1482 (1996) (interpreting the statute as intending that the worker's "communication in writing" under ORS 656.262(6)(d) precede the worker's request for hearing), aff'd mem Jenkins v. Continental Baking Co., 149 Or App 436 (1997).

Here, there is no evidence that claimant communicated to the employer that the bursitis and epicondylitis conditions were incorrectly omitted from the Notice of Acceptance. Instead, the record shows that claimant did not make such allegations until submitting his written arguments to the ALJ. Because no "communication in writing" preceded the request for hearing, claimant is precluded from alleging "de facto" denials of the conditions. Moreover, because the penalty and attorney fee matters are based on overturning the alleged "de facto" denials of bursitis and epicondylitis, and we have found that claimant is precluded from making such allegations, it follows that there is no basis for awarding a penalty and/or attorney fee.

ORDER

The ALJ's order dated May 9, 1997 is reversed in part and affirmed in part. The Order on Reconsideration awarding 5 percent (9.6 degrees) unscheduled permanent disability is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. In the event that this compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane Volk. For services at hearing concerning only the unscheduled permanent disability issue, claimant is awarded an assessed attorney fee of $500, to be paid by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DURWOOD MCDOWELL, Claimant
Own Motion No. 95-0527M
RECONSIDERATION OF OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Kirby & Johnson, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our October 14, 1997 Own Motion Order Reviewing Carrier Closure, which affirmed the SAIF Corporation's May 27, 1997 Notice of Closure. With his request for reconsideration, claimant submits additional medical records.[1]

On November 13, 1997, we abated our order to consider claimant's motion for reconsideration and granted SAIF an opportunity to respond. Having received SAIF's response, we proceed with our reconsideration.

On May 27, 1997, SAIF issued a Notice of Closure that closed claimant's claim with an award of temporary disability compensation from May 20, 1995 through May 18, 1997. SAIF declared claimant medically stationary as of May 19, 1997. On reconsideration, claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed because he was admitted to the hospital for treatment of his compensable low back condition on May 27, 1997, the same date SAIF closed his claim.

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[1] Claimant informed us that these medical records had been submitted as exhibits in WCB Case No. 97-06277, the case before the Hearings Division as a result of claimant's appeal of SAIF's July 14, 1997 current condition denial in this claim. For ease of reference, where possible, we will cite to the exhibit numbers on these records.

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 27, 1997 Notice of Closure, considering claimant's condition at the time of closure and not 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 recite a brief history of this claim. Claimant sustained a low back injury on December 4, 1981. Claimant's aggravation rights expired on January 26, 1988. From May 20, 1995 to May 22, 1995, claimant was hospitalized for treatment of low back pain. On November 5, 1995, we authorized the reopening of claimant's claim for the payment of temporary disability benefits, commencing May 20, 1995, the date he was hospitalized for treatment of his worsened low back condition. SAIF requested reconsideration of our order, arguing that claimant's low back condition had not worsened and the hospitalization was for palliative treatment of an exacerbation of back pain. In an order issued on December 14, 1995, we rejected SAIF's argument and republished our prior order. Specifically, based primarily on medical evidence from Dr. Euhus, claimant's attending physician, we found that claimant's compensable condition worsened to the extent that his pain could not be treated on an outpatient basis and could only be managed by treating the condition during inpatient hospitalization.

Claimant was enrolled in a pain center rehabilitation program from April 1, 1997 through April 18, 1997. Dr. Murphy, pain center physician, opined that claimant was medically stationary as of April 18, 1997, and released claimant to full-time sedentary work. Dr. Murphy noted that claimant did not cooperate with the pain center program and would not agree to "an outlined medication taper." Dr. Murphy further reported that claimant was discharged from the pain center program because of non-compliance with the program, and recommended that further physical therapy, biofeedback or counseling was contraindicated.

Dr. Murphy discontinued claimant's Soma and Trazodone medications, instructed claimant to wean from Paxil over 10 days (as well as from Hydrocodone), and recommended that claimant follow up with Dr. Euhus within two weeks. In his April 30, 1997 discharge report, Dr. Murphy opined that claimant was medically stationary "due to lack of objective quantifiable findings."

No closing examination report from Dr. Euhus is in the record. However, in a May 19, 1997 response to SAIF, Dr. Euhus concurred with the medically stationary date as opined by Dr. Murphy in his report. Furthermore, in a May 12, 1997 chart note, Dr. Euhus stated that he was not aware of what else he could offer claimant and that not all medical problems had a solution. (Ex. 68-2). Dr. Euhus emphasized that claimant's pain was not being solved with treatment with narcotics and they were trying to keep the addiction factor down. Id. Dr. Euhus also stated that, although he supported claimant's attempt to seek an evaluation at the Mayo Clinic, he encouraged claimant not to get his hopes up because the Mayo Clinic might not have the answer to claimant's low back pain problem either. Id.

On May 27, 1997, SAIF closed claimant's claim, declaring him medically stationary on May 19, 1997, the date of Dr. Euhus' concurrence. Also on May 27, 1997, Dr. Euhus again admitted claimant to the hospital for treatment of low back pain, noting that "[p]rognosis for definitive treatment or cure is limited." (Ex. 72-2). Claimant's hospital treatment consisted of bed rest, nursing care, and narcotic medications that were ultimately delivered intravenously due to problems created by multiple injections of pain medications over the years. Claimant remained hospitalized until June 3, 1997, at which time Dr. Euhus repeated that claimant "prognosis for definitive treatment or cure is somewhat limited." (Ex. 82-2).

On July 14, 1997, SAIF issued a denial of claimant's current condition. That denial did not define the current condition which was denied. Claimant requested a hearing to contest the denial (WCB Case No. 97-06277), as well as Director's review of denied medical services. On July 25, 1997, we requested the parties' positions with respect to whether the July 14, 1997 denial and pending litigation

had any effect on claimant's request for review of SAIF's closure. We received no response from SAIF. However, in a September 18, 1997 brief, claimant stated that "the July 14, 1997 denial should not affect Board's Own Motion jurisdiction claim closure." In light of claimant's response, we proceed with our review.

Here, both Drs. Murphy and Euhus declared claimant medically stationary with respect to his compensable low back condition. Although claimant was admitted to the hospital for low back pain on the date his claim was closed, there is no medical opinion regarding the significance of that hospitalization in regard to claimant's medically stationary status. In this regard, in order to establish that his compensable condition was prematurely closed, claimant must prove that there is a reasonable expectation of further material improvement from medical treatment or the passage of time. ORS 656.005(17). While claimant argues that his May 27, 1997 hospitalization establishes that he was not medically stationary at claim closure, he offers no medical evidence in support of his argument. Dr. Euhus did not retract his opinion that claimant was medically stationary. Furthermore, Dr. Euhus gave no opinion regarding the affect of claimant's May 27, 1997 hospitalization for pain treatment on claimant's medically stationary status.

The issue of whether claimant was medically stationary at claim closure is a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App at 125; Austin v. SAIF, 48 Or App at 12. We are without the medical expertise to determine that claimant's May 27, 1997 hospitalization for low back pain, in itself, establishes that there is a reasonable expectation of further material improvement from medical treatment or the passage of time. ORS 656.005(17). This is especially true given Dr. Euhus' statements that he is unaware of any further treatment that would benefit claimant and his agreement that claimant is medically stationary. (Exs. 68, 72, 82). Furthermore, we note that a need for continuing medical treatment does not necessarily prove that a claimant was not medically stationary at claim closure. See Maarefi v. SAIF, 69 Or App 527, 531 (1984); Kenneth W. Meyers, 41 Van Natta 1375 (1989). Thus, on this record,[2] we are unable to determine that claimant's hospitalization for pain treatment on the date of claim closure establishes that he was not medically stationary. Thus, we continue to find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our October 14, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] We note that the record at the time of our order authorizing reopening claimant's claim contained persuasive medical evidence regarding the relevant issue at that time, i.e., whether claimant's May 20, 1995 hospitalization for pain treatment established a worsening of his compensable condition that would entitle claimant to have his own motion claim reopened. In this regard, Dr. Euhus' opinions regarding that hospitalization established that there was such a worsening. In contrast, for the reasons addressed above, the record regarding the issue currently before us, i.e., whether claimant's condition was medically stationary at claim closure, is inadequate to meet claimant's burden of proof at this time. Parenthetically, we also note that our finding that, on this record, the May 27, 1997 hospitalization does not establish that claimant was not medically stationary at claim closure does not necessarily mean that that hospitalization cannot be the basis for a future "reopening" of claimant's own motion claim.

In the Matter of the Compensation of
DARAL T. MORROW, Claimant
WCB Case Nos. 96-06161 & 95-08182
ORDER ON RECONSIDERATION
Bischoff, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests reconsideration of our November 18, 1997 Order on Review that reversed the Administrative Law Judge's (ALJ's) order upholding the employer's denial of claimant's current low back condition and reducing claimant's unscheduled permanent disability from 3 percent (9.6 degrees), as awarded by an Order on Reconsideration, to zero. In moving for reconsideration, the employer asks for "clarification" concerning the permanent disability issue, noting that the Board's order did not expressly address this matter. We agree with the employer that, although listing it as an issue on review, our order did not address claimant's entitlement to permanent disability. Thus, we proceed to do so on reconsideration.

In 1994, the employer was found responsible for claimant's low back condition pursuant to litigation. In July 1995, the employer denied claimant's "current low back condition." The employer then issued a Notice of Closure awarding no permanent disability. An Order on Reconsideration awarded 3 percent unscheduled permanent disability based on a medical arbiter's examination and consideration of a prior permanent disability award. After upholding the employer's denial of claimant's current low back condition, the ALJ found that claimant had no impairment due to the compensable injury. Consequently, the ALJ reduced the permanent disability award to zero.

On review, we decided that, because the employer had accepted a "new compensable injury" under ORS 656.308(1), it could not now deny compensability on the basis that the prior injury was the major contributing cause of claimant's current low back condition. Rather, pursuant to ORS 656.308(1), we concluded that the employer remained responsible for future compensable treatment and disability unless claimant sustained a "new compensable injury." As such, we found the employer's denial to be procedurally invalid.

The most persuasive evidence of claimant's impairment was from Dr. Fielden, the medical arbiter.[1] Having found that the employer could not deny claimant's current low back condition, we also consider Dr. Fielden's findings as relating to the condition for which the employer is responsible.

Dr. Fielden measured range of motion as follows: 60 degrees for flexion and 10 degrees each for extension, right lateral flexion and left lateral flexion. (Ex. 41-4). Under the applicable standards, these measurements result in a rating of 0 percent for flexion; 5 degrees for extension; and 3 percent each for right and left lateral flexion. Former OAR 436-35-360(19), (20), (21) (WCD Admin. Order 6-1992). These values are added, former OAR 436-35-360(22), for a total impairment value of 11 percent.

Dr. Fielden also indicated that claimant is capable of returning to regular work. (Ex. 41-8). Consequently, in determining adaptability, we find that claimant's residual functional capacity is equal to his base functional capacity. Thus, claimant is entitled to a value of 1 for adaptability. OAR 436-035-0270(4)(a) (WCD Admin. Order 96-072).[2]

At the time of closure, claimant was less than 40 years old; thus, his value for age is 0. Former OAR 436-35-290(2). Because claimant has a high school diploma, (ex. 17-2), his value for education also is 0. Former OAR 436-35-300(3)(a).

The value for skills is based on the highest Specific Vocational Preparation (SVP) met by claimant during the 10 years preceding the time of determination. Former OAR 436-35-300(4). SVP is

[1] The only other evidence of impairment is from examining orthopedic surgeon, Dr. Geist, who saw claimant in May 1995. The treating physician, Dr. Shames, concurred with Dr. Geist's report. (Ex. 37-1). Because the medical arbiter examined claimant much closer in time to the Order on Reconsideration, we consider that report more persuasive than Dr. Geist's findings.

[2] Although not in effect at the time of closure, this rule applies because the claim was closed after March 13, 1992 and claimant was medically stationary after June 1, 1990. OAR 436-035-0003(3).

obtained from the DOT. Id. Based on the record, we find that the highest SVP is 4, based on DOT 869.664-014.[3] Therefore, the value for skills is 3. Former OAR 436-35-300(4)(e). Adding age, education, and skills together results in an education value of 4.

Multiplying the adaptability value of 1 with the education value of 4 results in a value of 4. See former OAR 436-35-280(4). Adding that value to the impairment value of 11 results in an unscheduled permanent disability award of 15 percent. See former OAR 436-35-280(7).

Claimant has a prior 25 percent permanent disability award from his 1991 injury. Furthermore, because the record also shows that claimant's prior 1991 injury contributes to claimant's current low back condition, (exs. 26, 36, 37), the employer is entitled to an offset. Former OAR 436-35-007(3). In determining the extent of the current disability award, we consider: (1) claimant's current total loss of earning capacity; (2) conditions or findings of impairment from the prior award which were present prior to the current claim; (3) claimant's social-vocational factors which were present prior to the current claim; and (4) the extent to which the current loss of earning capacity includes impairment and social-vocational factors existing before the current claim. Former OAR 436-35-007(3)(b)(A)-(D).

With regard to the 1991 claim, an Order on Reconsideration awarded 15 percent unscheduled permanent disability based, in part, on 8 percent spinal impairment. (Ex. 17-2). Claimant's adaptability factor was based on a RFC factor of medium/light. Id. The parties subsequently entered into a stipulation that awarded claimant 25 percent unscheduled permanent disability. (Ex. 20A).

Based on medical evidence that, following claimant's 1994 injury, claimant's low back condition was "chronic" and in major part caused by the 1991 injury, we find that claimant's prior condition was present before the current claim and that claimant's current loss of earning capacity includes impairment from the prior claim. As shown above, claimant's range of motion decreased from 8 percent to 11 percent following the 1994 injury. With regard to social-vocational factors, at the time of the 1994 injury, claimant was working as a landscape laborer, which has a strength level of medium. Claimant therefore was working above his prior RFC level of medium/light.

In light of these factors, we conclude that claimant is entitled to 3 percent unscheduled permanent disability. Consequently, we affirm the Order on Reconsideration.

Claimant's counsel is entitled to 25 percent of any increased compensation created by our order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055. 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), aff'd on other grounds Volk v. America West Airlines, 135 Or App 565 (1995), rev den 322 Or 645 (1996).

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). After considering the factors set forth 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 $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved. As discussed in our Order on Review, because claimant's attorney did not submit a brief on review, he is not entitled to an attorney fee on review.

Accordingly, we withdraw our November 18, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our November 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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[3] DOT 869.664-014 is for construction worker, the job claimant was performing in 1991. (Ex. 17-3). There is evidence that claimant performed as a bricklayer apprentice, which has an SVP of 8. DOT 860-381.022. (Id.) Because the record does not show whether claimant performed such work during the 10 years preceding this determination, however, we find insufficient proof for basing the skills value on this work.

In the Matter of the Compensation of
PATRICK W. REAL, Claimant
WCB Case No. 95-07262
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's occupational disease claim for a mental disorder (depression).[1] On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" through the third full paragraph on page 5 of the Opinion and Order, except for the second sentence of the second full paragraph on page 4.

In addition, we offer the following supplementation.

For many years, claimant took pride in setting up newly purchased police cars for the employer. He was particularly skilled in wiring the cars' lights and sirens. In the spring of 1994, the employer began "outsourcing" this work to save money. Consequently, claimant was no longer allowed to do the work he enjoyed most. (See Ex. 19-91).

Claimant's psychological problems began in December 1994, before the January 11, 1995 meeting during which he believes he was accused of being a thief. (Ex. 19-75).

Claimant is a perfectionist. He has a personality type which is vulnerable to "narcissistic injury," that is, injury to his self esteem.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that employment conditions were the major contributing cause of claimant's psychological disorder, based on the opinion of Dr. Ruthven, treating psychiatrist. We disagree.

We begin with a summary of relevant facts.

Claimant began working for the employer as a mechanic in August 1981.

In late 1994 and early 1995, the employer instituted numerous workplace changes intended to increase efficiency and lower costs. Claimant disapproved of the changes and felt that he could not tolerate them. (Ex. 13-1; see Exs. 6-9; 19-73-74). He also believed that his new supervisor accused him of being a "thief"[2] and considered him "worthless." Claimant became depressed and irritable and sought psychological treatment.

Dr. Ruthven diagnosed a major depressive disorder resulting from workplace difficulties. Specifically, Dr. Ruthven opined that claimant suffered a "marked blow to his self-esteem from which he was unable to bounce back." (Ex. 13-2). He noted that claimant identified his diminished sense of self worth as the greatest loss associated with the changes at work. (Ex. 3B-10; see Ex. 18-81).

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[1] Submitting a "post ALJ's order" physician's chart note and a "post ALJ order" physician's letter which refer to claimant's marijuana use, the employer also seeks reopening of the record or remand. We consider the proffered evidence only for the purpose of addressing the employer's request. See Judy A. Britton, 37 Van Natta 1262 (1985). We conclude that remand is inappropriate because the chart note and letter would not likely affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

[2] He reported that "management called the mechanics together and called them 'worthless,' 'lazy,' and 'thieves of public funds.'" (Ex. 13-1). At hearing, claimant also reported that he felt that he had been accused of stealing a labelmaker (which he admitted using), when his supervisor told him to return it in front of co-workers. (See Ex. 18-28).

This is a claim for a major depression condition allegedly due to workplace stressors. To prevail, claimant must prove, inter alia, that employment conditions not otherwise statutorily excluded, were the major contributing cause of his disease. ORS 656.802(2)(a) and (3); McGarrah v. SAIF, 296 Or 145 (1983). There must be clear and convincing evidence that the psychological condition arose out of and in the course of employment. ORS 656.802(3)(d).

Certain employment conditions are excluded as noncompensable contributors, including "conditions generally inherent in every working situation."[3] ORS 656.802(3)(b). We find a substantial number of such "non-employment" conditions among claimant's reported stressors.[4]

On March 6, 1996, after his initial evaluation, Dr. Ruthven reported that claimant related his depressed mood and irritability to:

> "changes at work over the past year or so. . . . He states that he and others have been confused and angered by changes in the administrative control of the garage. He feels that he has been denied the ability to do his job the way he knows how, and has difficulty doing it due to the excessive paperwork and supervisory control involved. He says he has four supervisors, but that none of them know what goes on the garage floor, and they all tell him to do something different. He says 'I get to be a real mechanic about an hour a day.' He is angered by the message he feels they are given. 'I have received a number of commendations and awards for my work over the years, now they won't let me do what I know, and they tell us we're worthless and thieves.'" (Ex. 3A-1).

In August 1996, Dr. Ruthven listed the factors contributing to claimant's condition as "difficulties with supervisors, feeling degraded by them, changes in administrative functioning at place of employment." (Ex. 18-107).

Claimant was very upset when the employer took his favorite work away from him and contracted it elsewhere. Claimant had taken particular pride in wiring the lights and sirens of police cars, including the DARE car. (Ex. 18-35-36; 18-55; see Ex. 14-3). His attitude toward his job deteriorated when he was no longer allowed to do the police car work. (Ex. 18-37; see Ex. 19-69).

Claimant was also disturbed and depressed by additional paperwork and time cards required by the new management procedures. (See Ex. X2A-2-3). He felt that the changes were inefficient (Ex. 19-143) and complained that he had to increasingly justify how he spent his time at work. (Exs. 9-1; 18-37-38; see ex. 14-2). He also felt that new management's tighter control of shop keys indicated that employees were not trusted. He complained of "mixed messages" regarding his work performance: He was praised for quality work, but criticized for lack of speed.[5]

The employer contends that the police car work was contracted out to save money[6] and that other changes (including time cards to keep track of time spent on individual jobs, a key check-out system, and additional paperwork) were instituted to improve accountability and efficiency. We find the employer's new management means consistent with its goals. Because we further find that the above-described methods were neither excessive nor unreasonable, we conclude that these employment

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[3] Conditions "generally inherent in every working situation" are conditions that are common to all employments. Housing Authority of Portland v. Zimmerly, 108 Or App 596, 599 (1991). We develop the standard defining "generally inherent" conditions on a case-by-case basis. SAIF v. Campbell, 113 Or App 93, 96 (1992).

[4] Claimant argues that noncompensable contributors are "irrelevant," because he does not rely on them. We disagree. Such contributors must be considered and weighed, because they are identified causes of claimant's mental disorder. See McGarrah, 296 Or at 166 ("[T]he worker must [ ] prove that employment conditions, when compared to non-employment conditions, were the 'major contributing cause' of the mental disorder.") (emphasis added).

[5] Claimant preferred to judge himself according to work quality, not speed. (Ex. 18-50). However, because we find both job evaluation criteria (quality and speed) to be reasonable standards, we do not find that the employer gave claimant "mixed messages" regarding his work performance.

[6] The employer states that it saved $2,000 per car by "outsourcing" the work.

conditions were conditions generally inherent in all working situations.[7] As such, they are noncompensable causes of claimant's psychological problems. Thus, the question becomes whether claimant has established that compensable causes (i.e., not including "generally inherent" new management conditions) contribute more to his psychological condition than all other causes combined. See McGarrah, 296 Or at 146; Dethlefs v. Hyster Co., 295 Or 309-11 (1983); David K. Boyer, 43 Van Natta 561, aff'd mem, 111 Or App 666 (1992).

Dr. Ruthven provides the only expert evidence arguably supporting the claim.[8] He opined that "the psychological injury at work, and in particular, being called a thief, was [ ] the major cause of [claimant's] major depression and the resulting symptoms." (Ex. 19A-6).

We find Dr. Ruthven's opinion inadequately explained and insufficient to carry claimant's burden, because it fails to weigh identified stressors. For example, Dr. Ruthven failed to explain why claimant's frustration with stricter management procedures or his depression with the loss of his favorite work duties (both noncompensable contributors) were less significant than claimant's perception that he had been unfairly accused of being a thief.[9]

Accordingly, even assuming, without deciding, that claimant's perceptions that the employer considered him worthless and called him a thief qualify as compensable stressors, the medical evidence supporting the claim is insufficient to carry claimant's burden because it does not adequately consider the other identified contributing causes for claimant's condition.[10] Under these circumstances, we conclude that the claim must fail.

ORDER

The ALJ's order dated April 11, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[7] See Gary W. Helzer, 47 Van Natta 143, 144 (1995) (New management and administrative procedures are generally inherent in every working situation); Karen M. Colerick, 46 Van Natta 930 (1995) (Changes in procedures and altered job descriptions are conditions generally encountered in all working situations); Michelle A. Nugent, 45 Van Natta 189, 190 (1993) (Where the employer's business decisions were reasonably explained, they were within the range of "generally inherent" conditions); Barry M. Bronson, 44 Van Natta 1427 (1992) (Operating within ever-changing legal parameters is a "generally inherent" condition.

[8] Dr. Turco opined that claimant's preexisting personality was the major contributing cause of his depression.

[9] Dr. Ruthven's opinion addresses some, but not all, of the necessary questions. He acknowledged that claimant's rigid, rather obsessive personality contributed to his recent depression because it made him more vulnerable to narcissistic injury. (Ex. 18-18, 18-61, 18-63-65; see Ex. 18-81). He also explained that claimant's preexisting personality type was not the major cause of his depression, because the depression did not occur without the workplace contributors. Dr. Ruthven also explained that claimant's perceptions of being called a thief was more significant than his perception of considered worthless, because claimant had no way to refute the "thief" label. (Ex. 18-11). However, because claimant similarly had no remedy for the loss of his most prized work activity (setting up police cars), Dr. Ruthven did not adequately explain why this acknowledged stressor contributed less to claimant's depression than the alleged "thief" label, or why the preexisting personality rigidity, together with the disappointing job change, are less significant or more within claimant's control than the asserted "thief" accusation. In other words, Dr. Ruthven failed to adequately weigh all contributing factors.

[10] See Lori Ann Wages, 47 Van Natta 1335, 1337 (1995), aff'd Bank of Newport v. Wages, 142 Or App 145 (1996) ("Medical evidence that does not factor out excluded from non-excluded employment conditions under ORS 656.802(3) cannot satisfy a claimant's burden of proving a compensable mental disorder); Helzer, 47 Van Natta at 144 (The medical evidence failed to meet claimant's burden, because it did not exclude from consideration the noncognizable elements set forth in the statute); Mary A. Murphy, 45 Van Natta 2238 (1993) (Medical expert's reliance on stressful condition generally inherent in every working situation--job rule/guideline changes--was basis for upholding denial of mental condition).

In the Matter of the Compensation of
OLGA LAZO, Claimant
WCB Case No. C702794
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Steven M. Schoenfeld, Claimant Attorney
Kenneth W. Stodd, Defense Attorney

Reviewed by Board Members Bock and Moller.

On November 4, 1997, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

On November 18, 1997, we wrote the parties, requesting clarification of the current status of the claim, as the Department's records indicated the claim was denied. We also noted that the agreement failed to give the date of first claim closure and the amount of any permanent disability award(s). We further noted a variety of other discrepancies/and or deficiencies within the document and requested the parties correct or clarify those matters.

On December 4, 1997, we received the parties' addendum. The addendum provided, in part, that: "On March 4, 1996, the date of Claimant's industrial injury occurred (sic), she was an employee of [employer] and her claim for said injury is accepted." We interpret this language to mean that the claim has been previously accepted separate from this CDA. We do not interpret this language as providing that the claim has been accepted in the CDA. Had we interpreted the CDA as accepting the claim, the CDA would not have met with our approval. In this regard, we note that a CDA may not be used to accept a denied claim or to perform other claim processing functions. See Salvador Preciado, 48 Van Natta 1559 (1996).

The addendum further provides that: "Since Employer originally denied that claimant was its employee, there was no claim closure and this Agreement will serve in lieu of claim closure and permanent partial disability determination." We have held that it is impermissible for a CDA to accomplish claim processing functions, including claim closure. See Kenneth R. Free, 47 Van Natta 1537 (1995). Thus, we interpret the language in the addendum regarding claim closure to mean that the claim has never been closed. See OAR 438-009-0022(4)(b) and (c) (CDA must provide the date of first claim closure, if any, and the amount of any permanent disability award(s), if any). We do not interpret the CDA as closing the claim as we have previously held that this is impermissible and would result in disapproval of the CDA.

The agreement, as corrected by the addendum and 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, as corrected and clarified, is approved. An attorney fee of $1,500, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
BOBBI J. BLAKELY, Claimant
Own Motion No. 97-0529M
OWN MOTION ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant, through her attorney, requests reconsideration of our December 1, 1997 Own Motion Order that denied reopening claimant's claim for temporary disability compensation because claimant failed to prove she was in the work force at the time of disability. With the request for reconsideration, claimant's attorney submitted additional medical records and stated that it was his understanding that claimant underwent arthroscopic surgery on November 21, 1997. Claimant's attorney also stated that "[c]laimant is not working but is willing to work and is not seeking work presently because a work-related injury makes that impossible." (Emphasis in original). We withdraw our prior order and proceed with our reconsideration.

There is no dispute that claimant's compensable right knee condition required surgery. Furthermore, claimant apparently underwent this surgery on November 21, 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 has the burden of proof regarding the work force issue. ORS 656.266.

Here, claimant's right knee injury claim was last reopened by an April 9, 1997 Own Motion Order [Own Motion No. 96-0530M] authorizing reopening of the claim as of November 19, 1996, the date claimant underwent a prior arthroscopy for her right knee condition. Bobbi J. Blakely, on recon 49 Van Natta 463, on recon 49 Van Natta 660 (1997). In determining the work force issue regarding that earlier reopening, we found that claimant had established that she was in the work force at the time of disability based on a March 1997 decision from the Social Security Administration (SSA) that claimant was not entitled to social security benefits beginning August 1994 because claimant had performed "substantial gainful work."

The current record [Own Motion No. 97-0529M] contains a March 26, 1997 letter from Dr. Mohler, claimant's treating physician, stating that claimant had reached medically stationary status regarding the November 19, 1996 surgery. Apparently, this earlier claim was subsequently closed by the SAIF Corporation and claimant did not request review of that closure. We base this assumption on the following: (1) in our prior order, we directed SAIF to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary; (2) OAR 438-012-0055(1) provides that the carrier must include a notice of claimant's right to seek Board review when closing an own motion claim; (3) there is no evidence that claimant requested review of any closure regarding Own Motion No. 96-0530M; and (4) on August 18, 1997, claimant requested that her claim be reopened for the right knee arthroscopy that is at issue in the current claim. Thus, during the time claimant's claim relating to the November 19, 1996 surgery was open, claimant was in the work force by virtue of being entitled to temporary disability benefits due to her compensable injury. Morris B. Grover, 48 Van Natta 2325 (1996); William L. Halbrook, 46 Van Natta 79 (1994).

However, the relevant issue in the current claim is whether claimant was in the work force at the time of disability related to the current claim, i.e., the date claimant underwent the current surgery in November 1997. John R. Johanson, 46 Van Natta 2463 (1994). For the following reasons, we find that claimant has failed to meet her burden of proving she was in the work force at the time of disability.

In a June 2, 1997 chart note, Dr. Mohler stated that he and claimant had discussed a return to work and claimant "is not yet ready to return to work activities." In a June 30, 1997 chart note, Dr. Mohler discussed claimant's right knee symptoms and stated that claimant "is not able to work." Although Dr. Mohler's first statement is ambiguous in that it could refer to either claimant's desire to return to work or her physical ability to return to work, his second statement clearly refers to claimant's physical ability to work. Thus, Dr. Mohler's unrebutted second statement establishes claimant's inability to work due to her compensable injury as of June 30, 1997.

However, even though unable to work, claimant must also establish that she was willing to work. Dawkins v. Pacific Motor Trucking, 308 Or at 258. Dr. Mohler's statement does not establish claimant's willingness to work. There is no evidence that claimant was working prior to Dr. Mohler's June 30, 1997 statement. Furthermore, if, before becoming unable to work due to the compensable injury, claimant was able to work but did not work or seek work, she has not proved her willingness to work. In addition, claimant's attorney's statement that claimant was willing to work does not meet claimant's burden of proving the willingness to work element of the work force issue. Earl J. Prettyman, 46 Van Natta 1137 (1994). Claimant has submitted no persuasive evidence regarding whether she was willing to work. Consequently, we conclude that claimant has failed to meet her burden of proving that she was in the work force at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 1, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

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

IT IS SO ORDERED.

December 12, 1997 Cite as 49 Van Natta 2112 (1997)

In the Matter of the Compensation of
RODRICK L. COTNER, Claimant
WCB Case Nos. 95-02202 & 94-13000
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corporation v. Cotner, 148 Or App 28 (1997). The court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that directed the insurer to pay claimant temporary disability for a period beyond the date that claimant became medically stationary pending a carrier's appeal of an earlier ALJ's compensability order. Concluding that claimant was not otherwise entitled to temporary disability benefits accruing from the date of the appealed ALJ's "compensability" order, the court has held that we lacked authority to award such benefits. Consequently, the court has remanded for reconsideration.

In accordance with the court's holding, claimant is not entitled to temporary disability benefits for the period coinciding with the insurer's appeal of the earlier ALJ's "compensability" order because claimant had already become medically stationary and had been released to modified work at the time of the earlier ALJ's "compensability" order. Consequently, the ALJ's temporary disability award for the aforementioned period is reversed. Furthermore, because claimant's "out-of-compensation" attorney fee and the ALJ's penalty assessment were based on this temporary disability award, it follows that those portions of the ALJ's order are also reversed.

Accordingly, those portions of the ALJ's order dated June 9, 1995, which awarded temporary disability, "out-of-compensation" attorney fees, and penalties, are reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID O. SCOTT, Claimant
WCB Case No. 96-09788
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's claim for a neck injury resulting from a workplace altercation. On review, the issue is whether claimant's injury arose in the course and scope of his employment.

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

Subsequent to the ALJ's order, the Supreme Court issued its opinion in Redman Industries v. Lang, 326 Or 32 (1997). Specifically, 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.

Here, there is no evidence that claimant and Mr. Nau had any relationship outside of work. Moreover, Mr. Nau's assault of claimant was precipitated by work events, *i.e.*, the dispute regarding the proper usage of the short-wave radio and the manner in which Mr. Nau drove and unloaded his truck. Under these circumstances, we agree with the ALJ that claimant's neck injury was caused by circumstances associated with the work environment, and therefore arose within the course and scope of his employment.[1] See James E. Scheuffele, 49 Van Natta 1517 (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 $1,500, 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.

ORDER

The ALJ's order dated July 11, 1997 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $1,500, payable by the SAIF Corporation.

[1] In reaching this conclusion, we specifically agree with the ALJ finding that, based on claimant's credible testimony, claimant was not an active participant as defined in ORS 656.005(7)(b)(A).

In the Matter of the Compensation of
DAVID VECCHI, Claimant
Own Motion No. 97-0531M
OWN MOTION ORDER OF WITHDRAWAL AND ORDER CONSENTING TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Whitehead & Klosterman, Claimant Attorneys

Claimant requests reconsideration of our November 18, 1997 Own Motion Order Denying Consent to Designation of Paying Agent. In that order, we declined to consent to the Department designating a paying agent under ORS 656.307 because the own motion record contained no evidence that surgery or hospitalization was requested for claimant's compensable bilateral carpal tunnel syndrome condition, the prerequisite for reopening a claim under the Board's own motion jurisdiction. With his request for reconsideration, claimant cites to evidence in the record regarding the responsibility issue pending before the Hearings Division (WCB Case Nos. 97-05283, 97-05654, 97-05655, 97-06687, 97-06879), contending that the cited evidence establishes that claimant has undergone surgery for his compensable condition. On reconsideration of the record, including the evidence cited by claimant in the above-referenced Hearings Division record,[1] we agree. Consequently, we withdraw our November 18, 1997 order and issue the following order in its place.

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 1992 injury claim with Crawford & Company expired May 26, 1997. Thus, that 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.

Here, on February 6, 1997, Dr. Hubbard, neurosurgeon, recommended that claimant undergo a right carpal tunnel release. (Ex. 17). Although the operative report is not in the record, claimant apparently underwent that surgery on May 12, 1997. We reach this conclusion based on the following. A May 30, 1997 form from Dr. Hubbard indicated that claimant was status post right carpal tunnel release. (Ex. 29C). That form also indicated that claimant had a six month post-surgical follow-up, noting the dates "5-12-97 to 11-12-97." Id. Therefore, we conclude that the right carpal tunnel surgery occurred on May 12, 1997.

Thus, the record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if the own motion carrier is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1992 own motion claim, beginning May 12, 1997, the date claimant underwent surgery. ORS 656.278(1)(a).

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

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[1] For ease of reference, we have identified the evidence we relied on in deciding the present case using the exhibit numbers assigned to the Hearings Division record.

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

IT IS SO ORDERED.

December 12, 1997 Cite as 49 Van Natta 2115 (1997)

In the Matter of the Compensation of
ROBERT C. GRAY, Claimant
WCB Case No. 96-08812
ORDER OF ABATEMENT
Starr & Vinson, Claimant Attorneys
Zimmerman, Nielsen, et al, Defense Attorneys

On November 12, 1997, we reinstated claimant's hearing request regarding the insurer's partial denial of his right knee surgery claim and upheld the insurer's denial. Claimant requests reconsideration, seeking remand or, alternatively, further analysis of the case in light of ORS 656.005(7)(a)(B) and SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997).

In order to further consider this matter, we withdraw our November 12, 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 will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD W. GREEN, SR., Claimant
WCB Case No. 97-02767
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's partial denial of claimant's current low back condition. On review, the issures are propriety of the denial and compensability.

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

We agree with the ALJ that the insurer's partial denial of claimant's current low back condition is procedurally proper under ORS 656.262(6)(c) and (7)(b).[1]

We also agree with the ALJ regarding the merits. In reaching this conclusion, we note that Dr. Nelson examined claimant on January 23, 1997 and opined that "any lack of abilities at this time would be [claimant's] own responsibility due to lack of compliance [with therapy]." (Ex.23). Later (without reexamining claimant), Dr. Nelson checked a box indicating that claimant's preexisting condition was the major contributing cause of his "current need for treatment." He also opined that claimant's "premanent disability" was 75 percent due to the compensable injury and 25 percent due to the preexisting condition. (Id.) Dr. Hubbard, treating surgeon, concurred. (Ex. 28). On this unrebutted evidence,[2] we agree with the ALJ that the insurer's partial denial of claimant's current low back condition must be upheld. See Richard Markum, 48 Van Natta 2204 (1996) (Current condition denial upheld under ORS 656.262(6)(c) because the claimant's compensable injury ceased to be the major contributing cause of his current condition).

ORDER

The ALJ's order dated July 15, 1997 is affirmed.

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[1] Claimant relies on Robert W. Stephenson, 48 Van Natta 2287 (1996), aff'd Stephenson v. Meyer, 150 Or App 300 (1997), in support of his contention that the denial was premature because it did not issue in response to a claim for compensation. We find Stephenson distinguishable because no "combined condition" was accepted in this case. Here, in contrast, the compensable condition is a combined condition and the particular provisions of ORS 656.262(6)(c) and (7)(b) provide for a denial (as explained by the ALJ) on the basis that claimant's compensable injury ceased to be the major contributing cause of his current condition. See Robin W. Spivey, 48 Van Natta 2363 (1996).

[2] We acknowledge the doctors' opinions supporting claimant's (20 percent) permanent disability award under this claim (which is based on a 9 percent impairment rating for the laminectomy performed by Dr. Hubbard). We find nothing inconsistent about the fact that claimant's "current need for treatment" is due to his preexisting condition, while his "permanent impairment" is injury-related. See e.g., SAIF v. Nehl, 148 Or App 191, on recon 149 Or App 309 (1997) (Where the record supports a distinction between the primary cause of the claimant's need for treatment (or disability) and the primary cause of his combined condition, the claimant satisfies ORS 656.005(7)(a)(B) by establishing that work is the major cause of the need for treatment or disability for the combined condition).

In the Matter of the Compensation of
JUAN RAMIREZ, Claimant
WCB Case No. 92-14197
ORDER ON REVIEW (REMANDING)
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that found an Order on Reconsideration void and remanded the claim to the Director for a medical arbiter examination. On review, the issues are validity of the Order on Reconsideration, remand and, if remand is not appropriate, extent of scheduled and unscheduled permanent disability for an injury involving left eye conjunctivitis and facial and scalp lacerations and contusions. We vacate the ALJ's order and remand to the ALJ.

FINDINGS OF FACT

The employer accepted claimant's August 1991 claim as a disabling injury for facial laceration and contusion, scalp laceration and contusion, and left eye conjunctivitis. (Ex. 13). On April 22, 1992, Dr. Karty, treating physician, found claimant's condition medically stationary and performed a closing examination. (Ex. 44).

On May 29, 1992, claimant's claim was closed by Determination Order that found his condition medically stationary as of April 29, 1992, and awarded temporary disability but no permanent disability. (Ex. 52). On July 31, 1992, claimant requested reconsideration of the Determination Order and appointment of a medical arbiter. (Exs. 55A, 56-1).

Claimant was incarcerated from August 1992 until January 3, 1996. (Tr. 7-8). On September 21, 1992, letters were mailed to claimant and his attorney advising claimant of separate scheduled examinations with three medical arbiters at their offices in Portland on October 6, 1992. (Ex. 55A). Because the examinations were scheduled at locations other than the institution where claimant was incarcerated, he was unable to attend the scheduled examinations.

On October 20, 1992, an Order on Reconsideration issued which affirmed the May 29, 1992 Determination Order in all respects. (Ex. 56). Noting that claimant failed to attend the scheduled medical arbiters' examinations, the Appellate Reviewer based the reconsideration on the record developed at claim closure. (Ex. 56-4).

CONCLUSIONS OF LAW AND OPINION

Retroactively applying amended ORS 656.268(7)(d), the ALJ held that the Order on Reconsideration should be voided and the claim remanded to the Appellate Unit for the Director to "perform his duty" under the amended statute; i.e., to determine whether claimant had good cause for failing to attend the medical arbiters' examinations. We disagree with the ALJ's interpretation of amended ORS 656.268(7)(d) and disposition of this claim.

Amended ORS 656.268(7)(d) provides:

> "The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment. If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall order suspension of all disability benefits until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn." Or Laws 1995, ch 332, § 30 (1995 Act, §30) (amended language is underlined).

Claimant argues that the amended statute applies retroactively and compels the result reached by the ALJ. While we agree that the added language applies retroactively, we disagree that it requires the result reached by the ALJ.

Because the amendments to ORS 656.268(7) were not excluded from the general retroactivity provisions in Section 66 of the Act, they apply to this case. See Volk v. America West Airlines, 135 Or App 565 (1995) (1995 Act applies to matters for which the time to appeal the Board's decision has not yet expired, or if appealed, has not been finally resolved on appeal).

Here, the issue involves the interplay between portions of former ORS 656.268(6) and amended ORS 656.268(7)(d). Unlike amendments to ORS 656.268(7), amendments to ORS 656.268(6) were excluded from the general retroactivity provisions of the Act by Section 66(4), which provided, inter alia, that amendments to ORS 656.268(6) shall apply only to claims that became medically stationary on or after June 7, 1995, the effective date of the Act. Because claimant became medically stationary before that date, the former version of ORS 656.268(6) applies to his claim. Former ORS 656.268(6) provided in part:

> "Reconsideration shall be completed within 18 working days from the date of receipt of the request therefor and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date of the receipt of the request for reconsideration, or within 75 days where a notice for medical arbiter review was timely mailed, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the 18th working day or where an order was timely mailed on the 75th day. Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding."

To interpret amended ORS 656.268(7)(d), we must discern legislative intent. ORS 174.020. We begin by examining the text and context of amended ORS 656.268(7)(d). PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. Id. at 611. In examining context, we consider relevant rules of statutory construction, such as the statutory mandate that, "where there are several provisions or particulars, such construction is, if possible, to be adopted as will give effect to all." ORS 174.010. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. PGE, 317 Or at 611-12.

The text of amended ORS 656.268(7)(d) provides that, if the Director determines that a worker failed to attend a medical arbiter examination without good cause or failed to cooperate with the medical arbiter, the Director shall order suspension of disability benefits until the worker attends the examination and cooperates or the request for reconsideration is withdrawn. Thus, the text of amended ORS 656.268(7)(d) is directed at determinations to be made by the Director, limits the Director to suspending disability benefits, and provides no specific time limits.

However, former ORS 656.268(6) provides an absolute time limit of 75 days within which the reconsideration process must be completed where the Department mails notice of review by a medical arbiter. Furthermore, if the reconsideration process is not completed within the deadlines provided in former ORS 656.268(6), "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" was timely mailed.

Thus, when read in the context of the strict statutory time limits provided in former ORS 656.268(6), it is apparent that provisions of amended ORS 656.268(7)(d) are limited to the 75-day time limit provided in former ORS 656.268(6). To find otherwise and hold, as claimant suggests, that the reconsideration process is not complete until the arbiter's examination has been performed would result in a statutory construction that creates a conflict between former ORS 656.268(6) and amended ORS 656.268(7)(d) or renders the time limits in former ORS 656.268(6) ineffective.[1] See Vaughn v. Pacific Northwest Bell Telephone, 289 Or 73, 83 (1980) (Court will avoid a statutory construction which creates a conflict between statutes or renders one statute ineffective). Therefore, we conclude that the

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[1] The court has held that the time deadlines for preparing reconsideration orders are mandatory. Benzinger v. Oregon Dept. of Ins. and Finance, 129 Or App 263 (1994); Benzinger v. Oregon Dept. of Ins. and Finance, 107 Or App 449 (1991).

legislature intended to limit the process described in amended ORS 656.268(7)(d) to the 75-day period described in former ORS 656.268(6). Because the legislature's intent is clear from the inquiry into text and context, further inquiry is unnecessary. PGE, 317 Or at 610-12.

Here, the Department timely mailed a notice for medical arbiter review. (Ex. 55A). Therefore, the 75-day deadline in former ORS 656.268(6) applied to the reconsideration proceeding. When claimant did not attend the scheduled medical arbiter examinations, the Appellate Reviewer based the reconsideration on the record developed at claim closure pursuant to former OAR 436-30-050(11). (Ex. 56-4). On October 20, 1992, an Order on Reconsideration issued affirming the Determination Order. Thus, the reconsideration process was completed and a valid Order on Reconsideration issued.[2] As discussed above, amended ORS 656.268(7)(d) does not extend the period within which to conduct the reconsideration process. Therefore, contrary to the ALJ's opinion, we conclude that the October 20, 1992 Order on Reconsideration is not void.

We further conclude that the ALJ did not have the authority to remand this matter to the Director for a "good cause" determination under ORS 656.268(7). In Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), the Court of Appeals held that the Board lacked authority to remand the case to the Department for consideration of a medical arbiter's report. In Pacheco-Gonzalez, the Department had ordered a medical arbiter's report because there was a dispute over the impairment findings used to close the claim; however, the report was not considered by the Department because it arrived after the order on reconsideration was issued. The claimant requested a hearing contesting the rating and impairment findings in the reconsideration order. The referee[3] dismissed the hearing request and the Board affirmed. Reasoning that the Department's reconsideration order was "invalid" because the Department did not review the medical arbiter's report, the Board concluded that the referee had no jurisdiction to review an "invalid" reconsideration order.

The Court of Appeals reversed, concluding that there was no statutory requirement of a "valid" reconsideration order in order for the referee to have jurisdiction. The court also concluded that, even though the medical arbiter's report was not reviewed by the Department, the report could and should have been considered by the referee and the Board under former ORS 656.268(6)(a) (renumbered ORS 656.268(6)(e)) which provided: "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." Finally, the court held that the referee and the Board did not have authority to remand the case to the Department, reasoning that former ORS 656.268(6)(a) permitted the referee to receive and consider the medical arbiter's report and that the statutes did not authorize the remand of cases to the Department.[4]

The Board applied the court's reasoning in Pacheco-Gonzalez to conclude in Linda M. Cross, 45 Van Natta 2130 (1993), that the referee did not have authority to remand a case to the Department for the appointment of a medical arbiter to examine the claimant. In Cross, the Department issued a reconsideration order rescinding the notice of closure based on the finding that the claimant's condition was not medically stationary. Because the Department found that the claim had been prematurely closed, no medical arbiter was appointed. The employer requested a hearing contesting the premature closure finding in the reconsideration order. The referee concluded that the claim had not been prematurely closed and reinstated the closure notice. Finding that the claimant had objected to the impairment findings used to rate her disability, the referee concluded that the claimant was entitled to a medical arbiter's examination and therefore remanded the case to the Department for the appointment of a medical arbiter.

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[2] In any event, even if the reconsideration process had not been timely completed, the reconsideration would have been deemed denied and further proceedings would have occurred as though an Order on Reconsideration affirming the Determination Order had timely issued.

[3] Since the Pacheco-Gonzalez decision, referees have been retitled administrative law judges.

[4] Subsequent to its decision in Pacheco-Gonzalez, the court held in Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993), that the Board has implicit authority to remand a case to the Director for the promulgation of a temporary rule rating the claimant's disability. The court distinguished Pacheco-Gonzalez on the basis that, in that case, the referee could grant the relief sought (i.e., receipt and consideration of the medical arbiter's report), whereas in Gallino only the Director had the authority to promulgate a temporary rule.

The Board reversed on the remand issue. Based on the court's reasoning in Pacheco-Gonzalez, the Board held that the referee lacked authority to remand the case to the Department. While the Board agreed with the referee's conclusion that the claimant was entitled to a medical arbiter's examination, it fashioned an alternative remedy (other than remand to the Department) for obtaining the examination. The Board remanded the case to the referee to bifurcate the "extent of disability" issue (by assigning a separate WCB Case number for that issue) and issue a final, appealable order resolving the "premature closure" issue. The Board ordered the referee to defer action on the "extent of disability" issue pending receipt of the medical arbiter's examination report. Finally, the Board advised the parties to inform the Director of the referee's decision that the claim was not prematurely closed and request that the Director schedule a medical arbiter's examination.

The Board's holding in Cross is instructive in this case. As in Cross, a medical arbiter's examination did not take place in this case. Although the examinations were actually scheduled in this case, whereas no medical arbiter was even appointed in Cross, the distinction is without significance. In each case, the claimant had disagreed with the impairment findings and was therefore entitled to a medical arbiter's report. ORS 656.268(7)(a) is clear: If the claimant disagrees with the impairment findings used in rating his/her disability, "the director shall refer the claim to a medical arbiter appointed by the director." (Emphasis supplied.) Once appointed, the medical arbiter may examine the claimant and perform reasonable and necessary tests to establish impairment. Amended ORS 656.268(7)(d). Thereafter, "[t]he findings of the medical arbiter. . . shall be submitted to the department for reconsideration of the determination order or notice of closure." ORS 656.268(7)(f) (Emphasis supplied.) If, however, the medical arbiter's report is not prepared in time for use in the reconsideration proceeding, the report may be received as evidence at the hearing. ORS 656.268(6)(e).

The mandatory language ("shall") in ORS 656.268(7)(a) and (f) expresses the legislature's intent that a worker who disagrees with the impairment findings is entitled to a medical arbiter's report.[5] In this regard, we disagree with the dissent's view that the legislature, by mandating that the Director "refer" the claim to a medical arbiter, did not create an entitlement to a medical arbiter's report. The dissent's interpretation overlooks the statutory mandate in ORS 656.268(7)(f) that the medical arbiter's findings "shall" be submitted to the Department for reconsideration. Use of that mandatory language persuades us that the legislature intended the Director's referral of the claim to the medical arbiter to result in a report of the medical arbiter's findings, to be submitted to the Department for reconsideration of the claim.

Furthermore, based on our reading of the statutes, we conclude that the statutory right to a medical arbiter's report is not waived by the worker's failure to appear for the medical arbiter's examination. Amended ORS 656.268(7)(d) provides that a worker who lacked "good cause" for failing to attend a medical arbiter's examination or failed to cooperate with the medical arbiter is subject to the Director's suspension of disability benefits "until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn." (Emphasis supplied.) Thus, in cases where the worker lacked good cause for failing to attend the medical arbiter's examination, amended ORS 656.268(7)(d) empowers the Director with suspension authority to compel the worker's attendance at the examination. The statute does not, however, treat the lack of good cause as a waiver of the statutory right to a medical arbiter's report.

Curiously, the statute is silent about the consequences of a Director's finding that the worker had good cause for failing to attend the medical arbiter's examination. However, given the statutory context which does not treat the lack of good cause as a waiver of the right to a medical arbiter's report, it did not appear to be the legislature's intent to deny the right of a medical arbiter's report to a worker who had good cause for not attending the examination. To conclude otherwise and bar a claimant with good cause from attending the examination, while a claimant lacking good cause is not so barred, would be an unjust and absurd reading of the statute. Therefore, based on the text and context of amended ORS 656.268(7)(d), see PGE v. Bureau of Labor and Industries, 317 Or at 610, we conclude that, regardless of whether a worker had good cause for not attending a medical arbiter's examination, the

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[5] There is one limited exception to the statutory right to a medical arbiter's report when there is a disagreement with impairment findings: If the worker is not medically stationary at the time of reconsideration, the Director is not required to appoint a medical arbiter. ORS 656.268(7)(h)(A).

legislature intended that the medical arbiter prepare a report to be submitted to the Department for reconsideration.[6] Without a report, the statutory mandate that the claim be referred to a medical arbiter would serve no purpose.

We recognize that our conclusion in this regard is inconsistent with the Board's prior declarations that a worker's failure to attend a medical arbiter's examination, without mitigating or just cause, is a waiver of the right to a medical arbiter's report. E.g., Joyce A. Crump, 47 Van Natta 1516 (1995); Franklin L. Kuntz, 46 Van Natta 1865 (1994); Mario Labra, 46 Van Natta 1183 (1994); Craig K. Witt, 45 Van Natta 1285 (1993); Deborah L. Vilanj, 45 Van Natta 260 (1993). However, Kuntz, Labra, Witt and Vilanj were decided before the 1995 amendments to ORS 656.268(7) and were effectively overruled by the amendments. Although Crump was decided after amended ORS 656.268(7)(d) took effect, it did not address the statutory scheme as has been done in this case. Therefore, to the extent that those cases stand for the proposition that a worker's failure to attend a medical arbiter's examination constitutes a waiver of the right to a medical arbiter's report, those cases are disavowed.

We are mindful that, under the Department's rules that were in effect at the time of the reconsideration proceeding in this case, a worker who requested reconsideration and failed to appear for the medical arbiter's examination was effectively deemed to have waived the right to a medical arbiter's report. Former OAR 436-30-050(11)(a) provided: "If the worker or the worker's representative requests reconsideration and the worker fails to appear for the medical arbiter exam, the record developed at the time of the [claim] closure will be used to issue the reconsideration order." (WCD Admin. Order 5-1992). By not providing for a medical arbiter's report, the rule appears to be inconsistent with the legislature's intent as expressed in the text and context of amended ORS 656.268(7)(d).[7] Therefore, to the extent that former OAR 436-30-050(11)(a) treated a worker's failure to attend a medical arbiter's examination as a waiver of the right to a medical arbiter's report, it is inconsistent with legislative intent and shall be given no effect. See Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988) (an administrative agency may not, by its rules, amend, alter, enlarge or limit the terms of a statute).

Because claimant's statutory right to a medical arbiter's report is not contingent on the Director's "good cause" determination under amended ORS 656.268(7)(d), the absence of that determination does not provide a compelling basis for remand.[8] Furthermore, we do not need to address the parties' arguments on the issue of whether a worker's incarceration in prison constituted "good cause" for not attending the scheduled examinations. That issue is not determinative of this case.

Rather, as we concluded in Cross, claimant remained entitled to a medical arbiter's report under amended ORS 656.268(7) even after the Department had concluded its reconsideration proceeding. We further conclude that claimant did not, either explicitly or implicitly (by conduct), waive his right to the medical arbiter's report. Claimant was incarcerated and unable to attend the originally scheduled examinations, and he was not advised of any procedures whereby he could request rescheduled examinations. Under these circumstances, claimant's failure to request rescheduled examinations before the December 1996 hearing did not rise to the level of a knowing and intentional relinquishment of a known right.[9] See Wright Schuchart Harbor v. Johnson, 133 Or App 680, 685-86 (1995). Therefore,

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[6] If the medical arbiter completes the report after the statutory time limit for reconsideration has expired, the report may be received at the hearing, even though it was not prepared in time for use in the reconsideration proceeding. See ORS 656.268(6)(e); Pacheco-Gonzalez, 123 Or App at 316; Linda M. Cross, 45 Van Natta at 2131.

[7] Unlike the former rules, the current rules allow a worker who has failed to attend a medical arbiter's examination to make a written request to reschedule the examination. OAR 436-030-0165(5)(b) (WCD Admin. Order 96-052). Thus, the current rule appears to provide for a medical arbiter's report, even though the worker did not attend the originally scheduled examination.

[8] The "good cause" determination would have been essential only to the Director's authority to suspend disability benefits under amended ORS 656.268(7)(d). There is no indication, however, that claimant was receiving disability benefits at the time of the reconsideration proceeding. Thus, there were no disability benefits for the Director to suspend.

[9] This case is factually distinguishable from Craig K. Witt, 45 Van Natta 1285 (1993), where the Board concluded that the claimant waived his right to a medical arbiter's report by escaping from the institution where he was incarcerated and where the arbiter's examination was scheduled to take place. Unlike Witt, the medical arbiters' examinations in this case were scheduled at locations other than the institution where claimant was incarcerated. Because claimant had no meaningful opportunity to attend the examinations, we conclude that his failure to attend was not a knowing and voluntary relinquishment of his right to a medical arbiter's report.

claimant is still entitled to a medical arbiter's report. At the same time, however, Pacheco-Gonzalez makes it clear that we do not have authority to remand this case to the Director for consideration of the medical arbiter's report. As in Cross, therefore, we must fashion a remedy which accommodates both the Pacheco-Gonzalez decision and claimant's statutory right to the medical arbiter's report.

After careful consideration, we conclude that the best remedy is to remand this case to the ALJ for deferral of the "extent of disability" issue pending receipt of the medical arbiter's report pursuant to ORS 656.268(6)(e).[10] The parties shall be responsible for contacting the Director to make arrangements for preparation and submission of the medical arbiter's report.[11] When the parties are ready to proceed to hearing on the "extent of disability" issue (including consideration of the medical arbiter's report), they shall contact ALJ Lipton. Thereafter, ALJ Lipton shall conduct further proceedings in any manner that achieves substantial justice.

ORDER

The ALJ's order dated January 13, 1997 is vacated. This case is remanded to ALJ Lipton for further proceedings consistent with this order.

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[10] The dissent cites Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73 (1996), for the proposition that a medical arbiter's report that is prepared after completion of the Department's reconsideration proceeding may be inadmissible at hearing because it is "subsequent medical evidence" that is barred under ORS 656.268(7)(g). However, Bourgo is distinguishable because the medical arbiter's report at issue in that case was a "supplemental" or "clarifying" report requested by a party, whereas, in this case, claimant is seeking an initial medical arbiter's report, to be requested by the Director. The Court of Appeals has held that ORS 656.268(7) prohibits the admission of evidence developed after the medical arbiter's report, not the medical arbiter's report itself. Pacheco-Gonzalez, 123 Or App at 316. Thus, ORS 656.268(7)(g) would not bar admission of a medical arbiter's report in this case. Were we to interpret ORS 656.268(7)(g) as restrictively as the dissent does, claimant would effectively be denied his right to a medical arbiter's report, a result clearly at odds with the statutory "medical arbiter" scheme set forth by the legislature.

[11] The current administrative rules provide that, upon referral of a claim to the medical arbiter, the medical arbiter "shall perform a record review or examine the worker as requested by the director. . . ." OAR 436-030-0165(3). Thus, the rules appear to allow the Director some discretion as to whether to request a record review or examination by the medical arbiter. In this case, because more than five years have elapsed since the reconsideration order issued in this case, the Director may elect to request a record review by the medical arbiter, rather than an examination that may have limited relevance to the rating of claimant's disability as of the issuance date of the reconsideration order. See ORS 656.283(7) (evaluation of the worker's disability shall be as of the date of issuance of the reconsideration order).

Board Member Haynes dissenting.

The majority employs the most persuasive reasoning possible to reach its conclusion. Unfortunately, the decision is not consistent with statutory or case law. Thus, I dissent.

First, I agree that the Order on Reconsideration is not void. This part of the order leads to the inevitable conclusion, however, that the reconsideration proceeding is over. As the majority itself extensively explains, this fact means that we lack authority to remand the case to the Director. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993).

In "fashioning a remedy," however, the majority directs the parties to "contact[] the Director to make arrangements for preparation and submission of the medical arbiters' reports." There is no statute or rule that requires the Director to do anything at this point of the process. The Director can deny the parties' request for a medical arbiter report, leaving claimant in the same position as today, only a little older.

The majority's "remedy" is based on its construction of ORS 656.268(7)(a) and (f) as showing a legislative "intent that a worker who disagrees with the impairment findings is entitled to a medical arbiter's report." The statute only requires that the Director "shall refer the claim to a medical arbiter appointed by the director." The Director in this case did exactly that--he appointed a medical arbiter

and referred the claim to that person. It was claimant who, due to incarceration, failed to attend the examination. I disagree with the majority that a statutory requirement for the Director to "refer" results in a wholesale entitlement in every case to a medical arbiter's report.[1]

Furthermore, I do not accept the majority's view that subjection (7)(f) "create[s] an entitlement to a medical arbiter's report." That provision states that findings of the medical arbiter or panel of medical arbiters "shall be submitted to the department for reconsideration of the determination order or notice of closure." Such language means only that, once there are findings by the medical arbiter or panel of medical arbiters, the findings must be "submitted" to the department. There is a substantive difference between an obligation to "submit" existing findings and a worker's entitlement to medical arbiter findings.

In sum, the provisions relied upon by the majority require two actions: (1) the Director must "refer the claim to a medical arbiter" if there is a disagreement with impairment; and (2) findings of the medical arbiter must be "submitted to the department for reconsideration." If the legislature really intended for the majority's interpretation of the statutes, it could have easily stated that the "director must refer the claim to a medical arbiter and obtain findings of the medical arbiter or panel of medical arbiters."

Assuming that the Director voluntarily cooperates with the parties' request for preparation and submission of a medical arbiter's report, I believe the employer has strong legal grounds for objecting to the admission of any resulting report. Although the majority does not expressly address this issue, at one point it cites to ORS 656.268(6)(e), which provides that "[a]ny medical report may be received as evidence at a hearing even if the report is not prepared in time for reconsideration proceeding."

As the court explained in Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73, 77 (1996), the purpose of the statute, as evident from the legislative history, was to ensure that a medical arbiter's report that was not prepared in time to be used in the reconsideration process could be considered in later proceedings reviewing the reconsideration order. The court also agreed with the Board's order stating that the statute "further confirms that the provision is intended to permit admission of evidence at hearing of a medical arbiter report that is designed for use by the Appellate Unit during the reconsideration process, but was not prepared in time for consideration prior to the issuance of the reconsideration order (whether actually or 'deemed' issued)." 143 Or App at 78.

Clearly, the report envisioned by the majority here does not fit such circumstances. Because the reconsideration process is over, any report prepared today would not have been developed for "use by the Appellate Unit." The only point of the report is for use at the hearing. Consequently, the employer would be justified in asserting that the report is not admissible at hearing pursuant to ORS 656.268(7)(g), which states that, "[a]fter reconsideration, no subsequent medical evidence of the worker's impairment is admissible before * * * the Worker's Compensation Board * * * for purposes of making findings of impairment on the claim closure."

In sum, the Director satisfied his statutory requirement, leaving us without a basis for remanding, whether to the Director or ALJ. Furthermore, if claimant is successful in obtaining a medical arbiter report, under the statutes, it is not admissible at hearing. In my opinion, the statutes leave us only with the option of addressing extent of permanent disability based on the existing record. Because the majority comes to a contrary result, I dissent.

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[1] I also disagree with the majority's statement that the distinction between this case and Linda M. Cross, 45 Van Natta 2130 (1993), "is without significance." Because the Director in Cross did not "refer the claim to a medical arbiter, "the Director did not satisfy that statutory obligation. As stated above, the Director in this case carried out that requirement. Consequently, Cross is entirely distinctive from this one.

In the Matter of the Compensation of
BENNY H. RASH, Claimant
WCB Case No. TP-97009
THIRD PARTY DISTRIBUTION ORDER
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Liberty Northwest Insurance (Liberty), 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, Liberty contends that a distribution in accordance with ORS 656.593(1) is just and proper, as it will recover full reimbursement of its lien in the amount of $124,716.73. In response, claimant asserts that the lien has been extinguished by virtue of the parties' Claim Disposition Agreement (CDA).[1]

As set forth below, we conclude that the parties' CDA did not extinguish Liberty's statutory lien. We further find that a distribution in accordance with ORS 656.593(1) is just and proper.

FINDINGS OF FACT

Claimant sustained a compensable injury to his cervical and lumbar spine on June 16, 1994. Liberty accepted the claim and paid compensation in the amount of $124,716.73 as follows: $33,725.43 in medical expenses, $2,065.30 in vocational rehabilitation benefits, $39,460.48 in temporary disability benefits, $14,465.52 in permanent disability benefits and $35,000 in connection with a CDA.

The parties' CDA, which was approved by the Board on July 29, 1996, provides, in pertinent part, as follows:

> "Pursuant to ORS 656.236, in consideration of the payment of $35,000 by the insurer/employer, claimant releases all rights to the workers' compensation benefits allowed by law, including temporary disability, permanent disability, vocational rehabilitation, aggravation rights to reopen and survivor's benefits potentially arising out of this claim, **except for medical services**, regardless of the condition(s) stated in this agreement. The insurer/employer's obligation to provide these benefits is also released." (Emphasis in original).

In addition to his workers' compensation claim, claimant also pursued a tort action against third parties for his June 16, 1994 injury. In July 1997, Liberty advised claimant's counsel of its $124,716.73 lien. Based on the understanding that claimant's counsel had received an offer to settle the third party case for $350,000, Liberty expressed a willingness to waive $10,000 and accept $114,716.73 as satisfaction of its lien. Liberty noted, however, that should the third party settlement offer exceed $350,000, it intended to recover the full amount of its lien.

Claimant's counsel subsequently advised Liberty that he had negotiated a $400,000 settlement of claimant's third party claim. Liberty requested full reimbursement of its $124,716.73 lien. Claimant has received the third party settlement proceeds but has declined to pay Liberty any portion of the proceeds.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. Pursuant to ORS 656.580(2), the paying agency has a lien against the worker's cause of action, which lien shall be preferred to all claims except the cost of recovering such damages. Pursuant to ORS 656.593(1), the proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds.[2]

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[1] Claimant also submitted a "Claimant's Reply" brief in response to Liberty's Reply. Because this surreply brief was not authorized by the Board rules nor the briefing schedule implemented in this particular case, we are not inclined to consider it in resolving the parties' dispute. See OAR 438-011-0045(3). We note, however, that even if we were to consider claimant's surreply brief, it would not alter our analysis or determination herein.

[2] "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury allegedly as a result of the negligence of a third person. The claim was accepted by Liberty, which provided compensation in the amount of $124,716.73.[3] Liberty is therefore a paying agency under ORS 656.576. When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable.

Because claimant settled his third party claim and Liberty ultimately approved the settlement, the distribution of proceeds is governed by ORS 656.593(3). Pursuant to that statute, Liberty is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that claimant receives at least the amount to which he is entitled under ORS 656.593(1) and (2).[4] ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper" distribution shall be resolved by the Board. Id.

As noted above, Liberty contends that a distribution in accordance with ORS 656.593(1) is "just and proper" because it will recover its full lien and claimant will receive more than 1/3 of the balance of the recovery (after deductions for attorneys fees and costs). Although claimant does not dispute that Liberty has paid compensation on his claim in the amount of $124,716.73, he contends that Liberty's lien has been extinguished by virtue of the CDA. Essentially, claimant asserts that, pursuant to ORS 656.236(1)(a) (as amended in 1995), the CDA resolved "all matters" between claimant and Liberty related to claimant's claim, including Liberty's third party lien. Claimant argues that because Liberty did not expressly preserve its third party lien rights in the CDA, its statutory right to recovery from the third party proceeds has been "resolved," i.e., waived or extinguished, by operation of law. For the reasons set forth below, we reject claimant's argument.

ORS 656.236(1)(a) provides, in pertinent part, as follows:

> "The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Workers' Compensation Board may prescribe. * * * Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement."

The second sentence quoted above, stating that "all matters and all rights to compensation," are "resolved" by a CDA, was added to the statute in 1995 as part of Senate Bill 369. Prior to the 1995 amendments, we held that an executed CDA did not affect the insurer's third party lien rights unless the agreement included an express waiver of the lien as additional consideration. See, e.g., Reginald C. Norbury, 45 Van Natta 2407 (1993) (holding that, in the absence of a waiver of the lien in the parties' CDA, the insurer would have been lawfully entitled to recover a portion of its claims costs from the claimant's third party recovery). However, in light of the statutory amendments, we must decide whether the legislature intended that the phrase "all matters and all rights to compensation," encompass a carrier's statutory entitlement to third party proceeds. If so, then Liberty's lien may well have been "resolved" by the parties' CDA in this case. On the other hand, if the legislature did not intend the new language to include a carrier's third party lien rights, then Liberty remains lawfully entitled to a "just and proper" share of the settlement proceeds pursuant to ORS 656.593(3).

When interpreting statutory language, our task is to discern the intent of the legislature; this process begins with an examination of the text and context of the statutory provision. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). The context includes other statutes relating to the same subject matter. Id. at 611. If the intent of the legislature is not clear from the text and context inquiry, our next step is to consider the legislative history of the statute in question. Id. at 611-12. Finally, if, after consideration of the text, context and legislative history, the intent of the legislature remains unclear, we will resort to general maxims of statutory construction in resolving any uncertainty. Id.

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[3] CDA payments constitute "compensation" under ORS 656.005(8) and are generally reimbursable from a third party settlement. Turo v. SAIF, 131 Or App 572, 575 (1994).

[4] The amounts referred to in ORS 656.593(1) and (2) pertain to attorney fees, litigation expenses, and claimant's statutory 1/3 share of the balance.

In examining the text and context of ORS 656.236(1)(a), we note that the statute is expressly directed toward the "disposition of *any or all matters regarding a claim*, except for medical services." (Emphasis added). The phrase "matters concerning a claim" is defined in ORS 656.704(3) as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." While the language is not exact (matters "regarding" a claim vs. matters "concerning" a claim), we find the wording sufficiently similar so that the definition set forth in ORS 656.704 is instructive in construing the focus of ORS 656.236(1)(a).[5] A carrier's third party lien rights do not satisfy the definition of "matters concerning a claim" because the lien does not involve a worker's right to receive compensation.[6] See, e.g., Michael L. Harmon, 48 Van Natta 546 (1996) (holding that a claimant's entitlement to "compensation" is not affected by a third party settlement or the amount of the carrier's third party lien).

The other provisions of ORS 656.236 deal with, among other things, the requirements for Board approval of the disposition,[7] the effect submission of a disposition has on other proceedings and payment obligations, judicial review of Board orders disapproving the disposition, the timing of payments made pursuant to the disposition, and the immunity from other workers' compensation proceedings afforded to carriers who are parties to an approved CDA. For example, pursuant to ORS 656.236(7), a carrier who is a party to an approved CDA may not be joined as a party in a subsequent proceeding to determine responsibility for any non-medical service benefit resolved by the CDA, nor can any subsequent proceeding alter the obligations of the carrier set forth in the CDA, except insofar as those obligations concern medical services.

After examining the text and context of ORS 656.236(1)(a) (including the rules adopted by the Board to administer the statute), we find no indication that the statute contemplates the disposition of third-party actions or the carrier's lien on third-party proceeds. However, to the extent the precise meaning of the phrase "all matters and all rights to compensation" remains unclear, we look to the legislative history to discern the legislature's intent. See Sullivan v. Kizer, 115 Or App 206 (1992), rev den 315 Or 313 (1993) ("No matter how broad the apparent meaning of a statute may be, if we cannot tell whether the legislature intended a statute to apply in a particular context, we must resort to extrinsic aids to construction.")

In a January 30, 1995 joint meeting of the Senate and House Labor Committees to introduce SB 369, Representative Kevin Mannix (a co-author of the bill) described the amendments to the CDA statute as follows:

> "We change ORS 656.236 sub (1) to clarify claim release authority and accelerate the payment of some settlements. Right now there is some issue arising as to what's called the CDA (the claims disposition agreement). This was established in 1990; carefully established, we thought. *It allows someone to make a deal with the employer or insurer to say, I still want my medical benefits, but I want to buy out on my other benefits on the claim.* That was the understanding in 1990. Recently there has been some litigation, which was unsuccessful, where people try to say, yeah, well, I did settle out of the benefits on my claim, but I didn't really cover all the conditions; and there are some other conditions for which I still want benefits other than medical services. *This makes it clear that unless you*

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[5] Indeed, in common usage, the words "regarding" and "concerning" are used interchangeably. See, e.g. Webster's Ninth New Collegiate Dictionary (1985), which defines the word "regarding" as "with respect to: CONCERNING" and the word "concerning" as "relating to: REGARDING."

[6] In the workers' compensation context, "compensation" means benefits provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8).

[7] Pursuant to Board's administrative rules, a "Claim Disposition Agreement" is defined as a written agreement executed by all parties "in which *a claimant agrees to release rights, or agrees to release an insurer of self-insured from obligations*, under ORS 656.001 to 656.794, except for medical services, in an accepted claim." OAR 438-009-0001(1). (Emphasis added). The rules also identify the information required in a CDA, including "specific identification of all benefits, rights and insurer/self-insured employer obligations under Workers' Compensation Law which are released by the agreement." See OAR 438-009-0022(3)(h).

In this case, consistent with the Board's rules, the parties' CDA specifically identified the benefits and rights released by claimant in consideration for the payment of $35,000, and provided that Liberty's obligation to provide such benefits was also released. The CDA did not identify any additional consideration or specify any rights or benefits released by Liberty. (Ex. 6).

> *specify in that agreement that you are reserving something that hasn't been bought out that you are, in effect, selling all benefits except for medical services for the claim, not for part of it. Now you still could specify only part of it is you wish, but the assumption is that you selling it out for the entire claim."* (Tape 16, Side A) (Emphasis added).[8]

Later, in a March 6, 1995 presentation to the Senate Committee on Labor, Representative Kevin Mannix offered further explanation regarding the amendments to ORS 656.236(1):

> "Section 24 has to do with Claim Disposition Agreements. These are a new kind of, well, first of all, we start talking about the Workers' Compensation Board authority as to settlements and we talk about matters regarding claim and what are under Claim Disposition Agreements. Claim Disposition Agreements allows for a worker and the insurer or self-insured employer to in fact make an agreement that for payment of a certain sum, certain elements of a claim, or all elements of the claim, except for medical services, can be resolved.
>
> "The Claim Disposition Agreement process has worked fairly smoothly, but there are a couple of things here that are changed in this bill to make it work even more smoothly. First, it makes it clear that unless you are specifying otherwise, if you say you are resolving this claim, that means everything relating to the claim except for medical services. There has been some dispute that has arisen as to what kind of language you would have to use or whatever else. *This will make it very clear that you can buy out everything except the medical services and that the presumption is that is what you are doing when you are doing a Claim Disposition Agreement."* (Tape 45, Side A, page 741) (Emphasis added).

Representative Mannix's comments do not suggest that the amendments to ORS 656.236(1) were intended to encompass a carrier's third party lien rights, so that, in the absence of an express reservation of such rights in the parties' CDA, the carrier's lien would be extinguished. Rather, we discern from this testimony that the 1995 amendments were designed to clarify that a CDA resolves "all matters" *regarding a claimant's compensation,* i.e., all (non-medical service) benefits provided by the carrier for conditions arising from the compensable injury. Indeed, Representative Mannix's repeated references to the "buying out" or "selling" of "all benefits" (except the medical services) for "payment of a certain sum" suggests that it is the carrier (and not the claimant) that is doing the "buying out" of its obligation to pay compensation on the claim. Because there is nothing for the carrier to "buy out" with regard to its third party lien (which is a statutory entitlement of the carrier's, see ORS 656.580(2) and 656.593(1), that is distinct from the claimant's entitlement to compensation), it follows that the legislature did not intend for a carrier's third party lien rights to come within the "matters" and "rights to compensation, attorney fees and penalties" resolved by the CDA.[9]

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[8] The "litigation" referred to by Representative Mannix is the case of Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), aff'd Trevitts v. Hoffman-Marmolejo, 138 Or App 455 (1996). In that case, the claimant compensably injured his back and the employer initially accepted a disabling low back sprain/strain. After x-rays revealed a lumbar disc protrusion, claimant underwent surgery at the L4-5 level. Prior to claim closure, the parties executed a CDA in which claimant released his rights to all benefits except for medical benefits in exchange for $25,000. The Board-approved CDA listed the accepted conditions as lumbar strain/sprain and L4-5 disc protrusion. Several months later, claimant underwent surgery at the L5-S1 level and sought temporary disability benefits related to that surgery. Claimant argued that the CDA resolved only the conditions specified in the agreement and did not dispose of his later diagnosed L5-S1 disc condition. The employer asserted that the CDA had released it from the obligation to pay any benefits on the claim except medical services.

Both the Board and the court held that, to the extent the CDA was ambiguous, the parties' communications confirmed that the CDA was intended as a full release of all benefits, except medical services related to the claimant's compensable injury and therefore claimant was not entitled to any "non-medical service" benefits for his L5-S1 condition. The parties' CDA pertained to the claim as a whole and did not merely dispose of the listed conditions but rather all conditions arising from claimant's compensable injury.

[9] In finding that a carrier's third party lien rights are not encompassed by the phrase "all matters and rights to compensation" in ORS 656.236(1)(a) we do not suggest that the terms "matters" and "rights" are synonymous. Because they are used in the statute in the conjunctive, we assume the legislature intended that the two words have different meanings (albeit within the "regarding a claim" context). Thus, the term "all matters" may have a broader application than "all rights," and include such claim processing concerns as closure, offsets, overpayments, orders on reconsideration, requests for hearing, etc.

Consequently, we continue to find that, in the absence of an express waiver in the CDA of the carrier's lien rights under ORS 656.580 and 656.593, the parties' CDA does not deprive the carrier of its statutory right to recovery from the third party proceeds.[10] We therefore proceed to a determination of a "just and proper" distribution of the settlement proceeds in this case.

In determining a "just and proper" distribution, we judge each case based on its own merits. Urness v. Liberty Northwest, 130 Or App 454, 458 (1994). Since "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. Id. Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination is based on the merits of the case. Id.

As noted at the outset, Liberty proposes that the $400,000 settlement be distributed according to the statutory formula in ORS 656.593(1). Claimant does not specifically object to this proposed distribution, nor does he present any justification for reducing Liberty's $124,716.73 lien.[11] We note that a distribution of the $400,000 settlement pursuant to the third party judgment scheme would provide for full satisfaction of Liberty's lien and leave claimant with significantly more than one third of the balance of the recovery (after deduction for attorney fees and litigation costs).[12] Consequently, on this record, we find that Liberty's "just and proper" share of the third party settlement is $124,716.73. Claimant's counsel is directed to forward this amount to Liberty.

IT IS SO ORDERED.

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[10] We note that it is not uncommon for an insurer to waive all or part of its third party lien as additional consideration for a claimant's release of benefits under a CDA. See, e.g., Richard E. Anderson, DCD, 49 Van Natta 1199 (1997); Bradford Sexton, DCD, 49 Van Natta 740 (1997). In such a situation, however, the CDA contains information concerning the amount of third party proceeds and/or the amount of the carrier's lien sufficient to establish the value of consideration flowing to the claimant in exchange for his or her release of benefits. In other words, the parties' intention to simultaneously resolve both the third party lien and the claimant's entitlement to future benefits is evident from the "four corners" of the CDA.

[11] Claimant's response to Liberty's petition challenged only the survival of Liberty's lien in light of ORS 656.236(1)(a), which we addressed above.

[12] Although neither party has offered sufficient evidence for us to determine the precise amount of costs and attorney fees incurred during the litigation of the third party action, we note that, absent extraordinary circumstances, the attorney fee is limited to 33 1/3 percent of the gross recovery. See ORS 656.593(1)(a); OAR 438-015-0095.

In the Matter of the Compensation of
HERBERT K. SHINN, Claimant
Own Motion No. 66-0117M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 19, 1997 Second Own Motion Order on Reconsideration, in which we declined to reopen his claim for the payment of temporary disability compensation because the record failed to establish a causal relationship between claimant's current right hip and the compensable 1955 injury.

Additionally, it is unclear whether claimant mailed a copy of his request to the SAIF Corporation. Therefore, we enclose a copy of claimant's December 1, 1997, letter received by the Board on December 5, 1997. In the future, claimant is requested to send copies of information sent to the Board to all parties.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH R. REED, Claimant
WCB Case No. 96-06839
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that affirmed an Order on Reconsideration awarding 27 percent (40.5 degrees) for loss of use or function of the left leg (knee). Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to award additional scheduled permanent disability for weakness of the quadriceps muscle; (2) declined to admit into evidence certain records that were not part of the record on reconsideration; and (3) declined to grant him permanent total disability. On review, the issues are extent of scheduled permanent disability, evidence, constitutionality and permanent total disability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, age 54 at the time of hearing, compensably injured his left knee on September 12, 1995. He sought treatment the same day and was diagnosed with a left knee strain and possible medial meniscus tear. A subsequent MRI of the left knee showed, among other things, a tear of the posterior horn of the medial meniscus, a medial collateral ligament sprain, medial tibial plateau contusion and osteoarthritic changes involving the medial joint compartment and the patellofemoral joint. (Exs. 1-6)

In November 1995, the insurer accepted a nondisabling left medial knee strain and left medial meniscus tear. (Ex. 8). On February 20, 1996, claimant's attending physician, Dr. Karty performed a closing examination finding claimant medically stationary with permanent impairment. (Exs. 12, 13).

On March 25, 1996, the insurer reclassified the injury as disabling and issued a new notice of acceptance for a left medial knee strain and left meniscus tear. (Ex. 14). The same day, the insurer issued a request for determination (Form 1503), indicating the claim had been reclassified to disabling for permanent partial disability rating purposes only. (Ex. 15).

An April 9, 1996 Determination Order awarded temporary disability and 19 percent (28.5 degrees) scheduled permanent disability for loss of use of the left leg (knee). (Ex. 16-1). The determination evaluator found that claimant had 32 percent permanent impairment,[1] but that the permanent disability award should be reduced based upon Dr. Karty's report estimating that 60 percent of claimant's permanent impairment was due to the industrial injury and 40 percent was due to a preexisting condition. (See Exs. 12-3, 16-2).

Claimant requested reconsideration, challenging, among other things, the apportionment of his measurable impairment. (Ex. 17). A July 2, 1996 Order on Reconsideration increased claimant's total scheduled permanent disability award to 27 percent, finding that claimant was entitled to 14 percent for

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[1] The Determination Order rated claimant's total impairment as follows: 14 percent for loss of motion, combined with 10 percent for mild instability, 6 percent for loss of quadriceps strength and 5 percent for a chronic condition.

loss of motion, 10 percent for mild (Grade 1) laxity of the medial collateral ligament and 5 percent for a chronic condition.[2] The appellate review specialist declined to apportion the disability pursuant to Dr. Karty's report. (Ex. 18).

Claimant has been released to return to work with permanent restrictions, and is able to engage in gainful and suitable employment.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability - Loss of Strength

As set forth above, claimant asserts that he is entitled to an additional award of scheduled permanent disability under OAR 436-035-0230(9) and (10) based on Dr. Karty's finding of 4/5 muscle strength of the left quadriceps muscle. In this regard, Dr. Karty reported as follows:

> "[Claimant] does not have evidence of any nerve loss but he does have weakness of the left quadriceps muscle with regards to secondary effect of the knee medial meniscus injury which makes walking and movement painful for [claimant]. With this he has some decreased use of the left leg." (Ex. 12-1).

OAR 436-035-0230(9) includes a table for rating loss of strength in the leg or foot due to a peripheral nerve injury. OAR 436-035-0230(10) provides, in pertinent part, that "[v]alid 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" unless the decreased strength is due to an amputation or a loss of range of motion.[3]

In this case, Dr. Karty did not report that claimant's quadriceps weakness was due to loss of motion (or amputation). Rather, Dr. Karty related claimant's loss of strength to pain and disuse. Therefore, pursuant to paragraph (10) of OAR 436-035-0230, claimant's quadriceps weakness shall be valued pursuant to paragraph (9). Claimant's 4/5 strength of the left quadriceps translates to a 6 percent impairment value of the leg. Based on Dr. Karty's other (uncontested) impairment findings, claimant has 32 percent permanent impairment of his left leg (knee).

Scheduled Permanent Disability - Apportionment

The insurer argues that, given Dr. Karty's opinion that only 60 percent of claimant's permanent impairment was due to his compensable injury, the ALJ erred in declining to apportion claimant's scheduled permanent disability award accordingly. We agree.

Claimant has the burden of proving the extent of permanent disability due to his compensable knee injury. ORS 656.214(2), 656.266. Dr. Karty is claimant's attending physician and the only physician to provide medical evidence concerning the nature and extent of claimant's permanent impairment. See ORS 656.245(2)(a)(B). His impairment findings are uncontested, as is his opinion that 60 percent of claimant's measured left knee impairment is due to his September 1995 left knee injury and 40 percent is caused by a preexisting condition.

In this case, the insurer did not accept claimant's preexisting underlying arthritis condition, nor did it accept a "combined condition."[4] Rather, the insurer accepted only those conditions arising from the September 12, 1995 industrial injury: the left knee strain and left medial meniscus tear. Insofar as the preexisting condition has not been accepted, it should not be considered in rating claimant's scheduled permanent disability even though it has contributed to claimant's impairment findings. See, e.g. David J. Keller, 49 Van Natta 697 (1997); Robin Spivey, 48 Van Natta at 2367.

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[2] The appellate review specialist found that claimant's left quadriceps weakness was not ratable under OAR 436-035-0230(9) and (10).

[3] Amputation and loss of range of motion do not receive a rating pursuant to OAR 436-035-0230(10) because they are ratable impairments under other rules.

[4] Because the insurer did not accept a combined or consequential condition, ORS 656.262(7)(b) does not apply to this case and the insurer was not obligated to issue a "pre-closure" denial pursuant to that section. See Robin W. Spivey, 48 Van Natta 2363 (1996).

Consequently, based on Dr. Karty's allocation (and the absence of any controverting evidence) we find that 40 percent of claimant's left knee impairment is due to a noncompensable condition. We reduce claimant's total 32 percent impairment accordingly, and reinstate the Determination Order's award of 19 percent scheduled permanent disability.[5]

Permanent and Total Disability

After considering the evidence submitted on reconsideration and made part of the reconsideration record, the ALJ determined that claimant was gainfully and suitably employed and declined to find him permanently and totally disabled.[6] On review, claimant asserts that the ALJ erred in declining to consider evidence outside the reconsideration record and argues that this matter should be remanded to the Hearings Division for a full evidentiary hearing on the issue of his entitlement to permanent and total disability. We disagree.

In Virginia McClearen, 48 Van Natta 2536 (1996), we held that the statutory limitation on evidence set forth in ORS 656.283(7) applied to hearings on reconsideration orders involving permanent total disability issues. Thereafter, in George D. Koskela, 49 Van Natta 529 (1997), we rejected constitutional challenges to the application of ORS 656.283(7) and held that although the statute affords less process than was previously available (because it imposes limitations on the form and timing of evidence relative to a claimant's permanent and total disability status), it did not violate the claimant's right to due process under the Fourteenth Amendment to the U.S. Constitution or his right to a substantial remedy under Article I, section 10 of the Oregon Constitution.

In Koskela, we agreed that the claimant's interest in permanent total disability was more significant than the interest in permanent partial disability benefits. Notwithstanding the differences, we found that the procedures during the reconsideration process are sufficient to guard against an erroneous deprivation of the claimant's interest in permanent total disability benefits. After considering the reconsideration procedures, including the right to submit information into the reconsideration record, the opportunity to correct or clarify information in the record that was erroneous and the right to an examination by a medical arbiter, we found that the reconsideration procedures enable the claimant to present in writing the lay, medical and vocational evidence supporting entitlement to permanent total disability benefits. Specifically, we concluded that the claimant had the right to present essentially the same evidence on reconsideration which he sought to present at hearing, albeit in a different form.

Here, as in Koskela, we find that claimant had the opportunity to present his position and evidence fully at the reconsideration proceeding.[7] Thus, we find, as we did in Koskela, that there was a low risk of erroneous deprivation of his interest in permanent total disability benefits. Consequently, we find no constitutional infirmity and decline claimant's request to remand the matter to the ALJ for a "full evidentiary hearing" on his entitlement to permanent total disability.

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[5] 32 x .6 = 19.2, which is rounded off to the nearest whole number. OAR 436-035-0007(14)(a).

[6] ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." In order to establish permanent total disability, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984). In this case, the record developed on reconsideration establishes that as of January 10, 1996, claimant returned to work in a light duty position in the employer's tool area. (See Ex. 12-2). In declaring claimant medically stationary on February 20, 1996, Dr. Karty released claimant for regular work (in this new, light duty position). (Ex. 13).

[7] Indeed, in requesting reconsideration, claimant did not challenge the impairment findings of Dr. Karty, only the apportionment of impairment attributable to his preexisting condition. (Ex. 17). Moreover, although he raised permanent total disability as a potential issue, claimant did not offer any further medical or vocational evidence suggesting that he was incapable of gainful and suitable employment, nor did he request postponement or a stay of the reconsideration proceeding to develop evidence on the issue.

Furthermore, the law now requires that claimant's permanent and total disability status be evaluated based on conditions existing at the time of reconsideration (as opposed to the time of hearing), without considering possible "post-reconsideration" changes in employment status. See ORS 656.283(7)[8]; cf. Gettman v. SAIF, 289 Or 609, 614 (1980) (holding that the determination of permanent total disability must be made based on occupational abilities existing at the time of the decision). Therefore, to the extent claimant experienced a change in circumstances subsequent to the issuance of the reconsideration order, these changed circumstances would not be relevant to the evaluation of claimant's permanent disability.

ORDER

The ALJ's order dated June 13, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that affirmed the Order on Reconsideration is reversed. The Determination Order, which awarded 19 percent (28.5 degrees) scheduled permanent disability for loss of use of function of the left leg(knee), is reinstated and affirmed. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

[8] As explained in Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), the 1995 amendments to ORS 656.283(7) were specifically intended to overrule court cases that had allowed the admission of further evidence after reconsideration, such as Leslie v. U. S. Bancorp, 129 Or App 1 (1994) (holding that former ORS 656.283(7) did not preclude the claimant from raising an issue for the first time at hearing), and Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) (holding that former ORS 656.283(7) allowed the ALJ to consider evidence that could not have been submitted on reconsideration).

In the Matter of the Compensation of
PETER J. ZEISZLER, Claimant
WCB Case Nos. 96-05676 & 96-03723
ORDER ON REVIEW
Anita Smith, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation, on behalf of the Department of Consumer and Business Services (DCBS), requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson's order that partially set aside its denial of responsibility for claimant's "new injury" claim for a current low back condition.[1] On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's need for treatment following a February 1996 incident at DCBS was due to a combination of the incident and his preexisting low back condition. Applying ORS 656.005(7)(a)(B), the ALJ further found that the February 1996 incident was the major contributing cause of the need for treatment for the combined condition. Therefore, he set aside SAIF/DCBS' responsibility denial to the extent it denied the need for treatment for the combined condition. At the same time, however, the ALJ found that there was insufficient proof that the February 1996 incident was the major contributing cause of the combined condition itself; therefore, the ALJ upheld the portion of SAIF/DCBS' denial that denied the combined condition itself.

[1] Claimant presented to the ALJ a bifurcated theory of compensability to support his "new injury" claim, asserting that, even if he had not established the compensability of the current "combined condition" itself, he had established the compensability of treatment for the "combined condition." The ALJ ultimately adopted this analysis, setting aside the portion of SAIF's denial that denied treatment for the current "combined condition" but upholding the portion of the denial that denied the "combined condition" itself. However, for the reasons set forth in the body of this order, we decline to adopt this bifurcated analysis.

On review, the parties do not dispute the ALJ's finding that claimant's need for treatment following the February 1996 incident was due to a combined condition. However, SAIF disagrees with the ALJ's finding that the February 1996 incident was the major contributing cause of claimant's subsequent need for treatment, and contends that its denial should be upheld in its entirety. For the following reasons, we disagree and set aside SAIF/DCBS' responsibility denial in its entirety.

ORS 656.005(7)(a)(B) provides:

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

Subsequent to the ALJ's order, the Court of Appeals construed ORS 656.005(7)(a)(B) to mean that, if the otherwise compensable injury is the major contributing of the need for treatment of a combined condition, then the combined condition itself is compensable. SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309, 315 (1997). The court expressly declined to read the statute to distinguish between the compensability of a combined condition and the compensability of the need for treatment of the combined condition. Id. Rather, the court stated that if the need for treatment of the combined condition is compensable, then the combined condition itself is compensable under ORS 656.005(7)(a)(B). Id.

Based on the court's modified opinion in Nehl, we decline to adopt the ALJ's "bifurcated compensability" analysis. Instead, our analysis is to determine whether the February 1996 incident was the major contributing cause of claimant's need for treatment of the combined condition. If so, then the combined condition itself is compensable and SAIF/DCBS' denial must be set aside in its entirety.

Claimant's combined condition is symptomatic spinal stenosis at L3-4, which required decompression surgery in April 1996. The ALJ relied on the opinion of claimant's treating orthopedic surgeon, Dr. Stevens, in finding that the February 1996 incident was the major contributing cause of the need for treatment, including surgery, of the spinal stenosis at L3-4. On review, SAIF argues that Dr. Stevens' opinion was not sufficiently persuasive to carry claimant's burden of proof by a preponderance of the evidence. We disagree and adhere to the ALJ's finding for the following reasons.

Contrary to SAIF's assertion, we do not believe that Dr. Stevens relied entirely on a "precipitating cause" analysis in formulating his ultimate opinion that the February 1996 incident was the major contributing cause of claimant's need for treatment of the spinal stenosis. In deposition, Dr. Stevens stated that, during surgery in April 1996, he observed that the ligament and capsular tissue that was compressing claimant's dura was "extremely edematous and swollen," a finding consistent with an acute condition (of short duration) rather than a degenerative stenosis condition. (Ex. 46, pp. 21-22, 30-31). He opined that the acute condition was more probably than not caused by the February 1996 incident. (Ex. 46-31).

Dr. Stevens further opined that the February 1996 incident was serious enough to cause the onset of severe and unremitting pain in both legs, a disabling condition that necessitated surgery. (Ex. 46, pp. 9-10, 19, 32). He noted that, if the pain following the incident had subsided, surgery would not have been required for the preexisting stenosis. (Ex. 46-32).

Finally, Dr. Stevens stated that it was a "little fast" and "unusual" for the onset of severe, disabling stenotic pain to occur six or seven years after a one-level (L4-5) fusion surgery, as it did in claimant's case. (Ex. 46-35). Thus, based on our review of Dr. Stevens' testimony, we conclude that he properly weighed the relative contribution of the February 1996 incident and the preexisting stenosis and determined that the February 1996 incident was more probably than not the primary cause of claimant's need for treatment of the spinal stenosis at L3-4. (Ex. 46-32). Dr. Stevens' analysis conforms to the "major contributing cause" standard, as explained by the court in Dietz v. Ramuda, 130 Or App 397, 401 (1994).

As claimant's treating surgeon, Dr. Stevens' opinion is entitled to greater weight than the opinions of Dr. Mayhall, who examined claimant only once, and Dr. Dickerman, who performed a records review only. See Argonaut Insurance Co. v. Mageske, 93 Or App 698, 702 (1988); Weiland v.

SAIF, 64 Or App 810, 814 (1993). Furthermore, Dr. Stevens' opinion was well reasoned and, given his opportunity to observe claimant's condition during surgery, based on more complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986). Based on Dr. Stevens' opinion, we agree with and adopt the ALJ's finding that the February 1996 incident with DCBS was the major contributing cause of claimant's need for treatment of the spinal stenosis at L3-4. Accordingly, the stenosis at L3-4 is compensable, see Nehl, 149 Or App at 315, and SAIF/DCBS' denial of that condition shall be set aside.

Although SAIF/DCBS' denial has been set aside in its entirety, because it was a denial of responsibility only, claimant's attorney is entitled to no more than the $1,000 assessed fee awarded by the ALJ, unless there is a showing of extraordinary circumstances justifying a larger fee. See ORS 656.308(2)(d); Foster-Wheeler Constructors, Inc. v. Smith, 151 Or App 155 (1997); Liberty Northwest Ins. Corp. v. Gordineer, 150 Or App 136, 141 (1997). Based on our review of the record, we do not find extraordinary circumstances justifying an assessed fee in excess of $1,000 for services rendered in prevailing against SAIF/DCBS' responsibility denial.[2]

ORDER

The ALJ's order dated January 22, 1997 is reversed in part and affirmed in part. The portion of the order that upheld SAIF/DCBS' denial of responsibility for the combined condition is reversed. SAIF/DCBS' denial is set aside in its entirety and the claim for the combined condition is remanded to SAIF/DCBS for processing according to law. The remainder of the order is affirmed.

[2] In reaching our conclusion regarding the absence of extraordinary circumstances, we have particularly noted that, on Board review, claimant did not challenge the portion of the ALJ's order that upheld SAIF/DCBS' denial to the extent that it denied responsibility for the combined condition itself.

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

The SAIF Corporation requests reconsideration of our November 18, 1997 Own Motion Order, in which we set aside SAIF's September 18, 1997, Notice of Closure.

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
MARIO R. CASTANEDA, Claimant
WCB Case No. 96-07085
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) directed it to pay procedural temporary disability for the period beginning July 19, 1995; and (2) assessed a penalty for its allegedly unreasonable claims processing. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

On July 11, 1994, claimant sustained a compensable low back injury while performing heavy work for the employer. Following this injury, claimant experienced low back pain with radiating pain into the left thigh. These symptoms were attributed to a low back strain, and the insurer accepted a claim for that diagnosis. A July 17, 1995 Determination Order closed the claim and awarded 25 percent permanent disability and temporary disability compensation through October 14, 1994. That order was not appealed and became final as a matter of law.

On June 29, 1995, claimant began treating with Dr. Puziss. Diagnostic studies on July 7, 1995 confirmed the existence of an L4-5 disc bulge. On July 13, 1995, Dr. Puziss provided medical verification of a sedentary work restriction related to the disc bulge. (Ex. 17). Claimant filed a new medical condition claim for the disc bulge which the insurer denied. By Opinion and Order issued on February 23, 1996, ALJ McKean found the L4-5 disc condition compensable and remanded the claim to the insurer for "acceptance, payment of benefits, and processing in accordance with law." (Ex. 21). That order was not appealed and became final as a matter of law. On April 11, 1996, the insurer issued a modified notice of acceptance to include the L4-5 disc condition.

Meanwhile, on March 20, 1996, Dr. Puziss provided medical verification of a medium work restriction related to claimant's disc bulge. (Ex. 32). On August 3, 1996, Dr. Puziss indicated on a "check-the-box" form that temporary disability was warranted because claimant could not perform his regular heavy job cleaning trucks. (Ex. 35A).

Claimant has never filed an aggravation claim for the L4-5 disc condition, and the insurer has not paid additional temporary disability benefits for that condition.

CONCLUSIONS OF LAW AND OPINION

On review, the insurer challenges the ALJ's conclusion that: the present claim for temporary disability is not barred by the July 17, 1995 Determination Order or the February 23, 1996 Opinion and Order; claimant's injury claim is in open status pursuant to that Opinion and Order; and the insurer had a duty under ORS 656.262(4) to pay procedural temporary disability for claimant's L4-5 disc condition commencing on July 19, 1995.

We adopt the ALJ's res judicata ruling with the following comment regarding the insurer's reliance on Rex A. Howard, 46 Van Natta 1265 (1994). In Howard, the Board determined that a final Determination Order was not invalidated by subsequent litigation finding additional compensable conditions that were not medically stationary when the claim was closed. The Howard Board relied on the fact that the claimant could have raised the issue of premature closure before the Determination Order became final. The present case is distinguishable from Howard on its facts. Here, claimant is not attempting to invalidate the July 17, 1995 Determination Order. Moreover, as discussed by the ALJ, claimant's entitlement to temporary disability benefits for his L4-5 disc condition could not have been determined by that order.

We also adopt the ALJ's ruling that the claim is in open status, and we provide the following additional basis for that ruling. After the ALJ's order, the legislature enacted ORS 656.262(7)(c). HB 2971, 69th Leg., Reg. Sess. (July 25, 1997). Pursuant to this statutory provision, "[i]f a condition is

found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." (Emphasis added). ORS 656.262(7)(c) is retroactively applicable to this case.[1] Bay Area Hospital v. Landers, 150 Or App 154 (1997); Ronald D. Smith, 49 Van Natta 1807 (1997). Pursuant to the clear and unambiguous language of ORS 656.262(7)(c), the insurer had a duty to reopen the claim and pay whatever additional benefits were due for the L4-5 disc condition.

Having concluded that claimant's injury claim is in open status, we next address the criteria for determining procedural temporary disability benefits. The insurer contends that it has no obligation to pay such benefits unless and until claimant perfects an aggravation claim under ORS 656.273. ALJ Herman rejected that argument and, instead, concluded that the insurer had a duty to pay procedural temporary disability under ORS 656.262(4), the provision that is used to determine such benefits in initial claims and other claims in open status.

In resolving this issue, we rely on the text and context of the statue, and the legislative history if necessary. ORS 174.20; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). We focus our analysis on ORS 656.262(7)(a) and (c), the two statutory provisions that expressly address post-closure claims for new medical conditions. These provisions provide in pertinent part:

> "(7)(a) 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[.] Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."
>
> "* * * * *
>
> "(c) * * * If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition. (Emphasis Added)."

Nothing in the express language of ORS 656.262(7)(a) or (c) suggests that the legislature intended to make the filing of an aggravation claim a prerequisite to receiving procedural temporary disability for conditions found compensable after claim closure. To the contrary, the language of ORS 656.262(7)(a) recognizes a distinction between aggravation and post-closure new medical condition claims. Specifically, that provision references "claims for aggravation or new medical conditions" and allows workers to "initiate a new medical condition claim at any time." In addition, the mandate under ORS 656.262(7)(c) to "reopen" the claim is stated in absolute terms without reference to the special requirements for aggravation claims under ORS 656.273. The term "reopen" is not defined and is used elsewhere in the statute in the context of both aggravation claims and other claims that are not processed under ORS 656.273.[2]

Furthermore, a new medical condition claim under ORS 656.262(7)(a) and (c) falls within the definition of the term "claim" as it is used in ORS 656.262(4). As discussed above, the ALJ relied on ORS 656.262(4) in awarding procedural temporary disability benefits for claimant's L4-5 disc condition. Under this provision, the first payment of temporary disability compensation is due "no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." The statutory definition of the term "claim" is used unless this would create a conflict with one or more aspects of the structure or purpose

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[1] ORS 656.262(7)(c) applies to all claims or causes of action existing or arising on or after the July 25, 1995 effective date of HB 2971, regardless of the date of injury or the date a claim is presented. HB 2971, Section 2. Because the claim in this case existed on the effective date of HB 2971, and because that Act is intended to be fully retroactive, we apply ORS 656.262(7)(c) to this case.

[2] See ORS 656.252(2)(c) (notice of attending physician recommendation to reopen a claim); ORS 656.262(15) (sanctions for failure to cooperate in investigation regarding aggravation claim); ORS 656.278(5) (voluntary reopening to provide benefits or grant additional medical care); ORS 656.625 (reimbursement from Reopened Claims Program for own motion awards, including medical benefits for pre-1966 injuries).

of the workers' compensation scheme as a whole. ORS 656.003; Astleford v. SAIF, 319 Or 225, 233 (1994). The statute defines the term "claim" as a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge. ORS 656.005(6). This statutory definition is broad enough to include a post-closure new medical condition claim under ORS 656.262(7)(a) and (c). Accord SAIF v. Allen, 320 Or 192, 203 (1994) (definition of claim under ORS 656.005(6) is not limited to initial claims). We conclude that this construction does not conflict with the structure or purpose of the workers' compensation scheme as a whole. In particular, we find no statutory provision that expressly or impliedly excludes new medical condition claims from the provisions of ORS 656.262(4).

Moreover, we conclude that determining claimant's procedural temporary disability under ORS 656.262(4) is consistent with the relevant legislative history. The testimony regarding ORS 656.262(7)(a) demonstrates the legislature's goal of reducing litigation by requiring prior notice of claims for new medical conditions.[3] The testimony regarding ORS 656.262(7)(c) shows a legislative intent to ensure that claims for new medical conditions would not delay closure regarding accepted conditions, and that the carrier would, instead, reopen the claim for processing of the new medical condition and rating of permanent disability for that condition.[4] Nothing in this legislative history evidences an intent to determine procedural temporary disability for post-closure new medical conditions under the aggravation statute.

In summary, based on the text and context of ORS 656.262(7)(a) and (c) and the relevant legislative history, we conclude that procedural temporary disability for conditions accepted after claim closure should be determined under ORS 656.262(4). To the extent that this conclusion is inconsistent with our prior decisions in other cases, we note that these prior cases were not subject to the requirements of ORS 656.262(7)(c) and are distinguishable on that basis. See Daniel I. Vanwechel, 49 Van Natta 685 (1997); Kelly R. Eisenberg, 49 Van Natta 538 (1997); Julianne Cartwright, 48 Van Natta 918 (1996); Sandra Miles, 48 Van Natta 553 (1996). See also Anthony J. Telesmanich, 49 Van Natta 166 (1997) (dicta).[5]

Accordingly, we affirm the ALJ's conclusion that procedural temporary disability benefits for claimant's L4-5 disc condition should be determined under ORS 656.262(4), notwithstanding the fact that claimant did not perfect an aggravation claim. We must, therefore, determine whether the record in this case establishes claimant's entitlement to temporary disability benefits under that provision.

Pursuant to ORS 656.262(4), the duty to pay procedural temporary disability compensation is triggered by the attending physician's verification that claimant's L4-5 disc condition prevents him from performing his at-injury job. In addition, the insurer has a duty to continue paying such benefits until the attending physician withdraws this temporary disability authorization or does not provide medical verification of claimant's continued inability to work when so requested by the insurer.

Here, ALJ Herman concluded that claimant was entitled to procedural temporary disability benefits commencing July 19, 1995. In awarding these benefits, the ALJ relied on Dr. Puziss' verification that claimant's L4-5 disc condition prevented him from returning to the heavy job he was performing at the time of his injury. (Ex. 17, 32, 35A). We adopt and affirm the ALJ's conclusion and rationale on this issue. In so doing, we have considered Dr. Puziss' "check-the-box" concurrence with Dr. Bergquist's October 9, 1996 report. In that report, Dr. Bergquist took the position that claimant's low back condition has remained medically stationary since claim closure, and the cause of claimant's low

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[3] Tape Recording, House Committee on Labor, March 6, 1995, Tape 46A, Testimony of Representative Mannix, SB 369 Sponsor.

[4] Tape Recording, House Committee on Labor, May 20, 1997, Tape 84, Testimony of Bob Shiprack Co-Chair of Management Labor Advisory Committee (MLAC) and Jan Reece, MLAC member; Tape Recording, House Committee on Labor, June 11, 1997, Tape 91, Testimony of Tom Mattis, Deputy Administrator of the Workers' Compensation Division.

[5] Our recent decision in Paul D. Johansen, 49 Van Natta 2013 (1997), is also distinguishable from the present case. In Johansen, we found that ORS 656.262(7)(c), which requires the claim to be "reopened" for processing if a new medical condition is found compensable "after claim closure," was inapplicable since the claim was nondisabling, and thus had never been closed. Here, in contrast to Johansen, the claim has previously been closed. Therefore, because claimant's "new medical condition" claim has been found compensable (i.e., accepted) after claim closure, the "reopening" requirement of ORS 656.262(7)(c) is applicable. See Ronald D. Smith, Sr., 49 Van Natta 1807 (1997).

back complaints is unknown. (Ex. 36, 37). Claimant's medically stationary status is not relevant to our determination of procedural temporary disability. Moreover, Dr. Puziss' conclusory concurrence is not a sufficient basis for terminating procedural temporary disability benefits given his previous narrative opinions expressly relating claimant's persistent symptoms and work restrictions to the L4-5 disc condition.

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

Penalties

The ALJ assessed a penalty against the insurer for its failure to pay temporary disability benefits. On review, the insurer argues that it acted reasonably in assuming that the claim remained closed in light of our prior decision in Sandra Miles.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time it denies benefits. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Because there was no prior decision holding that procedural temporary disability benefits for conditions accepted after claim closure should be paid under ORS 656.262(4), we find that the insurer had a legitimate doubt regarding its legal liability, and a penalty is not warranted.

ORDER

The ALJ's December 16, 1996 order is affirmed in part and reversed in part. The ALJ's assessment of a penalty is reversed. The remainder of the ALJ's order is affirmed. For services on review regarding the temporary disability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
RANDY B. BAKER, Claimant
WCB Case No. 96-09302
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On November 19, 1997, we reversed that portion of an Administrative Law Judge's (ALJ's) order which held that the SAIF Corporation's denial of claimant's current right median neuropathy condition was precluded and we affirmed those portions of the ALJ's order which alternatively found that SAIF's denial was not an invalid "back-up" denial and that claimant's current condition was not compensable. Challenging the ALJ's reasoning regarding the appropriate statutory compensability standard and the medical evidence, claimant seeks reconsideration of our decision to adopt and affirm the ALJ's conclusion that claimant's current right median nerve condition was not compensable.

In order to further consider claimant's contentions, we withdraw our November 19, 1997 order. SAIF 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
ROBERT P. DAVIS, Claimant
WCB Case No. 96-09138
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's injury claim for a recurrent L4-5 herniated disc condition. On review, the issue is compensability.

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

We do not adopt the next-to-last paragraph of the "Conclusions of Law and Reasoning."

We agree with the ALJ that claimant has carried his burden regarding compensability by establishing that his early May 1996 compensable injury is the major contributing cause of his current need for medical treatment for his L4-5 herniated disc condition. See SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997).

The insurer argues that Dr. Golden's opinion supporting the claim is unpersuasive because it is based on an "assumption" that claimant's initial symptoms were associated with a specific work incident. The insurer also contends that claimant's back condition is not work related because his symptoms began while he was sitting, rather than while lifting. We disagree, for two reasons.

First, claimant credibly testified that he was doing his normal work activities, including lifting 5 by 8 sheets of particle board on May 7, 1996, when he felt a catch in his hip. Later that day, while sitting at his desk (and working), claimant felt the onset of low back and left leg pain which worsened until May 10, 1996, the last day he worked. Accordingly, because the initial symptom, the "catch" in claimant's hip, occurred while claimant was lifting, we find Dr. Golden's history regarding a specific "incident" accurate.

Second, we do not read Dr. Golden's opinion as does the insurer. Although the doctor referred to claimant becoming symptomatic at work at a "specific time," he also reported claimant's history of injuring his back at work "on or about May 10, 1996 and related claimant's need for surgery to his "work activities beginning on May 7, 1996 through May 10, 1996." (Exs. 213, 216).

In our view, Dr. Golden acknowledged both the initial "catch" at a specific time and the subsequent more severe symptoms, including leg pain, which began while claimant was sitting (working), and worsened over the next three work days. Thus, Dr. Golden's history was consistent with claimant's credible reporting. (See Tr. 14-18, Exs. 213-2; 194-4-6). In addition, we note that claimant's more severe symptoms did not begin until after the lifting incident. Dr. Golden reasoned that claimant had worked this job successfully before May 7, 1995 and had no leg symptoms following his 1988 surgery until that day. Under these circumstances, Dr. Golden related claimant's need for treatment for a herniated disc and nerve root compromise to both the initial lifting incident and claimant's subsequent work activities over the next few days. We find nothing inconsistent or illogical about Dr. Golden's reasoning or conclusions.

In addition, we agree with the ALJ that Dr. Reeves' ultimate opinion[1] is persuasive, but the contrary opinions of Drs. Brooks and Coletti are not persuasive because they are less consistent with claimant's history and inadequately explained. Under these circumstances, we rely on the opinions of Drs. Golden and Reeves, treating surgeons, and conclude that claimant has established that his work

[1] Dr. Reeves explained that, although claimant's prior surgery and degenerative disease contributed to his recent herniation, claimant's work activities were the major cause of the herniation, considering those activities and the length of time claimant had been asymptomatic before the 1995 onset of symptoms. (Ex. 219-11-18).

activities (including the May 7, 1995 incident) over a discrete period of time were the major contributing cause of his need for treatment for a herniated L4-5 disc condition. See Nehl on recon at 315; Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

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 June 2, 1997 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
BRIAN P. HANSBERRY, Claimant
WCB Case No. 96-08392
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Poland's order which set aside the insurer's denial of his occupational disease/injury claim for an L5-S1 disc herniation, S1 radiculopathy and lumbosacral neuritis. On review, the issue is compensability.

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

The ALJ determined that claimant had established a compensable occupational disease despite his representation to a private insurance carrier that his low back condition was not work related. On review, the insurer contends that the ALJ incorrectly determined that claimant proved a compensable claim because of claimant's admission that he lied in an attempt to obtain general health insurance benefits. (Tr. 24). The insurer asserts that the fact that claimant was willing to lie to obtain benefits must weigh against his credibility and against the accuracy of the medical opinion that relied on his history.

Despite claimant's admission, we, nevertheless, agree with the ALJ that claimant may still sustain his burden of proving a compensable occupational disease claim.[1] See Taylor v. Multnomah School District # 1, 109 Or App 499, 501 (1991); Mashadda v. Western Employers Insurance, 75 Or App 93, 96 (1985); Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985). Moreover, we agree for the reasons cited by the ALJ that claimant's employment activities were the major contributing cause of his low back condition.[2] Cf. David F. Ierulli, 47 Van Natta 2092, 2093 n. 1

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[1] Board member Bock notes that, given the difficulty in establishing a compensable workers' compensation claim in Oregon, it is understandable that claimant would seek coverage under general health insurance.

[2] Dr. Eikrem, claimant's attending physician, reported that "[claimant] feels that this injury is not work related." (Ex. 12). Although claimant's lay opinion concerning causation may be probative, it is not persuasive when, as here, the claim involves a complex medical question. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). For the reasons the ALJ cited, we rely on Dr. Eikrem's unrebutted opinion that claimant's condition is work related in concluding that claimant has proven a compensable occupational disease.

(1995) (although the claimant initially reported an accident as non work-related to a private insurance carrier, the evidence persuasively established that a compensable injury occurred). Accordingly, we affirm the ALJ's decision to set aside the insurer's denial.[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 concerning the compensability issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 30, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

[3] The insurer contends that, even if we determined that claimant's disc herniation and radiculopathy are compensable, we should still uphold its denial of claimant's lumbosacral neuritis because there is no evidence that this condition is the same as a herniation and radiculopathy. The insurer's contention notwithstanding, we conclude that, based on Dr Eikrem's opinion, lumbosacral neuritis is a diagnosis interchangeable with the diagnosis of radiculopathy which was due to the compensable L5-S1 disc herniation. (Ex. 15). Accordingly, we reject the insurer's argument that claimant's neuritis condition is not compensable.

December 19, 1997 Cite as 49 Van Natta 2141 (1997)

In the Matter of the Compensation of
BEVERLY J. HOTCH, Claimant
WCB Case No. 95-07094
SECOND ORDER ON REMAND
Goldberg & Mechanic, Claimant Attorneys
Ronald Atwood & Associates, Defense Attorneys

On October 2, 1997, we withdrew our September 23, 1997 Order on Remand, which had dismissed this case in light of our August 29, 1997 approval of the parties' Claim Disposition Agreement (CDA). We abated our September 23, 1997 order in response to the insurer's announcement that the parties wished to have the insurer's partial denials reinstated. Having received the parties' stipulation, we proceed with our reconsideration.

Pursuant to the "Stipulation of the Parties," they agree that the insurer's June 2, 1995 denial of claimant's C5-6 and C6-7 disc herniations is reinstated and that claimant's hearing request regarding that denial is dismissed. Consistent with their CDA, the parties further stipulate that claimant retains all rights to medical care for her previously accepted conditions.

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
GERALD K. BURLAGE, Claimant
WCB Case No. 96-06977
ORDER ON REVIEW
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of claimant's low back injury claim. On review, the issues are remand, penalties, timeliness of claim filing, and, if the claim was filed timely, compensability.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's arguments.

Remand

Claimant contends that, because the record is insufficiently developed, the case should be remanded to the ALJ for the taking of additional evidence. We disagree.

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 seeks remand in order to have Exhibit B admitted into the record, to show to whom claimant reported his injury on the day of the incident, and to present evidence regarding the date on which the employer had knowledge of the incident. Regarding all these matters, we find that claimant, who was represented by counsel at the hearing, had ample opportunity to present evidence had he chosen to do so. The points that claimant now wishes to clarify were all apparent on the face of the record well in advance of the hearing. Claimant has not shown that he was unable to marshall evidence or witnesses at the hearing to clarify the points that he raises on review. Nor has claimant shown that he exercised due diligence in trying to obtain evidence on these points prior to the hearing. Claimant was aware, well in advance of the hearing, that the insurer had raised the issue of the timeliness of claim filing. Accordingly, we conclude that claimant has failed to show any compelling basis for remanding this case for the taking of additional evidence. Therefore, claimant's motion for remand is denied.

Timeliness of Claim Filing/Compensability

The ALJ held that claimant's claim was barred under ORS 656.265(4)(a)[1] because the employer did not have knowledge of claimant's injury. The ALJ's holding was based on a finding that claimant informed only a co-worker immediately after the accident on June 16, 1995. The ALJ reasoned that the co-worker's knowledge did not impute knowledge to the employer.

Claimant argues that he also informed a supervisor approximately three hours after the incident. Claimant further argues that he informed the employer approximately one week prior to filing his claim in April 1996. Claimant contends that ORS 656.265(4) sets no time limit within which the employer must have knowledge of the injury. Therefore, since the employer had knowledge of the injury at the time claimant filed the claim, claimant contends that he has satisfied the terms of the statute. The insurer, on the other hand, argues that the employer must have knowledge of the injury within 90 days after the accident.

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[1] ORS 656.265(4) provides:

"Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death[.]"

We need not resolve this issue because, even if the claim was timely, the record does not establish that claimant's low back condition is compensable. We base this conclusion on the following reasoning.

The ALJ held that claimant failed to prove that his low back injury claim is compensable. Claimant contends that Dr. Miller's report is most persuasive and establishes compensability of his claim. We disagree.

To establish compensability of his low back injury claim, claimant relies on the report of Dr. Miller, chiropractor. Dr. Miller, who first examined claimant on November 12, 1996, some 17 months after the incident, found that claimant's examination findings were "consistent with a chronic lumbar strain/sprain."[2] (Ex. 10-2). Dr. Miller also diagnosed "[c]hronic moderately severe compressive lumbosacral disc strain and chronic moderately severe posterior facet joint imbrication sprain/strain," both of which he believes were caused, at least in material part, by the June 16, 1995 elevator incident. (Id.). Dr. Miller explained that "[t]he elevator dropping ten floors and then coming to an abrupt stop resulted in [claimant's] body being compressed toward the elevator floor." Dr. Miller further explained that the compressive force caused excessive disc and facet joint compression, resulting in damage to the diskal material, facet joint cartilage, and capsular ligaments. (Id.).

Dr. Miller's opinion is based on his understanding that the elevator in which claimant was riding "dropped ten floors and stopped on a dime." Dr. Miller further believed that claimant "sustained a full body jolt with his knees buckling when the elevator stopped." (Ex. 10-1). This incident description is considerably more dramatic than was reported by either Dr. Gerry, claimant's initial treating physician, or Dr. Duff, an orthopedist who examined claimant at the insurer's request. (Compare Exs. 2-1, 4-2). It is also more dramatic than claimant's description of the incident at hearing. (See Tr. 40-41). Only Dr. Miller believed that the elevator "dropped" ten floors and that claimant's knees buckled when the elevator stopped. Considering that Dr. Miller's history differs significantly from the other physicians' histories and claimant's own testimony, we are not persuaded that Dr. Miller's opinion is based on an accurate history of the incident. Therefore, we accord his opinion little weight. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we give more weight to those opinions which are both well-reasoned and based on complete information).

Because we do not find Dr. Miller's opinion persuasive, and because we agree with the ALJ that neither Dr. Duff nor Dr. Gerry opined that claimant's low back condition was even materially related to the June 16, 1995 work incident, we conclude that claimant's low back condition is not compensable.

Penalties

Claimant contends that he is entitled to penalties[3] for the insurer's unreasonable conduct in denying this claim. We disagree. Because claimant's claim is not compensable and, therefore, no compensation is due, claimant is not entitled to any penalties. See ORS 656.262(11)(a);[4] Ellis v. McCall Insulation, 308 Or 74, 78 (1989) (no penalty can be assessed when there are no amounts "then due").

ORDER

The ALJ's order dated May 15, 1997 is affirmed.

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[2] Based on this statement by Dr. Miller, we find no error in the ALJ's last finding of fact on page 2 of the Opinion and Order.

[3] Claimant also seeks "damages." Money "damages" are not available under the Workers' Compensation Law.

[4] ORS 656.262(11)(a) provides, in material part:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, * * * the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

In the Matter of the Compensation of
JIMMY R. CAMPBELL, Claimant
WCB Case No. 97-03197
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's injury claim for a partial left rotator cuff tear. On review, the issue is compensability.

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

We find that Dr. Loch was claimant's treating surgeon for this injury. (See Tr. 14-15).

We agree with the ALJ that claimant's torn rotator cuff injury is consistent with his sudden catching of a 300 pound winch bucket at work on October 1, 1996. We also agree that Dr. Loch's opinion relating the shoulder condition to claimant's activities that day (which include catching the winch bucket) is the most consistent with the undisputed mechanism of injury and the onset of claimant's symptoms. Moreover, even if the left shoulder condition is properly characterized as a "combined condition," we would find that claimant satisfied the "major contributing cause" standard under ORS 656.005(7)(a)(B), based on the opinion of Dr. Loch.[1] See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 28, 1997 is affirmed. Claimant is awarded a $1,750 attorney fee for services on review, payable by the insurer.

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[1] We do not find the contrary opinions persuasive because they assume, without explaining, that claimant's preexisting degeneration caused his rotator cuff tear. (See Exs. 11-5, 18, 19-2). Moreover, the examiners' belief that the work incident was a "minor event," a strain which "resolved," is inaccurate. (See Exs. 11-5, 19-5).

In the Matter of the Compensation of
CHRISTINA CASTILLO, Claimant
WCB Case No. 97-01563
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) affirmed an Order on Reconsideration's award of 3 percent (9.6 degrees) unscheduled permanent disability for claimant's lumbar and cervical strain injury; and (2) awarded a $2,000 attorney fee pursuant to ORS 656.382(2). On review, the issues are unscheduled permanent disability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable cervical and lumbar injury on August 8, 1996. The ALJ affirmed the February 18, 1997 Order on Reconsideration's award of 3 percent unscheduled permanent disability based on the cervical range of motion findings in the January 25, 1997 medical arbiters' report.

On review, the employer notes the conclusion of a panel of examining physicians (Drs. Adams and Arbeene), with which the attending physician (Dr. Barish) concurred, that claimant has no evidence of permanent impairment. (Ex. 20-6). The employer also notes Dr. Barish's observation in his closing examination that claimant's cervical and lumbar ranges of motion were "normal." (Ex. 21). Emphasizing the medical arbiters' statement that claimant has no evidence of permanent impairment due to the compensable August 9, 1996 injury (Ex. 35-5), the employer contends that the medical evidence as a whole establishes that claimant does not have permanent disability due to the accepted injury. For the following reasons, we agree with the employer's contention.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Only disability that is due to the compensable injury gives rise to entitlement to an award. ORS 656.214. In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993) (Impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings), aff'd Roseburg Forest Products v. Owen, 129 Or App 442 (1995). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993).

Here, Dr. Barish, the attending physician, reported that claimant's ranges of cervical and lumbar motion were "normal" and that claimant's injury had resolved. (Ex. 21). We find no persuasive reasons not to rely on that opinion. Weiland v. SAIF, 64 Or App 810 (1983).

Although the ALJ gave less weight to Dr. Barish's range of motion findings because he did not specify the instrument used to make his determination, we find no reason to conclude that Dr. Barish's calculations were other than competently made. Moreover, we note that Dr. Barish concurred with the Adams/Arbeene panel who opined that claimant has no evidence of permanent impairment. (Ex. 20-6, 22). Accordingly, we conclude that the medical evidence apart from the medical arbiters' report strongly supports a finding that claimant has no permanent impairment due to the compensable injury.

We acknowledge that the medical arbiters' report documented range of cervical motion less than that set forth in the standards for rating disability. (Ex. 35-3). The employer argues, however, that this report does not establish permanent impairment due to the compensable injury because of the panel's overall conclusion that claimant did not have evidence of permanent impairment due to the accepted injury. (Ex. 35-5). We agree, particularly in light of the opinions of Dr. Barish and the IME panel with whom Dr. Barish concurred.

Accordingly, we conclude that claimant has not satisfied her burden of proving that she has permanent impairment due to the compensable injury. ORS 656.266. We, therefore, reverse the ALJ's decision to affirm the reconsideration order's award of unscheduled permanent disability.

Finally, because the employer's request for hearing and request for review have ultimately resulted in the disallowance of claimant's compensation in the reconsideration order, claimant's attorney is not entitled to an assessed fee for services at hearing or on review. ORS 656.382(2). It follows that the ALJ's attorney fee award must also be reversed.

ORDER

The ALJ's order dated June 11, 1997 is reversed. In lieu of the Order on Reconsideration's award of 3 percent (9.6 degrees) unscheduled permanent disability, claimant is awarded no permanent disability for her cervical and low back injury. Claimant's attorney fee award is also reversed.

December 19, 1997 Cite as 49 Van Natta 2146 (1997)

In the Matter of the Compensation of
ELIZABETH NIMMO-PRICE, Claimant
WCB Case No. 95-00779
ORDER ON RECONSIDERATION
Gatti, Gatti, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On September 19, 1997, we withdrew our August 21, 1997 Order on Review that had: (1) 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; (2) 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); (3) affirmed an ALJ's $1,750 attorney fee award for the employer's "pre-hearing" acceptance of a headache and post-concussion syndrome; (4) modified the ALJ's $3,000 attorney fee award to $2,300; and (5) awarded a $1,200 attorney fee for claimant's counsel's services on Board review. We abated our decision in response to the employer's announcement that the parties had settled their dispute.

When no settlement was forthcoming, the Board's staff counsel contacted the parties' counsels to determine the current status of this case. In response, the employer's counsel advised that the parties' settlement had been finalized. However, rather than submitting the settlement for our consideration (see OAR 438-009-0015(5)), the employer's counsel stated that "the reconsideration process should be dismissed and the Order on Review of August 21, 1997 affirmed."

In light of such circumstances, we interpret the employer's position to be that it has withdrawn its motion for abatement and reconsideration of our August 21, 1997 order. Based on this interpretation, we republish our August 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
JOHN G. GESNER, Claimant
WCB Case No. 97-01547
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that increased claimant's scheduled permanent disability award for loss of use or function of the left foot from 3 percent (4.05 degrees), as awarded by an Order on Reconsideration, to 8 percent (10.8 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured his left ankle on August 8, 1995. SAIF accepted a nondisabling left ankle sprain on August 24, 1995. Claimant's left foot pain did not subside, and he was later diagnosed with lateral sesamoiditis of the left foot. The claim was reclassified as disabling. On February 23, 1996, Dr. Gallagher performed an excision of the lateral sesamoid. The removed lateral sesamoid appeared necrotic.

On September 18, 1996, Dr. Gallagher declared claimant medically stationary. Dr. Gallagher found no impairment of function but noted that claimant continued to have pain of the left foot. The claim was closed by a November 7, 1996 Determination Order awarding temporary disability only.

Claimant requested reconsideration and a medical arbiter examination. On January 3, 1997, claimant was evaluated by Dr. Scheinberg, serving as medical arbiter. Dr. Scheinberg found reduced motion in the left ankle and left great toe. He also reported, among other things, that he observed "[n]o obvious sensory abnormality" although claimant reported a slight feeling of somewhat decreased sensation over the entire plantar surface of his left foot.

On February 7, 1997, an Order on Reconsideration issued awarding claimant 3 percent scheduled permanent disability based upon the arbiter's findings of decreased range of motion in claimant's great toe and left ankle.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant asserted that, based on the medical arbiter's report, he was entitled to additional scheduled permanent disability for loss of sensation in his left foot. The ALJ agreed, and awarded claimant 5 percent for partial loss of sensation under OAR 436-035-0200.

On review, SAIF argues that the ALJ erred in awarding claimant 5 percent for loss of sensation in the left foot because there were no "objective findings" in that regard. Specifically, SAIF argues that the medical arbiter's notation that claimant "has a slight feeling of somewhat decreased sensation" over the plantar surface of the left foot is a subjective finding that is not reproducible, measurable or observable, as required by ORS 656.005(19). We agree.

ORS 656.283(7) requires that "any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings." See also ORS 656.726(3)(f)(B) ("Impairment is established by a preponderance of medical evidence based upon objective findings."); OAR 436-035-0010 ("all disability ratings * * * shall be established on the basis of medical evidence that is supported by objective findings"). ORS 656.005(19) defines objective findings as "verifiable indications of injury or disease." The statute further provides that "'objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In Tony D. Houck, 48 Van Natta 2443 (1996), we examined 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 a physician's mere adoption of a worker's complaint of pain does not constitute an objective finding,[1] a physician's interpretation of a worker's verifiable subjective response to clinical testing can be an objective finding, provided it was "reproducible, measurable or observable." 48 Van Natta at 2448-49. We also observed that the requirements of "reproducible, measurable or observable" are expressed in the disjunctive, rather than the conjunctive. Thus, meeting any one of these requirements is sufficient to support a finding of "objective findings."

Because the claimant in Houck responded positively to clinical tests used in diagnosing his bilateral carpal tunnel syndrome and left epicondylitis conditions (including Tinel's and Phalen's tests and clinical testing involving resisted extension and flexion of the wrist), we concluded that claimant's positive responses constituted verifiable subjective responses to pain that were "reproducible" and came within the definition of "objective finding." Id. at 2449. We specifically noted that the Phalen's and Tinel's test results were "reproducible" because claimant had positive results on a series of tests, conducted at various times in different examinations. Id. at 2444, n.4.

In this case, with regard to claimant's sensation, the medical arbiter reported as follows:

> "Sensory testing to pinwheel is, in my opinion, normal except that [claimant] has a slight feeling of somewhat decreased sensation over the entire plantar surface of the left foot compared to the right, except for the plantar surface of the toes where he perhaps has some increase perception of sensation on the left compared to the right." (Ex. 14-4.)

In responding to the specific question concerning sensation loss, the arbiter indicated: "No obvious sensory abnormality was observed. Please see body of report for findings." (Ex. 14-5.)

Obviously, the results of a pinwheel test over the plantar surface of the foot are dependent upon a claimant's subjective response. If, however, the record shows that the results were "verifiable indications of injury" which were "reproducible," then the subjective responses reported by the medical arbiter can constitute objective findings under ORS 656.005(19). See Tony D. Houck, 48 Van Natta at 2449.

Contrary to Tony D. Houck, the record in this fails to establish that claimant's subjective responses to the pinwheel test constitute verifiable indications of injury. Because the record does not indicate whether claimant reported feeling a loss of sensation on more than one occasion (or whether the medical arbiter repeated the pinwheel testing a number of times during his examination), we are not persuaded that this finding is "reproducible."[2] Furthermore, considering the arbiter's comment that no obvious sensory abnormality was observed, we also cannot find that claimant's subjective responses regarding decreased sensation were "measurable" or "observable." Compare Donald L. Grant, 49 Van Natta 250 (1997) (findings of an antalgic gait and pain centered over the plantar medial heel are verifiable indications of injury which are observable); Michael J. Coomer, 49 Van Natta 247 (1997) (findings of reduced range of motion are measurable and observable). Consequently, we conclude that claimant failed to prove a loss of plantar sensation in the left foot by medical evidence supported by objective findings.

ORDER

The ALJ's order dated June 11, 1997 is reversed. The Order on Reconsideration, awarding 3 percent (4.05 degrees) scheduled permanent disability for the left foot, is reinstated and affirmed.

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[1] See Jairo J. Garcia, 48 Van Natta 235 (1996) (a physician's indication that the worker experiences pain, standing alone, is not sufficient to constitute "objective findings" under ORS 656.005(19) as amended).

[2] Indeed, Dr. Gallagher, claimant's treating physician, found normal sensation to light touch throughout the left foot and toes. (Ex. 10).

In the Matter of the Compensation of
ROY HAKANSON, Claimant
Own Motion No. 97-0069M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cole, Cary & Wing, Claimant Attorneys

Claimant requests review of the self-insured employer's August 29, 1997 Notice of Closure that closed his claim with an award of temporary disability compensation from September 29, 1996 through August 7, 1997. The employer declared claimant medically stationary as of August 7, 1997. Claimant contends that he is entitled to additional benefits because he was not medically stationary regarding additional consequential conditions when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 29, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

In an October 28, 1997 letter, we requested the employer to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on November 5, 1997; however, no further response has been received from claimant. Therefore, we will proceed with our review.

On May 14, 1990, claimant sustained a compensable disabling low back strain injury. Claimant's aggravation rights on that claim expired on November 26, 1995. Subsequently, on September 23, 1996, claimant underwent bilateral L5-S1 hemilaminotomies and microdiskectomies performed by Dr. Kitchel. As a result of that surgery, claimant's claim was reopened by our March 17, 1997 Own Motion Order. On August 25, 1997 and August 29, 1997, the employer issued claimant a "Modified Notice of Acceptance" and an "Updated Notice of Acceptance at Closure," respectively. Both of those documents listed claimant's accepted conditions as a "disabling low back strain" and "disabling L5-S1 herniation." The employer closed claimant's own motion claim with an August 29, 1997 Notice of Closure, which is the subject of the present case.

In requesting that the Board review the employer's closure, claimant contended that his claim was prematurely closed, stating "[t]here are additional consequential conditions the insurer [sic] has yet to accept or address their medically stationary status." We agree that, in order for claimant's condition to be medically stationary, all compensable conditions must be medically stationary. Rogers v. Tri-Met, 75 Or App 470 (1985); Paul E. Voellar, on recon 42 Van Natta 1962 (1990). However, the Board in its own motion jurisdiction does not have authority to determine compensability of any condition, including consequential conditions. ORS 656.278; Charles C. Day, 49 Van Natta 511 (1997); Bonnie L. Turnbull, 49 Van Natta 139, on recon 49 Van Natta 470 (1997); Gary L. Martin, 48 Van Natta 1802 (1996).

Here, the record indicates that the employer has accepted only a disabling low back strain and disabling L5-S1 disc herniation as part of this claim. On the other hand, the record also indicates that claimant has neurogenic bladder and bowel conditions. If claimant believes that these conditions, or any other condition, has been incorrectly omitted from the employer's notice of acceptance, he must first notify the employer of his objections in writing.[1] ORS 656.262(6)(d). The employer has 30 days from

[1] We note that the employer's "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" both stated that claimant must communicate any concerns about those acceptances to the employer's claims processing agent in writing within 30 days from the date of those notices. To the extent that this notation of a "30 day" period attempts to establish a "deadline" limiting the period of time within which claimant may object to the notices of acceptance, it should be noted that ORS 656.262(6)(d) explicitly states that "[n]otwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time." (Emphasis added).

receipt of this written communication to revise or otherwise make a written clarification of its acceptance. Id. If the employer denies compensability of the disputed condition, claimant may appeal that denial to the Hearings Division for initial determination of compensability by an Administrative Law Judge (ALJ). ORS 656.283.

Claimant does not identify the "additional consequential conditions" that he contends are compensable and not yet medically stationary. Presumably, claimant is referring to the neurogenic bladder and bowel conditions. However, there is no evidence that the employer has accepted, either voluntarily or through a litigation order, any additional consequential conditions or that claimant is pursuing compensability of any such conditions. Therefore, on this record, the only accepted/compensable conditions are the disabling low back strain and disabling L5-S1 disc herniation identified in the employer's notices of acceptance.

Moreover, Dr. Kitchel opined that claimant had "reached maximum medical improvement as of 8/7/97" regarding his low back surgery. (Dr. Kitchel's August 7, 1997 chart note). Dr. Kitchel's opinion is unrebutted. Furthermore, although Dr. Kitchel did not mention claimant's neurogenic bladder and bowel conditions, as addressed above, to date, those conditions have not been claimed to be a component of claimant's compensable low back condition.

Consequently, 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 employer's August 29, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
TOUMNGEUN CHANTHANOUVONG, Claimant
WCB Case No. 97-01654
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that awarded a $1,975 attorney fee for claimant's counsel's services in obtaining a pre-hearing rescission of the insurer's denial of claimant's right shoulder injury claim. On review, the issue is attorney fees.

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

The insurer focuses its arguments on the "hourly rate" used by claimant's attorney in his statement of services and argues that the rate "does not square with the market." The insurer does not contend, however, that the fee is unreasonable based on an application of the factors set forth in OAR 438-015-0010(4).[1]

The ALJ, in this case, applied the factors identified by the rule and determined that the fee was reasonable. Specifically, the ALJ noted the favorable result secured for claimant, the significant benefits secured for claimant, the skill and experience of the attorneys and the risk that claimant's attorney's efforts might go uncompensated. The ALJ also considered the amount of time claimant's attorney spent

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[1] 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.

on the case and noted that the attorney filed a hearing request, prepared for hearing and obtained a written medical report on claimant's behalf. After our "de novo" review of the record, we agree that the attorney fee is reasonable under the factors set forth in OAR 438-015-0010(4). Finally, we do not award an attorney fee for claimant's counsel's services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 2, 1997 is affirmed.

December 22, 1997 Cite as 49 Van Natta 2151 (1997)

In the Matter of the Compensation of
LARRY A. GREENWALT, Claimant
WCB Case No. C703074
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Parker, Bush & Lane, Claimant Attorneys
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On December 12, 1997, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his or her compensable injury. We approve the proposed disposition.

The first page of the agreement has been amended to provide for a partial release of temporary disability. In addition, the language in the body of the document, on page 3, number 13, providing that claimant has released his rights to temporary disability has been deleted by interlineation. These changes to the CDA were not initialed by the parties or their attorneys. Additionally, claimant's attorney's cover letter provides that "claimant's right to time loss is not released, as agreed by the parties," with a copy to the insurer's attorney.

Under these circumstances, we find that it is the parties' intention that claimant's rights to temporary disability be retained.

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 $700, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ELDA E. JENKINS, Claimant
WCB Case No. C703110
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorneys
Darren W. Lee, Defense Attorney

On December 11, 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.[1]

The first page of the agreement originally provided for a "full" release of penalties and attorney fees. However, the full release has been deleted by interlineation, and the agreement now provides for a "partial" release. Additionally, on page 2, line 24, attorney fees and penalties have been deleted from the list of benefits claimant is releasing under the CDA. Claimant, her attorney and the insurer's attorney have initialed this change. In addition, attached to the CDA is an addendum which provides that the "terms of the CDA do not include attorneys fees or penalties associated with any act, or failure to act, occurring only after the day the Board received this agreement; and attorney fees permitted or awarded by this agreement itself." The addendum has been signed by claimant's attorney, but fails to provide the signature of the insurer's counsel. The amended CDA was accompanied by a cover letter which was signed by the insurer's attorney.

Based on his signature on the cover letter forwarding the CDA and addendum to the Board, we conclude that the insurer's counsel approved the CDA as amended. Thus, we find that the CDA provides for only a partial release of penalties and attorney fees as provided in the addendum to the CDA.

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 $50, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

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[1] The CDA originally provided for a total consideration to claimant of $500 with no attorney fee. However, the agreement has been amended by interlineation to provide for a $450 payment to claimant and a $50 attorney fee for a total consideration of $500. Claimant, her attorney and the insurer's attorney have approved the changed amounts by initialing the changes.

In the Matter of the Compensation of
GENEVA A. JOHNSON, Claimant
WCB Case No. 97-00949
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) Hoguet's order that upheld the insurer's partial denial of claimant's current left knee condition. On review, the issue is compensability.

We adopt and affirm with the following supplementation.

After the ALJ's order issued, the court decided SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997), in which it clarified the standard of proof required under ORS 656.005(7)(a)(B)[1] regarding combined condition claims. Specifically, the court determined that a claimant need not establish that the compensable injury is the major contributing cause of the entire combined condition; instead, the claimant need only establish that the compensable injury is the major contributing cause of the need for treatment of the combined condition to establish compensability of the combined condition. 149 Or App at 312, 314-15. In making this determination, the court held that "the extent of [a] 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." Id. at 312. The court also explained that "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." Id. at 313 (emphasis in the original; citation omitted).

Under this standard, claimant's combined condition claim fails. As the ALJ found, there is no dispute that claimant's compensable left knee medial meniscus tear combined with her preexisting left knee degenerative osteoarthritis condition. Thus, ORS 656.005(7)(a)(B) applies to determine compensability of the combined condition.

For the reasons given by the ALJ, we find that Dr. Treible, treating surgeon, provided the most persuasive medical opinion regarding the major contributing cause of the need for treatment of claimant's combined condition. Dr. Treible opined that the major contributing cause of claimant's need for treatment (consisting of a left total knee arthroplasty) is her preexisting degenerative osteoarthritis, with the injury estimated to contribute only one percent to her need for treatment. (Exs. 20, 23, 29, 39).

Although claimant urges us to rely on the opinion of Dr. Manley, M.D., we agree with the ALJ that Dr. Manley's opinion is unpersuasive. Dr. Manley appears to minimize the extent of claimant's preexisting degenerative osteoarthritis, noting that it had been "very slowly progressing" and "had not been something severe" prior to the injury. (Exs. 37, 38-2). However, Dr. Treible observed advanced degenerative changes in the left knee during the arthroscopy he performed for the compensable medial meniscus tear, a procedure that occurred less than two weeks after the work injury. (Exs. 13, 29). Moreover, Dr. Manley appeared unaware of the opinion of Dr. Neufeld, claimant's prior treating physician, who had found it likely in January 1991 that claimant would need a left total knee arthroplasty within a year due to her severe degenerative arthritis. (Exs. 6B-2, 37, 38). In addition, Dr. Manley presumes that claimant sustained injuries in addition to the compensable medial meniscus tear during her work injury. (Exs. 37-2, 38-2). However, Dr. Treible denies this, finding that the arthroscopy documented only a medial meniscus tear as a result of the work injury. (Ex. 39).

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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."

As the treating surgeon, Dr. Treible was in a better position to determine both the extent of claimant's degenerative osteoarthritis and the nature of claimant's injury, having observed them both first hand during the arthroscopy. Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988) (opinion of worker's treating surgeon entitled to particular deference).

On review, claimant also argues that she is entitled to the left total knee arthroplasty pursuant to ORS 656.225.[2] However, it is not apparent that claimant raised this issue at hearing. Instead, the sole issue at hearing was compensability of claimant's current left knee condition, with the focus being on the combined condition aspect of the left knee. (Tr. 1-2, Ex. 38). To the extent that claimant raises a new issue on review, we are not inclined to address it. Fred Meyer, Inc. v. Hofstetter, 151 Or App 21 (1997) (Board did not abuse its discretion in refusing to consider an issue first raised on Board review).

Nevertheless, even if we were to address claimant's argument, we would conclude that claimant failed to meet her burden of establishing the prerequisite under ORS 656.225 -- that the work injury was the major contributing cause of a pathological worsening of the preexisting degenerative osteoarthritis. ORS 656.266. As we concluded above, Dr. Manley's opinion is not persuasive. Furthermore, although Dr. Treible makes a statement that the work injury hastened claimant's need for a total knee arthroplasty, neither that statement, nor any other statement from Dr. Treible supports a finding that the work injury is the major contributing cause of a pathological worsening. (Ex. 29). Instead, Dr. Treible's opinion is to the contrary, i.e., the work injury contributed only 1 percent to claimant's overall need for a total knee arthroplasty. (Ex. 39). Thus, claimant's claim would also fail if we applied ORS 656.225. See also Anne M. Walker, 49 Van Natta 600 (1997) (where the current condition is a "combined condition," ORS 656.225 is not germane); Paul E. Hargreaves, 48 Van Natta 1676 (1996) (same).

ORDER

The ALJ's order dated May 21, 1997 is affirmed.

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[2] 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) * * *, and not merely as an incident to the treatment of a compensable injury or occupational disease."

In the Matter of the Compensation of
MEL I. LOWERY, Claimant
WCB Case No. C702851
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Richard Walsh, Claimant Attorney
Reinisch, et al, Defense Attorneys

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

As originally submitted, the first page of the CDA provided for a $500 payment to claimant and a $500 attorney fee for a total consideration of $1,000. The body of the CDA provided that, in addition to the $1,000 lump sum payment, part of the consideration for the agreement was the carrier's waiver of its $1,664 overpayment.

On November 19, 1997, we wrote the parties to request an addendum to the CDA. Our letter noted that since the offset cannot constitute consideration, the CDA's total consideration should be reduced and that as drafted, the attorney fee would be considered in excess of the Board's administrative rule regarding attorney fees. See OAR 438-015-0052(1). Therefore, we requested that the attorney fee be either modified to comply with the rule or the agreement supplemented to include extraordinary circumstances to warrant an extraordinary attorney fee.

On December 16, 1997, the Board received the parties' addendum to the agreement which provided that claimant's attorney should receive an attorney fee of $250. We interpret the addendum as amending the first and fourth pages of the original CDA to provide for a total consideration of $1,000, less a $250 attorney fee.

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 $250, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

December 22, 1997 Cite as 49 Van Natta 2155 (1997)

In the Matter of the Compensation of
REBECCA S. MOAR, Claimant
WCB Case No. 96-05474
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for a right wrist and hand condition; and (2) assessed a penalty for its allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Facts," with the following exception and modification.

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

Madalene Anderson is a nurse practitioner, not a physician.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found claimant's right wrist and hand condition compensable, based on the opinion of Dr. Nash. We agree and adopt his opinion in this regard, with the following supplementation.

Drs. Nash and Thomas observed that, although claimant has some nerve conduction delay in her asymptomatic left wrist, she only has motor nerve slowing in her right wrist. The doctors' conclusion that claimant's "right only" motor nerve slowing supports the work-connected etiology of her right wrist and hand condition is uncontradicted. (See Exs. 11, 13). On this evidence, as well as that set out by the ALJ, we find that the opinions of Drs. Nash and Thomas are well-reasoned and based on the most complete histories. Accordingly, based on these opinions, we agree with the ALJ that the claim is compensable.

Penalties

The ALJ concluded that as of the date of its denial the insurer had no legitimate doubt about its liability for claimant's right hand and wrist condition, based on a finding that the only evidence regarding causation at that time clearly related claimant's condition to her repetitive hand activities for the employer. We disagree.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). A carrier's "refusal to pay is not unreasonable if it has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc., v. Porras, 103 Or App (1990).

Because this case has always been an occupational disease claim, we find that the insurer was aware that claimant needed to establish that her work activities contributed more to her condition than all other causes combined (including the identified noncompensable potential contributor, diabetes). We further find that the insurer was aware of Nurse Practitioner Anderson's opinions ascribing claimant's right hand and wrist condition to her work activities and her opinion that claimant's diabetes was a possible or "undetermined" contributor, when the denial issued. (See Exs. 4, 5). Because diabetes was implicated as a potential contributing cause (and considering the applicable standard of proof), we conclude that the insurer had a legitimate doubt regarding its liability at the time of the denial. See Lauri A. Terrell, 46 Van Natta 2273 (1994) (Where the insurer had a medical opinion implicating the claimant's preexisting condition and was aware that the claimant would probably be subject to the major contributing cause standard, it had a legitimate doubt regarding its liability for the claim); Diane C. Marquardt, 46 Van Natta 980, 982 (1994) (Where the insurer had information before it suggesting that claimant's condition might be related to noncompensable causes, the insurer had a legitimate a doubt as to its liability). Accordingly, we reverse the ALJ's penalty assessment.

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

ORDER

The ALJ's order dated May 21, 1997, as reconsidered June 20, 1997, is reversed in part and affirmed in part. That portion of the order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review regarding the compensability issue, claimant is awarded a $1,000 attorney fee, payable by insurer.

In the Matter of the Compensation of
ROBERT M. NEILSON, Claimant
WCB Case No. 96-07438
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) declined to award an attorney fee pursuant to former ORS 656.386(1); and (2) dismissed his request for hearing. On review, the issues are dismissal and attorney fees.

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

Relying on our decision in Shannon E. Jenkins, 48 Van Natta 1482 (1996), the ALJ dismissed claimant's request for hearing after concluding that claimant's February 26, 1996 request for hearing did not satisfy the "written communication" requirements of ORS 656.262(6)(d).

Pursuant to ORS 656.262(6)(d),[1] a worker with an accepted claim is required to first present his written objections to the notice of acceptance to the carrier and allow 30 days for a response before the worker requests a hearing. Merely filing a hearing request alleging a "de facto" denial does not satisfy the "communication in writing" prerequisite in ORS 656.262(6)(d), because the communication must precede the hearing request. Shannon E. Jenkins, 48 Van Natta 1482 (1996), aff'd mem Jenkins v. Continental Baking Co., 149 Or App 436 (1997). Accordingly, under such circumstances, the worker is precluded from proceeding to hearing on the issue of "de facto" denial. 48 Van Natta at 1484, 1486.

Here, claimant had an accepted claim for a right cervical strain. All benefits were paid and the claim was closed on October 2, 1995. Claimant made no written communication to the insurer objecting to the fact that his closed head injury-concussion, thoracic sprain and occipital headaches conditions were not included in the Notice of Acceptance. Instead, on February 26, 1996, claimant requested a hearing alleging a "de facto" denial of those conditions. On August 9, 1996, claimant submitted another request for hearing alleging a "de facto" denial of the same conditions, with a cover letter contending that the February 26, 1996 hearing request served as his "written communication" under ORS 656.262(6)(d) manifesting his objection to the scope of the insurer's Notice of Acceptance and that the August 8, 1996 hearing request was a request for hearing on the alleged "de facto" denial. On August 23, 1996, the insurer expanded its Notice of Acceptance to include the closed head injury-concussion, thoracic sprain and occipital headaches conditions.

We have previously rejected the contention that an initial hearing request alleging a "de facto" denial in a series of hearing requests making the same allegation satisfies the "written communication" requirement in ORS 656.262(6)(c). Carl L. Gruenberg, 49 Van Natta 750 (1997) (holding that none of a series of hearing requests alleging a "de facto" denial would satisfy ORS 656.262(6)(c); to hold otherwise would thwart the legislative intent of ORS 656.262(6)(c)); see also Ronald M. James, 49 Van Natta 1994 (1997).

In addition, even if claimant's attorney's August 9, 1996 letter was a "written communication," there is no evidence that the insurer denied the claim. See Jerome M. Baldock, 48 Van Natta 355, aff'd mem 143 Or App 360 (1996) (where there has been no refusal to pay compensation, no express denial of a claim, and no questioning of causation by the carrier, no "denied claim" has been established; therefore, no attorney fee may be awarded under former ORS 656.386(1)).[2]

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[1] ORS 656.262(6)(d) was not amended by the 1997 legislature and provides:

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

[2] Former ORS 656.386(1) provides, in relevant part:

"In all cases involving denied claims where a claimant finally prevails against the denial * * * in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or the board shall allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed. 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 is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

Although ORS 656.386(1) was amended by the 1997 Legislature, the revisions that went into effect on July 25, 1997 were not made retroactive and are therefore not applicable to this case. See Stephenson v. Meyer, 150 Or App 300, 304 n.3 (1997) (noting that the 1997 revisions to ORS 656.386(1) were not made retroactive).

To the contrary, the evidence indicates that claimant's attorney provided notice to the insurer on August 12, 1996 that he was making a written communication in accordance with ORS 656.262(6)(d) in which he asserted that the closed head injury-concussion, thoracic sprain and occipital headaches should be included in the scope of acceptance, along with a letter from claimant's attending physician stating that claimant's employment was the major cause of those conditions. These conditions were accepted on August 23, 1996. (Ex. 14). Accordingly, there had been no "denied claim" as that term is defined in former ORS 656.386(1) that would support an attorney fee award.

ORDER

The ALJ's order dated October 17, 1996 is affirmed.

December 22, 1997 Cite as 49 Van Natta 2158 (1997)

In the Matter of the Compensation of
EFREN QUINTERO, Claimant
Own Motion No. 97-0288M
OWN MOTION ORDER ON RECONSIDERATION
Robert E. Nelson, Claimant Attorney
David L. Bussman, Defense Attorney

The insurer requested reconsideration of our October 6, 1997 Own Motion Order, as reconsidered on December 2, 1997, in which we authorized the reopening of claimant's claim for the payment of temporary disability compensation. In its request for reconsideration, the insurer disagrees with our findings that, although willing to work, claimant was unable to work due to his compensable low back injury. Alternatively, the insurer requests that we refer the case for a hearing to develop the record regarding the work force issue.

The insurer's arguments regarding the work force issue were adequately addressed in our initial October 6, 1997 order, as reconsidered on December 2, 1997. Accordingly, we decline to alter this portion of our prior decision.

With respect to the insurer's request to refer this matter for a hearing, we acknowledge our authority to refer disputes to the Hearings Division for fact finding. See OAR 438-012-0040(3). Such actions are normally taken when the disputes are directly attributable to a witness' credibility or reliability (there is a need to develop testimonial and documentary evidence), or when the factual record is insufficiently developed to permit the Board adequate and proper review. See e.g. Charles Tedrow, 48 Van Natta 616 (1996).

Here, the insurer argues that claimant's affidavit presents an issue of claimant's credibility and reliability. In support of this argument, the insurer notes that claimant states in his affidavit that he is unable to write; however, he submitted a hand written letter dated October 12, 1997. We do not find that these circumstances present any credibility or reliability issues. In this regard, in a January 23, 1989 report, Dr. Hoeflich, M.D., from Providence Disability Prevention Services, stated that claimant was "unable to read anything but can write his name." We also note that the text of the letter is obviously not the same handwriting as the signature on the letter. Both of these factors support claimant's statement that, although he is able to sign his name he is unable to read or write Spanish or English. Therefore, we do not find that claimant's affidavit presents an issue of his credibility or reliability that would necessitate a fact finding hearing. Moreover, because we consider the record to be adequately developed, we need not refer this matter to another forum for taking of further evidence. See Jeffrey T. Knudson, 48 Van Natta 1708 (1996); Frank L. Bush, 48 Van Natta 1293 (1996); Gary A. Toedtemeier, 48 Van Natta 1014 (1996). Consequently, we deny the insurer's request for a fact finding hearing.

Accordingly, withdraw our prior order. On reconsideration, as supplemented herein, we adhere to our October 6, 1997 Own Motion Order, as reconsidered on December 2, 1997. The parties' rights of appeal shall begin to run from the date of the order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH A. RICHTER, Claimant
WCB Case Nos. 95-12885, 95-10305, 95-11168 & 95-11170
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Lundeen, et al, Defense Attorneys
James B. Motley (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Referee Hoguet's order that upheld the SAIF Corporation's denial of his aggravation claim for a C6-7 disk herniation. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a 34-year old male, has an accepted claim for a right shoulder contusion and cervicothoracic strain which he sustained while working as an edger operator for SAIF's insured on March 16, 1993. This injury occurred when claimant slipped while running up some steps to return to his work station. Claimant fell into the end of the metal handrail on the steps, hitting his right upper chest and then falling backwards onto his back/buttocks. The documented complaints and findings at the time of this injury included pain in the right anterior and posterior shoulder area, cervicothoracic pain and muscle tension, reduced cervical motion, and increased sensation in the cervical area. After a short period of light duty, claimant returned to his regular duties. He received chiropractic treatment from Dr. Zapf through April 1993. By this time, claimant's symptoms had markedly improved, and the claim was closed without permanent disability.

Claimant continued working for SAIF's insured as an edger operator. He received no further treatment for his neck, back, shoulder or right arm/hand until August 1994, when he sustained a separate work injury to his right hand. Dr. Gray, D.O., provided conservative treatment for a brief period. Claimant then returned to a less physically demanding job for the employer as an oiler. Claimant worked in this capacity until he left his employment with SAIF's insured in March 1995.

Claimant received no further medical treatment for his neck, back, shoulder or right arm/hand until May 15, 1995. On that date, claimant sought treatment from Dr. Gray for right upper extremity symptoms associated with a brief period of hand sanding activity for a different employer. Claimant's documented complaints and findings at that time included cervical spasm, right shoulder pain, and numbness and pain in the right elbow. In the latter part of May 1995, claimant also developed severe right arm pain, followed by right triceps weakness and atrophy, and numbness in the right index finger. Dr. Bergquist, neurosurgeon, evaluated claimant on referral from Dr. Gray.

Dr. Brett, neurosurgeon, assumed responsibility for claimant's care in January 1995. A cervical MRI on August 14, 1995 demonstrated a right C6-7 disk herniation effacing the thecal sac. Cervical x-rays taken on January 29, 1996 demonstrated multi-level degenerative disk disease with disk space and neural foramina narrowing. Dr. Brett performed an anterior cervical discectomy and fusion at C6-7 in February 1996.

Claimant filed a claim for this C6-7 disk herniation as an aggravation of his March 1993 injury claim. Dr. Quarum, M.D., and Dr. Fuller, orthopedic surgeon, examined claimant for SAIF in November 1995 and February 1996, respectively. SAIF issued a denial of the aggravation claim on September 7, 1995.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the medical record did not establish a compensable relationship between claimant's C6-7 disk herniation and his March 1993 injury with SAIF. The ALJ relied on the opinions of Dr. Gray, the initial treating physician, Dr. Bergquist, the consulting neurologist, and Drs. Quarum and Fuller, who examined claimant for SAIF. These medical experts opined that there was no causal relationship between the disk herniation and the March 1993 injury.

The ALJ rejected the contrary opinion of Dr. Brett, the treating neurosurgeon, and Dr. Zapf, the treating chiropractor. Drs. Brett and Zapf related the disk herniation to the March 1993 injury. The ALJ reasoned that Dr. Brett's opinion was unsupported by reference to specific medical records and demonstrated "an element of advocacy/leaping to conclusion." The ALJ discounted Dr. Zapf's opinion because it was conclusory and equivocal, Dr. Zapf only provided treatment for a brief period in 1993, and he had no special expertise in evaluating disk herniations.

On review, claimant argues that the ALJ did not articulate a legally sound basis for discounting the opinion of Dr. Brett. Claimant further contends that the contrary opinions of Drs. Fuller, Quarum, Gray and Bergquist are inconsistent and assume an inaccurate history.

We affirm the ALJ's ultimate decision based on the following alternative analysis.

The causation issue in this case is a complex medical question that must be resolved with expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). In evaluating competing medical opinions, special deference is generally given to the opinion of a treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983).

We decline to defer to the opinion of Dr. Zapf for the reasons given by the ALJ. We do not, however, rely on the opinions of Drs. Gray and Fuller. Dr. Gray was unable to reach an opinion after being given an accurate history of the March 1993 injury. Dr. Fuller was disinclined to accept that claimant sustained a cervicothoracic strain in March 1993.

We, instead, conclude that Drs. Quarum and Bergquist provide a persuasive basis for discounting Dr. Brett's opinion. Drs. Quarum and Bergquist explained that Dr. Brett's opinion is not consistent with the documented medical record in this case, including: the absence of radicular or neurological findings in March 1993; the fact that claimant's symptoms at that time are explained by the accepted shoulder contusion and cervicothoracic strain; and the absence of ongoing and/or progressive symptoms between May 1993 and May 1995. Drs. Quarum and Bergquist also explained why Dr. Brett's operative finding of fibrosis does not establish that the disk was injured in March 1993. In addition, the opinion of Drs. Quarum and Bergquist is consistent with the presence of multi-level degenerative changes in claimant's cervical spine.

Moreover, we are not persuaded that Drs. Quarum and Bergquist relied on an inaccurate history. Both doctors adhered to their opinion after reviewing a complete description of claimant's symptoms, findings and diagnoses at the time of the March 1993 injury. Furthermore, claimant's testimony and the contemporaneous documentary record are consistent with the assumption of Drs. Quarum and Bergquist that claimant has not had ongoing and/or progressive symptoms since the March 1993 injury.

Accordingly, based on the medical record as a whole, we conclude that claimant has not established that his March 1993 injury is either a material or the major contributing cause of his C6-7 disk herniation.

ORDER

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

In the Matter of the Compensation of
RUSTEE R. ST. JEAN, Claimant
WCB Case No. 97-02228
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) Mongrain's order that declined to award interim compensation. On review, the issue is interim compensation.

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

On February 13, 1997, the insurer received notice of claimant's claim for an October 3, 1996 injury and for an occupational disease arising out of her work activity as a waitress. In addition to this notice of claim, the insurer also received a copy of a letter, signed by Dr. Anderson and addressed "to whom it may concern", stating that claimant had two prior hospitalizations for severe back strain, that she will be unable to continue working as a waitress because of her back and that she will need retraining for a less strenuous position because of her chronic back problem. The insurer denied the claim on May 12, 1997 and did not, in the meantime, pay any interim compensation.[1]

The ALJ found that claimant failed to prove an entitlement to interim compensation because Dr. Anderson's letter did not attribute her inability to work to any work-related injury or disease. On review, claimant asserts that Dr. Anderson's authorization sufficiently ties her disability and need for treatment to her work activity. We disagree.

A worker is entitled to interim compensation if she has suffered a loss of earnings as a result of a work-related injury or disease. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994). ORS 656.262(4)(a) provides that "the first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." To trigger the worker's entitlement to interim compensation, the attending physician's authorization must relate the claimant's inability to work to a job-related injury or occupational disease. See Debra A. Kahn, 48 Van Natta 548 (1996); see also Stephen M. Snyder, 47 Van Natta 1956 (1995) ("A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim, if the attending physician verifies an injury-related inability to work.").

In this case, although Dr. Anderson's letter establishes that claimant is unable to continue working as a waitress because of her chronic back condition, it does not indicate that her chronic back condition is work-related. In the absence of any medical verification of claimant's inability to work as a result of a work-related injury or occupational disease, claimant has not proven an entitlement to interim compensation.

ORDER

The ALJ's order dated July 3, 1997 is affirmed.

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[1] "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 the Matter of the Compensation of
JOYCE A. STAUDENRAUS, Claimant
WCB Case Nos. 97-02139 & 97-00074
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that found that claimant's right fourth finger and right iliac crest injury claim was prematurely closed. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last sentence, with the following modification.

We do not find that Dr. Norris observed that Dr. Thomas' treatment was assisting claimant. (See Opinion and Order, p.3). Instead, we find that Dr. Norris reported claimant's belief "that Dr. Thomas is making some progress in relief of her discomfort, even though we were not objectively able to find a reason for her discomfort that she was experiencing after her injury." (Ex. 72A).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the October 23, 1996 Determination Order prematurely closed claimant's July 16, 1996 injury claim, because claimant's range of motion improved after September 3, 1996 (the medically stationary date determined at claim closure). We disagree.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that he was not medically stationary on the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence submitted after closure; however, medical evidence submitted after closure that pertains to changes in claimant's condition subsequent to closure is not properly considered. See Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 rev den 303 Or 590 (1987). 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).

The dispositive issue in this case is whether there was a reasonable expectation of material improvement in claimant's compensable conditions at the time of claim closure (October 23, 1996). See Glenn C. Smith, 48 Van Natta 192, aff'd mem 145 Or App 261 (1996).

Claimant relies on the absence of medical evidence indicating that she was medically stationary on and after September 3, 1996 in support of her contention that the claim was prematurely closed. She also contends that the opinion of Dr. Thomas, treating physician, should be understood to indicate that claimant was not medically stationary at the time of October 23, 1996 Determination Order which closed the claim. We disagree.

In reaching this conclusion, we note that Dr. Thomas reported on October 24, 1996 that he had "no real treatment planned other [than] encouraging exercises and minimal medication." (Ex. 69). Dr. Thomas also commented that claimant "still ha[d] subjective complaints that outweigh objective findings." (Id).

Regarding his November 5, 1996 examination of claimant, Dr. Norris reported that claimant:

> "was able to walk without antalgia, and sat comfortably in the waiting room prior to being seen, for at least 30 minutes. Walking down the hall to the bathroom with quite a pressed gait. Twice during our interview, after she had been seated on the examining table for approximately ten minutes, she got up off the table to stretch briefly, stated that she was having uncomfortableness in her right hip from sitting and then was able to sit back down and continue the interview." (Ex. 72A).

Considering this evidence regarding claimant's condition at (and soon after) claim closure, we cannot say that Dr. Thomas (or any other physician) had a reasonable expectation of material improvement in claimant's compensable conditions as of the October 23, 1996 Determination Order. Accordingly, we conclude that claimant has not carried her burden of proving that her claim was prematurely closed.[1] Finally, we authorize offset of a $1,077.56 overpayment, pursuant to the parties' stipulation. (See Opinion and Order, p. 1).

ORDER

The ALJ's order dated May 14, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the October 23, 1996 Determination Order and the October 25, 1996 Order on Reconsideration is reversed and those orders are reinstated and affirmed. The ALJ's attorney fee award is reversed. The insurer is authorized to offset a $1,077.56 overpayment against future awards of temporary or permanent disability in the manner prescribed in ORS 656.268(13) and (15). The remainder of the order is affirmed.

[1] We do not find claimant's improved range of motion findings, after September 3, 1996, indicative of an expectation of improvement as of claim closure. See Maarefi v. State Acc. Ins. Fund Corp., 69 Or App 527, 531 (1984) (Pre-closure expectation of material improvement not established by post-closure improvement).

In the Matter of the Compensation of
ALKA THORNSBERRY, JR., Claimant
WCB Case Nos. 96-09872, 96-06804 & 95-13246
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that declined to award interim compensation. In its respondent's brief, the SAIF Corporation (Northwest Log Scalers) contests that portion of the ALJ's order that set aside its denial of claimant's occupational disease claim for an L4-5 disc condition. Noting that SAIF/Northwest Log Scalers neglected to file a formal cross-request for review, claimant moves to strike its "cross-appellant's" brief. On review, the issues are claimant's motion to strike, interim compensation, and compensability. We deny the motion to strike and reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant requested review of that portion of the ALJ's order that declined to award interim compensation. SAIF did not formally cross-appeal any portion of the ALJ's order. However, in its respondent's brief, SAIF contended that the ALJ improperly set aside its denial of claimant's L4-5 disc herniation condition. Claimant has moved to strike SAIF's "cross-appellant's" brief on the ground that SAIF did not timely cross-appeal.

It is well-settled that a party may contest any portion of an ALJ's order in the absence of a timely cross-appeal, provided that the other party which requested review does not withdraw its request for review. See Catherine E. Wood, 47 Van Natta 2272, 2274 n. 1 (1995) (citing Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983)). Because claimant has not withdrawn her request for review, we can address SAIF's contentions regarding the ALJ's decision to set aside its denial. Accordingly, we deny claimant's motion to strike.

Interim Compensation

The ALJ declined to award claimant interim compensation, finding that her attending physician, Dr. Bert, did not specifically authorize temporary disability. See ORS 656.262(4)(a) and (f). On review, citing Scott Maloney, 48 Van Natta 1075 (1996), claimant contends that there was ample evidence of authorization of temporary disability. Claimant cites evidence that he was given instructions for bedrest, was hospitalized, and eventually underwent surgery under general anesthesia. Asserting that these circumstances constituted authorization of temporary disability, claimant argues that SAIF should have paid interim compensation and, because it failed to do so, should be penalized for nonpayment.

In Maloney, we found that the claimant's attending physician did authorize temporary disability benefits when he stated in a "pre-closure" chartnote that the claimant was limited in what he could do at the time and was not able to use his right hand or wrist for repetitive movement or lifting. 48 Van Natta at 1076. However, Maloney was a case that concerned substantive entitlement to temporary disability, which does not require specific authorization of temporary disability by an attending physician. See Kenneth P. Bundy, 48 Van Natta 2501, 2505 (1996). Thus, Maloney is distinguishable. Moreover, our initial order in Maloney was withdrawn when the parties settled the claim. Scott Maloney, 48 Van Natta 1530 (1996). Because our approval of the parties' settlement was in lieu of all prior orders, our decision in Maloney has no precedential value.[1]

Because ORS 656.262(4)(a) and (f) require specific authorization by the attending physician of procedural temporary disability, and because none was provided in this case, we agree with the ALJ that claimant was not entitled to interim compensation. Accordingly, we affirm the ALJ's decision on this issue.

Responsibility

On January 4, 1986, claimant suffered a compensable low back injury while employed by Three O Logging, insured by SAIF. He eventually received a total award of 25 percent unscheduled permanent disability.

Claimant began work for another SAIF insured, Northwest Log Scalers, in 1989. In July 1990, claimant filed a claim with SAIF/Northwest Log Scalers for an alleged low back injury that occurred on or about June 14, 1990, when he slipped on a piece of bark. (Ex. 60). On August 9, 1990, SAIF denied aggravation of the 1986 injury on behalf of Three O Logging. (Ex. 62). On November 15, 1990, SAIF denied responsibility for a new injury claim on behalf of Northwest Log Scalers. (Ex. 64). Claimant requested a hearing regarding the denials.

On December 14, 1990, SAIF rescinded its aggravation denial on behalf of Three O Logging and reopened the 1986 claim. (Ex. 70). Claimant then withdrew all hearing requests. (Ex. 68). SAIF/Northwest Log Scalers' denial of claimant's new injury claim then became final. Claimant last worked for Northwest Log Scalers in October 1990. (Tr. 10, 11).

In August 1995, claimant sought treatment for low back pain upon awakening. (Ex. 90). A disc herniation at L4-5 was later identified, for which Dr. Bert performed a laminectomy, discectomy and foraminotomy in September 1995. (Ex. 97).

On November 22, 1995, SAIF/Three O Logging denied the herniated disc claim. (Ex. 101). Claimant then provided SAIF/Northwest Log Scalers with notice of a claim for benefits on December 12, 1995. (Ex. 101A). When SAIF did not respond, claimant filed a request for hearing, alleging a "de facto" denial. After claimant filed an occupational disease claim against Northwest Log Scalers, SAIF denied responsibility for the L4-5 disc condition on October 21, 1996. (Ex. 109). On November 21, 1996, SAIF accepted responsibility under the 1986 Three O Logging claim. (Ex. 112).

Notwithstanding SAIF's acceptance of the disc herniation under the 1986 Three O Logging claim, the parties still litigated the issue of whether SAIF/Northwest Log Scalers was responsible for claimant's herniated disc. Applying the doctrine of res judicata, the ALJ initially concluded that

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[1] The other cases claimant cites, Fred E. Smith, 42 Van Natta 1538 (1990); Jerry F. Foster, 40 Van Natta 1682 (1988); Susan K. Teeters, 40 Van Natta 1115 (1988), were all decided prior to enactment of Senate Bill 369 in 1995 and, thus, are not applicable.

SAIF/Northwest Log Scalers was not responsible for claimant's herniated disc under an injury theory because its denial of claimant's 1990 new injury claim had become final. However, the ALJ determined that SAIF/Northwest Log Scalers was responsible under an occupational disease theory. The ALJ reasoned that the medical evidence established that claimant's work exposure for Northwest Log Scalers, including the 1990 slip and fall injury, was the major contributing cause of the combined condition and of the pathological worsening of the disease under ORS 656.802(2)(b).

On review, SAIF/Northwest Log Scalers contends that the ALJ improperly allowed claimant to establish an occupational disease claim based on the denied 1990 injury. Based on the following reasoning, we agree.

As previously noted, SAIF/Three O Logging accepted responsibility for the L4-5 disc herniation under its 1986 claim. Under ORS 656.308(1), to shift responsibility to Northwest Log Scalers, there must be proof that claimant suffered a new injury or occupational disease involving the "same condition." Dan D. Cone, 47 Van Natta 1010, on recon 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995). We agree with the ALJ's reasoning that claimant is precluded from establishing a new injury based on the 1990 slip and fall. Therefore, in order to shift responsibility to SAIF/Northwest Log Scalers, claimant would have to proceed under an occupational disease theory, which requires that employment conditions for Northwest Log Scalers be the major contributing cause of the combined condition and pathological worsening of his preexisting low back condition. See ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta at 2221.

SAIF argues that the ALJ erred in considering claimant's 1990 injury to be a causal factor in the occupational disease claim. Emphasizing that its denial of that injury on behalf of Northwest Log Scalers became final, SAIF argues that the occupational disease claim cannot be based on the 1990 injury. Thus, the issue is whether claimant's entire employment with Northwest Log Scalers, including the 1990 slip and fall injury, can be considered in determining the occupational disease claim, or whether only claimant's "post-June 14, 1990" employment for Northwest Log Scalers can be considered in determining major causation.

Claimant argues that his 1990 injury was diagnosed only as a low back strain. Because his current claim is for an L4-5 herniated disc, a different condition, claimant reasons that the 1990 denial does not preclude an occupational disease claim for the new condition.

Even assuming that the final 1990 denial does not preclude claimant's current occupational disease claim for the L4-5 herniated disc, we agree with SAIF that the June 1990 slip and fall incident cannot be considered as a causal factor in determining whether claimant has established a new occupational disease. That incident was previously accepted by SAIF/Three O Logging as an aggravation of the 1986 injury. Thus, claimant may not relitigate that incident under a new occupational disease theory. See Stacy v. Corrections Division, 131 Or App 610, 614 (1994) (to establish that current condition was a new occupational disease, claimant required to prove that work activities after acceptance of injury claim were the major contributing cause of current condition). Accordingly, we conclude that, in order to establish a new occupational disease, claimant must prove that his work activities for SAIF/Northwest Log Scalers after June 14, 1990 are the major contributing cause of the combined condition and pathological worsening of the disease.

The medical evidence in this record establishes that the 1990 injury was the major contributing cause of claimant's current herniated disc. (Exs. 103, 104, 108-7, 113). Because there is no medical evidence that claimant's work activities after the June 1990 injury through his termination of employment in October 1990 are the major contributing cause of his herniated disc, we conclude that claimant has failed to prove a new occupational disease claim against SAIF/Northwest Log Scalers. Accordingly, SAIF/Northwest Log Scalers' denial of claimant's low back condition must be upheld. Inasmuch as the ALJ concluded otherwise, we reverse.

ORDER

The ALJ's order dated March 6, 1997 is affirmed in part and reversed in part. That portion which set aside SAIF/Northwest Log Scalers' denial is reversed. SAIF/Northwest Log Scalers' denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GERALDINE BEDORTHA, Claimant
WCB Case No. 97-00384
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that declined to reclassify her low back condition claim as disabling. On review, the issue is claim classification. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not established that her accepted back condition had become disabling and declined to reclassify her claim. We agree that claimant is not entitled to have her claim reclassified, but do so based on the following reasoning.

Pursuant to ORS 656.277, a claimant has one year from the date of injury, in which to seek reclassification of his or her claim. See Donald R. Dodgin, 45 Van Natta 1642 (1993). If a request for reclassification is not made within the one year time period, the claim cannot be reclassified except by making a claim for aggravation pursuant to ORS 656.273. ORS 656.277(1) and (2); Charles B. Tyler, 45 Van Natta 972 (1993). However, the claimant must be notified of the classification of the claim, as well as the right to challenge that classification within a sufficient time period that would allow the status of the claim to be challenged. ORS 656.262(b) & (c); Degrauw v. Columbia Knit, Inc., 118 Or App 277, rev den 316 Or 527 (1993).

Here, claimant was clearly aware of the classification of her claim following the October 1994 injury. In this regard, she first sought reclassification of her claim in January 1995. (Ex. 15A). By Determination Order dated March 6, 1995, the Department declined to reclassify claimant's claim. (Ex. 17). On August 31, 1995, claimant requested a hearing concerning her claim classification. (Ex. 23A). However, claimant apparently withdrew that issue as it was not addressed in the prior ALJ's Opinion and Order. (Ex. 38). Under these circumstances, claimant was not precluded from challenging her claim classification in a timely manner, and indeed did so.

The request for reclassification at issue in this case is based on claimant's then-counsel's November 7, 1995, request to the employer for acceptance of a head contusion, lumbar strain and S-I joint dysfunction. Assuming that claimant's counsel's November 7, 1995 letter was a request for claim reclassification (i.e., a second such request), it was made more than one year after the date of claimant's October 1994 injury. Because the "request" was made more than one year after the date of injury, it must be filed and established as an aggravation pursuant to ORS 656.273.[1] See ORS 656.277(2) For these reasons, we agree with the ALJ that claimant's claim remains in non-disabling status.

ORDER

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

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[1] To the extent the employer's acceptance of claimant's lumbar strain condition could be construed as an acceptance of a new medical condition, that would likewise not be a basis for challenging the classification of claimant's claim. See Paul D. Johansen, 49 Van Natta 2013 (1997) (ORS 656.277(2) applicable to situation where "new medical condition" is accepted more than one year after the date of an originally classified nondisabling injury).

In the Matter of the Compensation of
REBECCA J. CARTWRIGHT, Claimant
WCB Case No. 96-10933
ORDER ON REVIEW
Philip H. Garrow, 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) Brazeau's order that set aside its denial of claimant's thoracic condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Pursuant to a November 1, 1996 order by the ALJ, SAIF accepted a claim for "acute traumatic grade 3 thoracolumbar sprain/strain and right shoulder strain." (Ex. 25). On November 25, 1996, SAIF issued a denial of claimant's current need for treatment.

The ALJ first found that claimant had two "separable" conditions: one in the "lower lumbar" and the other in the "thoracic" region. Although finding that claimant did not carry her burden of proving the compensability of the "lower lumbar" condition, the ALJ concluded that claimant established that the major contributing cause of her thoracic condition was the compensable injury. Consequently, the ALJ set aside SAIF's denial to the extent it denied claimant's treatment for a thoracic condition.

On review, SAIF challenges that portion of the order concerning the thoracic condition. SAIF contends that the ALJ improperly "bifurcated" the claim into two separate conditions. According to SAIF, the medical evidence does not support this conclusion and, as a legal matter, the ALJ acted improperly because it accepted a single condition--"thoracolumbar sprain/strain."

Whether or not the ALJ acted properly in analyzing the claim as two separate conditions, we conclude that the record does not support finding a thoracic condition to be compensable. The ALJ relied on the following report from Dr. Maloney, one of claimant's treating physicians, in deciding that claimant established compensability:

> "I am currently treating [claimant] for a low back strain. I had not evaluated [claimant] recently following her 4-15-96 work related injury as she was following with other physicians at that time. I have treated her for soft tissue pain arising from low back and buttock region. It appears that the soft tissue strain was the major reason for physician visits and general treatment that I provided. I do not believe she suffered a new injury on 11-4, hence I have not placed a significant effect on the right mid back pain as it relates to her underlying condition and subsequent need for treatment. I do concur that she has two factors contributing to her low back condition, including soft tissue pain and facet arthrosis of the lower lumbar spine. I consider the soft tissue strain following the [sic] 4-15-96 to be the major contributing cause for my treatment. I have considered the 4-15-96 on-the-job injury the major contributing cause of her combined condition for my treatment. * * *." (Ex. 33). (Emphasis supplied).

We disagree that this opinion carries claimant's burden of proof. On the contrary, it expressly states that claimant's mid-back pain relates to an "underlying condition." Furthermore, that portion attributing claimant's need for treatment to the compensable injury relates to claimant's low back condition.

The only other opinion concerning claimant's current need for treatment is from claimant's other treating physician, Dr. Newby. As discussed by the ALJ, however, Dr. Newby stated that claimant's symptoms were "primarily" located in the low back and he did not treat the thoracic area after his initial evaluation in April 1996. (Ex. 35-7, 35-17, 35-18). Based on this evidence, we agree with the ALJ that Dr. Newby did not provide an opinion concerning the cause of any thoracic condition.

Consequently, we find an absence of medical opinion showing that claimant's need for treatment in the thoracic area (whether or not that condition should be analyzed separately) is, in major part, caused by the compensable injury.

ORDER

The ALJ's order dated May 1, 1997 is reversed in part and affirmed in part. That portion of the order finding compensable claimant's need for treatment in the thoracic area is reversed. SAIF's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
LAURITZ P. PILLERS, Claimant
WCB Case No. 96-08985
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Neal's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability.

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

On review, the employer argues that, because its denial encompassed only degenerative disc disease and the issue litigated at hearing concerned the compensability of a combined condition (a herniated disc and a preexisting degenerative disc disease), we should reinstate and uphold the denial.

We disagree with the employer's characterization of its denial. The denial states that it "has received notice of a reported injury to your BACK while working for [the employer] on 06/09/96." (Ex. 17-1). The denial further states that there is "insufficient medical evidence to support your alleged claim of a new injury on 06/09/96" and that the medical evidence instead shows that claimant's current condition was caused by a noncompensable preexisting degenerative lumbar disc disease condition. (Id.) Based on such language, we find that the denial was of a back injury and not just a preexisting condition.

Furthermore, because we agree with the ALJ that claimant proved that the major contributing cause was the compensable injury, we affirm the order. Finally, we correct the ALJ's reference to "the June 9, 1996 denial" in the ORDER portion to "the September 6, 1996 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 $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 8, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
CURTIS S. WELCH, Claimant
WCB Case No. 97-01292
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Brazeau's order that increased claimant's unscheduled permanent disability award for an allergy/reactive airway condition from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to 17 percent (54.4 degrees). On review, the issue is extent of unscheduled permanent disability.

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

SAIF argues that the ALJ erred in relying on claimant's affidavit to rate claimant's impairment. SAIF also argues that the ALJ erred in addressing whether work with a respirator, or otherwise within claimant's medical restrictions, is available to claimant. SAIF contends that these considerations are not relevant to the impairment question because impairment may be established only by medical evidence. In addition, SAIF contends that the ALJ erred by failing to accept claimant's treating physician's impairment rating. We disagree with SAIF's contentions.

We first note that the ALJ's finding that employer's workplace business is essentially permeated with Red Cedar dust is undisputed. We further note that claimant has a compensable allergy to Red Cedar with a delayed reactive airways disease component. The issue is whether claimant's compensable condition precludes him from performing some or most of his regular work activities. See OAR 436-035-0450(1)(b) and (c).

We have previously held that medical evidence is required to establish permanent impairment under the standards and that a claimant's testimony alone is insufficient to establish impairment. William K. Nesvold, 43 Van Natta 2767, 2768 (1991); see OAR 436-035-0010(1). However, nothing in the standards indicates that nonmedical evidence is necessarily irrelevant to an impairment determination. Karen A. Sepich, 46 Van Natta 1171, 1173 (1994); Ryan F. Johnson, 46 Van Natta 844, 846 (1994); Sherry L. Low, 45 Van Natta 953 (1993). Moreover, in a case such as this, where the nature of claimant's work is essential to evaluating his impairment, we agree with the ALJ that evidence concerning the workplace conditions is both relevant and probative. Indeed, such lay evidence is relevant as probative to the foundation of what constitutes claimant's regular work and what constitutes the workplace claimant would return to, upon which the medical and legal assessment of claimant's ability to work is based. In addition, we specifically agree that the absence of evidence suggesting that work is available to claimant, within his medical limitations, is a persuasive indication that the compensable condition prevents claimant from performing most of his regular work activities.

Finally, we do not find that the ALJ failed to accept Dr. Rughani's impairment rating. Dr. Rughani did, at one point, summarily indicate that claimant's condition prevents him from performing some of his regular work activities. (Ex. 1-147). He later opined that claimant could return to work if he used a respirator mask. (Ex. Ex. 1-152). We consider Dr. Rughani's entire opinion regarding claimant's impairment, not just his initial "check-the-box" conclusion. See Jose L. Hernandez, 49 Van Natta 1030 (1997) (Where the treating physician's opinion concerning the claimant's impairment was based only on his own interpretation of the relevant rule and other evidence was probative, the physician's conclusion alone was not determinative.). Further considering the record regarding claimant's work and working conditions, we conclude, as did the ALJ, that claimant's compensable condition prevents him from performing most of his regular work activities. See Michael H. McMurphy, 49 Van Natta 1238, 1239 (1997) (Where the claimant was allergic to epoxy resins and some of his work involved exposure to them, the claimant's condition prevented some of his regular work activities, even though his treating physician said that he could work).

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 and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 9, 1996 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the SAIF Corporation.

December 23, 1997 Cite as 49 Van Natta 2170 (1997)

In the Matter of the Compensation of
SAHARA L. WHITE, Claimant
WCB Case No. 96-11194
ORDER ON REVIEW
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that upheld the SAIF Corporation's denial of her thoracic condition. On review, the issue is compensability.

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

Claimant, age 40 at the time of hearing, works at a rehabilitation center as a habilitative training technician. On September 15, 1996, claimant experienced thoracic and lumbar pain while sliding a patient up to the dining table. Despite the pain and pins and needles sensation, she was able to finish her shift and did not seek medical treatment. Then, on October 20, 1996, she experienced similar, but sharper pain while moving the same patient to the dining table. She left work early because of this pain and self-treated with heat and ice for a few days.

On October 22, 1996, claimant sought treatment with Dr. Pribnow, who ultimately diagnosed thoracic strain, by history, and hypertrophic spurring, unrelated to work. On October 31, 1996, claimant was examined by Dr. Corrigan on referral from Dr. Pribnow. Dr. Corrigan similarly diagnosed left paradorsal strains, by history, on September 15 and October 20, 1996, and heterotopic ossification, related to a preexisting left 10th costovertebral articulation. Dr. Corrigan opined that claimant's symptoms were caused by a combination of her on-the-job activities and the preexisting lesion in the left costovertebral articulations, and that the preexisting condition was the major contributing factor to her discomfort.

On December 4, 1996, SAIF issued a denial of claimant's combined condition and need for treatment on the grounds her work activity was not the major contributing cause. Claimant was released to return to regular work on January 15, 1997.

The ALJ found that claimant failed to prove that her work activity (sliding the patient's chair up to the dining table on September 15 and October 20, 1996) was the major contributing cause of her combined condition or need for treatment of the combined condition. In upholding SAIF's denial, the ALJ also rejected claimant's constitutional challenges to the applicable workers' compensation statutes.

On review, claimant argues, in essence, that her combined condition is compensable because her preexisting hypertrophic spurring was caused in major part by a January 1993 compensable injury, in which she slipped and fell on ice in the employer's parking lot. There is no indication in the record that claimant raised this argument at hearing and the ALJ did not address it.[1] We have consistently held that we will not consider an issue raised for the first time on review. See Stevenson v. Blue Cross of

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[1] Although she is pro se on review, claimant was represented by counsel at hearing.

Oregon, 108 Or App 247 (1991). We further note, however, that even if we were to consider this late-raised issue, the medical evidence fails to establish any causal relationship between claimant's preexisting condition and her 1993 accepted low back strain and contusion. Consequently, we affirm the ALJ's order upholding SAIF's denial.

ORDER

The ALJ's order dated July 18, 1997 is affirmed.

In the Matter of the Compensation of
LOGAN A. ADAMS, Claimant
WCB Case No. 96-07974
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our December 2, 1997 Order which set aside its denial of claimant's degenerative disc disease, disc scolerosing and possible spondylosis. Specifically, SAIF asserts that we erred in concluding that it had accepted claimant's degenerative spine disease. After considering SAIF's motion and memorandum in support, we grant the request to address SAIF's contentions.

While SAIF does not contend it formally accepted a lumbosacral strain, it contends that the contemporaneous medical evidence establishes that claimant's condition was a lumbosacral strain superimposed on the degenerative condition. Whether an acceptance has occurred is a question of fact. See SAIF v. Tull, 113 Or App 449 (1992). As we found in our prior order, claimant's condition at the time his claim was filed included a lumbosacral strain and degenerative spine condition. (Exs. 1, 2, 3, 5). Moreover, the medical treatment from Dr. Pfeiffer included treatment for an "aggravation of L5 disc scolerosing and possible spondylosis." (Ex. 2). These conditions were confirmed by the August 1976 x-ray. (Ex. 3). In this regard, to the extent that Dr. Smith's opinion is contrary to that of Dr. Pfeiffer, we rely on Dr. Pfeiffer's opinion as he treated claimant. See Weiland v. SAIF, 64 Or App 810 (1983). Finally, although our prior order noted claimant's subsequent lumbar surgeries, we do not rely on the surgeries, in and of themselves, as evidence of SAIF's acceptance. Rather, the subsequent surgeries reveal the ongoing and progressive nature of claimant's condition from the 1976 compensable injury. Based on this, we continue to conclude that SAIF's non-formal acceptance included claimant's degenerative spine disease.[1]

Accordingly, our December 2, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 2, 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] SAIF also submitted a November 27, 1997 Administrative Order from the Workers' Compensation Division (WCD) which found the claimant's current low back surgery appropriate, noting that the order indicates that the accepted claim was a non-disabling strain. We find this submission of limited value. First, the issue before WCD was the appropriateness of the surgery and not the causal relationship between the surgery and claimant's compensable injury. As noted in the WCD's order, it does not have jurisdiction over such issues. Moreover, the order indicates that SAIF does not contest compensability, not that the "acceptance" issue was litigated by the parties. Consequently, the WCD order has no preclusive effect on our decision.

In the Matter of the Compensation of
CHARLOTTE M. ASHFORD, Claimant
WCB Case No. 96-07611
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denial of her left shoulder condition. The insurer cross-requests review of that portion of the ALJ's order that increased claimant's unscheduled permanent disability for a right shoulder condition from 13 percent (41.6 degrees), as awarded by an Order on Reconsideration, to 16 percent (51.2 degrees). On review, the issues are compensability and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant, age 47 at the time of hearing, works as a licensed practical nurse. On August 20, 1994, she compensably injured her right elbow when she bumped it on a door handle while moving a bed. The insurer accepted a right elbow contusion. Claimant subsequently developed right shoulder symptoms and was diagnosed with a rotator cuff impingement and adhesive capsulitis. These right shoulder conditions were accepted pursuant to a Stipulated Settlement entered September 18, 1995.

In January 1996, claimant was seen for a physical capacities evaluation. The evaluators determined, among other things, that claimant was capable of working in the sedentary/light category, but that inconsistencies in the evaluation indicated a lack of full effort by claimant. The evaluators therefore questioned the validity of the testing results. Claimant's attending physician, Dr. Hanley, concurred with the report.

In May 1996, claimant was examined by Dr. Strum at the employer's request. Dr. Strum found claimant medically stationary and made impairment findings. Dr. Hanley concurred with Dr. Strum's report and, on June 6, 1996, reported that claimant could return to work full time in a light to medium work capacity with restrictions on repetitive lifting above shoulder level. On June 20, 1996, Dr. Hanley completed a Physical Limitations Request form indicating that claimant was permanently limited to light work.

A July 3, 1996 Notice of Closure awarded temporary disability and 13 percent unscheduled permanent disability for the right shoulder condition.[1] Claimant requested reconsideration and was examined by a medical arbiter on October 5, 1996. The arbiter found, among other things, that claimant could work in at least the light/medium category. A November 6, 1996 Order on Reconsideration affirmed the Notice of Closure insofar as it awarded claimant 13 percent unscheduled permanent disability.

Meanwhile, in late 1995, claimant complained to Dr. Hanley of mild symptoms in her left shoulder. In October 1995, Dr. Hanley found restricted motion in both shoulders. Claimant also complained of pain in her left shoulder during a December 1995 examination by Dr. Switlyk, and her physical therapist in early 1996.

In July 1996, claimant made a claim for her left shoulder condition. Dr. Hanley reported that claimant had adhesive capsulitis of the left shoulder of unknown etiology. He noted that the cause of her left shoulder pain and subsequent adhesive capsulitis was unclear to him at that time. On August 5, 1996, the insurer denied claimant's left shoulder condition.

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[1] This award was based on an impairment value of 7 plus an age, education and adaptability value of 6.

On October 30, 1996, Dr. Laycoe concurred with Dr. Hanley's opinion regarding claimant's left shoulder condition. Dr. Strum subsequently reported that neither shoulder condition was related to claimant's right elbow injury. On April 17, 1997, Dr. Hanley opined that claimant's left shoulder condition arose indirectly from her right shoulder and elbow injury, as a result of overuse of the left shoulder followed by disuse with the onset of pain.

Claimant requested a hearing on the insurer's denial of her left shoulder condition, which was consolidated with her challenge to the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Compensability

At hearing and on review, claimant asserts that her left shoulder condition is compensable as a consequence of her August 20, 1994 accepted right elbow injury. Like the ALJ, we find to the contrary.

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. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (holding that, when a condition or need for treatment is caused by the compensable condition, as opposed to the industrial accident, the major contributing cause standard is applied). Thus, in this case, claimant must prove by a preponderance of the evidence that her compensable right elbow injury is the major cause of her left shoulder adhesive capsulitis.[2]

Because claimant's left shoulder 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 symptoms or 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 July 1996, claimant's treating doctor, Dr. Hanley, reported that he was unsure as to the etiology of claimant's left shoulder condition. He noted that, due to the substantial interval of time between her right elbow injury (August 1994) and the onset of her left shoulder symptoms (October 1995), he did not believe the two conditions were related. Dr. Laycoe (who examined claimant in July 1995 in connection with her right shoulder symptoms) subsequently concurred with this assessment. Dr. Strum also opined that claimant's left shoulder condition was not a consequence of her work activities.

Nine months after his initial report concerning the cause of claimant's left shoulder condition, Dr. Hanley indicated in a "check-the-box" report that but for the use of her left arm in place of her right arm following her right shoulder adhesive capsulitis, claimant would not have developed her left shoulder symptoms. He further agreed that claimant's left shoulder condition arose "indirectly from the right shoulder and elbow injury, as a result of overuse followed by disuse with the onset of left shoulder pain" and concluded that the right shoulder and elbow injury was the "major, though indirect," cause of her disability and need for treatment in the left shoulder.

First, we note that Dr. Hanley did not explain the reason for his change of opinion, which renders his opinion unpersuasive. See Kelso v. City of Salem, 87 Or App 630 (1987). As claimant's treating doctor, he was aware at the time of his initial (July 1996) opinion that claimant's left shoulder symptoms developed slowly and subsequent to her right elbow contusion and right shoulder condition. (Exs. 47, 51, 55). He was also of the opinion that claimant's right shoulder adhesive capsulitis was directly related to her right elbow condition (Ex. 40), but nevertheless declined to relate her subsequent left shoulder condition to her compensable injury or to her work activities at that time. In the absence of any explanation for his later change of opinion, we find Dr. Hanley's assessment concerning the cause of claimant's left shoulder adhesive capsulitis of little probative value.

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[2] Claimant does not assert that her left shoulder condition arose out of treatment for her compensable right elbow and/or right shoulder conditions. Therefore, this case is not governed by the standard set forth in Barrett Business Services v. Hames, 130 Or App 190, 193 (1994).

We are also not persuaded that, in later identifying claimant's right shoulder and elbow injury as the major (albeit "indirect") cause, Dr. Hanley considered and weighed the relative contribution of other factors leading to claimant's claimed left shoulder condition.[3] See Dietz, 130 Or App at 401. As noted above, Dr. Hanley's later opinion is set forth in a relatively conclusory "check-the-box" report that lacks an adequate foundation. Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of expert opinion depends on the persuasiveness of the foundation on which the opinion is based; least weight given to conclusory, poorly analyzed opinions). Indeed, Dr. Hanley did not explain how claimant's use of her left arm or sleeping on her left side to avoid her right shoulder pain led to the pain in her left shoulder which, in his opinion, led to the diagnosis of adhesive capsulitis.

Consequently, on this record, we find that claimant failed to prove that her compensable right elbow injury is the major contributing cause of her left shoulder adhesive capsulitis. We therefore uphold the insurer's denial.

Extent of Unscheduled Permanent Disability

As set forth in the ALJ's order, the only "extent" issue in dispute is the adaptability factor, specifically the appropriate level of claimant's residual functional capacity (RFC). We adopt and affirm the ALJ's reasoning and conclusion that claimant has established a "light" RFC. Consequently, claimant is entitled to an adaptability factor of 3. This value, when multiplied by her age/education value (3) and added to her impairment value (7) results in a total unscheduled permanent disability award of 16 percent.

Attorney Fee

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

ORDER

The ALJ's order dated May 21, 1997 is affirmed. For services on review (with regard to the extent of disability issue), claimant's counsel is awarded $750, payable by the insurer.

[3] For example, the record indicates that in March 1995, claimant slipped in her driveway at home and threw both of her arms out to balance herself. (Exs. 22, 39, 68, 90). This incident immediately worsened her preexisting right shoulder pain (see Exs. 22, 39-7) and predated her gradual onset of left shoulder pain, but is not addressed in either of Dr. Hanely's causation opinions.

In the Matter of the Compensation of
DUSTIN L. CROMPTON, Claimant
Own Motion No. 970523M
OWN MOTION ORDER OF ABATEMENT
Glen J. Lasken, Claimant Attorney

Claimant requests reconsideration of our December 11, 1997 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BRENDA E. FEIGNER, Claimant
WCB Case No. 96-05750
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Safeco Legal, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the insurer's denial of claimant's injury claim for a C5-6 disc condition; and (2) declined to assess penalties or attorney fees for an allegedly untimely denial. On review, the issues are compensability, penalties and attorney fees.

We adopt the ALJ's order with the following exception and supplementation. We do not adopt the paragraph preceding the "Order" section on page 4 of the ALJ's order. We add the following supplementation.

Compensability

The insurer has accepted "cervical and bilateral shoulder strains," in relation to the December 14, 1994 injury, but has denied compensability of claimant's C5-6 disc condition. The parties agree that claimant has no preexisting condition and that claimant must only prove that the injury is a material contributing cause of the denied disc condition in order to establish compensability.

The cause of claimant's C5-6 disc condition is a complex medical question which must be resolved by expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967). This record contains no persuasive medical evidence which establishes that the C5-6 disc condition is materially related to the work injury or that claimant's current cervical and upper extremity symptoms are caused by the disc condition, rather than the accepted conditions.

Dr. Bills, the orthopedic surgeon who has treated claimant's cervical condition, has offered conflicting opinions regarding whether the disc condition is the cause of claimant's current symptoms. Dr. Bills initially indicated that he believed the disc condition was the cause of claimant's symptoms. (Ex. 10). However, Dr. Bills later concurred with a report by examining physicians, Drs. Marble and Rich, which concluded, among other things, that claimant's pattern of pain complaint was "not really consistent" with a disc herniation at the C5-6 level.[1] (Exs. 11-6; 13). In a later report, Dr. Bills indicated that claimant had a subligamentous disc herniation which appeared to be significant and continued to be symptomatic. (Ex. 15-1). In yet another report, Dr. Bills concurred that claimant's neck and upper extremity complaints were related to her December 1994 compensable injury, but in the same report also indicated that claimant's disc condition was not contributing to claimant's pain complaints. (Ex. 20). In a later opinion, Dr. Bills stated that claimant's disc protrusion could account for her symptoms. (Ex. 21).

With regard to the cause of the disc condition, Dr. Bills initially indicated he could not render an opinion as to whether the December 14, 1994 fall caused the herniated C5-6 disc. (Ex. 18). Dr. Bills also concurred with the report by Drs. Rich and Marble which described claimant's L4-5 disc herniation as "degenerative." When asked, after receiving additional medical information, whether it was medically more probable than not that the disc condition was a result of the December 1994 industrial injury, Dr. Bills stated: "Since I have stated the disc condition was not the current cause of her pain this would seem moot." (Ex. 20).

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[1] Drs. Marble and Rich opined that claimant's "current complaints and conditions" were related to the December 14, 1994 injury. However, other than to list the diagnosis of the C5-6 disc herniation, and to note that claimant's pain complaints were not really consistent with the disc herniation, the physicians did not specifically address the cause of the disc condition. Under such circumstances, we find their opinion insufficient to establish that the disc condition was materially related to the compensable injury.

Given the conflicting nature of Dr. Bills' opinions and his failure to causally relate the disc condition to the December 1994 injury, we are unable to conclude, based on this record, that claimant has established compensability of that condition.

Penalties and Attorney Fees

Based on this record, claimant made a claim for the disc condition on March 8, 1996 and the insurer denied the claim on April 4, 1997, more than a year after the claim was made. Thus, whether the claim was for a new medical condition or a claim that the disc condition was incorrectly omitted from the notice of acceptance, the claim was not processed in a timely manner. See ORS 656.262(6)(d); 656.262(7)(a). However, because the claim has been found not compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support the award of an attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991).

ORDER

The ALJ's order dated April 24, 1997 is affirmed.

December 24, 1997 Cite as 49 Van Natta 2176 (1997)

In the Matter of the Compensation of
NARCISO RENTERIA, Claimant
WCB Case No. 97-01100
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Johnson's order that set aside its denial, on behalf of the noncomplying employer, of claimant's claim for a right shoulder injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the first and second paragraphs on page 3 of the ALJ's order. We make the following additional findings.

At 4:36 p.m. on October 8, 1996, claimant telephoned Mr. Hager on his cell phone and told Mr. Hager that he was getting ready to leave work for the day. Claimant did not mention to Mr. Hager that he had injured his shoulder at work that day. Before leaving work on October 8, 1996, claimant saw Jerry Dodd, who is the owner of the building in which Mr. Hager's business is located. Claimant did not mention a shoulder injury to Dodd when he helped Dodd repair a hose.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that he injured his right shoulder at work while working on a transmission on October 8, 1996. Finding claimant credible based upon his demeanor, the ALJ concluded that claimant had sustained a compensable right shoulder injury. On de novo review, we disagree.

Although we generally defer to an ALJ's demeanor-based credibility findings, for the following reasons, we decline to do so in this case. First, we are troubled by the fact that claimant testified that he told his soccer coach on the evening of October 8, 1996 that he injured his right shoulder at work that day, but did not call this witness even though he was present at the hearing. (Tr. 29).[1]

[1] Claimant also indicated he told his wife about his shoulder injury on October 8, 1996, and his apartment manager saw him come home from work injured, but neither of these witnesses was present or testified at the hearing.

The issue at hearing was whether claimant sustained his right shoulder injury at work on October 8, 1996. Claimant testified that he told several people about his work injury on the day it occurred, including the employer, Mr. Hager, his soccer coach and Mr. Dodd. Because the injury was unwitnessed, these individuals could have corroborated claimant's testimony that the injury occurred at work. Claimant's soccer coach, in particular, could have corroborated claimant's testimony that claimant told him about the work injury on the evening of October 8, 1996. This testimony could also have corroborated claimant's testimony that claimant suffered no injury at soccer practice on that date.

Claimant has the burden of proof. ORS 656.266. Because claimant identified his soccer coach as a witness who could corroborate his testimony regarding the injury and because he gave no reason why the coach was not called, we construe claimant's failure to call this witness against claimant. See John Mahon, 47 Van Natta 1647 (1995); Gloria Vaneekhoven, 47 Van Natta 670 (1995); see also Roberts v. SAIF, 18 Or App 590 (1974).[2]

The only witnesses to testify at hearing gave testimony that was contrary to claimant's. Claimant testified that he told both the employer, Hager, and Dodd, who owned the building in which the employer's business was located, about the injury on the day it occurred. Both of these witnesses refuted claimant's testimony that he told them on that date about the injury. Witness Dodd testified that claimant did not mention any injury to his right shoulder when he helped Dodd fix a hose at around 4:30 p.m. on October 8. Dodd also did not remember giving claimant Advil that day. Dodd's testimony contradicts claimant's testimony that he showed Dodd his injured shoulder and was given two Advil by Dodd. Hager testified that claimant called him on the afternoon of October 8, 1996 before leaving work, but did not mention an injury. Claimant indicated that he did tell Hager in the conversation about his injury.

We also find troubling claimant's admission that he did not tell SAIF's investigator that he went to soccer practice the night of October 8, 1996. Claimant told the investigator that after leaving work, he went home, took a shower and went to bed. (Tr. 65-66). At hearing, claimant testified that he also went to soccer practice on the evening of October 8, 1996 to talk to his coach.

Finally, claimant talked to Mike Warren on the telephone on the evening of October 8, 1996. Claimant and Warren had business dealings together. Claimant did not mention the shoulder injury to Warren that evening and Warren heard about the injury the next morning from claimant's employer, Hager.

The discrepancies noted above cause us sufficient doubt that we do not find claimant's testimony reliable. Under such circumstances, we find that claimant has not met his burden of proof and that the denial should be upheld.

ORDER

The ALJ's order dated June 17, 1997 is reversed. The denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

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[2] Claimant argues that Vaneekhoven and Roberts v. SAIF are distinguishable because in those cases, the claimant failed to produce a witness who had actually witnessed the incident causing the injury. Here, claimant argues, the injury occurred when claimant was alone and there could be no eyewitness. We do not agree that these cases are materially distinguishable. Claimant identified witnesses who could corroborate his testimony that his right shoulder injury occurred at work on October 8, 1996. Because claimant's injury was unwitnessed and because there is testimony contradicting portions of claimant's testimony, it was as crucial, if not more crucial in this case, for claimant to call the corroborating witness as it was in Vaneekhoven or Roberts. Moreover, we note that the Mahon case, like this one, involved a witness who did not observe the injurious event, but whose testimony could have corroborated the claimant's testimony regarding the occurrence of the injury.

In the Matter of the Compensation of
MARSHA E. WESTENBERG, Claimant
WCB Case No. 97-05176
ORDER ON REVIEW (REMANDING)
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Davis' order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is the propriety of the dismissal order. We vacate and remand.

PROCEDURAL HISTORY

On September 21, 1995, the Board affirmed the prior ALJ's order which set aside the insurer's denial of claimant's then-current left wrist and thumb condition, but upheld its denial of claimant's then-current aggravation claim for those conditions. (Unpublished order). On June 6, 1996, the Court of Appeals affirmed the Board's order in a memorandum opinion. Consolidated Freightways v. Westenberg, 141 Or App 479 (1996). Thus, as of the 1994 hearing, claimant's left thumb and wrist conditions (thumb joint arthritis and consequential carpal tunnel syndrome) were compensable.

Before the above litigation ended, claimant wrote to the Department requesting penalties based on the employer's alleged unreasonable failure to pay time loss benefits.

On November 17, 1995, the Department issued a "Notification of Decision," which stated that the Director lacked jurisdiction over the matter because there was an entitlement issue as well as a penalty issue. See ORS 656.262(11). The Notification stated, "Since the insurer contends that they [sic] have no obligation to pay time loss under the terms of the Opinion and Order or the Order on Review, Compliance Section no longer retains jurisdiction; instead, resolution of the issue would be within the jurisdiction of the Workers' Compensation Board Hearings Division."

Nonetheless, on May 27, 1997, the Department issued an "Order Denying Assessment of a Penalty Pursuant to ORS 656.262(11)," stating that no time loss had ever been "authorized or ordered" in this matter and there were no amounts ever "then due." The Order indicated that it could be appealed by requesting a hearing before the Director.

On June 24, 1997, claimant requested a hearing before the Workers' Compensation Board Hearings Division and sent a copy of this request to the Department.

On June 30, 1997, the employer requested dismissal of claimant's request for hearing on jurisdictional grounds.

On July 1, 1997, the Department sent claimant a "Notice of a Telephone Hearing," which stated, "It's apparent from your letter that you're appealing the [May 27, 1997] Order Denying Assessment of a Penalty []." On July 8, 1997, claimant requested that the Department acknowledge that the Board, not the Department, has jurisdiction over issues related to the insurer's failure to pay time loss.

On July 25, 1997, the Department wrote to claimant, notifying her that the hearing before the Department would be postponed. On July 28, 1997, claimant responded, stating that she had not requested a hearing before the Department, but had only sent it a courtesy copy of her request for hearing before the Board's Hearings Division.

On August 4, 1997, the present ALJ issued an order dismissing claimant's request for hearing before the Board's Hearings Division for lack of jurisdiction. Claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the Hearings Division lacked authority to address this matter because the Department has exclusive jurisdiction when the sole issue is penalties under ORS 656.262(11). In addition, because appeal of a Director's order following a contested case hearing regarding a penalty issue would be to the Court of Appeals, the ALJ dismissed claimant's request for hearing without admitting evidence or taking testimony. See ORS 183.482.

On review, claimant reiterates her request for hearing. She seeks a penalty based on the employer's nonpayment of temporary disability compensation. In addition, she argues entitlement to temporary disability under her compensable claim.[1] Thus, contending that the requested penalty is not the only issue, claimant argues that the ALJ should not have dismissed her request for hearing for lack of jurisdiction. We agree.[2]

Based on claimant's representations to the ALJ, we find that the issues raised included temporary disability, as well as penalties. Under these circumstances, the Hearings Division has jurisdiction over this dispute. See Leonard W. Kirklin, 48 Van Natta 1571 (1996) (The Board has jurisdiction over unsatisfied "enforcement" requests regarding prior ALJ/Board orders and the assessment of any related penalties) (citing Harry E. Forrester, 43 Van Natta 1480 (1991)).

In addition, we note that there are potential factual issues[3] in need of resolution. Because no evidence was received and no testimony taken, we conclude that the record has been incompletely developed. See ORS 656.295(5). See also Eston Jones, 49 Van Natta 1841 (1997) (Where the ALJ dismissed the claimant's request for hearing on jurisdictional grounds without admitting any evidence or taking any testimony, even though the claimant desired to proceed to hearing, the record was inadequately developed and remand was appropriate).

Accordingly, we vacate the ALJ's order dated August 4, 1997. This matter is remanded to ALJ Davis for further proceedings consistent with this order to be conducted in any matter that the ALJ determines will achieve substantial justice to all the parties. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] Claimant argues that the employer raised the temporary disability issue by denying "all relief requested." She also argues that the employer should be estopped from arguing that there is no entitlement issue now because it previously contended that there was such an issue before the Department We express no opinion regarding the estoppel argument, the existence of a denied claim for temporary disability compensation, or the merits of any such claim. We do not reach the potential preclusive effect of any prior proceedings. Such issues are for the ALJ to address in the first instance.

[2] Our conclusion is that the Hearings Division has jurisdiction in the first instance because penalties are not the sole issue. This is not an appeal of the Department's May 27, 1996 "Order Denying Assessment of a Penalty Pursuant to ORS 656.262 (11)." See ORS 183.482.

[3] Such issues include whether or when the insurer received notice of a claim for temporary disability and whether any time loss claimed was authorized by claimant's attending physician.

In the Matter of the Compensation of
WALTER P. ZOLNIKOV, Claimant
WCB Case No. 95-13753
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) affirmed a Determination Order which declined to revoke claimant's award of permanent total disability (PTD); and (2) awarded claimant's attorney an assessed fee of $7,000 pursuant to ORS 656.382(2). On review, the issues are PTD and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding the attorney fee issue.

The ALJ awarded a $7,000 attorney fee pursuant to ORS 656.382(2) for claimant's counsel's efforts in successfully defending a prior PTD award. SAIF argues that the ALJ's attorney fee award should be reduced. We disagree.

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

Our review of the record reveals the following information. The issue in dispute was whether claimant's award of PTD should be discontinued. Approximately 59 exhibits were received into evidence. Several post-hearing depositions were conducted. The hearing transcript consists of 95 pages. Four witnesses, including claimant's wife (but not claimant), testified at hearing. Two of the witnesses were experts. Claimant's counsel submitted a statement of services attesting to 30 hours of service.[1]

As compared to a typical case in the Hearings Division, the issue here was of above average complexity. The claim's value and the benefits secured are of well above average proportions, consisting of maintenance of PTD benefits. The hearing was over three hours long. Claimant's counsel skillfully advocated claimant's claim. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)).

After consideration of the aforementioned factors, we conclude that $7,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In reaching this conclusion, we have particularly considered the value of the interest involved and the benefits secured, the time devoted to the PTD issue (as represented by the hearing record and claimant's counsel's statement of services), the complexity of the issue, and the risk that claimant's counsel might go uncompensated.

Furthermore, after considering and applying the same factors to this case on review, we find that a reasonable fee pursuant to ORS 656.382(2) for claimant's counsel's services on review concerning the PTD issue 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. No attorney fee is available for defending the ALJ's attorney fee award. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated June 27, 1997, as "corrected" on July 22, 1997, is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,500, payable by SAIF.

[1] The statement of services describes counsel's time expenditures, including 16 hours of legal research and 8 hours of hearing preparation.

In the Matter of the Compensation of
RAY M. OWEN, Claimant
WCB Case No. 96-02358
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's partial denial of his right inguinal hernia condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable left inguinal hernia on July 19, 1995. (Ex. 9). Dr. Lawson performed surgery on July 20, 1995. (Ex. 4). Three days after surgery, claimant sneezed or coughed and felt discomfort in his right groin. (Exs. 14, 16). Dr. Lawson diagnosed a right inguinal hernia and performed surgery on November 7, 1995. (Exs. 14, 15).

Dr. Blumberg reviewed claimant's medical records on behalf of the insurer and opined that the right inguinal hernia was not related to the July 19, 1995 injury. (Ex. 19). He felt that claimant's right hernia was a congenital defect. (Id.)

On February 28, 1996, the insurer issued a partial denial of claimant's right inguinal hernia claim. (Ex. 20). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPIMON

Claimant relies on Dr. Lawson's opinion to argue that the surgical repair of the compensable left inguinal hernia was the major contributing cause of the consequential right inguinal hernia. See ORS 656.005(7)(a)(A). The ALJ concluded that, although the right hernia was a natural consequence of the left hernia repair, Dr. Lawson's opinion was not sufficient to prove medical causation.

When a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). Barrett Business Services v. Hames, 130 Or App 190, 193, rev den 320 Or 492 (1994).

Claimant's treating physician is Dr. Lawson. In a "check-the-box" letter from the insurer's attorney, Dr. Lawson agreed that "the development of a right sided herniation subsequent to repair of the left is coincidence and there is no indication that [claimant's] right inguinal hernia is related to his work activities ending prior to repair of the left inguinal hernia." (Ex. 21).

In subsequent reports, Dr. Lawson said that claimant's inguinal tissues were weakened on both the left and right sides before the July 19, 1995 injury. (Exs. 23, 24). He explained:

> "The strengthening and repair of the left side corrected the area of greatest weakness first identified when he lifted a heavy chair. His sneezing then produced another episode of high abdominal pressure which at this time was concentrated in what was now the weakest area of the abdominal wall, that being the right groin, and the hernia was manifest." (Ex. 23).

Dr. Lawson felt that, had the left inguinal hernia not been repaired, claimant would not likely have developed the right inguinal hernia. (Id.) Dr. Lawson agreed in a "check-the-box" letter from claimant's attorney that the major contributing cause of the right hernia was the repair of the left hernia. (Ex. 24).

Dr. Lawson's deposition testimony, however, is inconsistent with his agreement that the major contributing cause of claimant's right hernia was the repair of the left hernia. Dr. Lawson testified that claimant had congenital and developmental factors that caused him to develop the right-sided hernia. (Ex. 25-5). Dr. Lawson was asked to consider the congenital and developmental defects, the coughing or sneezing episode and the weakness created by the left hernia repair in order to determine the major causal factor. (Ex. 25-7). Dr. Lawson responded that the main source of claimant's symptoms was the weakness and stretched out condition of other muscles, i.e., the developmental defect. (Ex. 25-8). He opined that claimant had a "typical old man's hernia" that developed over a period of time. (Ex. 25-9). Dr. Lawson did not think the left side repair made the right side any weaker. (Ex. 25-16). He explained that the right side tissues were "very, very weak, very stretched out" and set the stage for a hernia. (Id.) Dr. Lawson said that "the primary cause is the weakness, the stretching out that evolved over many, many years, and that the cough was the straw that broke the camel's back." (Ex. 25-19).

Dr. Lawson's deposition testimony is that the major cause of claimant's right-sided hernia was the developmental defects that developed over many years. We discount Dr. Lawson's earlier agreement that the major contributing cause of claimant's right hernia was the repair of the left hernia because it is conclusory and inconsistent with his subsequent testimony. We conclude that Dr. Lawson's opinion is insufficient to establish that claimant suffered a right inguinal hernia as the direct result of reasonable and necessary treatment of the left inguinal hernia. Rather, Dr. Lawson's testimony establishes that the preexisting developmental defects were the primary cause of the right inguinal hernia. The only other medical opinion in that record was from Dr. Blumberg, who opined that the right inguinal hernia was a congenital defect. (Ex. 19). We agree with the ALJ that claimant's right inguinal hernia condition is not compensable.

ORDER

The ALJ's order dated June 13, 1997 is affirmed.

In the Matter of the Compensation of
LORIS D. WHITTON, Claimant
WCB Case No. 97-04553
ORDER OF DISMISSAL
Reinisch, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Howell's October 16, 1997 order. Contending that claimant neglected to provide notice of his appeal to all parties to the proceeding within 30 days of the ALJ's order, the self-insured employer moves for dismissal of the request for Board review. Because the record does not establish that all parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On October 16, 1997, the ALJ issued an Opinion and Order that: (1) found that claimant had not established "good cause" for his failure to timely request a hearing from the employer's denial of his occupational disease claim for a right elbow condition; and (2) dismissed claimant's hearing request. Copies of that order were mailed to claimant, the employer, its claim processing agent and their attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period.

On Monday, November 17, 1997, the Board received claimant's letter requesting Board review of the ALJ's October 16, 1997 order. Claimant's request, which was enclosed in an envelope postmarked November 14, 1997, did not indicate that copies had been provided to the other parties to the proceeding.

On November 19, 1997, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. See ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance Co. v. King, supra.

Here, the 30th day after the ALJ's October 16, 1997 order was November 15, 1997, a Saturday. Consequently, the final day to perfect an appeal from the ALJ's order was Monday, November 17, 1997. Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as claimant's request for review was received by the Board on November 17, 1997, it was timely filed. See ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, based on the employer's counsel's submission, the employer's first notice apparently occurred when it received a copy of the Board's November 19, 1997 letter acknowledging claimant's request for review. Under such circumstances, the employer's notice of claimant's appeal is untimely. Debra A. Hergert, 48 Van Natta 1052 (1996); John E. Bafford, 48 Van Natta 513 (1996).

Consequently, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's October 16, 1997 order.[1] Therefore, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In the event that claimant can establish that he provided notice of his request for Board review to the other parties to the proceeding within 30 days after the ALJ's October 16, 1997 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his submission as soon as possible.

WORKERS' COMPENSATION CASES

Decided in the Oregon Court of Appeals: Page

Cite as 149 Or App 457 (1997) August 20, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rodney W. Carothers, Claimant.
Rodney W. CAROTHERS, *Petitioner,*
v.
ROBERT WESTLUND CONSTRUCTION and SAIF, *Respondents.*
(Agency No. 96-00472; CA A95577)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 12, 1997.
Robert Sola argued the cause for petitioner. On the brief was Richard Dobbins.
Michael O. Whitty argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration.

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149 Or App 459> Claimant seeks judicial review of a Workers' Compensation Board's order that held that he was not an Oregon subject worker and was not entitled to Oregon workers' compensation benefits. We reverse and remand.

The Board found and concluded:

"Claimant began working for an Oregon employer in April 1995 as a carpenter. His first job was in Oregon, but he was subsequently assigned in September 1995 to a job in Vancouver, Washington. Claimant regularly worked at the Washington job site for about three months.

"The employer obtained workers' compensation coverage through SAIF effective April 1, 1995. SAIF advised the employer that Oregon workers at a temporary Washington worksite would be covered under its policy. SAIF cautioned, however, that, if work was performed at the Washington location for more than 30 days, Washington workers' compensation coverage would be necessary. Aware that the Washington job would take more than 30 days, the employer obtained Washington workers' compensation coverage for its workers at the Vancouver location.

"Claimant was injured in the course and scope of his employment on December 4, 1995 in Vancouver, Washington. Claimant filed a Washington claim that was accepted in that state. Claimant then filed a claim against SAIF that was denied on the ground that he was not an Oregon subject worker. Claimant requested a hearing.

"The [Administrative Law Judge (ALJ)] determined that, if the 'permanent employment relation' test were applied, claimant would be considered an Oregon employee temporarily absent from the state when injured. *See* ORS 656.126(1)[1] *Northwest Greentree, Inc. v. Cervantes-Ochoa,* 113 Or App 186[, 830 P2d 627] (1992). Therefore, the ALJ **<149 Or App 459/460>** reasoned that claimant would have a compensable claim if the test was applicable.

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[1] ORS 656.126(1) provides:

"If a worker employed in this state and subject to this chapter temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of this chapter as though the worker were injured within this state."

"However, the ALJ found that the interstate agreement between Washington and Oregon regarding jurisdiction over out-of-state injuries replaced the employment-relation test. * * * Applying the terms of that accord, the ALJ concluded that, because claimant was injured at a Washington location where the employer did work for more than 30 days in a calendar year, claimant was not employed at a temporary Washington workplace and, thus, was not entitled to Oregon workers' compensation coverage under ORS 656.126(1).

"* * * * *

"* * * Inasmuch as claimant's injury does not qualify for Oregon coverage under the Oregon/Washington interstate agreement, claimant is not considered an Oregon employee temporarily out of the state under ORS 656.126(1). Thus, we agree with the ALJ that claimant is not an Oregon subject worker." (Footnotes and citations omitted.)

In ruling that claimant was not an Oregon subject worker, the Board relied on the agreement between the states of Washington and Oregon regarding reciprocity of workers' compensation benefits. The agreement provides, in part:

"That the Department of Insurance and Finance, Workers' Compensation Division of the State of Oregon in keeping with the provisions of the Oregon Workers' Compensation Law will extend protection for any Oregon employer under its jurisdiction, and benefits to any of the employer's Oregon workers who may be injured in the course of employment in Washington while the employer has a temporary workplace in the State of Washington. In the event of injury to one of these workers, the worker's exclusive remedy would be that provided by the Workers' Compensation Law of the State of Oregon.

"That for the purpose of this agreement, 'temporary workplace' does not include a specific location within the state where the employer's work is performed for more than 30 days in a calendar year."[2]

149 Or App 461> Claimant argues that the agreement does not control his case. SAIF argues that the Director has the authority to enter into agreements that limit when out-of-state workers receive Oregon workers' compensation coverage. *See* ORS 656.126(5).[3] According to SAIF, when the agreement between the states of Washington and Oregon is read in conjunction with ORS 656.126(5), there is no Oregon coverage for a worker in claimant's status unless the worker is working at a temporary workplace. Here, it is uncontroverted that claimant was not working at a temporary workplace.

We disagree that the statute and the agreement have the effect that SAIF urges. They apply when a worker is injured at a temporary workplace. They are silent about when an injury occurs at a nontemporary workplace. If an employer has only a "temporary workplace" in Washington, it is not required to obtain any Washington workers' compensation coverage because Oregon insurers continue to provide exclusive coverage for the employer's workers. The agreement defines what is a "temporary workplace." *See also* ORS 656.126(7).[4]

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[2] This agreement became effective January 1, 1990.

[3] ORS 656.126(5) provides:

"The Director of the Department of Consumer and Business Services shall have authority to enter into agreements with the workers' compensation agencies of other states relating to conflicts of jurisdiction where the contract of employment is in one state and the injuries are received in the other state, or where there is a dispute as to the boundaries or jurisdiction of the states and when such agreements have been executed and made public by the respective state agencies, the rights of workers hired in such other state and injured while temporarily in Oregon or hired in Oregon and injured while temporarily in another state, or where the jurisdiction is otherwise uncertain, shall be determined pursuant to such agreements and confined to the jurisdiction provided in such agreements."

[4] ORS 656.126(7) defines what is a "temporary workplace" within Oregon:

"For the purpose of this section, 'temporary workplace' does not include a single location within this state where the employer's work is performed by one or more workers for more than 30 days in a calendar year."

In this case, it is undisputed that employer was not operating a "temporary workplace" in Washington. Therefore, the agreement and ORS 656.126(5) are inapplicable to claimant's case.

Thus, the question of who is a subject Oregon worker at employer's "nontemporary" workplace in Washington **<149 Or 461/462>** raises an issue outside the scope of the agreement. Because employer's workplace in Washington is outside the definition of a temporary workplace as defined by the agreement and the statute, the status of each worker at that site could vary depending on the circumstances surrounding each worker's employment. For instance, an Oregon worker for employer who works one day at the Washington workplace, where he is injured, might not lose his or her status as a subject Oregon worker, whereas a different employee under different circumstances could lose that status at the same workplace. As we said in *Northwest Greentree, Inc. v. Cervantes-Ochoa*, 113 Or App 186,,188, 830 P2d 627 (1992):

> "With certain exceptions, 'subject workers' include all workers who work in Oregon. ORS 656.005(26); ORS 656.027. Persons who work temporarily outside Oregon generally continue to be covered for workers compensation in Oregon if it is the place of their permanent employment."

The appropriate test to determine whether an employee of an Oregon employer injured in another state is an Oregon subject worker is the permanent employment relation test. *Northwest Greentree, Inc.*, 113 Or App at 189; *see also* ORS 656.126(6).[5] The test requires an evaluation of all the circumstances of the particular employee, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding the claimant's work assignment, the state laws and regulations to which the employer otherwise is subject and the residence of the employee. *Northwest Greentree, Inc.*, 113 Or App at 189-90.

149 Or App 463> Under the proper test, the agreement between the states of Oregon and Washington and the purchase of coverage under Washington law are nonexclusive factors to be considered in the determination of the status of a particular worker. The Board declined to apply the "permanent employment relation test," believing that the Department's agreement exclusively controlled. As we have pointed out, the Department's agreement does not extend to defining who is a subject worker in a nontemporary workplace.

Reversed and remanded for reconsideration.[6]

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[5] ORS 656.126(6) provides:

> "When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon, the total amount of compensation paid or awarded under such other workers' compensation law shall be credited against the compensation due under Oregon workers' compensation law. The worker shall be entitled to the full amount of compensation due under Oregon law. If Oregon compensation is more than the compensation under another law, or compensation paid the worker under another law is recovered from the worker, the insurer shall pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law."

[6] We cannot determine from the Board's opinion whether a majority of the Board would have found claimant to be a subject Oregon worker under the correct test, and, therefore, remand is necessary.

Cite as 149 Or App 581 (1997) September 10, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Roger C. Atchley, Jr., Claimant.
Roger C. ATCHLEY, Jr., *Petitioner,*
v.
GTE METAL ERECTORS and Liberty Northwest Insurance Corporation, *Respondents.*
(95-13677; CA A93414)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 5, 1997.
James S. Coon argued the cause for petitioner. With him on the brief was Swanson, Thomas & Coon.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Reversed and remanded for reconsideration.

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149 Or App 583> Claimant seeks review of an order of the Workers' Compensation Board (Board) upholding a denial of claimant's request for temporary disability benefits. We review for errors of law, ORS 656.298(6); 183.482(8), and reverse.

The undisputed facts, as stated by the Board, are:

> "Claimant sustained a [disabling] compensable injury on May 7, 1993. A Notice of Closure issued on July 7, 1994, finding claimant medically stationary as of June 9, 1994. On January 3, 1995, claimant began an authorized training program (ATP), and the insurer reinstituted payment of temporary total disability (TTD) benefits. Claimant completed the ATP on September 18, 1995, and the insurer suspended payment of TTD benefits at that time.
>
> "A Determination Order (DO) issued on January 5, 1996, reclosing the claim. Noting that claimant had completed the ATP, the DO awarded temporary disability from January 3 through September 18, 1995. The DO also affirmed the June 9, 1994 medically stationary date. Claimant requested a hearing, contending that the insurer was required to continue payment of temporary disability benefits until termination was authorized by ORS 656.268(9). The [administrative law judge (ALJ)] assessed a 25 percent penalty for the insurer's unreasonable suspension of TTD benefit (from which insurer does not appeal). However, citing *Lebanon Plywood v. Seiber,* 113 Or App 651, [833 P2d 1367] (1992), the ALJ declined to award further [temporary] benefits."

The Board affirmed the ALJ's decision.

Claimant contends that the Board erred when it found that claimant was not entitled to temporary disability benefits from September 19, 1995 through January 5, 1996. Specifically, claimant argues that the Board improperly characterized his right to temporary benefits during this period as procedural, not substantive, and thereby improperly applied *Lebanon Plywood* to claimant's case. Claimant argues that because his "entitlement to temporary disability benefits * * * arises from a specific Department rule"--OAR 436-60-040(3)[1]--his entitlement is substantive, and, thus, **<149 Or App 583/584>** his case is not controlled by *Lebanon Plywood.* We agree with claimant.

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[1] Respondents do not dispute the applicability of OAR 436-60-040(3) to this case. We note, however, that since the hearing, OAR 436-60-040 has been amended, renumbering subsection (3) as subsection (2) and making some minor word changes. The changes do not affect this case. Here, we refer to the older version of OAR 436-60-040 as cited by the parties and in effect at the time of the hearing.

Although, as claimant posits, the "development of the distinction between 'procedural'and 'substantive' temporary disability benefits [is] somewhat obscure," the distinction can be ascertained. In *Lebanon Plywood,* the employer sought review of orders of the Board that required it to pay temporary disability benefits during the period betwebn the point at which the claimant became medically stationary and the issuance of a determination order. 113 Or App at 653. This court reversed the Board, reasoning as follows:

> "Substantively, the worker's entitlement to temporary benefits ends on the medically stationary date. Because of delays in processing, the actual payment of temporary benefits continues until the determination order is issued. That delay results in an overpayment of temporary benefits that the employer is entitled to recoup by deduction from any permanent disability compensation awarded. * * * If processing delay does not result in overpayment, the Board has no authority to impose one." *Id.* at 654 (citing ORS 656.268(10)).

In *Roseburg Forest Products v. McDonald,* 116 Or App 448, 841 P2d 697 (1992), the employer appealed a determination order closing the claimant's claim and awarding the claimant temporary disability benefits. The employer argued that the claimant was not entitled to temporary benefits because he had withdrawn from the workforce and, accordingly, refused to pay benefits during the pendency of the appeal. We affirmed, holding that, because the claimant's right to temporary disability benefits during the pendency of appeal arose directly from an earlier version of ORS 656.313(1), his entitlement to such benefits was unconditional, and payment was required regardless of the outcome of the appeal. *Id.* at 452.

Similarly, in *Anodizing, Inc. v. Heath,* 129 Or App 352, 879 P2d 218 (1994), the employer appealed an order of **<149 Or App 584/585>** the Board awarding the claimant temporary disability benefits. During the pendency of the appeal, the employer did not pay the claimant these benefits. The Board relied on the current version of ORS 656.313(1)(a)(A), which provides, in part:

> "Filing by an employer or the insurer of a request for hearing on a reconsideration order * * * stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs[.]"

We held that, because the statute unconditionally entitles a claimant to temporary disability benefits during the pendency period, a claimant was

> "entitled to those benefits during the appeal process, regardless of the outcome. * * * No overpayment of benefits results, as in *Lebanon Plywood.* Had employer paid the benefits during the appeal, it would not be entitled to recoup any of those benefits upon obtaining a reversal of the order on reconsideration." *Anodizing, Inc.,* 129 Or App at 357.

Thus, the general distinction between a substantive and procedural entitlement 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.[2]

Claimant contends that his entitlement to temporary disability benefits is substantive because, unlike *Lebanon Plywood,* but similar to *Roseburg Forest Products* and *Anodizing, Inc.,* it derives from an explicit entitlement. Claimant argues that because OAR 436-60-040(3), like ORS 656.313(1)(a)(A), explicitly mandates the continued payment of temporary disability benefits for a specified period, claimant is substantively entitled to such benefits. We agree.

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[2] We also addressed the "procedural vs. substantive" question in *Vega v. Express Services,* 144 Or App 602, 927 P2d 1106 (1996), *rev den* 325 Or 446 (1997); however, at issue in that case was an order awarding an erroneous amount of compensation, not a question regarding temporary disability benefits. Notwithstanding the distinct factual circumstance, we held generally, and in accord with *Lebanon Plywood* and its progeny, that a substantive entitlement must derive from explicit statutory authority. *Id.* at 607.

149 Or App 586> OAR 436-60-040(3) provides:

> "The insurer shall stop temporary disability compensation payments and resume any suspended award payments upon the worker's completion or ending of the training, unless the worker is not then medically stationary. If no award payment remains due, temporary disability payments shall continue pending a subsequent determination order by the Division. However, if the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by the Division."

The rule requires the insurer to continue to pay temporary disability benefits during the period between completion of a training program and issuance of a redetermination order if the worker is medically stationary, is not entitled to additional permanent disability awards and is not working. Further, like ORS 656.313(1)(a)(A), the regulation makes such payments unconditional. Here, the undisputed facts indicate that, between September 19, 1995 and January 5, 1996, claimant's situation was exactly as described in the rule. Generally, administrative rules and regulations have the same regulatory force as statutes. *Bronson v. Moonen,* 270 Or 469, 476, 528 P2d 82 (1974); *see also Harsh Investment Corp. v. State Housing Division,* 88 Or App 151, 157, 744 P2d 588 (1987), *rev den* 305 Or 273 (1988) (citing *Bronson*). Because claimant was entitled substantively to temporary disability payments during that period, the Board erred in applying *Lebanon Plywood* and in denying claimant temporary benefits for the period in question.

Reversed and remanded for reconsideration.

Cite as 149 Or App 682 (1997) September 10, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sharon A. Daquilante-Richards, Claimant.
Sharon A. DAQUILANTE-RICHARDS, *Petitioner,*
v.
CIGNA INSURANCE COMPANIES and Crane Company, *Respondents.*
(WCB 93-12931, 93-12181; CA A90076)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 1, 1996.
Susan D. Isaacs argued the cause and filed the brief for petitioner.
Vera Langer argued the cause for respondents. With her on the brief was Scheminske, Lyons & Bussman.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Affirmed.

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149 Or App 684> Claimant seeks review of a Workers' Compensation Board order sustaining a notice of closure. We affirm.

Claimant, who was employed as a warehouse worker, sustained an on-the-job injury on November 15, 1990. On December 5, 1990, claimant saw Dr. Irvine, complaining of left lateral elbow pain. Irvine diagnosed work-related left lateral epicondylitis[1], and left rotator cuff syndrome, and on May 2, 1991, insurer accepted those two conditions.

After further examination and treatment of claimant, who was experiencing continuing pain in her neck, left shoulder, and elbow, Irvine began to suspect that he had misdiagnosed her condition. Consequently, he ordered an MRI scan of her neck and, on July 5, 1991, referred claimant to Dr. Flemming for an evaluation of possible cervical radiculopathy. Flemming confirmed the cervical disc herniation shown on the MRI and believed that the elbow pain was not related to the cervical condition.

---

[1] Epicondylitis as described in this case is an infection or inflammation of a projection on the humerus, the long bone of the upper arm. *Stedman's Medical Dictionary,* 536 (2d unabridged lawyers' ed 1966).

Irvine continued to treat claimant's elbow and shoulder pain unsuccessfully and, on November 15, 1991, referred her to Dr. Denekas, who also confirmed cervical disc herniation in her neck. Irvine then referred claimant to Dr. Misko for possible surgery.

Misko corroborated the cervical difficulties and proposed surgery to fuse the discs of claimant's neck. Claimant filed a workers' compensation claim for the cervical disc herniation. After claimant was examined by several other doctors, who concluded that the cervical condition was unrelated to work and was a separate condition from the accepted left lateral epicondylitis and left rotator cuff syndrome, insurer denied compensability of the cervical disc herniation on May 13, 1993.

In a proceeding that was separate from the matter before us, claimant challenged the denial of the cervical disc **<149 Or App 685/685>** disease, contending that insurer's prior acceptance of the left lateral epicondylitis and left rotator cuff syndrome necessarily included her ostensibly related left arm and shoulder synptoms, and any causes of those symptoms, including her cervical condition. The administrative law judge (ALJ) concluded that the

> "insurer asked Dr. Irvine for his diagnosis and then specifically accepted two separate identifiable medical conditions: left rotator cuff syndrome and left lateral epicondylitis. Insurer did not accept symptoms as in *[Georgia Pacific v. Piwowar,* 305 Or 494, 753 P2d 948 (1988)] but accepted medical conditions. It cannot be said that insurer accepted responsibility for whatever the cause of claimant's symptoms were, but rather restricted its acceptance to the two medically recognized conditions. Consequently, [*Piwowar*] is not applicable to the facts of this case. *Boise Cascade Corp. v. Katzenbach,* 104 Or App 732f, 802 P2d 709 (1990), *rev den* 311 Or 261 (1991)].
>
> "* * * Insurer is not barred from denying this condition."

The Board, without comment, adopted and affirmed the ALJ's order on July 29, 1994. Claimant did not seek review of that decision.

On September 3, 1993, while the disposition of claimant's herniated disc condition claim was still pending, insurer closed the accepted claim for epicondylitis and rotator cuff syndrome. That closure is the subject of this appeal. Claimant sought reconsideration, and the Workers Compensation Division rescinded the closure, determining that claimant was not medically stationary on October 28, 1993.

Insurer appealed the Division's order on reconsideration, raising two alternative arguments in support of closure. First, insurer asserted that claimant's accepted epicondylitis and rotator cuff conditions did not exist--and in fact had never existed--and because nonexistent conditions cannot improve, the accepted conditions were necessarily medically stationary. Second, in all events, even if claimant's accepted conditions did exist, those conditions were, nonetheless, stationary on the date of closure.

Claimant responded that insurer, in asserting that her accepted conditions did not exist, was, in effect, issuing a **<149 Or App 685/686>** backup denial. Claimant also asserted that she was not medically stationary, and, thus, that her claim was closed prematurely.

An ALJ set aside the October 28, 1993 order, reinstating the September 3, 1993 notice of closure. The ALJ determined that

> "[c]laimant does not suffer from conditions of left lateral epicondylitis or left rotator cuff syndrome. The symptoms which led to the misdiagnosis of left rotator cuff syndrome and left lateral epicondylitis were actually symptoms of claimant's noncompensable disc condition."

The ALJ further concluded that insurer, by denying the existence of the accepted condition as a basis for closure, had not issued a backup denial.

Claimant appealed, and the Board adopted and affirmed the ALJ's order with supplementation. In its supplementation, the Board emphasized that claimant had the burden of proving that her condition was not medically stationary, *see, e.g., Berliner v. Weyerhaeuser,* 54 Or App 624, 628, 635 P2d

1055 (1981), and that she failed to meet that burden. Consequently, her claim was not closed prematurely. In so holding, the Board expressly rejected as insufficient and unpersuasive the opinions of Irvine and Misko, on which claimant relied:

> "Dr. Irvine, claimant's attending physician, initially diagnosed claimant's condition as left rotator cuff syndrome and left lateral epicondylitis. Later, Dr. Irvine indicated that claimant had cervical radiculopathy that had been present all along and accounted for claimant's upper extremity symptoms. Dr. Irvine explained that it became obvious that his initial diagnoses were in error * * *. Dr. Irvine later stated that claimant did, in fact, have epicondylitis but that this condition was secondary to her C4-5 disc herniation. Dr. Irvine did not believe that any of claimant's conditions were medically stationary at claim closure.
>
> "* * * Dr. Irvine did not adequately explain how claimant's C4-5 cervical disc herniation caused either epicondylitis or rotator cuff pathology. * * * [W]e are not persuaded **<149 Or App 686/687>** that Dr. Irvine distinguished between the accepted conditions and the noncompensable cervical condition when he rendered his opinion concerning claimant's medically stationary status on the date of closure. Accordingly, we find Dr. Irvine's opinion that claimant's condition was not medically stationary on the date of closure to be unpersuasive.
>
> "* * * * *
>
> "* * * Dr. Misko opined that claimant's noncompensable cervical condition was not medically stationary. However, Dr. Misko never addressed whether or not the accepted rotator cuff syndrome and epicondylitis conditions were medically stationary. Accordingly, Dr. Misko's opinion is not persuasive concerning whether or not the accepted condition was medically stationary on the date of closure." (Emphasis in original.)

On judicial review, claimant reiterates her arguments that (1) "insurer's argument that accepted conditions never existed constitutes an improper backup denial under ORS 656.262(6)(a)";[2] and (2) her accepted conditions were not medically stationary on the date of claim closure. We do not address or resolve claimant's backup denial argument because we conclude that the Board's alternative ground for sustaining the notice of closure--*i.e.*, that, even assuming the accepted conditions existed, claimant had failed to meet her burden of proving that they were not medically stationary affords an independent and sufficient basis for affirmance.[3]

149 Or App 688> We review Board orders for substantial evidence and errors of law. ORS 183.482(7),(8); ORS 656.298; *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). To be properly reviewed, the Board order must establish a set of findings of fact and explain why the facts support its conclusion. *Id.* at 207. "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).

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[2] ORS 656.262(6)(a) provides in pertinent part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer * * * within 90 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer * * * shall not revoke acceptance except as provided * * *. If the insurer * * * accepts a claim in good faith, and later obtains evidence that the claim is not compensable the insurer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance."

[3] Given our disposition, we imply no opinion as to the propriety of insurer's arguments that claimant's accepted conditions "never existed," particularly with respect to any entitlement to permanent compensation, which is not at issue here. *Cf Boise Cascade v. Borgerding*, 143 Or App 371, 374, 923 P2d 1308 (1996) (where insurer denied compensability, after discovering more than two years from the date of acceptance that claimant's condition had been misdiagnosed and was not work-related, that denial constituted a "back-up denial" under ORS 656.262(6)).

ORS 656.268(1) permits an insurer to close accepted claims when the compensable conditions have become medically stationary. An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). *See Pratt v. SAIF,* 29 Or App 255, 258, 562 P2d 1242 (1977) (describing "medically stationary" as less than complete recovery, but continued treatment or the passage of time, with reasonable medical probability, will not likely improve the injured worker's condition). Claimant had the burden of proving, by competent medical evidence, that her condition was not medically stationary at the time of closure. *Berliner,* 54 Or App at 628; *Harmon v. SAIF,* 54 Or App 121, 125, 634 P2d 274, *rev den* 292 Or 232 (1981).

We agree with insurer that substantial evidence supports the Board's determination that claimant did not meet her burden of showing that she was not medically stationary when insurer issued a Notice of Closure on September 3, 1993. Claimant asserts, as she did before the Board, that the opinions of Irvine and Misko were sufficient to meet that burden.[4] However, the Board could and did determine that, although Irvine did not believe that claimant was medically stationary, his opinion did not adequately distinguish between the status and effects of claimant's noncompensable **<149 Or App 688/689>** cervical condition and the accepted rotator cuff and epicondylitis conditions. Similarly, the Board could and did determine that Misko's opinion focused on the noncompensable cervical condition and, as the Board determined, "never addressed whether or not the accepted rotator cuff syndrome and epicondylitis conditions were medically stationary." We perceive no error in assessment of those opinions. *See, e.g., Bank of Newport v. Wages,* 142 Or App 145, 919 P2d 1189 (1996). Because substantial evidence supports the Board's determination that claimant failed to establish that the accepted conditions were not medically stationary at the time of closure, the Board did not err in sustaining the notice of closure.

Affirmed.

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[4] Claimant contends that Irvine, as her treating physician, was the only person who could declare her medically stationary. However, OAR 436-030-0035(1) provides:

> "A worker's compensable condition shall be determined to be medically stationary when the attending physician *or a preponderance of medical opinion* declares the worker either 'medically stationary,' 'medically stable,' or uses other language meaning the same thing." (Emphasis supplied.)

Cite as 150 Or App 136 (1997) September 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Harley J. Gordineer, Claimant.
LIBERTY NORTHWEST INSURANCE CORPORATION and M.O. Nelson & Sons, Inc., *Petitioners - Cross-Respondents,*
v.
Harley J. GORDINEER, *Respondent - Cross-Petitioner,* and H & B TRUCKING and CIGNA Ins. Co.; Oceanway Transportation, Inc. and SAIF Corporation, *Respondents.*
(94-04853, 94-00533, 93-14467; CA A91688)

Judicial Review from Workers' Compensation Board.

On Claimant/Respondent's Petition for Award of Attorney Fee filed November 13, 1996, and Petitioners' Objection to Claimant/Respondent's Motion for an Extraordinary Attorney Fee filed November 27, 1996.

David C. Force for petition.

David O. Wilson, *contra.*

Before Landau, Presiding Judge, and Haselton and Armstrong, Judges.

LANDAU, P. J.

Petition for an award of attorney fees allowed in the amount of $3,500.

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150 Or App 138> Employer M.O. Nelson & Sons (Nelson) sought judicial review of an order of the Workers' Compensation Board (Board) that set aside Nelson's responsibility denial. We affirmed without opinion. *Liberty Northwest Insurance Corp. v. Gordineer,* 144 Or App 495, 928 P2d 364 (1996).

Claimant now petitions for attorney fees on appeal. We allow the petition and award claimant $3,500 in attorney fees.

The facts relevant to our disposition of this petition are taken from the Board's findings. In January 1979, claimant compensably injured his lower back while working for employer H & B Trucking (H & B). He became medically stationary in June 1980. The July 1980 determination order closing his claim awarded him 10 percent unscheduled permanent disability. The claim was later reopened, and claimant underwent further treatment. The claim was reclosed in November 1984, and claimant was awarded an additional 50 percent unscheduled permanent disability. In May 1986, claimant compensably injured his left shoulder and back while working for employer Oceanway Transportation, Inc. (Oceanway). In August 1987, claimant's Oceanway claim was closed, with claimant receiving temporary disability, but no permanent disability.

On September 28, 1993, while working as a truck driver for Nelson, claimant was loading his trailer when he was hit in the right eye by a tree limb. He recoiled, lost his balance, and fell onto his left side and back. Although he received intervening treatments for his eye injury, claimant did not mention that the incident had also caused additional back pain until a doctor's appointment on October 5, 1993. On October 13, 1993, claimant filed an injury claim alleging eye and back injuries. On December 8, 1993, Nelson denied responsibility for claimant's back injury and asserted that Oceanway was responsible. On March 17, 1994, H & B similarly denied responsibility for the back injury. On May 31, 1994, Oceanway advised claimant that "this is a denied claim and as a matter of law [claimant] has no aggravation rights in this claim." Claimant filed separate requests for hearing on the denials of responsibility issued by H & B and Nelson. He also filed a hearing request against Oceanway on issues of **<150 Or App 138/139>** temporary disability, but not of responsibility. The Director declined to issue an ORS 656.307 order.

The Board found that the September 28, 1993, incident was the major contributing cause of claimant's subsequent low back condition and resulting disability. Because claimant had sustained a new compensable injury, the Board concluded, responsibility had shifted from H & B to Nelson. *See* ORS 656.308(1). The Board set aside Nelson's responsibility denial.

Claimant requested an award of $10,822.50 in attorney fees under ORS 656.386(1), which provides for an award of attorney fees when a claimant finally prevails against an employer's refusal to pay compensation on the express ground that the condition or injury is not compensable. Claimant argued that, although neither H & B nor Nelson had denied compensability, the statute still applied, because *the effect* of their responsibility denials would have been to deny claimant any compensation, given that claimant had not filed a claim against Oceanway. The Board agreed and awarded claimant $8,000 in attorney fees.

Meanwhile, the 1995 legislature amended the workers' compensation statutes by, among other things, enacting a new provision at what is now 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."

That amendment applies to pending cases. *See generally Volk v. America West Airlines,* 135 Or App 565, 572-73, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). Accordingly, on its own motion, the Board withdrew its order awarding attorney fees to consider the effect, if any, of ORS 656.308(2)(d). Claimant argued that the amendment did not apply, because the case represented effectively a denial of compensability, not merely a denial of responsibility. The Board concluded that it was not necessary to decide that question, because even if the case involved a responsibility denial, extraordinary circumstances justified the $8,000 fee.

Nelson petitioned for judicial review, assigning error only to the portion of the Board's order setting aside Nelson's responsibility denial; Nelson did not assign error to the award of attorney fees. Following our affirmance, claimant now moves for an award of an additional $6,912.50 in attorney fees, once again under ORS 656.386(1) and also under ORS 656.382(2), which provides for an award of

attorney fees to a claimant on an employer appeal, if the court concludes "that the compensation awarded to a claimant should not be disallowed or reduced." Nelson opposes the award, citing ORS 656.308(2)(d), arguing that, under the new statute, claimant's award must be limited to $1,000. Claimant replies that the new statute does not apply, because this effectively is a compensability case, and ORS 656.308(2)(d) applies only to responsibility denials. In fact, claimant argues that, because the Board agreed with him on that point, we are bound to follow it as a matter of "*res judicata.*"

We first address whether ORS 656.308(2)(d) applies to claimant's petition. We conclude that it does. The statute applies to "responsibility denials," and there is no debate that Nelson's sole defense to the claim was its denial of responsibility.[1] We find unpersuasive claimant's arguments that, either because the Board said so or because the claim is, in its pragmatic essence, not really a responsibility denial, ORS 656.386(1) and ORS 656.382(2) govern this motion and that ORS 656.308(2)(d) is irrelevant. As for the Board's prior decision, we understand claimant's reliance on what he characterizes as "*res judicata*" to refer to the principle of the "law of the case." *See Blanchard v. Kaiser Foundation Health Plan,* 136 Or App 466, 470, 901 P2d 943, *rev den* 322 Or 362 (1995) (explaining law of the case rule). That principle does not apply in this case for the simple reason that the Board did not hold that ORS 656.308(2)(d) does not apply. It held that, whether the statute applied or not, claimant was entitled to $8,000 in fees. As for the merits of the point, claimant is simply incorrect. First, ORS 656.386(1) applies only if an **<150 Or App 140/141>** employer refuses to pay "on the express ground that the injury or condition for which compensation is claimed is not compensable." That did not occur in this case, in which Nelson expressly disclaimed *responsibility,* not compensability. Second, and in any event, ORS 656.308(2)(d) applies, by its own terms, "*[n]otwithstanding ORS 656.382(2), [and ORS] 656.386.*" Thus, even if the statutes on which claimant relies otherwise apply, if claimant finally prevails on a responsibility denial, ORS 656.308(2)(d) applies.

We turn, then, to the question whether ORS 656.308(2)(d) limits the extent to which claimant may recover attorney fees on review. The text of the statute unambiguously provides that, in the absence of "extraordinary circumstances," the maximum attorney fee a claimant may recover "in finally prevailing against a responsibility denial" is $1,000. That is a limitation on the amount of fees a claimant who finally prevails may recover "against a responsibility denial," that is, for the entire case. The statute does not impose a limitation of $1,000 on the amount of fees that may be awarded at various stages of the case. When the legislature intends to do that, it plainly says so. *See, e.g.*, ORS 656.386(1) (allowing an award of fees "where a claimant finally prevails against the denial in an appeal" (emphasis supplied)); ORS 656.382(2) (allowing an award of fees to a claimant who prevails on an employer-initiated "request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court"); ORS 656.388(1) (allowing an award of fees when a claimant "finally prevails after remand from the Supreme Court, Court of Appeals or Board"). In contrast, in ORS 656.308(2)(d), the legislature chose different language, calling for a single award when a claimant finally prevails in a responsibility denial case. That award is limited to $1,000, "absent a showing of extraordinary circumstances."

In this case, we need not examine precisely what the legislature intended "extraordinary circumstances" to mean, because Nelson does not challenge the Board's finding that such extraordinary circumstances exist in this case. Nelson does suggest that we should conclude that, even though there may have been extraordinary circumstances at the Board level, none exist on appeal. We reject that suggestion. As we **<150 Or App 141/142>** have noted, the statute plainly does not contemplate reexamining, at each stage of a claim, the extent to which an award may exceed $1,000. If extraordinary circumstances exist, then the final award of attorney fees to a claimant who prevails against a responsibility denial is not limited to $1,000. The Board so found, and Nelson does not challenge that finding.

That leaves us with the final issue of the amount of the fee to which claimant is entitled under ORS 656.308(2)(d). The statute provides that, whether the $1,000 "cap" applies, in all cases, the award of attorney fees must be reasonable. Nelson contends that claimant's request of nearly $7,000 is

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[1] We do not hold that ORS 656.308(2)(d) necessarily applies to all responsibility denials. In particular, we do not address whether responsibility denials processed under ORS 656.307--and for which "a reasonable fee for claimant's attorney" may be awarded under ORS 656.307(5)--are subject to the limitation of ORS 656.308(2)(d). This is not a "section 307" case.

unreasonable. According to Nelson, the petition for judicial review involved two substantial evidence issues that required no great amount of research or preparation, certainly not a virtual duplication of the expense involved in presenting the case at the hearing level. Claimant replies with the assertion that his fee request is reasonable. We agree with Nelson, and conclude that an award of $3,500 is reasonable given the nature of the issues presented to this court.

Petition for an award of attorney fees allowed in the amount of $3,500.

Cite as 150 Or App 154 (1997) September 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patricia A. Landers, Claimant.

BAY AREA HOSPITAL and Health Future Enterprises, *Petitioners,*
v.
Patricia A. LANDERS, *Respondent.*
(95-12560; CA A94758)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 23, 1997.
Cynthia A. Wiens argued the cause for petitioners. With her on the brief was Cowling, Heysell, Plouse, Ingalls & Moore.
Benton Flaxel argued the cause for respondent. With him on the brief was Flaxel & Nylander.
Before Deits, Chief Judge, and Edmonds and Haselton, Judges.
HASELTON, J.
Reversed and remanded for reconsideration in the light of amended ORS 656.262(10).

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150 Or App 156> Employer petitions for review of an order issued by the Workers' Compensation Board, in which the Board affirmed an administrative law judge's order setting aside employer's partial denial of claimant's chondromalacia condition. We reverse and remand.

This case arises from an aggravation claim that claimant filed with employer for an alleged worsening of the chondromalacia patella condition in her left knee. Claimant had previously suffered an on-the-job injury to her left knee and had filed a claim with regard to that injury, which employer accepted. Claimant suffered intermittent pain in her left knee, and her physician diagnosed her condition as chondromalacia patella in the left knee. Claimant thereafter filed an aggravation claim for that condition, which employer denied on the ground that her chondromalacia patella condition was a preexisting condition that predated her left knee injury, and, therefore, that the worsening of that condition was not caused by the on-the-job injury. The Board concluded that: (1) employer did not accept the chondromalacia patella condition when it accepted her original injury claim; but (2) under *Deluxe Cabinet Works v. Messmer,* 140 Or App 548; 915 P2d 1053, *rev den* 324 Or 305 (1996) *(Messmer II),* employer was "precluded from contesting the compensability of claimant's chondromalacia patella condition because it did not appeal the orders which awarded permanent disability based, in part, on [that condition]."

Thus, the Board's holding was premised on our analysis in *Messmer II.* After the Board's decision, and after oral argument in this case, the legislature materially amended ORS 656.262(10), the statute at issue in *Messmer II. See* Or Laws 1997, ch 605, § 1. The amended subsection 10 now reads:

> "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 **<150 Or App 156/157>** 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 language emphasized.)

That amendment retroactively applies to "all claims or causes of action existing * * * on the effective date of this Act * * *." Or Laws 1997, ch 605, § 2.

The amendment may well affect the Board's rationale for setting aside the employer's denial. Consequently, we reverse and remand to the Board to consider the effect of that amendment.

Reversed and remanded for reconsideration in the light of amended ORS 656.262(10).

Cite as 150 Or App 245 (1997) September 24, 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.

On respondent Murphy Plywood/Liberty Northwest Insurance Corporation's petition for reconsideration filed July 31, 1997; and on respondents Douglas County Forest Products/Liberty Northwest Insurance Corporation's and Parkway Ford/Liberty Northwest Insurance Corporation's petition for reconsideration filed July 31, 1997. Opinion filed June 18, 1997. 148 Or App 484, 941 P2d 1030.

Brian L. Pocock for respondent Murphy Plywood/Liberty Northwest Insurance Corporation's petition.

David O. Wilson for respondents Douglas County Forest Products/Liberty Northwest Insurance Corporation's and Parkway Ford/Liberty Northwest Insurance Corporation's petition.

Patricia Nielsen and Mannix, Nielsen & Crawford, P.C., *contra.*

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

150 Or App 246> LEESON, J.

Reconsideration allowed; opinion modified and adhered to as modified.

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150 Or App 248> Respondents Liberty Northwest Insurance Corporation and its insureds, Douglas County Forest Products, Parkway Ford and Murphy Plywood, seek reconsideration of our opinion in this case. *Norstadt v. Murphy Plywood,* 148 Or App 484, 941 P2d 1030 (1997). In our opinion, we held that an insurer that fails to comply with the disclaimer requirement of ORS 656.308(2) (1990) loses the defense of no responsibility. Because none of claimant's past employers insured by Liberty Northwest properly disclaimed responsibility for the claim, we remanded the case to the Workers' Compensation Board to determine how responsibility should be assigned among the improperly disclaiming employers.

On July 3, 1997, the Supreme Court decided *Beneficiaries of Strametz v. Spectrum Motorwerks,* 325 Or 439, 939 P2d 617 (1997), holding that the last injurious exposure rule cannot place responsibility on an employer whose working conditions were *capable* of causing the claimant's disease, but who has established that *in fact* those conditions did not cause the claimant's disease. We allow reconsideration to consider the effect of the Supreme Court's opinion and to correct a factual misstatement in our opinion.

In our opinion we said:

> "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."

Norstadt, 148 Or App at 488 (emphasis supplied). In their petitions for reconsideration, respondents correctly point out that the emphasized portion is a misstatement. The Board found that periods of employment before and after DCFP/ LUA did not independently contribute to claimant's condition. The significance of those findings is that claimant's periods of employment with each of the petitioning Liberty employers did not independently contribute to claimant's condition.

150 Or App 249> In our opinion, we relied on the 1990 version of ORS 656.308(2) to conclude that the Liberty employers nonetheless are precluded from denying responsibility for the claim. That statute 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."

We held that that version of the statute, without its 1995 amendments, was applicable to this case and further held that none of the Liberty employers had disclaimed responsibility for the claim properly. *Norstadt,* 148 Or App at 495. Consequently, we held, they are precluded from asserting as a defense that actual responsibility for the claim lies with another insurer or employer.

Our conclusion depended on application of the *procedural* requirements of the 1990 version of ORS 656.308(2): An employer that does not properly disclaim responsibility may not argue that it is not responsible for a claim. The Supreme Court's opinion in *Strametz* involved the last injurious exposure rule, not the procedural requirements of the 1990 version of ORS 656.308(2). The question in *Strametz* was whether, as a substantive matter, responsibility may be assigned to an insurer that has established that it was not the actual cause of the claimant's condition. The court's answer was "no." However, when an insurer is barred from asserting no responsibility as a defense, whether the actual cause of the condition is the work with the insurer's employer or with another employer is of no moment. Consequently, the Board's finding in this case, that claimant's periods of **<150 Or App 249/250>** employment with the Liberty employers did not contribute independently to his condition, does not affect our analysis. The Liberty employers are precluded by the 1990 version of ORS 656.308(2) from asserting that they are not responsible for the claim. We adhere to that holding in our original opinion.

Reconsideration allowed; opinion modified and adhered to as modified.

Cite as 150 Or App 269 (1997) October 1, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joseph S. Baggett, Claimant.

Joseph S. BAGGETT, *Petitioner,*
v.
THE BOEING COMPANY and AETNA Casualty Co., *Respondents.*
(WCB 92-13133; CA A95217)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 9, 1997.
Nicholas M. Sencer argued the cause for petitioner. With him on the brief was Pozzi Wilson Atchison.
Jerald P. Keene argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Reversed and remanded.

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150 Or App 271> Claimant seeks review of an order of the Workers' Compensation Board that established his permanent disability award. The Board held that the proper date for determining the Specific Vocational Preparation (SVP) component of the education component of rating his unscheduled permanent disability is the date of the original determination order, not of the subsequent order on reconsideration. In reaching that conclusion, the Board followed the applicable rule. *Former* OAR 436-35-300.[1] Because we conclude that that portion of the rule is contrary to the relevant statute, we reverse.

A claimant or employer who objects to a determination order must first request reconsideration. ORS 656.268(5)(b). On reconsideration, the claimant or employer may correct erroneous information and submit certain medical evidence; the department may also require additional medical or other evidence. ORS 656.268(6)(a), (b).

A party who objects to the reconsideration order may request a hearing. ORS 656.268(6)(f). After reconsideration, however, no additional medical evidence is admissible for the purpose of making findings on impairment. ORS 656.268(7)(g). Any other evidence concerning the worker's impairment that was not submitted on reconsideration is not admissible at the hearing, and no party may raise any issue that was neither raised on reconsideration nor arises out of the reconsideration order. Evaluation of the worker's disability shall be as of the date of the issuance of the reconsideration order. ORS 656.283(7).

The statutes, thus, tie both the evidence and the substantive issues at the hearing to what occurred on the reconsideration of the original determination order rather than on **<150 Or App 271/272>** the issuance of the order itself In contrast, *former* OAR 436-35-300(3) tied the determination of the value of SVP to the "time of determination," which *former* OAR 436-35-005(12) defined as the mailing date of the determination order.[2] In *Safeway Stores, Inc. v. Smith,* 122 Or App 160, 857 P2d 187 (1993), we held that ORS 656.283(7) was unambiguous and required that the adaptability factor be rated as of the date of the reconsideration order. We see no reason to reach a different conclusion as to the SVP aspect of the education factor and therefore hold that former OAR 436-35-300(3) was invalid to the extent that it provided a different date for determining SVP.

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[1] SVP is based on the job or jobs that the worker has held within the previous five years. *Former* OAR 436-35-300(3). The lower the skill level of the job, the greater the SVP value and, thus, the greater the award of compensation. In this case, if the applicable period is measured from the determination order, the value for the education factor derived from SVP will be 1; if it is measured from the order on reconsideration, the value will be 4. In the first case, claimant will receive total unscheduled disability of 43 percent; in the second, after correcting a scrivener's error, he will receive 55 percent.

[2] The current rules use different terms to reach the same result. *See* OAR 436-035-0300(3); OAR 436-035-0005(15).

The Board held that the rule was valid because of the director's authority under ORS 656.726(3)(f) to establish standards for evaluating disabilities and of the requirement in ORS 656.283(7) that the ALJ and the Board apply the director's rules. It distinguished between the date for assigning an SVP value and the date for evaluating the claimant's disability.

We do not see the distinction that the Board saw. The SVP value is an essential part of evaluating the disability. As we held in *Safeway Stores, Inc.*, the statute is unambiguous. The time for rating permanent disability is an exact term that is not subject to administrative alteration. A rule that purports to alter it is, to that extent, not valid. *See England v. Thunderbird*, 315 Or 633, 848 P2d 100 (1993) (rules that worker who returned to worker's usual work could not have age, education, or adaptability considered in determining permanent loss of earning capacity were contrary to statutory directive and therefore invalid).

ORS 656.726(3)(f) requires the Board to apply the director's standards; it does not require the Board to apply those standards as of a time that is contrary to the time that the statutes established. The legislature has provided a time certain, the date of the order on reconsideration, for that purpose. The director cannot, by rule, change that time certain **<150 Or App 272/273>** as to SVP any more than it could as to any of the other factors that are part of determining the extent of disability.

Employer argues that rejecting the director's rules as to the time of determination could lead to anomalous results. It posits that a claimant who had a skilled job almost five years before the determination order might seek reconsideration of the order solely to extend the time of determination, thus ensuring that that job would not factor into the ultimate determination of disability. Employer fails to note that, in the same way, an employer could seek reconsideration because it knew that a claimant had taken a skilled job after issuance of the determination order and could thereby reduce a claimant's award. Either result is the necessary consequence of the legislative decision to establish a precise time for determining the extent of disability. That policy decision is within the legislature's authority and the director cannot change it, by rule or otherwise.

Reversed and remanded.

Cite as 150 Or App 300 (1997) October 1, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert W. Stephenson, Claimant.

Robert W. STEPHENSON, *Petitioner,*
v.
Larry MEYER; Helen Meyer; and Country Companies, *Respondents.*
(Agency No. 95-06940; CA A95935)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 12, 1997.
Dale C. Johnson argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson & Jensen.
John E. Pollino argued the cause for respondents. With him on the brief was Garrett, Hemann, Robertson, Paulus, Jennings & Comstock.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Affirmed.

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150 Or App 302> Claimant seeks review of an order of the Workers' Compensation Board (Board) that denied claimant's request for employer-paid attorney fees after the Board ruled in claimant's favor by setting aside employer's denial of a claim as premature.

Claimant filed a claim for symptoms that he attributed to an on-the-job exposure to pesticide spray. While the claim was being processed,[1] his employer's insurer sent claimant a letter regarding a supposed condition that was not part of his claim. The letter said, in part:

[1] Claimant subsequently withdrew his original claim.

> "Medical information recently received concludes that your mild obstructive airway disease, and any current obstruction, is entirely consistent with your underlying problems of longstanding reactive airway disease with intermittent exacerbations, and in no way can be construed to represent a permanent injury related to the inhalation/spray exposure of June 6, 1992. Therefore we must issue this partial denial of your current condition and of any permanent impairment associated with it as your work exposure was not the major cause."

Based on the insurer's letter, claimant requested a hearing. At the hearing, he contended that the letter constituted the denial of a claim and that the denial was premature because no claim had ever been filed for the condition described in the letter. The administrative law judge (ALJ) agreed with claimant's argument and awarded claimant attorney fees pursuant to ORS 656.386(1). The insurer sought review. The Board, on review and by order on reconsideration, upheld the ALJ's analysis regarding the denial of a claim but held that claimant was not entitled to attorney fees, reasoning that claimant "received no benefit as a result of our decision that the carrier's denial was a nullity because there was no 'claim' to deny."

In his petition for review to this court, claimant contends that under ORS 656.386(1) he is entitled to attorney fees as a matter of law because he prevailed in the setting **<150 Or App 302/303>** aside of a prematurely denied claim. He concedes that if the statutory definition of the word "claim" in ORS 656.005(6) is applicable to ORS 656.386(1), the Board's order denying him attorney fees is correct because no "written request for compensation" was ever made. However, citing ORS 656.003, claimant argues that, in the context of ORS 656.386(1), the phrase "denied claim" "must be read broadly enough to allow attorney's fees * * * when insurers force litigation by issuing a formal expressed denial without first having received a claim."

Employer argues that "a 'claim' is required before any award of attorney fees can be made pursuant to ORS 656.386(1)," and that, because claimant made no claim for the condition described in the letter, the Board properly denied attorney fees.

Unless specifically authorized by statute, the Board has no authority to award attorney fees, even though an inequity could result. *Forney v. Western States Plywood*, 297 Or 628, 632, 686 P2d 1027 (1984); *see also Safeway Stores, Inc. v. Cornell*, 148 Or App 107, 939 P2d 99 (1997) (holding that even though claimant prevailed in his request to be reimbursed for taxi fares to medical appointments, no statutory basis for an award of attorney fees existed). ORS 656.386(1) provides, in part:

> "In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. * * * 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 is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation.*" (Emphasis supplied.)

ORS 656.003 provides:

> "Except where the context otherwise requires, the definitions given in this chapter govern its construction."

ORS 656.005(6) provides, in part:

> "'Claim' means a written request for compensation from a subject worker or someone on the worker's behalf[.] "[2]

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[2] The second clause of ORS 656.005(6), which provides that in addition to a written request for compensation a claim is also "any compensable injury of which a subject employer has notice or knowledge," is not at issue in this case.

Our task in interpreting a statute is to discern the intent of the legislature. Our first level of inquiry is to examine the text and context of the statute and, if the legislature's intent is clear from that examination, no further inquiry is necessary. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). Under ORS 656.005(6), a "claim" is a "written request for compensation." A "denied claim" under ORS 656.386(1) is "*a claim for compensation* which an insurer or self-insured employer *refuses to pay* * * *." (Emphasis supplied.) The legislature's intent is clear. In context, a "denied claim" is an insurer's refusal to pay in response to a written request for compensation. *See SAIF v. Allen*, 320 Or 192, 201, 881 P2d 773 (1994) ("The term 'claimant' in * * * ORS 656.386(1) indicates that a 'claim' is a prerequisite to the recovery of a fee award."); *Safeway Stores, Inc. v. Johnson*, 134 Or App 432, 436, 895 P2d 811 (1995) ("The right to attorney fees under ORS 656.386(1) 'is predicated on the existence of a "claim for compensation * * *."'")[3] (Citation omitted.)

The rest of the text of ORS 656.386(1) is also clear. The statute limits the Board's authority to award attorney fees to claimants in cases where (1) there is a request for compensation; (2) the request for compensation is denied; and (3) the claimant prevails finally against the refusal to pay compensation as requested. Therefore, because no claim was ever made in this case as defined by ORS 656.005(6), the legal predicate for an award of attorney fees under ORS 656.386(1) does not exist. Neither we nor the Board possess the authority to expand the language of the statute to **<150 Or App 304/305>** embrace circumstances not covered by it. *See* ORS 174.010. Claimant's argument is one that must be made to the legislature. We conclude that the Board did not err by denying claimant's request for attorney fees.

Affirmed.

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[3] These cases construe the statutes in question before ORS 656.386(1) was revised by the 1995 Legislature. In our view, the 1995 revisions did not affect the basis for the reasoning in either *Allen* or *Johnson* but were intended to address an entirely different problem. We note that the 1997 Legislature has again revisited ORS 656.386(1) but that the revisions that went into effect on July 25, 1997, were not made retroactive and are therefore not applicable to this case.

Cite as 150 Or App 357 (1997) October 1, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Susan A. Michl, Claimant.

BEVERLY ENTERPRISES, *Petitioner*,
v.
Susan A. MICHL, *Respondent*.
(93-04959; CA A94779)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 11, 1997.
Jerald P. Keene argued the cause and filed the brief for petitioner.
David C. Force argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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150 Or App 359> Employer petitions for review of a decision by the Workers' Compensation Board setting aside employer's denial of claimant's compensation claim. We conclude that the decision of the Board is supported by substantial evidence in the record and, accordingly, affirm.

Claimant applied for workers' compensation benefits after she slipped at work and dislocated her knee. Employer denied her claim on the ground that her injury was not work related. Claimant requested a hearing, where the referee upheld the denial. Claimant then requested review by the Board, which reversed the order of the referee and held claimant's injury to be compensable.

Employer argues that the Board failed to apply the proper standard of proof to the evidence before it. Specifically, employer argues that it is clear from the medical evidence that claimant suffered from a preexisting condition, described as a "patellae tracking problem," that predisposed her knee to dislocation and that the Board neglected to apply the standard of proof required by ORS 656.005(7)(a)(B) for injuries caused in part by preexisting conditions.[1] Claimant argues in response that there is no medical evidence that she suffered from a preexisting condition and that, without such evidence, the Board was not required to find that her injury was caused, in part or in whole, by a preexiisting condition. We agree with claimant.

150 Or App 360> The medical evidence before the Board consisted of copies of claimant's medical files and a letter from claimant's treating physician. The files showed that claimant had suffered injuries to her left knee in the past, including dislocation. The physician's letter noted the previous dislocation, stated that it was fully healed and concluded that the complained of injury solely was attributable to claimant's work-related accident. Employer points to notations in claimant's medical records of "patellae tracking problems" and diagnoses of "dislocating kneecap" to argue that claimant suffers from a predisposition to knee dislocation. We are not persuaded. The medical exhibits do not indicate definitively that such "tracking" problems were an ongoing condition, existing even while there was no apparent injury to daimant's knee. Employer also failed to present any medical evidence defining a "patellae tracking problem" as an ongoing condition. The only *objective* medical evidence[2] before the Board as to the cause of claimant's disputed injury was the attending physician's letter, which stated that the injury solely was caused by the work-related accident.[3] ORS 183.484(4)(c) provides that "[s]ubstantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." Given the medical evidence available to the Board, it was reasonable for it to conclude that claimant's knee dislocations were specific, discrete injuries, not the result of an ongoing condition predisposing claimant's knee to dislocation. Accordingly, the Board did not err in refusing to apply the standard set forth in ORS 656.005(7)(a)(B) for injuries combined with preexisting conditions.

Affirmed.

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[1] ORS 656.005(7)(a)(B) provides:

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

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."

[2] ORS 656.005(7)(a) requires that compensable injuries be established by medical evidence supported by objective findings.

[3] Employer also contends that physician's use of the term "recurrent" in relation to the knee dislocation indicates a preexisting condition. We disagree. It is equally reasonable that the physician's use of that word merely indicates a recognition by the physician that claimant had had such an injury before, without creating a link between the injuries.

Cite as 150 Or App 361 (1997) October 1, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marilyn A. Crisp, Claimant.

WEYERHAEUSER COMPANY, *Petitioner,*
v.
Marilyn A. CRISP, *Respondent.*
(WCB 96-01221; CA A96001)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 9, 1997.
John M. Pitcher argued the cause and filed the brief for petitioner.
Dale C. Johnson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

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150 Or App 362> Employer seeks review of a decision in which the Workers' Compensation Board held that an administrative law judge's (ALJ) previous unappealed award of permanent disability foreclosed employer from denying claimant's current back problems. *See Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 915 P2d 1053, *rev den* 324 Or 305 (1996). The legislature has since amended ORS 656.262(10) to read, in part:

> "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." Or Laws 1997, ch 605, § 1 (new language emphasized).

The amendment expressly applies to "all claims or causes of action existing or arising on or after the effective date of this Act" and thus applies to this claim. Or Laws 1997, ch 605, § 2. The Board must reconsider the claim in light of that amendment.

Reversed and remanded for reconsideration.

Cite as 150 Or App 391 (1997) October 8, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Gaylen BROWN, *Appellant*,
v.
BOISE-CASCADE CORPORATION, a Delaware corporation, *Respondent*.
(9403-02265; CA A89371)

Appeal from Circuit Court, Multnomah County.
Robert W. Redding, Judge.
Argued and submitted February 19, 1997.
J. Rion Bourgeois argued the cause and filed the briefs for appellant.
Thomas M. Christ argued the cause for respondent. With him on the briefs was Mitchell, Lang & Smith.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Reversed and remanded for new trial on inadequate lighting specifications of plaintiffs negligence *per se* claim; otherwise affirmed.

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150 Or App 393> Plaintiff, who suffered grievous injuries after he fell from a structure at defendant Boise Cascade Corporation's St. Helens paper mill, appeals from an adverse judgment entered after a jury trial on claims of negligence, negligence *per se*, and violation of the Employer's Liability Law (ELA), ORS 654.305 *et seq.* Plaintiff raises 22 assignments of error challenging both the trial court's refusal to submit substantial aspects of his claims to the jury, as well as rulings pertaining to those matters that were submitted to the jury. Defendant asserts, through four cross-assignments of error, that the trial court erred in denying its motions for a directed verdict as to each of plaintiff's claims. Based primarily on our disposition of the cross-assignments of error, we affirm the trial court in most respects but reverse and remand for a new trial on that portion of plaintiff's negligence *per se* claim that pertains to alleged inadequate lighting in the workplace.

Plaintiff worked as a painter for Partridge Industrial Coating (Partridge). In early April 1992, defendant contracted with Partridge to have its St. Helens paper mill painted. That painting was part of a general "sprucing up" of the mill before a tour by company executives and other mill managers.[1] On April 3, 1992, plaintiff was engaged in painting part of a very large room in the plant, called the "core room" because it contained "cores," which are the cardboard frames around which defendant wraps paper as it is produced. The core room was approximately 160 feet long, 65 feet wide, and 30 feet high. In one corner of, and inside, the core room was a smaller room, the "sample room," which was fully enclosed by walls and a roof. The sample room was 22 feet long, 11 feet wide, and nine feet high.

Partridge's foreman, Tom Tallon, directed plaintiff to paint the portion of the core room wall that was adjacent to the sample room. To perform that work, plaintiff climbed onto the sample room's roof, using a ladder. There were no railings around the sample room roof and no fall protection **<150 Or App 393/394>** below that area. Although Partridge had provided plaintiff with a harness and a lanyard, he did not tie the lanyard to anything. As plaintiff was standing on the sample room roof and was painting the core room wall, he fell from the roof to the core room floor. Plaintiff fractured his neck and was rendered quadriplegic.

Plaintiff filed this action on March 31, 1994, alleging claims for negligence and violation of the ELA. Plaintiff asserted nine specifications of common-law negligence, including failure to provide

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[1] The relationship between defendant and Partridge and their respective involvements in the work plaintiff performed are described more particularly below in the discussion of plaintiff's ELA claim. 150 Or App at 397-406.

railings, lack of fall protection, and failure to provide adequate lighting for his painting activities.[2] As part of his negligence claim, plaintiff further alleged that defendant had violated regulations promulgated under the Oregon Safe Employment Act (OSEA), and that those violations materially contributed to his injuries.[3] Plaintiff asserted, particularly, that defendant had violated regulations that required: (1) guardrails on platforms; (2) scaffolds and guardrails on scaffolds; (3) adequate fall protection equipment; (4) adequate lighting; and (5) workplace safety instruction.

150 Or App 395> The case was tried to a jury. Before submission, defendant moved for a directed verdict against each of plaintiff's claims. Although the court denied the motions, it did strike all specifications of negligence other than those pertaining to inadequate lighting and all allegations of regulatory violations other than those pertaining to inadequate lighting. Thus, although plaintiff's negligence, negligence *per se* (based on OSEA) and ELA claims were submitted to the jury, the only allegations the jury actually considered concerned inadequate lighting. The jury returned a defense verdict, specifically determining that (1) defendant was not subject to the ELA; (2) defendant either had not violated the OSEA or, if so, that violation had not caused plaintiff's injuries; and (3) defendant was not negligent with respect to inadequate lighting or, if so, that negligence had not caused plaintiff's injuries.

On appeal, plaintiff raises 22 assignments of error that challenge: (1) the trial court's rulings striking all of his allegations other than those pertaining to inadequate lighting and (2) various rulings pertaining to the inadequate lighting allegations. Defendant, through four cross-assignments of error, argues that we need not address the particulars of plaintiff's assignments because, in all events, defendant was entitled to a directed verdict against each of plaintiff's claims in its entirety. For clarity of analysis, we begin by addressing the cross-assignments.

In its first cross-assignment, defendant contends that the court erred in denying a directed verdict against plaintiff's ELA claim in its entirety. Defendant argues that, even viewing the evidence most favorably to plaintiff,[4] plaintiff failed to prove the requisites of ELA liability. As explained below, we agree.

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[2] Plaintiff alleged that defendant was negligent and violated the ELA by:

"1) failing to remove materials stored in the vicinity of the walls to be painted which materials interfered with the painters' access to the walls to be painted;

"2) failing to provide or allow the use of scaffolding or manlifts;

"3) failing to provide reasonable or any means of ingress or egress to and from the roof of an interior storage room upon which the Defendant invited Plaintiff to stand and paint the walls;

"4) failing to provide a lifeline or other device for Plaintiff to attach his safety harness while painting the walls above the interior storage room;

"5) failing to install or provide railings on the edge of the roof of the interior storage room;

"6) failing to install or provide safety nets or padding around the edges of the roof of the interior storage room;

"7) failing to provide adequate lighting in the area surrounding the interior storage room;

"8) failing to implement and maintain a systematic maintenance schedule for the lights in the area where Plaintiff fell; and

"9) fail[ing] to develop and implement a fall protection program for its mill."

[3] As described below, 150 Or App at 402-04, the parties dispute whether plaintiff's allegations with respect to the OSEA sufficiently alleged either an independent statutory claim or a claim for negligence *per se*.

[4] We review the denial of a directed verdict in the light most favorable to the party opposing the motion; if there is some evidence to support each element of the claim, a directed verdict was appropriately denied. *Hickey v. Settlemier*, 141 Or App 103, 108, 917 P2d 44, *rev den* 323 Or 690 (1996).

The ELA imposes a heightened standard of care on employers or others who are in charge of work involving danger or risk to employees. *Miller v. Georgia-Pacific Corp.*, 294 Or 750, 753, 662 P2d 718 (1983). ORS 654.305 provides:

> **150 Or App 396>** "Generally, all owners, contractors or subcontractors and other persons having charge of, or responsible for, any work involving a risk or danger to the employees or the public, shall use every device, care and precaution which it is practicable to use for the protection and safety of life and limb, limited only by the necessity for preserving the efficiency of the structure, machine or other apparatus or device, and without regard to the additional cost of suitable material or safety appliance and devices."

The ELA applies not only to direct employers but also to "indirect employers." *See, e.g., Miller*, 294 Or at 754.

Here, plaintiff asserted that defendant was his indirect employer for ELA purposes. Before a defendant can be held liable as an indirect employer under the ELA,

> "the defendant must be in charge of or have responsibility for work involving risk or danger in either (a) a situation where defendant and plaintiff's employer are simultaneously engaged in carrying out work on a common enterprise, or (b) a situation in which the defendant retains a right to control or actually exercises control as to the manner or method in which the risk-producing activity is performed." *Miller*, 294 Or at 754 (citations omitted).

Thus, "indirect employer" liability is triggered if any of three *disjunctive* tests is satisfied: (1) the "common enterprise" test; (2) the "retained control" test; or (3) the "actual control" test. *Id.*; *see also Wilson v. P.G.E. Company*, 252 Or 385, 391-92, 448 P2d 562 (1969); *Quackenbush v. PGE*, 134 Or App 111, 114-16, 894 P2d 535, *rev den* 322 Or 193 (1995). Defendant contends that none of those tests was met; conversely, plaintiff asserts that the evidence was sufficient to satisfy any or all of those tests.

We first consider "common enterprise" liability. To be held liable as a participant in a "common enterprise," a defendant employer must "do more than have its own employees working with plaintiff toward the furtherance of a common enterprise." *Sacher v. Bohemia, Inc.*, 302 Or 477, 485, 731 P2d 434 (1987). Rather, the defendant must exercise "control or charge over the activity or instrumentality that causes the injury[.]" *Id.* at 486 (footnote omitted):

> **150 Or App 397>** "When, as the result of the activities of defendant's employees or use of his equipment, a risk of danger is created which contributes to an injury to plaintiff who is the employee of another engaged in work on the same project, defendant has been considered to have sufficient control over the work to be subject to the duties imposed by the [ELA]. * * * We do not construe the ELA to impose a duty upon each employer, engaged in a common enterprise with another, to make safe the equipment and method of work of the other, even though both have a measure of control over the activity in which they are jointly engaged. The injury must result by virtue of the commingling of the activities of the two employers and not be solely attributable to the activities or failures of the injured workman's employer." *Wilson*, 252 Or at 391-92 (citation omitted).

See Quackenbush, 134 Or App at 115 ("Although an employer can be 'in charge' of an activity that forms only a component part of the common enterprise, that component part must be part of the commingling of the activities of the two employers out of which the injury arises."); *Schroeder v. Northrop Services, Inc.*, 86 Or App 112, 118-19, 739 P2d 33, *rev den* 304 Or 185 (1987) (the defendant's participation in joint activity and the plaintiff's injury were causally linked).

The thrust of those holdings is that, to trigger common enterprise liability, there must be a causal link between the defendant's involvement in joint work and the plaintiff's injury. Here, there was no such nexus. Viewed most favorably to plaintiff, the evidence established that plaintiff's employer, Partridge, and defendant were both participants in the project of "sprucing up" the St. Helens

mill in preparation for a visit by Boise Cascade executives. Partridge was painting certain areas of the plant, and defendant's employees were also involved in painting and clean-up activities. However, defendant's involvement in that regard had no causal relationship to plaintiff's injury. There was no evidence that defendant's employees were involved in painting in the core room or that plaintiff's injury resulted from defective equipment provided by defendant.[5] *See Miller v. Georgia-Pacific Corp.*, 55 Or App 358, 362, 637 P2d 1354 (1981), *aff'd* **<150 Or App 397/398>** *in part, rev'd in part* 294 Or 750, 662 P2d 718 (1983) (no causal link demonstrated between the defendant's participation in joint work and the plaintiff's injury). In fact, there was no evidence that defendant was aware that plaintiff was using the sample room roof as a base for his painting. Consequently, "common enterprise" liability did not apply.

Nor did plaintiff's proof permit the imposition of "retained control" liability--*i.e.*, that defendant "retain [ed] a right to control * * * the manner or method in which the risk-producing activity [was] performed." Miller, 294 Or at 754. Plaintiff refers, particularly, to a work order, which provided that "[all] work is to be completed per the directions of owner's representative Rick Shaw." That work order was issued pursuant to the "annual contractor services agreement" between defendant and Partridge. That agreement provided:

> "[Partridge's] relationship with Boise Cascade shall in all respects be that of an independent contractor. Boise Cascade shall have no power to determine or control [Partridge's] manner of performing the Work except insofar as may be necessary to allow Boise Cascade to properly inspect the Work and ensure itself that [Partridge] is complying with the Contract Documents."

The agreement further provided that "[a]uthorization to perform Work shall be made by issuing a Work Order, which Work Order shall specify the *scope* of the Work to be performed[.]" (Emphasis supplied.) Thus, any retention of control by defendant necessarily pertained solely to the *scope* of Partridge's work--*i.e.*, what areas of the plant should be painted--and not to the "manner or method" of Partridge's performance. *See Miller*, 294 Or at 754. Accordingly, there was no basis for "retained control" liability.

Finally, defendant was not subject to ELA liability under the "actual control" test. There is no evidence that defendant ever told Partridge how to paint or which equipment to use. Nevertheless, plaintiff argues that the jury could have found that defendant exercised actual control over **<150 Or App 398/399>** the painting activities because: (1) a term in Partridge's contract with defendant stated that Partridge "accepts the physical condition of the Project Site at the time of [its] inspection"; (2) there is evidence that defendant asked Partridge and its employees not to move the cores; and (3) the presence of cores in the core room precluded the use of scaffolds and mechanized manlifts in performing the painting and, thus, forced Partridge's employees, including plaintiff, to use ladders. Thus, plaintiff reasons, defendant, by effectively precluding the use of certain equipment, exercised actual control over the manner and method of Partridge's work.

The fatal deficiency in plaintiff's "actual control" argument is--as defendant emphasizes--that Partridge, and Partridge alone, made the decision to use ladders, rather than scaffolds or manlifts, in painting the core room and that, in making that decision, Partridge's supervisors, Korpella and Tallon, determined that lifts were unnecessary and that ladders were safe. Moreover, although defendant had previously moved materials in other areas of the plant at Partridge's request, there was no evidence that, before making the decision to use ladders, Korpella or Tallon asked defendant to move the cores out of the core room to permit the use of scaffolds or manlifts. Defendant did not exercise actual control with respect to the painting of the core room.

The record did not permit the imposition of indirect employer ELA liability on any basis. Thus, the court erred in denying defendant's motion for a directed verdict against the ELA claim.

Defendant's second cross-assignment of error asserts that the court erred in failing to direct a verdict *in toto* against plaintiff's common-law negligence claim. As noted, 150 Or App at 395, the trial court struck all specifications of common law negligence except those pertaining to inadequate lighting but submitted the latter to the jury. Defendant argues that where, as here, a property owner hires an

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[5] There is no evidence that defendant's employees assisted Partridge's employees, including plaintiff, in their painting activities or that defendant shared any equipment with Partridge's employees, including plaintiff.

independent contractor to perform specialized work, it cannot be liable to the contractor or its employees for injuries resulting from hazards that normally attend that contractor's work--*e.g.*, the risk of a painter falling. *See Esko v. Lovvold*, 272 Or 27, 30-31, 534 P2d 510 (1975); *Yowell v. General Tire &* **<150 Or App 399/400>** *Rubber*, 260 Or 319, 325, 490 P2d 145 (1971). In a related sense, defendant argues that, in any event, it could not be liable under principles of premises liability because

> "[t]he hazard here--falling off the sample room roof was not a hazard defendant knew about, nor one it should have known about. The roof was a roof, not a work station. There is no evidence that anyone had ever worked up there before plaintiff decided to. Nor is there any evidence that defendant knew plaintiff would paint from the roof rather than bringing in a scaffold or lift. Without reason to suspect that plaintiff would use the roof as a makeshift scaffold, defendant had no duty to make it safe for him."

We agree with defendant that, under the analysis of *Yowell and Esko*, it was entitled to a directed verdict against plaintiff's common-law negligence claim. In *Yowell*, the defendant hired the plaintiff's employer to repair an advertising sign. In attempting the repair, the plaintiff placed his ladder against a second, lower, sign that had been defectively hung and that, ultimately, gave way, causing the plaintiff to fall. The plaintiff brought an action for negligence, contending that "he was upon the defendant's premises as an invitee to whom the defendant owed a duty to exercise reasonable care to provide a safe place to work." 260 Or at 322-23. The trial court granted the defendant's motion for an involuntary nonsuit, and the Supreme Court affirmed:

> "Regardless of whether defendant is to be viewed in its relation to plaintiff primarily as a possessor of land or as one who contracts for services, we believe the result in this case should be the same. * * *
>
> "Plaintiff's employer, the independent contractor, held itself out to the public as being engaged in the business of manufacturing, installing and repairing all kinds of signs. Defendant was therefore entitled to assume, until notice to the contrary, that plaintiff's employer and its employees who were sent to work on defendant's signs were proficient and expert in detecting any defects in signs which formed a danger to those working in or around them. Defendant was not shown to have known of the defect in the sign. Nor was it shown to have had any expertise concerning signs. * * *
>
> "A person who orders repairs or work to be done by a third party owes no duty to such third party or his workman **<150 Or App 400/401>** to discover and warn of any unknown dangerous conditions surrounding the work which fall within a special expertise or knowledge, not shown to have been had by the person ordering the work, and which the third party impliedly represents to the public that he possesses." *Id.* at 324-25 (footnote omitted).[6]

In *Esko*, the court reiterated *Yowell's* analysis. There, the defendant trailer park owners hired the plaintiff's employer, which held itself out as being a specialist in installing and maintaining cables on utility poles, to restring some cables in defendants' park. A latently defective pole gave way, injuring the plaintiff. The trial court granted the defendant's motion for a directed verdict against the plaintiff's negligence claim, and the Supreme Court affirmed:

> "Plaintiff's employer held itself out to the public as having proficiency in the installation and maintenance of a cable strung on poles. Plaintiff, a lineman of considerable experience, was fully cognizant of the risks and dangers of his trade. Defendants were not shown to possess any special expertise or familiarity with poles beyond that possessed by an ordinary landowner, and had no actual knowledge of the defect in the pole. Under these circumstances, defendants were entitled to rely upon the expertise of plaintiff and his employer to deal with unknown dangerous conditions necessarily encountered in the performance of their special skills." 272 Or at 30-31 (footnotes omitted).

The same principles apply here. Each of plaintiff's nine specifications of common-law negligence pertained to defendant's failure to take particular measures to insure the safety of the painting contractors--*e.g.*, providing safety harnesses, railing, fall protection, adequate lighting, etc. The

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[6] In so holding, the court reserved the issue of "what duty, if any, defendant would have owed had it known of the defect." *Yowell v. General Tire & Rubber*, 260 Or 319, 325 n 1, 490 P2d 145 (1971).

advisability and efficacy of those measures was a matter peculiarly within Partridge's "special expertise or knowledge." Partridge, not defendant, was the expert in painting and painter safety.

Plaintiff argues, nevertheless, that *Yowell and Esko* are inapposite because here, unlike in those cases, the unsafe condition was obvious, not hidden: "The risk in this case was **<150 Or App 401/402>** a fall from a nine foot roof[.] * * * The risk of falling is obvious to all employers[.]" Even if we were to agree with plaintiff that the *Yowell/Esko* analysis does not apply if the defendant owner knows of a defect or hazard--a question *Yowell* itself expressly reserved[7]--defendant would still have been entitled to a directed verdict because there was no evidence from which the jury could conclude that defendant knew that plaintiff would paint from the roof of the sample room. In particular, there is no evidence that defendant knew that plaintiff, or any painter, intended to use the sample room roof as a work platform. Nor was there evidence that the roof had ever been so used.

There were, in short, no circumstances alerting defendant, "as a reasonably prudent landowner, * * * that the premises might not be safe[.]" *Wriglesworth v. Doyle,* 244 Or 468, 472-73, 417 P2d 999 (1966). Consequently, the trial court erred in denying defendant's motion for a directed verdict against plaintiff's common-law negligence claim.

Defendant's third cross-assignment of error asserts that the trial court erred in denying defendant's motion for a directed verdict against plaintiff's allegations that defendant had violated the Oregon Safe Employment Act (OSEA). Before addressing the substance of that contention, we must dispose of a preliminary matter that preoccupies the parties. Defendant argues, at some length, that there is no private statutory right of action under the OSEA. Conversely, plaintiff contends that the OSEA does, at least implicitly, give rise to a statutory right of action. We decline to resolve that issue because, given the procedural posture of this case, it is inapposite.

Plaintiff's operative second amended complaint consisted of two "counts," one captioned "Negligence," and the other, "Employer's Liability Law." The negligence "count," in turn, included one paragraph, which alleged nine specifications of negligence without reference to the OSEA,[8] and six **<150 Or App 402/403>** other paragraphs, which alleged that defendant had violated 13 occupational safety regulations, promulgated pursuant to the OSEA and set out in OAR chapter 437, designated "The Oregon Occupational Safety and Health Code" (OOSHC).[9] With respect to each of those regulations, plaintiff alleged that he

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[7] *See* 150 Or App at 401 n 6. We note, parenthetically, that, at least in some circumstances, plaintiff's "obvious hazard" analysis is tautological. For example, if a homeowner hires a specialist to patch a roof or to prune some trees, the risk of a fall is obvious. Under plaintiff's reasoning, the homeowner could be liable in negligence for failing to provide a railing or fall protection.

[8] *See* 150 Or App at 394 n 2.

[9] Plaintiff alleged that defendant violated particular regulations. Those regulations were in effect at the time of the accident. Since that time, several of the regulations have been modified, but those subsquent changes do not affect our analysis. Also, in 1997, the Department of Consumer and Business Services changed the numbering system and the form of its regulations. Throughout this opinion, we refer to the regulations that were in effect at the time of the accident.

Plaintiff alleged that defendant violated the following regulations:

OAR 437-02-D-1910.23(c) (requiring guardrails on platforms);
OAR 437-03-M-1926.500(a), (d) (requiring guardrails on platforms);
OAR 437-02-D-1910.28(a)(1) (requiring scaffolds);
OAR 437-03-1926.451(a)(4) (requiring guardrails on scaffolds);
OAR 437-02-1-1910.132 (requiring protective equipment to protect against work hazards);
OAR 437-03-1926.28 (requiring protective equipment to protect against work hazards);
OAR 437-03-040 (requiring employees' fall protection);
OAR 437-03-045 (requiring fall protection);
OAR 437-03-1926.104 (requiring fall protection equipment);
OAR 437-03-C-1926.26 (requiring adequate illumination of work areas);
OAR 437-03-C-1926.56 (requiring adequate illumination of work places);
OAR 437-03-1926.20(a)(1) (proscribing contractors from requiring laborers to work in unsanitary, hazardous, or dangerous conditions);
OAR 437-03-1921 (requiring employee instruction on avoiding unsafe conditions). No such regulation exists; however, in its brief, plaintiff cites OAR 437-03-C-1926.21(b)(2), which pertains to the same subject matter.

> "was within the class of persons intended to be protected by the regulation, his injury was of the type intended to be avoided by the regulation, and his injury was caused by the Defendant's violation of the regulation."

Those matters were pleaded solely within plaintiff's negligence "count"; his complaint did not plead a separate claim for relief under the OSEA. Ultimately, and consistent with the configuration of plaintiff's pleadings, the trial court instructed the jury that violation of the OSEA, and, particularly, pertinent OOSHC lighting standards, would constitute negligence *per se*. Plaintiff did not ask that the jury be **<150 Or App 403/404>** instructed on some separate right of action under the OSEA and does not contend that the trial court generally erred in instructing the jury on negligence *per se*.[10] Thus, the only issue before us is whether the trial court erred in denying a directed verdict against plaintiff's OSEA-based negligence *per se* allegations.

The OSEA provides:

> "Every employer, owner, employee and other person shall obey and comply with every requirement of every order, decision, direction, standard, rule or regulation made or prescribed by the department in connection with the matters specified in ORS 654.001 to 654.295 and 654.750 to 654.780, or in any way relating to or affecting safety and health in employments or places of employment, or to protect the life, safety and health of employees in such employments or places of employment, and shall do everything necessary or proper in order to secure compliance with and observance of every such order, decision, direction, standard, rule or regulation." ORS 654.022.

Defendant argues that, as a matter of law, it could not be liable for negligence *per se* based on the OSEA, because plaintiff was not its direct employee. Defendant is correct--but only to a point. We have held that the OSEA "does not extend its coverage to indirect employees" and have sustained a dismissal of negligence *per se* claims on that basis. *German v. Murphy*, 146 Or App 349, 357, 932 P2d 580 (1997); *see Flores v. Metro Machinery Rigging, Inc.*, 99 Or App 636, 641, 783 P2d 1024 (1989), *rev den* 309 Or 521 (1990) ("The purpose of the SEA is to require an employer to take necessary steps to protect its own employees, not those of other employers.").

The difficulty with defendant's argument is that it ignores--or, at least, does not adequately acknowledge--the OSEA's express application to "owner[s]." ORS 654.022. The statute defines "owner" as "every person having ownership, control or custody of any place of employment." **<150 Or App 404/405>** ORS 654.005(6).[11] Defendant owned the St. Helens plant.[12] Thus, defendant, as owner, is subject to the OSEA. The critical question remains: What is the scope of an owner's obligations under the OSEA?

The only reported decision squarely addressing that issue is *Moe v. Beck*, 311 Or 499, 815 P2d 692 (1991), *aff'd* 100 Or App 177, 785 P2d 781 (1990). In *Moe*, the defendant owned a dump truck which it leased to another party, who, in turn, subleased the truck to the plaintiff's employer. The plaintiff was injured when the truck's brakes failed. The plaintiff sued the defendant, alleging that the defendant

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[10] Plaintiff does assign error to certain particulars of the court's negligence *per se* instructions but not to the propriety of instructing on negligence *per se* in general.

[11] ORS 654.005(8) defines "place of employment":

> "'Place of employment' means and includes every place, whether fixed or movable or moving, whether indoors or out or underground, and the premises and structures appurtenant thereto, where either temporarily or permanently an employee works or is intended to work and every place where there is carried on any process, operation or activity related, either directly or indirectly, to an employer's industry, trade, business or occupation, including a labor camp provided by an employer for employees or by another person engaged in providing living quarters or shelters for employees, but 'place of employment' does not include any place where the only employment involves nonsubject workers employed in or about a private home."

[12] In *German v. Murphy*, 146 Or App 349, 932 P2d 580 (1997), and *Flores v. Metro Machinery Rigging, Inc.*, 99 Or App 636, 783 P2d 1024 (1989), *rev den* 309 Or 521 (1990), the defendant subcontractors who were the object of the OSEA-based claims did not own the premises where the injuries occurred.

had been negligent in failing to comply with various OOSHC regulations, including requirements that vehicles have effective brake systems that are regularly tested and serviced. The defendant successfully moved for summary judgment, contending that it had no liability as an "owner" under the OSEA.

This court, in banc, reversed:

> "The legislature did not define as 'owner' any person with 'ownership, control *and* custody.' Rather, it defined as 'owner' any person who has 'ownership, control or custody.' ORS 654.005(6). [Defendant] is the record owner. The statute does not distinguish between various types of ownership interests. We may not insert what the legislature omitted from the statute. ORS 174.010." 100 Or App at 180-81 (footnotes omitted; emphasis in original).

150 Or App 406> Two judges dissented, asserting that "[t]he majority's application of the literal meaning of 'owner' produces an absurd result. * * * 'Owner,' in the context of the SEA means a person who has the ability to comply with ORS 654.022[.]" *Id.* at 182-83 (Edmonds, J., dissenting). In response to that "absurd result" assertion, the majority observed:

> "The dissent would have us read out of the statute the word 'or' and, instead, redefine 'owner' as a person who is in a position to exercise control over a workplace. The dissent's reworking of the definition of 'owner' is based on its opinion that the legislature did not intend that 'ownership' of a workplace should be a sufficient basis for having to comply with SEA, even though that is what the statute clearly says. * * * Perhaps the dissent, or even the majority, would make a different policy choice if that were our responsibility, but requiring an owner of a workplace to comply with the SEA, even an owner who has chosen not to exercise actual control, cannot be said to be absurd; nor is it inconsistent with the policy of making every Oregon workplace a safe place." *Id.* at 180-81 n 3.

On review, the Supreme Court affirmed our holding, concluding that the defendant was a "person having ownership * * * of [a place of employment]." ORS 654.005(6). In so holding, the court observed:

> "The OSEA refers to 'owner' on only six occasions. In those provisions where 'owner' does appear, its use suggests that the 'owner' possesses some involvement with the work activity or workplace. ORS 654.015 prohibits an 'owner' from *'construct [ing] or caus[ing]* to be constructed or maintained' unsafe places of employment. (Emphasis added.) ORS 654.067 permits safety and health authorities to inspect the workplace premises 'upon presenting appropriate credentials to the owner, employer or agent in charge.' We read 'agent *in charge*' (emphasis added) to mean either the 'employer's' or the 'owner's' agent. One reasonable import of the statute's language is that the word 'owner' is used in a vein similar to the word 'employer,' one who performs an authoritative or supervisory function. Similarly, ORS 654.150 and 654.160 combine to require the owner of a construction site and the employer of the construction crew to specify in the construction contract which party will supply sanitation facilities at the work site. If no such provision appears in the contract, the owner of the site is liable for the **<150 Or App 406/407>** employer's costs associated with providing such facilities. The tenor of the OSEA's provisions with regard to an 'owner's' responsibilities arguably suggests that the 'owner' is one who enjoys some degree of involvement with the work or workplace. Even though the word 'owner' is ambiguous, as demonstrated by the Oregon cases and statutes cited above, it is nonetheless clear that the OSEA defines an owner in three *alternative* ways: First, as a person who has 'control' of a place of employment. *Or* second, as a person who has 'custody' of a place of employment. *Or* third, as a person 'having ownership' of a place of employment.
>
> "* * * * *
>
> "Under the contract between the defendant and Beck, the defendant has an ownership interest. * * * In the absence of some legislative history indicating that the legislative

> intent was that the OSEA not apply to persons in the position of the defendant, we interpret the OSEA to include a lessor in the position of the defendant within the definition of 'owner.'" 311 Or at 504-05 (footnotes omitted; emphasis in original).

Thus, at least in some circumstances, ownership of a premises where OSEA violations occur is sufficient to support negligence *per se* liability even if the defendant had no direct involvement in, or control over, the injury-producing activity. *Id.*

Read broadly, *Moe* could be viewed as subjecting owners to negligence *per se* liability any time a worker is injured on premises because of an OSEA violation. That would be so regardless of the owner's relationship to the worker or to the OSEA violation. Such an expansive reading would yield remarkable results. Taken to its logical extension, it would require property owners who hire specialized subcontractors--*e.g.*, roofers, window washers, painters--to oversee the safety-related details of their work and to provide safety equipment or face possible negligence *per se* liability based on the OSEA. That would, of course, largely abrogate the long-standing common-law limitations of negligence liability with respect to specialized contractors described above. *See* 150 Or App at 399-402.

Conversely, ownership liability under the OSEA, as construed in *Moe*, may--and we believe should--be cast more **<150 Or App 407/408>** narrowly. In particular, and consistent with the requirements of negligence *per se*, such liability arises only when the *defendant owner* has violated an applicable OOSHC regulation. *See, e.g., McAlpine v. Multnomah County*, 131 Or App 136, 144, 883 P2d 869 (1994), *rev den* 320 Or 507 (1995) (reiterating principle that negligence *per se* is premised on defendant's violation of a statute). That is, the mere fact that a plaintiff has been injured on a defendant's premises as a result of an OSEA violation is not enough to trigger negligence *per se* liability; rather, the defendant itself must have violated the applicable requirement. Thus, the defendant owner is liable only if the regulation whose violation underlies the OSEA claim is one that either explicitly, or by nature, imposes obligations on owners of premises.

Moe itself is exemplary. There, the ordinary and foreseeable use of the "workplace" that the defendant owned--the dump truck--was driving. Providing and maintaining adequate brakes was essential to the continuing structural integrity and safe operation of that "workplace" in its ordinary and intended manner. Thus, although the regulations underlying the plaintiff's negligence *per se* claim in *Moe* did not expressly refer to owners, the defendant there was nevertheless subject to those regulations. An analogous hypothetical would be if Boise Cascade were to lease its paper mill to a third party, and an employee of that party were injured because of unguarded machinery, in violation of the OSEA; in that circumstance, Boise Cascade, as owner, could be subject to negligence *per se* liability.

Conversely, other OOSHC regulations, which pertain to work practices or methods, as opposed to requirements pertaining to workplace structures or safeguards, may not apply to owners. For example, nothing in the text or context of the OSEA suggests that owners (as distinct from employers) are subject to requirements pertaining to lifelines, safety belts, or lanyards. *See, e.g.*, OAR 437-03-1926.28, discussed below at 150 Or App at 410-11.

We turn, then, to plaintiff's particular allegations of OSEA-based negligence *per se* to determine which, if any, of the regulations underlying those allegations applies to owners. Plaintiff's specifications fall into five general categories: **150 Or App 408/409>** (1) failure to provide safety instruction; (2) failure to provide railings; (3) failure to furnish scaffolds, including guarded scaffolds; (4) failure to provide protection against fall hazards; and (5) inadequate lighting/illumination. *See* 150 Or App at 403 n 9.

Plaintiff's "inadequate [safety] instruction" specification was deficient as a matter of law. OAR 437-03-C-1926.21(b)(2), by its terms, applies only to employers.[13] Owners have no responsibility under that provision.

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[13] OAR 437-03-C-1926-21(b)(2) provides:

> "The employer shall instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to his work environment to control or eliminate any hazards or other exposure to illness or injury."

Plaintiff's "failure to provide guardrails" specifications, based on OAR 437-02-D-1910.23(c) and OAR 437-03M-1926.500(a) and (d),[14] were legally insufficient because, even if it is assumed that those regulations apply to owners generally, they were inapposite here. In particular, the former regulation applies only to "platforms," and the sample room roof was not a "platform" for purposes of that regulation. OAR 437-02-1910.21(a)(4) defines "platform" as "[a] working space for persons, elevated above the surrounding **<150 Or App 409/410>** floor or ground; such as a balcony or platform for the operation of machinery and equipment." Here, there is no evidence from which a jury could conclude that the sample room roof had ever been used as a "working space" or that defendant knew that plaintiff would use it for that purpose. *See* 150 Or App at 401-02.

The second regulation, OAR 437-03-M-1926.500(a) and (d), similarly pertains to "platforms" but does not define that term. Nevertheless, in context, we find that definition of "platform" in OAR 437-02-1910.21(a)(4) to be instructive and conclude that the guardrail standard of OAR 437-03-M1926.500(a) and (d) did not apply to the sample room roof.

Plaintiff's "scaffolding" specifications are based on OAR 437-03-1926.451(a)(4) and OAR 437-02-D-1910.28(a)(1).[15] Regardless of whether those regulations pertaining to the erection of temporary structures apply to owners generally, plaintiff's specifications were deficient in two respects. First, the former applies only to platforms or scaffolds at least 10 feet high; here, the sample room roof, even if it could be properly characterized as a "scaffold" or "platform," was only nine feet high. Second, the latter does not require scaffolding in all instances, but, instead, explicitly permits the use of ladders, as Partridge did in this case.[16]

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[14] OAR 437-02-D-1910.23(c) provides, in part:

"(1) Every open-sided floor or platform 4 feet or more above adjacent floor or ground level shall be guarded by a standard railing (or the equivalent as specified in paragraph (e)(3) of this section) on all open sides except where there is entrance to a ramp, stairway, or fixed ladder. The railing shall be provided with a toeboard wherever, beneath the open sides:

"(i) Persons can pass.

"(ii) There is moving machinery, or

"(iii) There is equipment with which falling materials could create a hazard."

OAR 437-03-M-1926.500(a) and (d) provides, in part:

"(a) This subpart shall apply to temporary or emergency conditions where there is danger of employees or materials falling through floor, roof, or wall openings, or from stairways or runways.

"* * * * *

"(d)(1) Every open-sided floor or platform 6 feet or more above adjacent floor or ground level shall be guarded by a standard railing, or the equivalent, as specified in paragraph (f)(1)(i) of this section, on all open sides, except where there is entrance to a ramp, stairway, or fixed ladder. The railing shall be provided with a standard toeboard wherever, beneath the open sides, persons can pass, or there is moving machinery, or there is equipment with which falling materials could create a hazard."

[15] OAR 437-03-1926.45l(a)(4) provides:

"Guardrails and toeboards shall be installed on all open sides and ends of platforms more than 10 feet above the ground or floor, except needle beam scaffolds and floats (see paragraphs (p) and (w) of this section). Scaffolds 4 feet to 10 feet in height, having a minimum horizontal dimension in either direction of less than 45 inches, shall have standard guardrails installed on all open sides and ends of the platform."

OAR 437-02-D-1910.28(a)(1) provides:

"Scaffolds shall be furnished and erected in accordance with this standard for persons engaged in work that cannot be done safely from the ground or from solid construction, except that ladders used for such work shall conform to § 1910.25 and § 1910.26."

[16] Plaintiff does not contend that the ladders Partridge supplied for the core room painting did not conform to applicable regulations.

Plaintiff's "inadequate fall protection" specifications fail because the underlying regulations, OAR 437-02-I-1910.132, OAR 437-03-1926.28, OAR 437-03-040, OAR 437103-045, and OAR 437-03-1926.104, by their nature, pertain **<150 Or App 410/411>** to the method and manner of work and, thus, do not apply to owners.[17] That construction is textually and contextually buttressed by the explicit imposition of employer responsibility in OAR 437-03-1926.28. A contrary conclusion would obligate nonemployer owners to oversee the details of work performed on their premises and to provide specialized safety equipment.

Finally, plaintiff alleges violation of OSHA lighting regulations:

> "OAR 437-03-C-1926.26 and OAR 437-03-C-1926.56 of the state OSHA code requires adequate illumination in construction areas and storage areas where work is in progress and warehouses of not less than 5 foot-candles, and in general construction plants and shops of not less than 10 foot-candles. The lighting provided by Defendant at the location where Plaintiff fell was less than that required by the regulations. Plaintiff was within the class of persons intended **<150 Or App 411/412>** to be protected by the regulation, his injury was of the type intended to be avoided by the regulation, and his injury was caused by the Defendant's violation of the regulation."

OAR 437-03-C-1926.26 provides:

> "Construction areas, aisles, stairs, ramps, runways, corridors, offices, shops, and storage areas where work is in progress shall be lighted with either natural or artificial illumination. The minimum illumination requirements for work areas are contained in Subpart D of this part."

OAR 437-03-C-1926.56 similarly provides, in part:

> "(a) Construction areas, ramps, runways, corridors, offices, shops, and storage areas shall be lighted to not less than the minimum illumination intensities listed in Table D-3 while any work is in progress [.]"

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[17] OAR 437-02-1-1910.132(a) provides:

> "Protective equipment, including personal protective equipment for eyes, face, head, and extremities, * * * and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition whenever it is necessary by reason of hazards of processes or environment[.]"

OAR 437-03-1926.28 provides:

> "(a) The employer is responsible for requiring the wearing of appropriate personal protective equipment in all operations where there is an exposure to hazardous conditions or where this part indicates the need for using such equipment to reduce the hazards to the employees.
>
> "(b) Regulations governing the use, selection, and maintenance of personal protective and lifesaving equipment are described under Subpart E of this part."

OAR 437-03-040 provides, in part:

> "(i) All employees shall be protected from fall hazards when working on unguarded surfaces more than 10 feet above a lower level or at any height above dangerous equipment, except when connecting steel beams as stipulated in OAR 437-03-040(2)."

OAR 437-03-045(2) is merely a definitional section that, in defining "dangerous equipment," includes:

> "Equipment such as pickling or galvanizing tanks, degreasing units, machinery, electrical equipment, and other units which, as a result of form or function, may be hazardous to employees who fall onto or into such equipment."

OAR 437-03-1926.104 provides, in part:

> "(b) Lifelines shall be secured above the point of operation to an anchorage or structural member capable of supporting a minimum dead weight of 5400 pounds."

Table D-3, referred to in the latter rule, specifies "Minimum Illumination Intensities in Foot-Candles" for work areas according to function or operation:

> "5... General construction area lighting.
>
> "3... General construction areas, concrete placement, excavation and waste areas, accessways, active storage areas, loading platforms, refueling, and field maintenance areas.
>
> "5... Indoors: warehouses, corridors, hallways, and exitways.
>
> "5... Tunnels, shafts, and general underground work areas: (Exception: minimum of 10 foot-candles is required at tunnel and shaft heading during drilling, mucking, and scaling. Bureau of Mines approved cap lights shall be acceptable for use in the tunnel beading.)
>
> "10... General construction plant and shops (*e.g.*, batch plants, screening plants, mechanical and electrical equipment rooms, carpenter shops, rigging lofts and active storerooms, barracks or living quarters, locker or dressing rooms, mess halls, and indoor toilets and workrooms).
>
> "30... First aid stations, infirmaries, and offices."

150 Or App 413> Defendant argues that those regulations are inapposite because they apply only when "work is in progress" and that there was no evidence that any of defendant's employees were working in the core room, much less near the sample room, when the accident occurred. Plaintiff responds that defendant's argument improperly focuses on its own employees and ignores its obligation, under the OSEA, as owner of the mill. In particular, defendant reasons, *he* was working at the time of the accident and because *that* work was "in progress," the lighting regulations applied to defendant in its capacity as owner.

Defendant is correct if OAR 437-03-C-1926.26 and OAR 437-03-C-1926.56 generally apply to owners, as well as to employers. The question is close. On one hand, the lighting requirements are defined by reference to the general structure and function of the work area-office, warehouse, etc. In that respect, the lighting standards are similar to the brake requirements in *Moe* and should support owner liability. Conversely, the regulations' "work in progress" language seems to pertain to workplace practices or methods; that is, whether the regulations apply--and are violated--depends on what is being done in a given place at a given time.

We conclude that the lighting regulations at issue here do apply to owners. That is, owners are obligated, as a structural matter, to equip workplaces with lighting adequate for the work that ordinarily would occur within that type of work space. In so holding, we need not decide what an owner's obligation might be if a lessee converted one type of space to another type of use--*e.g.*, converting a warehouse into a construction shop or a storage room into an office. Nor do we imply any view that an owner who has equipped a work space with adequate lighting could, nevertheless, be subject to negligence *per se* liability if a lessee/employer failed to make use of such lighting while work was in progress. The point, for present purposes, is simply that, just as an owner of a work vehicle must provide adequate brakes, an owner of a work space must equip that space with lighting adequate for the work ordinarily performed within that space.

150 Or App 414> Given our conclusion that OAR 437-03-C-1926.26 and OAR 437-03-C-1926.56 did apply to defendant in the fashion just described, plaintiff's negligence *per se* allegations based on those regulations were legally sufficient.[18] Consequently, although the trial court correctly struck all of plaintiff's negligence *per se* allegations except those pertaining to inadequate lighting, it did not err in denying defendant's motion for a complete directed verdict against plaintiff's negligence *per se* claims. We thus reject defendant's third cross-assignment of error.

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[18] Defendant does not contend that plaintiff did not otherwise satisfy the requirements of negligence *per se* with respect to those allegations. In particular, defendant does not dispute either that plaintiff was a member of the class of persons meant to be protected under the regulations or that plaintiff's injury was not of the type that the regulation was enacted to prevent.

Defendant's fourth and final cross-assignment of error is that the court erred in denying its directed verdict motion as to plaintiff's inadequate lighting specifications because plaintiff failed to prove that inadequate lighting caused him to fall. Plaintiff responds that his evidence of causation was sufficient. We agree with plaintiff that the evidence was sufficient to permit the jury to reasonably infer causation, and we reject the final cross-assignment of error without elaboration.

We turn, then, to plaintiff's 22 assignments of error. Our discussion and disposition of the cross-assignments necessarily disposes of plaintiff's first six assignments of error, as well as his 18th, 19th, and 21st assignments, all of which pertain to his ELA and common-law negligence claims or to his negligence *per se* allegations other than those pertaining to inadequate lighting.

Plaintiff's seventh through tenth assignments of error concern the trial court's instructions to the jury regarding the applicable lighting standard under the OSEA. Plaintiff argues, particularly, that the trial court should have ruled, as a matter of law, that the minimum standard was 10 foot-candles, the standard applicable for general construction plants and shops. Plaintiff contends that the trial court erred in failing to give a peremptory instruction to that effect and, **<150 Or App 414/415>** instead, in instructing the jury that plaintiff had the burden of proof as to what lighting standard applied. [19]

Plaintiff's premise is that he was entitled to a peremptory instruction because the necessary facts as to which lighting standard applied were undisputed. Defendant responds that there were issues of fact as to which lighting standard applied and, therefore, the question was correctly submitted to the jury.

Defendant is correct. Although the interpretation and application of safety regulations may properly be a subject for a peremptory instruction, *see, e.g., Hagan v. Gemstate Manufacturing, Inc.*, 148 Or App 192, 939 P2d 141 (1997), factual disputes precluded giving such an instruction here. *Compare Hagan*, 148 Or App at 194-95 (no factual dispute as to configuration of vehicles subject to "anti-underride" regulation).

As explained above, the lighting regulations at issue in this case require different minimum levels of lighting for different areas of operation. Here, there was a factual issue as to which lighting standard applied because different witnesses described the pertinent work space differently. In particular, there was a factual issue as to whether the core room was: (1) an "active storage area," thus requiring the lowest level of lighting, three foot-candles; (2) a warehouse, requiring an illumination of five foot-candles; or (3) a "general construction plant and shop," requiring lighting of at least 10 foot-candles. The issue was further complicated because the sample room roof from which plaintiff fell was located in one corner of the much larger core room. Given those factual disputes, the court properly rejected plaintiff's proposed peremptory instruction and correctly submitted to the jury the question of which lighting standard applied.

150 Or App 416> We bypass plaintiff's 11th assignment of error and proceed to his 12th assignment, which is dispositive. Plaintiff's 12th assignment of error challenges the exclusion of certain testimony by plaintiff's industrial hygienist, Gilmore.[20] Gilmore, who holds a masters degree in industrial hygiene, had provided industrial health and safety consultation to businesses and governmental entities, including the Atomic Energy Commission and the United States Department of Labor, for 21 years. Most of Gilmore's testimony, as presented via an offer of proof, pertained to matters that ultimately, and correctly, were not presented to the jury, such as guardrail and scaffolding requirements, personal protective equipment, and fall protection; thus, any error in the exclusion of that testimony was necessarily harmless. However, Gilmore also would have testified about matters pertaining to plaintiff's inadequate lighting allegations that were properly submitted to the jury. In the offer of proof, Giltnore testified that he had reviewed, *inter alia*, "light measurements taken at the accident scene." He then testified:

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[19] The trial court submitted the lighting claim to the jury, allowing it to decide which lighting standard applied. It read the pertinent regulation as part of the jury instructions, and provided a table, *see* Table D-3 set out at 150 Or App at 412, by which the jury could determine the appropriate standard. The chart provided the proper lighting standards (measured in foot-candles) for the different operating areas of a workplace.

[20] Gilmore described an "industrial hygienist" as follows: "An industrial hygienist is an individual specialized in health, safety, and environmental affairs primarily in an industrial environment. In a workplace setting, evaluating health and hazards. In the workplace identifying, evaluating them, and recommending controls."

> "Q [By plaintiff's counsel] And what about illumination? At my request, did you also investigate the illumination standards?
>
> "A I did. And I believe the standard that would apply in this area as well would be five foot-candles of illumination at the point of work would be the minimum standard. There may also be (indiscernible), but if you really go back and review the standard, the actual number that applies is clearly five foot-candles in those work areas. And I saw some data that indicated that the levels were far below that."

Defendant objected to Gilmore's putative testimony, including the lighting standard testimony, asserting that it should not be admitted under OEC 702, because it was not properly the subject of expert testimony. The court sustained that objection, concluding that Gilmore's testimony "would not assist the jury in assessing what hazards were present **<150 Or App 416/417>** and, in fact, would only confuse the jury and tend to give undue weight to a person's opinion on a matter that's fully within the competence of the jury to assess and determine themselves." With due respect, we disagree.

OEC 702 provides:

> "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise."

Such testimony may embrace "an ultimate issue to be determined by the trier of fact." OEC 704.

Where, as here, the trial court excluded the expert's testimony on grounds other than the witness's lack of qualification or competence[21] the court's discretion is somewhat circumscribed. In such circumstances, the court's exercise of discretion is tested against the principle that such testimony should be admitted if that testimony would materially "aid or * * * help the jury to conclude the ultimate question framed by the pleadings." *Yundt v. D & D Bowl, Inc.*, 259 Or 247, 258, 486 P2d 553 (1971):

> "[T]he only true criterion is: On *this subject* can a jury from *this person* receive appreciable help? In other words, the test is a relative one, depending on the particular subject and the particular witness with reference to that subject * * *." 7 Wigmore, *Evidence* (3d ed) 21, § 1923, quoted with approval in *Yundt*, 259 Or at 258 (emphasis in originally quoted material).

In *State v. Brown*, 297 Or 404, 409, 687 P2d 751 (1984), the court generally reiterated:

> "Under the Oregon Evidence Code and traditional evidence law, expert testimony is admissible if it is relevant under OEC 401 and will help the trier of fact in deciding a disputed issue. To be helpful, the subject of the testimony must be within the expert's field, the witness must be qualified, and the foundation for the opinion must intelligibly **<150 Or App 417/418>** relate the testimony to the facts. If these conditions are satisfied, the testimony will be excluded only if it is unduly prejudicial, repetitive, or falls under some other exclusionary provision as provided in OEC 403 [.]
>
> "* * * * *
>
> "In applying OEC 401, 702 and 403, this court must identify and evaluate the probative value of the evidence, consider how it might impair rather than help the factfinder, and decide whether truthfinding is better served by exclusion or admission."

See also State v. O'Key, 321 Or 285, 297-99, 899 P2d 663 (1995) (quoting *Brown* with approval); *Paragano v. Gray*, 126 Or App 670, 681, 870 P2d 837 (1994) ("A court should admit expert testimony when it is clear that the jury needs the help of an expert to find the truth and should exclude it when it does not. Between those extremes, the decision to admit the testimony is within the discretion of the court.").

Applying those principles, we conclude that the court erred in excluding Gilmore's testimony with respect to inadequate lighting. That testimony was highly relevant to two crucial and disputed

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[21] Defendant did not object to Gilmore's competence. The Supreme Court has held that exclusion of "expert" testimony on that ground is a matter of broad discretion. *Myers v. Cessna Aircraft*, 275 Or 501, 519-20, 553 P2d 355 (1976).

issues on the inadequate lighting allegations: (1) Which minimum lighting standard applied to the area where plaintiff was injured? And (2) did the lighting that defendant provided meet that standard? Gilmore's expert opinion regarding the correct lighting standard, based on his expert assessment of the proper classification or characterization of the work area where plaintiff was injured--*i.e.*, warehouse vs. active storage area--would have aided the jury in its determination of that technically complex question. Similarly, Gilmore's testimony pertaining to violation, based on his assessment of light measurements and readings, could have materially assisted the jury on the second issue. Thus, contrary to the trial court's observation, Gilmore's testimony on inadequate lighting would have assisted the jury "in assessing what hazards were present."

Conversely, we cannot agree that, at least as summarized in the offer of proof, Gilmore's testimony with respect to inadequate lighting would have been unduly confusing or prejudicial. As described above, that testimony would have pertained to two central issues, and there is no **<150 Or App 418/419>** reason on this record to conclude that the jury would have given that testimony "undue" weight. We thus conclude that the trial court erred in excluding that testimony.

We further conclude that the error was not harmless. Although evidentiary error is not presumed to be prejudicial, OEC 103(1), reversal is required where that error "substantially affect [ed] the rights of a party." ORS 19.125(2). *See Baker v. English*, 324 Or 585, 589-93, 932 P2d 57 (1997) (discussing methods for determining whether error resulted in prejudice to party). In applying ORS 19.125(2), the Supreme Court and this court have often framed the inquiry in terms of "likelihood that the error affected the result." *See id.* at 590-91 (noting various formulations by which error was held reversible where "it is likely that [error] affected the outcome"; "error either did or may have affected the outcome"; or error "might have affected the jury's consideration of the evidence").

In the evidentiary context, we have held that error warrants reversal where the erroneously excluded evidence would have had "some likelihood of affecting the result." *Hass v. Port of Portland*, 112 Or App 308, 314, 829 P2d 1008, *rev den* 314 Or 391 (1992). Although we have not amplified the contours of the "some likelihood" inquiry, consigning it to case-by-case application, it is at least settled that "likelihood" does not mean probability; that is, we need not be persuaded that the result at trial would have been different but for the evidentiary error. *Id. See, e.g., Dyer v. R. E. Christiansen Trucking*, Inc., 118 Or App 320, 325, 848 P2d 104 (1993) (evidentiary error was not harmless where "the result of the trial might have been different" if the erroneously admitted evidence had been excluded), *rev'd on other grounds* 318 Or 391, 868 P2d 1325 (1994). Perhaps the best approximation of our inquiry is that we view evidentiary error as reversible error--*i.e.*, as "substantially affecting the [appellant's] rights"--when, based on our assessment of the whole record, we believe that there was a substantial possibility that the error affected the result of the trial.

Applying that standard, we conclude that the erroneous exclusion of Gilmore's testimony pertaining to inadequate lighting requires reversal. As already noted, that testimony was highly probative with respect to two hotly **<150 Or App 419/420>** contested issues of liability. Moreover, that testimony does not appear to have been substantially duplicative of other evidence before the jury. Accordingly, we reverse and remand for a new trial on the inadequate lighting specifications of plaintiffs negligence *per se* claim.

Our disposition in that regard obviates the need to consider all but one of plaintiff's remaining assignments of error, the balance of which are either unlikely to reoccur on retrial or may arise, if at all, in a different context or posture. However, to afford guidance on remand, we address, and reject, plaintiff's 16th assignment of error. That assignment challenges the trial court's exclusion of plaintiff's exhibit 77, a demonstrative computer animation, which purports to depict the accident scene and plaintiff's theories of how the accident itself occurred.[22] We understand the trial court to have excluded that evidence as being potentially misleading. Trial courts exercise broad discretion with respect to such evidence, *see James v. Carnation Co.*, 278 Or 65, 81, 562 P2d 1192 (1977), and the court's ruling here was within the permissible range of discretion.

Reversed and remanded for new trial on inadequate lighting specifications of plaintiff's negligence *per se* claim; otherwise affirmed.

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[22] The animation showed two scenarios in which a human figure fell from what resembled the sample room roof--first, after hitting his head on an overhead pipe and becoming disoriented and, second, after tripping over a conduit. Plaintiff himself has no memory of the fall, and no one was present to witness it.

Cite as 150 Or App 422 (1997) October 15, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gary L. Brenner, Claimant.

DEAN WARREN PLUMBING and Liberty Northwest Insurance Corporation, *Petitioners,*
v.
Gary L. BRENNER, Fullman Company and Liberty Northwest Insurance Corporation, *Respondents.*
(WCB Nos. 94-05388, 94-02694, 94-02693, 94-02692; CA A92294)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted October 3, 1996; resubmitted in banc September 4, 1997.

Patricia Nielsen argued the cause for petitioners. With her on the brief was Mannix, Nielsen, Yunker & Crawford, P.C.

Gordon S. Gannicott argued the cause for respondent Gary L. Brenner. With him on the brief were David J. Hollander and Hollander, Lebenbaum and Gannicott.

Ian Harrasser, Certified Law Clerk, argued the cause for respondents Fullman Company and Liberty Northwest Insurance Corporation. With him on the brief was Alexander D. Libmann.

DEITS, C. J.

Affirmed.

Warren, J., dissenting.

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150 Or App 424> Employer Dean Warren Plumbing (Dean Warren)[1] seeks review of an order of the Workers' Compensation Board granting claimant an award of attorney fees of $3,500, pursuant to ORS 656.307(5), for claimant's attorney's representation before an administrative law judge (ALJ) in a responsibility proceeding under ORS 656.307. Dean Warren argues that the Board erred because the fee award exceeded $1,000, the maximum allowable award of fees under ORS 656.308(2)(d). We affirm.

In March 1989, claimant injured his knee while working for employer Fullman Company (Fullman).[2] The claim was accepted by Fullman as a lateral meniscal tear of the left knee. It was closed by a determination order in 1991. Claimant was awarded no permanent disability for this injury. In January, 1992, by stipulated settlement, claimant's scheduled disability for his left knee was increased by 7.5 percent.[3] In March 1992, claimant entered a claims disposition agreement with Fullman releasing his rights to any further workers' compensation benefits for that injury except for medical services.

Claimant started working for Dean Warren as a plumber in 1992. In late 1993, he began experiencing pain in his left knee and eventually sought medical attention for the condition. He was diagnosed as having a medical meniscal tear of the left knee. Claimant filed a workers' compensation claim against Dean Warren in February 1994. Dean Warren agreed that claimant's condition was compensable but denied responsibility and requested the issuance of a "307" order[4] naming Fullman as a potentially responsible employer. Fullman also agreed that claimant's condition was compensable, **<150 Or App 424/425>** but denied responsibility. The Department, noting that both employers agreed that responsibility was the only issue, issued a "307" order designating Liberty Northwest as the paying agent for Fullman. On March 23, Fullman officially agreed that the condition was compensable, but denied responsibility.

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[1] Petitioners on appeal are Dean Warren Plumbing and its insurer, Liberty Northwest Insurance Corporation. We refer to petitioners as Dean Warren.

[2] Fullman was also insured by Liberty Northwest Insurance Corporation. They appear as respondents in this case and concur in Dean Warren's argument that the limitations of ORS 656.308(2)(d) apply to the fee award before the ALJ in this case.

[3] Claimant had a previous award of 10 percent scheduled permanent disability for a 1986 injury to his left knee while working for another employer. That award has no relevance here.

[4] A "307" order is shorthand commonly used to refer to an order issued pursuant to ORS 656.307.

Claimant filed requests for hearing against both Fullman and Dean Warren. After the hearing, the ALJ affirmed Fullman's denial and, concluding that Dean Warren was the responsible employer, set aside Dean Warren's denial. The ALJ also awarded claimant an attorney fee of $1,000 to be paid by Dean Warren based on her conclusion that the fee limitation in ORS 656.308(2)(d) was applicable. Shortly thereafter, however, the ALJ reconsidered the fee award on her own motion. She concluded, based on the Board's decision in *Dan J. Anderson*, 47 Van Natta 1929 (1995), that the limitations of ORS 656.308(2)(d) were not applicable and that, under ORS 656.307(5), claimant was entitled to an award of attorney fees of $3,500 for services rendered on claimant's behalf at the hearing before the ALJ.

Dean Warren sought review by the Board of the ALJ's order. The Board affirmed the ALJ on both the issues of responsibility and attorney fees. In rejecting Dean Warren's argument that the fee limitations of ORS 656.308(2)(d) apply to this case, the Board explained:

> "In *Dan J. Anderson, supra*, we held that amended ORS 656.308(2)(d) applies retroactively to cases pending on Board review, but that it does not limit assessed fees awarded under ORS 656.307(5) for services rendered in a '307' responsibility proceeding. In reaching our conclusion, we relied on the fact that ORS 656.307 was not included among the statutes listed in amended ORS 656.308(2)(d). After considering Liberty/Warren's arguments, we decline to depart from our reasoning in *Anderson*. *See Allen T. Knight*, 48 Van Natta 30 (1996)."

The Board also awarded claimant $1,000 in attorney fees for legal services rendered before the Board.[5]

150 Or App 426> The question that we must decide is whether the limitation on attorney fees in ORS 656.308(2)(d) also limits awards of attorney fees authorized under ORS 656.307(5). ORS 656.307(5)[6] provides:

> "The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningftilly participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim."

ORS 656.308(2)(d)[7] provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

When construing statutes, our task is to ascertain the intent of the legislature when enacting the provisions in question. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). We begin with the text and context of the statutes, because the best evidence of legislative intent is the statute itself. *Id.* at 610. We may employ rules of construction at this level, such as the rule that other provisions within the same statutory scheme are considered part of the context, the rule that a particular provision controls a general provision that is inconsistent with it, and the rule that whenever possible, we construe the provisions of statutes so as to give effect to each and all of the provisions within that scheme. *Id.* at 611. If the legislature's intent is clear from that inquiry, we go no further. *Id.*

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[5] That attorney fee award is not challenged in this appeal, nor is it argued that the $1,000 limitation is a cumulative limit on proceedings before the ALJ under ORS 656.307(5) and other proceedings before the ALJ and the Board.

[6] This statute was amended by SB 369 during the pendency of claimant's claim. Because this statute was not among the exceptions to the general retroactivity provision of SB 369, it applies to cases arising under the former and present versions of ORS 656.307. *See Volk v. America West Airlines*, 135 Or App 565, 572-73, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). However, none of the amendments to this statute were substantive.

[7] This statute also was not among the exceptions to the general retroactivity provision of SB 369. Thus, it applies to cases arising under the former and present versions of ORS 656.308. *See Volk v. America West Airlines*, 135 Or App at 572-73.

150 Or App 427> Dean Warren argues that the text of ORS 656.308(2)(d) clearly provides that its fee limitations also apply to an award of fees authorized by ORS 656.307(5). Dean Warren's argument focuses on the words "in finally prevailing against a responsibility denial" in ORS 656.308(2)(d). It asserts that the general reference to a *responsibility* denial means that the limitation applies to *any* case involving a responsibility denial, which would include cases processed under ORS 656.307. Claimant, on the other hand, asserts that the Board's reading of these two statutes is correct, both because ORS 656.307(5) is a more specific statute than ORS 656.308(2)(d) and because ORS 656.308(2)(d) fails to reference ORS 656.307(5) in its "notwithstanding" clause.

We agree with claimant's and the Board's understanding of these two statutes. ORS 656.307(5) specifically authorizes attorney fees under specific circumstances; that is fees for legal services before an ALJ in a proceeding under ORS 656.307 where only responsibility is disputed. ORS 656.308(2)(d), on the other hand, authorizes attorney fees awards in responsibility cases in a number of contexts. The authorization of fees in the particular circumstances identified in ORS 656.307(5) is more specific and, under the rules of statutory construction, that statute should control over the more general language of ORS 656.308(2)(d). ORS 174.020. That reading also gives effect to all of the provisions of the statutory scheme.

Our reading of the statute is also supported by the fact that ORS 656.308(2)(d) includes a "notwithstanding" clause that specifically references a number of other statutes (ORS 656.382(2), 656.386, and 656.388) that authorize fees in particular circumstances, but does not reference ORS 656.307(5). This omission indicates that the legislature did not intend that the limitations of ORS 656.308(2)(d) would apply to proceedings under ORS 656.307(5). *See State v. McFee,* 136 Or App 160, 901 P2d 870 (1995), *rev dismissed* 323 Or 662 (1996) (where statute expressly provides that it applies to a number of specific statutory crimes, absence of a crime from those listed indicates that it was intended to be excluded, notwithstanding evidence that the legislature intended that it be included). The dissent purports to carry out the intent of the legislature with its reading of the statutes. However, in doing so, it ignores the language that the **<150 Or App 427/428>** legislature used. The dissent essentially would have us read ORS 656.307(5) into the "notwithstanding" clause of ORS 656.308(2). However, we may not insert into a statute what has been omitted. ORS 174.010.

Dean Warren also argues that interpreting ORS 656.308(2)(d) as not limiting attorney fees awarded under ORS 656.307(5) is illogical because an attorney representing a claimant in a more complex "hybrid" case under ORS 656.308 would have only limited fees available, while the attorney in a simple, "pure" responsibility case has access to unlimited fees, and that could not have been the legislature's intent. That argument overlooks the fact that in a hybrid case subject to ORS 656.308 there may be other statutes that authorize fees in the nonresponsibility aspects of the case. Regardless, as discussed above, the text and context of these two statutes lead us to the conclusion that the limitations of ORS 656.308(2)(d) do not apply to proceedings before the ALJ under ORS 656.307(5). *See Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 553, 915 P2d 1053, *rev den* 324 Or 305 (1996) (legislature's incorrect reading of a holding and enactment of statute in attempt to alter the effect of that decision does not give court authority to add words to statute; "we are constrained by the reasonable construction of the language that the legislature actually enacted"). We conclude that the Board did not err in awarding claimant fees of $3,500 for legal services before the ALJ.

Affirmed.

WARREN, J., dissenting.

The majority incorrectly assumes that because the legislature did not mention ORS 656.307 in ORS 656.308 it must have intended a result inconsistent with its overriding intent to limit attorney fees in responsibility cases. However, a permissible interpretation is available which provides consistency between the sections and at the same time adheres to the legislative purpose of limiting attorney fees in responsibility disputes. Because the majority fails to recognize this interpretation, I dissent.

ORS 656.307(5) provides, in part:

> **150 Or App 429>** "The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any [hearing to determine responsibility between multiple employers] and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employers or insurer

ORS 656.308(2)(d) provides:

> "Notwithstanding ORS 656.382(2), 656.386, and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

The issue is whether ORS 656.308(2)(d) limits attorney's fees to $1,000 even if the proceedings were governed by ORS 656.307 (referred to as a 307 hearing). A 307 hearing may be requested only when all parties agree that an injury is compensable and responsibility is the only question. *See* OAR 436-060-180.

In addressing this issue we must adhere to the settled principle that whenever possible we attempt to construe statutes on the same subject to achieve consistency. *Urban Renewal v. Swank,* 54 Or App 591, 599, 635 P2d 1344 (1981), *rev den* 292 Or 450 (1982); *Circuit Court v. AFSCME,* 295 Or 542, 545, 669 P2d 314 (1983); *see also Vaughn v. Pacific Northwest Bell Telephone,* 289 Or 73, 83, 611 P2d 281 (1980) ("This court will avoid a construction which creates a conflict between statutes or renders one statute ineffective."). The majority fails to mention this principle and instead focuses on tools of statutory construction based on the *assumption* that the sections conflict. This assumption is incorrect.

ORS 656.308(2)(d) sets a limit on attorney fees for that portion of the proceedings which deals with disputes between employers over which is responsible for compensating a claimant. Responsibility addresses only *who* is going to compensate a claimant, not *whether* a claimant will be compensated. The role of an attorney at this stage is generally **<150 Or App 429/430>** insignificant compared to his or her role in a dispute over whether an injury is compensable.[1] The legislature has made the policy decision to limit claimant attorney's fees in a dispute over responsibility. It would be incongruous for ORS 656.308(2)(d), which expressly targets responsibility cases, not to apply to a 307 hearing, which deals exclusively with responsibility.

There is no conflict between ORS 656.307(5) and 656.308(2)(d). Section 656.307(5) provides that a reasonable attorney fee may be awarded if the claimant's attorney meaningfully participates in a responsibility hearing. Obviously, if the claimant has absolutely nothing to gain or lose in a 307 hearing, any legal representation cannot be meaningful and should not be compensated. However, when an attorney's presence is necessary to protect or further an interest that may be in jeopardy, the statute provides for a "reasonable" attorney fee. Section 656.308(2)(d) provides that absent extraordinary circumstances, such reasonable attorney fees shall not exceed $1,000.

Read together, these statutes provide for reasonable attorney fees when an attorney meaningfully participates in a 307 hearing limited to $1,000 absent extraordinary circumstances. This simple construction gives effect to both statutes and furthers the legislative purpose behind ORS 656.308(2)(d), which is to limit the incentive for claimant attorneys to unnecessarily participate in proceedings which are really fights between employers.

Granted, ORS 656.308(2)(d) fails to include ORS 656.307 in its notwithstanding clause. However, this omission is far more likely an oversight than an indication of an intent that conflicts with the legislative goal to limit attorney fees in responsibility proceedings. Nothing in the statutes *require* the conclusion that the majority reaches. The construction that I propose is consistent with both the language **<150 Or App 430/431>** of the statutes and the legislative policy. Because the majority unnecessarily reaches a conclusion inconsistent with the clear legislative policy, I dissent.

Edmonds and Landau, JJ., join in this dissent.

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[1] There are times when legal representation in responsibility cases is very important. Deciding which employer pays the benefits may significantly impact the amount of those benefits due to such factors as time loss rates, medical providers and aggravation claim periods. However, the more crucial the attorney's role is in the proceeding, the more likely it will fall under the extraordinary circumstances of ORS 656.308(2)(d).

Cite as 150 Or App 531 (1997) October 15, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jody Crompton, Claimant.

FRED MEYER, INC., *Petitioner,*
v.
Jody CROMPTON, *Respondent.*
(95-06699, 95-03643; CA A93709)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 16, 1996.

Paul A. Dakopolos argued the cause for petitioner. With him on the brief was Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.

Edward J. Hill argued the cause for respondent. With him on the brief was Carney, Buckley, Kasameyer & Hays.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Affirmed.

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150 Or App 533> Employer seeks review of an order of the Workers' Compensation Board (Board), claiming that the Board applied the wrong standard for determining compensability. We affirm.

The following facts are taken from the Board's findings. In 1989, claimant suffered compensable carpal tunnel syndrome (CTS), which was accepted and treated in 1990. For the next few years, claimant received no medical attention, yet she continued to "experience [] minimal chronic symptomatology which flared with over-usage." Claimant became pregnant in 1994. She continued to work, but, due to the pregnancy, she experienced a significant increase in bilateral symptomatology for which she sought treatment in December 1994. In that same month, claimant filed a new claim for occupational disease for the renewed bilateral CTS; that claim was denied, and claimant did not appeal the denial. She gave birth in February 1995 and, the following April, underwent a surgical right carpal tunnel release.

Claimant requested payment for medical services related to the continuous CTS on June 5, 1995, and employer, who is self-insured, denied the request. At a hearing requested by claimant, the administrative law judge (ALJ) characterized claimant's request as one for payment of medical services under ORS 656.245(1)(a) and set aside the denial, holding that the 1989 condition was materially related to the 1995 need for medical services. Employer appealed to the Board, which adopted the reasoning and conclusions of the ALJ.

Employer seeks review of that decision, arguing that the Board erred in applying a "material contribution" standard. Specifically, employer contends that the 1995 condition is either a combined or a consequential condition and, in either case, claimant must prove that the 1995 need for medical services was "caused in major part" by the 1989 CTS. ORS 656.245(1)(a). We review the Board's order to determine whether, as a matter of law, the Board applied an incorrect legal standard. ORS 183.482(8)(a); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 202, 752 P2d 312 (1988).

150 Or App 534> Employer first argues that the 1989 injury, together with claimant's pregnancy, creates a combined condition. A combined condition is defined in ORS 656.005(7)(a)(B), which provides:

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

Under ORS 656.245(1)(a), combined conditions are compensable if they are "caused in major part" by a compensable injury. According to employer, the preexisting condition is claimant's pregnancy, and the compensable injury is the 1989 accepted claim. It makes no sense, however, to contend that a 1994 pregnancy preceded a 1989 injury. Employer insists that, under ORS 656.005(24), the pregnancy is properly considered a preexisting condition, because it preceded claimant's December 1994 claim. 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."

(Emphasis supplied.) Thus, under the statute, a preexisting condition must precede either (1) the onset of the initial claim for injury or occupational disease, or (2) a claim for worsening under ORS 656.273. In this case, employer does not argue that the pregnancy preceded a claim for injury or occupational disease. In any event, although the pregnancy did precede claimant's December 1994 occupational disease claim, that claim was denied by employer, was not appealed and is not before us in this case. Employer's only argument is that the pregnancy preceded claimant's 1994 claim, which it characterizes as a claim for worsening under ORS 656.273. That argument fails, because the 1994 claim was not a claim for worsening, as we have explained. We agree with the Board **<150 Or App 534/535>** therefore that this case does not present a combined condition.

Employer's second argument is that the "major contributing cause" test applies because claimant's 1995 claim is a consequential condition resulting from the 1989 CTS. ORS 656.005(7)(a)(A) provides:

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

We addressed the proper construction of that statute in *Albany General Hospital v. Gasperino,* 113 Or App 411, 833 P2d 1292 (1992). In that case, the claimant fell at work and suffered many injuries that were accepted for coverage. In the months following the accident, the claimant began to develop numbness in her arms and hands for which she sought treatment, resulting in surgery one-and-one-half years after the accident. A specialist concluded that the current condition, thoracic outlet syndrome (TOS), was materially caused by the fall; and the Board, using the "material contribution" standard, ordered coverage for the claimant. The employer argued that the TOS was a consequence of the compensable injury and that the "major contributing cause" standard applied. The claimant responded that the TOS was a part of the compensable injury rather than a consequence of it.

We held that "[t]he major contributing cause standard of ORS 656.005(7)(a)(A) was not intended to supplant the material contributing cause test for every industrial injury claim." *Id.* at 415. We explained further:

> "The distinction is between a condition or need for treatment that is caused by the *industrial accident,* for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the *compensable injury.* It is the latter that must meet the major contributing cause test."

Id. (emphasis in original). Applying that test to the facts, we found that the "claimant's TOS was directly caused by the **<150 Or App 535/536>** 1989 slip and fall itself, not by the injuries that she had sustained in the fall," and held that the material contribution standard applied. *Id.*

We followed our decision in *Gasperino* with *Beck v. James River Corp.,* 124 Or App 484, 863 P2d 526 (1993), *rev den* 318 Or 478 (1994). That case involved a noncompensable injury to the claimant's left shoulder in 1983, followed by a compensable injury to the same shoulder in 1986. In 1991, the claimant underwent unrelated neck treatment that caused muscle contractions in his left shoulder requiring treatment. The employer denied coverage, arguing that the shoulder injury constituted a combined condition and that the claimant had not met his burden of proving that the 1986 compensable injury was the major cause of the need for treatment. We concluded that ORS 656.005(7)(a) does not apply to claims for continued treatment made pursuant to ORS 656.245, noting that

> "[e]mployer does not argue that the [neck treatment] caused a new injury, and claimant does not seek compensation for a new injury or condition. The [neck treatment] merely caused a need for further treatment of the compensable shoulder condition."

Id. at 487.[1]

Both decisions make clear that a consequential condition is a separate condition that arises from the compensable injury, for example, when a worker suffers a compensable foot injury that results in an altered gait that, in turn, results in back strain. *See Gasperino,* 113 Or App at 415 n 2; *see also Barrett Business Services v. Hames,* 130 Or App 190, 193, 881 P2d 816, *rev den* 320 Or 492 (1994) (consequential condition under ORS 656.005(7)(a)(A) exists when a claimant suffers a new injury); *Roseburg Forest Products v. Ferguson,* 117 Or App 601, 604, 845 P2d 930, *rev den* 316 Or 528 (1993) (ORS **<150 Or App 536/537>** 656.005(7)(a)(A) not applicable when a claimant needs continued medical treatment under ORS 656.245 for a previously compensated condition).

As in *Gasperino* and *Beck,* this case does not involve two different injuries, one caused by another, but, rather, involves different occurrences of the same condition. Claimant's 1995 CTS is the same work-related CTS that developed in 1989. Thus, there is no consequential condition, and ORS 656.005(7)(a)(A) does not apply.

Affirmed.

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[1] Subsequent to the *Beck* decision, the language of ORS 656.245 was amended to clarify that ORS 656.005(7)(a) may apply to claims for continued medical services. Nevertheless, the analysis of *Beck* as to why the facts failed to constitute a consequential condition under ORS 656.005(7)(a)(A) remain unaffected by the changes in statutory language to ORS 656.245.

Cite as 150 Or App 548 (1997) October 15, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Glenda Jensen, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and St. Elizabeth Hospital, *Petitioners,*
v.
Glenda JENSEN, *Respondent.*
(95-07344; CA A93483)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 24, 1997.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Michael A. Gilbertson argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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150 Or App 550> Employer seeks review of a Workers' Compensation Board (Board) order holding that employer's termination of temporary total disability was improper and imposing a penalty, on the ground that employer's offer of modified work to claimant was defective. We hold that employer's offer was not defective and reverse.

Claimant was employed as a certified nurse assistant for employer. On December 31, 1993, she compensably injured her left shoulder while lifting a patient into a wheelchair. Employer accepted her claim for left shoulder impingement syndrome. In March 1994, claimant was released to light-duty work and then accepted two different positions with employer, neither of which claimant ultimately was able to perform. On November 29, 1994, employer offered claimant a temporary job as a switchboard operator. The written offer contained the following statement:

> "We are offering you a temporary position. Attached is a copy of the work release. We are offering you a temporary light/modified duty job as described below. The continued availability of this position will be re-evaluated periodically."

The offer also attached a copy of the work release, sent to and signed by the attending physician, which stated:

> "We will provide the temporary position described above as long as it is available or until you release her to regular duties."

Claimant refused the position. Employer then terminated claimant's temporary total disability benefits, paying her only the temporary partial disability benefits to which she would have been entitled had she accepted employer's offer.

Claimant sought a hearing concerning the adequacy of employer's offer, arguing that it did not satisfy the requirements of OAR 436-60-030(12) (1996),[1] which implemented the statutes governing payment of temporary partial disability compensation. That rule provided:

> **150 Or App 551>** "An insurer shall cease paying temporary total disability compensation an start paying temporary partial disability compensation under section (8) of this rule as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:
>
> "(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;
>
> "(b) The attending physician agrees the employment appears to be within the worker's capabilities; and
>
> "(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; *the duration of the job, if known;* the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."[2]

OAR 436-60-030(12) (1996) (emphasis supplied). She also argued that the offer was unreasonable on other grounds. The administrative law judge held that employer's offer did not state the duration of the position, except to say that the position was temporary, contrary to the requirements of OAR 436-60-030(12)(c) (1996) and held that the offer was invalid on that basis. The ALJ did not address claimant's other arguments. The Board affirmed.

On judicial review, employer argues that its offer did comply with OAR 436-60-030(12)(c) (1996), because the rule does not require employer to state that the duration is not known and that its offer stated the duration to the extent it was known. Employer also argues that, if the Board correctly **<150 Or App 551/552>** interpreted the rule, the rule exceeds the scope of the statute it seeks to implement. In any event, employer argues, the Board erroneously assessed a penalty against it. Claimant argues that the offer is defective because it does not state explicitly that the duration of the employment is unknown.

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[1] OAR 436-60-030 (1996) since has been renumbered to OAR 436-060-0030, but the text of the rule has remained unchanged in all material respects.

[2] OAR 436-060-0030 and its predecessor implement ORS 656.325(5)(a), among other statutes. ORS 656.325(5)(a) provides that, notwithstanding ORS 656.268:

> "An insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 [temporary total disability] and shall commence making payment of such amounts as are due pursuant to ORS 656.212 [temporary partial disability] when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

See also ORS 656.268(3)(c).

We review the Board's interpretation of the administrative rule for errors of law. ORS 183.482(8)(a).[3] In interpreting administrative regulations, we apply the same rules that apply to the construction of statutes. *Perlenfein and Perlenfein*, 316 Or 16, 20, 848 P2d 604 (1993). Consequently, we begin with an examination of the text and context of the rule; if the meaning of the rule is clear, our inquiry is at an end. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993).

The text of OAR 436-60-030(12)(c) (1996) is straight-forward: The employer must provide the worker with a written offer of employment that states the "duration of the job, *if known.*" (Emphasis supplied.) The rule does not require a statement of the duration if it is not known. In this case, employer stated that the job was temporary and would be re-evaluated. There is no allegation that employer knew the duration of the job and withheld it. Accordingly, because employer did not know the duration of the job, its offer is not defective simply because it stated what employer did know that the job was temporary and subject to re-evaluation. We hold that employer has complied with the rule, and we are not at liberty to impose additional requirements on employers that are not present in the rule. *See Perlenfein*, 316 Or at 22-23 (in construing an administrative rule, courts may not omit what has been inserted or insert what has been omitted). Consequently, the Board erred in holding otherwise and in imposing a penalty against employer on that ground.

Because we hold that the Board incorrectly interpreted OAR 436-60-030(12)(c) (1996), we need not address **<150 Or App 552/553>** employer's challenge to the validity of the rule itself. We also do not address whether employer's offer may be invalid on other grounds, as asserted by claimant. The ALJ and the Board did not reach those argument, and they are not before us on review.

Reversed and remanded for reconsideration.

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[3] Claimant argues that we review the Board's decision for substantial evidence that the employer failed to comply with the requirements of OAR 436-60-030(12)(c) (1996). Claimant is incorrect. The Board's interpretation of what the rule required employer to submit to claimant raises a question of law and is not reviewed for substantial evidence as a factual issue. *See* ORS 183.482(8)(c) ("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." (Emphasis supplied.)).

Cite as 150 Or App 554 (1997) October 15, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Harry L. Lyda, Claimant.

STATE FARM INSURANCE COMPANY and Harry Lyda Realty, *Petitioners,*
v.
Harry L. LYDA, *Respondent.*
(93-06409; CA A93995)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 10, 1997.

Chess Trethewy argued the cause for petitioners. With him on the brief was Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.

David W. Hittle argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander, McCann & Smith.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Affirmed.

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150 Or App 556> Insurer seeks review of an order of the Workers' Compensation Board (Board) setting aside the insurer's denial under ORS 656.262(6)(c) on the ground that the compensable injury continued to be the major contributing cause of claimant's combined condition. Insurer contends that the Board erroneously "shifted the burden" of proving compensability, that the Board's order is not supported by substantial evidence and that the Board's factual findings are not rationally connected to its legal conclusions. We affirm.

On March 10, 1983, claimant injured his left shoulder, neck and left upper back while opening a file cabinet drawer at work. Insurer accepted the claim for those injuries. In February 1991, claimant reported severe right neck and shoulder pain to his treating physician, Dr. Athay. Insurer denied that claim, contending that claimant's symptoms were not related to his accepted 1983 injury. In December 1991, claimant and insurer entered into a stipulated agreement, which provided in part that insurer would withdraw its denial and continue processing the claim. In January 1992, Athay described claimant's condition as "chronic pain condition." In March 1992, insurer denied the compensability of all claimant's conditions other than the accepted neck, left upper back and left shoulder pain arising out of the 1983 injury. Claimant contested that denial.

The contest ultimately resulted in a Board decision on May 27, 1993, in which the Board concluded that insurer had not accepted specific diseases or conditions, but had accepted symptoms, including a preexisting chronic pain syndrome and a preexisting cervical degenerative condition underlying claimant's left upper back, neck and left shoulder pain. The Board also concluded that neither claimant's chronic pain syndrome nor degenerative condition was independently compensable, but that they had combined with his compensable 1983 injury to cause a need for medical treatment. Thus, the Board concluded that claimant's current chronic pain syndrome was compensable. Additionally, because the chronic pain syndrome had been accepted and **<150 Or App 556/557>** had not changed since its acceptance, claimant's compensable 1983 injury was the major contributing cause of the combined condition.

In a letter to claimant's attorney dated May 26, 1994, Athay stated that claimant's 1983 injury was medically stationary, but that the preexisting conditions gradually had deteriorated. On November 8, 1994, claimant was awarded 41 percent unscheduled permanent disability and 7 percent scheduled permanent disability for the loss of use or function of his left arm. As part of claimant's requested reconsideration, medical arbiter examinations were conducted on May 17, 1995. Claimant was examined by Dr. Glass, a psychiatrist, Dr. Platt, a neurologist, and Dr. Dinneen, an orthopedist. Claimant's unscheduled disability award was increased to 46 percent, but, based on the information received during the examinations, insurer issued a denial on July 19, 1995, alleging that claimant's current chronic pain syndrome was not compensable. Claimant's challenge of the chronic pain syndrome denial forms the ground for this judicial review.

After examining the decisions of the medical arbiters, an administrative law judge (ALJ) concluded that claimant had not proven that his compensable 1983 injury still was the major contributing cause of his "combined condition" under ORS 656.005(7)(a)(B). Claimant appealed to the Board. The Board concluded that "claimant has sustained his burden of proving that his compensable 1983 injury remains the major contributing cause of his chronic pain syndrome." In reaching that conclusion, the Board explained:

> "We recognize that ORS 656.262(6)(c) allows a carrier to deny a 'combined condition' even if it had been previously accepted as a result of an order, provided that the otherwise compensable injury 'ceases' to be the major contributing cause of the combined condition. However, the word 'cease' implies that there must be a change in claimant's condition or a change of circumstances such that the compensable injury is no longer the major contributing cause of the claimant's combined condition.
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> "Although the medical arbiters, Drs. Platt and Dinneen, opined that claimant's present condition was not related to the March 1983 injury in a 'major way,' they did not identify **<150 Or App 557/558>** any change in claimant's condition or a change of circumstances such that claimant's compensable injury is no longer or 'ceased' to be the major contributing cause of claimant's combined condition. In a single unexplained sentence, Dr. Glass opined that claimant's compensable injury was not the major contributing cause of claimant's psychiatric symptoms. However, he, too, did not identify any change of circumstances or change in claimant's condition.
>
> "We recognize that there is evidence from Dr. Athay that claimant's degenerative conditions have generally deteriorated. However, Dr. Athay also observed that there had been no 'major changes' and that claimant's conditions have remained medically stationary. Thus, based on Dr. Athay's persuasive medical opinion, we are not inclined to find that there has been a change in claimant's condition or a change in circumstances to warrant the issuance of a denial under ORS 656.262(6)(c).

> "In any event, even if the requisite change of circumstances was present to support the procedural validity of such a denial, the persuasive medical evidence does not establish that claimant's compensable injury has 'ceased' to be the major contributing cause of his chronic pain disorder."

(Footnote omitted; citation omitted.) On review, insurer asserts three assignments of error. First, it contends that the Board erred in imposing upon insurers the burden of proving a change in a claimant's condition to permit denial of a combined condition under ORS 656.262(6)(c). Second, it contends that substantial evidence does not support the Board's finding that claimant's condition had not changed. Third, it contends that the Board's opinion is inconsistent and did not articulate a rational connection between its findings of fact and its legal conclusions.

Insurer's first assignment disputes the Board's construction of ORS 656.262(6)(c) and thus presents a legal question. The disputed statute provides:

> "An insurer's * * * acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer * * * from later denying the combined or consequential condition if the otherwise compensable injury **<150 Or App 558/559>** ceases to be the major contributing cause of the combined or consequential condition."

ORS 656.262(6)(c). There is no question that a claimant bears the burden of proof on questions of compensability. ORS 656.266. There is likewise no question that, in the case before us, the Board--although perhaps not artfully--correctly stated and correctly applied that rule of law. The Board's opinion clearly stated that "claimant has sustained *his burden* of proving that his compensable 1983 injury remains the major contributing cause of his chronic pain syndrome." (Emphasis supplied.)

What appears to have side-tracked insurer are two statements of the Board that, under ORS 656.262(6)(c), there must be a "requisite change of circumstances" and that "the word 'ceases' implies that there must be a change of circumstances" to support the insurer's denial. In context, however, it is apparent that the Board did not alter the burden of proof, but rather stated a conclusion that flows from the statutory requirement that an employer's denial be reasonable to avoid the imposition of penalties under ORS 656.262(11)(a).[1] Thus, the Board referred to establishing a requisite change of circumstances as necessary "to support the *procedural validity*" of the denial. (Emphasis supplied.) In that context, the Board's statements are correct, and they did not impermissibly shift the burden of proving compensability from claimant to insurer.

In its second assignment of error, insurer contends that substantial evidence does not support the Board's decision that the 1983 injury was the major contributing cause of claimant's chronic pain syndrome. Substantial evidence exists when the record, viewed as a whole, permits a reasonable person to find as the Board did, in the light of supporting and contrary evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 294, 787 P2d 884 (1990); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). In this case, the Board **<150 Or App 559/560>** relied on the opinion of Athay, claimant's treating physician. Athay stated in a letter dated May 26, 1994, that claimant's compensable 1983 injury was stationary, but that his "chronic anxiety state has a basis in his chronic pain syndrome, which * * * relate[s] to his on-the-job injury back in 1983." Athay also explained that claimant's preexisting neck condition with degenerative cervical disc disease and degenerative arthritis had worsened slightly and that claimant suffered from occasional flareups stemming from the underlying conditions.

Insurer argues that, because Athay noted a change in the preexisting degenerative disease changes, the Board erred in failing to find a change in the proportionate make up of claimant's combined condition. We disagree. It was claimant's burden to prove that his compensable 1983 injury was the major contributing cause of his combined condition. A slight change in the contributing factors does not necessarily result in the 1983 injury "ceas[ing]" to be the major contributing cause. Additionally, Athay had reported that there were no "major changes" in claimant's condition over several years.

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[1] ORS 656.262(11)(a) provides, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

The Board also examined the opinions of the medical arbiters, Platt, Glass and Dinneen, but did not find them persuasive. The Board noted that the doctors had explained neither a change in claimant's condition nor how the 1983 injury was no longer the major contributing cause. Upon examining the record as a whole, we conclude that the Board's findings are supported by substantial evidence.

In its third assignment of error, insurer asserts that the Board erroneously found that there was no change in claimant's condition yet relied on Athay's opinion, in which he stated that claimant's condition had worsened slightly. According to insurer, the Board's decision is inconsistent and without a rational connection between the finding of fact and legal conclusion, citing *Liberty Northwest Ins. Corp. v. Verner*, 139 Or App 165, 911 P2d 948 (1996). *Accord Drew v. PSRB*, 322 Or 491, 501, 909 P2d 1211 (1996). In *Verner*, we stated that, if the Board relies on an expert's opinion despite an inconsistency, it must explain its reason for so doing. *Id.* at **<150 Or App 560/561>** 169. In this case, the Board clearly recognized the inconsistency in Athay's letter. The Board explained that, despite the gradual deterioration in claimant's condition, Athay consistently professed that claimant's overall condition remained basically unchanged for several years. Additionally, the Board explained that, as claimant's treating physician, Athay had the benefit of many years of observation. In the light of the Board's explanation, we conclude that there was a rational connection between the Board's factual findings and its legal conclusion.

Affirmed.

Cite as 151 Or App 21 (1997) October 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Patricia J. Hofstetter, Claimant.

FRED MEYER, INC., *Petitioner,*
v.
Patricia J. HOFSTETTER, *Respondent.*
(96-01165 and 95-10561; CA A96104)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 3, 1997.

Paul L. Roess argued the cause for petitioner. With him on the brief was Moscato, Skopil & Hallock.

Robert Wollheim argued the cause for respondent. With him on the brief was Welch, Bruun, Green & Wollheim.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

EDMONDS, J.

Affirmed.

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151 Or App 23> Employer seeks review of an order of the Workers' Compensation Board (Board) in which the Board set aside employer's denial of claimant's claim and remanded the claim for processing. As part of its decision, the Board declined to address employer's "medical causation" argument on the ground that employer had not previously raised that issue. We review for substantial evidence and errors of law, ORS 656.298(6), ORS 183.482(8), and affirm.

Claimant worked for employer as a data entry clerk. She experienced pain in both shoulders and filed a claim for compensation. Her attending physician diagnosed her condition as a repetitive over-use strain of the shoulder girdle musculatures. Employer asked claimant's attending physician whether there were "objective findings," as that phrase is defined in ORS 656.005(19), to support his diagnosis of the left shoulder condition.[1] After reviewing the statute, the physician responded that

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[1] 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."

there were no objective findings regarding the left shoulder condition. Employer accepted claimant's right shoulder claim but denied the claim for the left shoulder condition.

Claimant sought a hearing on the denial, and the Administrative Law Judge (ALJ) agreed with employer's position. Claimant sought Board review. In its brief before the Board on review, employer asserted that, in addition to there being no objective findings, claimant had not established medical causation. The Board on review held for claimant and declined to address the medical causation issue, reasoning that medical causation had not been adequately raised by employer before the close of the evidentiary record.

Employer moved for reconsideration. On reconsideration, the Board said:

151 Or App 24> "Based on this record, it appears that the issue litigated at hearing was whether or not there were 'objective findings' of an injury. There was no contention raised on the record that the claim failed because medical causation was not established. A carrier is bound by the express language of its denial. Here, the specific basis given for the denial was a lack of objective findings supporting the claim. Accordingly, we find that the only compensability issue raised at hearing was the issue of whether claimant's claim was supported by 'objective findings.'

> "Parties to a workers' compensation proceeding may, by agreement, try an issue that is outside the express terms of the denial. Based upon this transcript, the existence of objective findings was the theory that was raised by the employer at hearing in support of the denial and that was the issue litigated by the parties.
>
> "In *John E. Noyer*, 46 Van Natta 395 (1994), a carrier raised a 'causation' theory at hearing even though the carrier's denial had only denied the claim based on a lack of 'objective findings.' The Board found that, by raising the 'causation' theory, the carrier had amended its denial. Accordingly, the Board remanded to allow claimant to respond to the 'amended' denial. Here, in contrast to *Noyer*, the employer did not seek to amend its denial at hearing and, according to the record, asserted only that objective findings had not been established. Under such circumstances, we find that there was no attempt to amend the denial at hearing.
>
> "To allow the employer to raise a new defense after the close of the evidentiary hearing would prejudice claimant if the case were resolved on that basis. Based on the employer's denial, the claim was denied because there were no 'objective findings.' Based on the record at hearing, whether there were 'objective findings' was the issue litigated. To decide the case on a different basis than was litigated at the hearing would be fundamentally unfair." (Citations omitted.)

Accordingly, the Board adhered to its earlier decision not to address the issue of medical causation.

The only issue before us on review is whether the Board was required to decide whether claimant proved medical causation. First, we inquire as to whether employer's **<151 Or App 24/25>** denial raised the issue of medical causation. OAR 438-005-0060 provides, in part:

> "Every notice of partial denial shall set forth with particularity the injury, condition, benefit or service for which liability is denied and *the factual and legal reasons therefor.*" (Emphasis supplied.)

Employer's denial said:

> "We are denying compensability of your left shoulder strain claim because Dr. Davis reports there are no objective findings.
>
> "Therefore, without waiving further questions of compensability, we issue the denial of your claim for benefits."

The second sentence of the partial denial, while apparently attempting to reserve the right to raise other "questions of compensability," does not affirmatively "set forth with particularity" the lack of medical causation as a reason for the denial as required by OAR 438-005-0060. Employer argues that the issues of whether there are objective findings and whether there is evidence of medical causation are inextricably intertwined. In other words, to raise one issue necessarily results in the other being raised, according to employer. Employer is mistaken. "Objective findings" refer to "verifiable indications of injury or disease," while medical causation pertains to the causal link between the claimed injury or disease and the employment. The Board's conclusion that the denial did not raise the issue of medical causation is correct.

Next, the Board reviewed the record to determine whether the parties had tried the issue of medical causation by consent, or if employer had amended the denial before the hearing before the ALJ. In its order, the Board reviewed the correspondence between employer and claimant[2] and employer's opening statement[3] at hearing and found that the **<151 Or App 25/26>** only issue raised by employer at any stage of the proceedings was whether there were objective findings regarding the left shoulder condition. Furthermore, the Board found no mention of the issue of medical causation in the record.[4]

It is generally recognized that the Board has discretion on whether to reach issues not raised before the ALJ. *Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 685, 893 P2d 560 (1995). In this case, the Board declined to exercise its discretionary authority to review employer's argument because of its concern that claimant had not been put on notice that medical causation was at issue before the evidentiary record was made. It concluded that claimant would be unfairly prejudiced if it were to decide that issue on the record before it. In view of its findings, the Board did not abuse its discretion in refusing to consider the issue of medical causation.

Affirmed.

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[2] The Board's order states, "A letter from the employer's claims processor to claimant's attorney also indicates that the [left] shoulder claim was being denied 'because there are no objective findings.'"

[3] The board quoted the following passage from employer's opening statement in its order:

> "' * * * * I wrote Dr. Davis a letter * * *. And in that I just listed or wrote out the statutory definition of objective findings. I said, this is what the objective--how objective findings are defined by 656.005(19). And I--the letter goes on to ask [claimant] mention (sic) that she had some left-sided complaints, are there objective findings. And so he responded that--on January 5 and said, "you are correct in your understanding that [claimant] had some left-sided shoulder complaints, but at the time I saw her, there were no objective findings to support her problem," so [employer] issued the Denial on the basis that there wasn't any--weren't any objective findings to support the left-sided complaints. And Dr. Davis was the treating physician for all those left--for all those shoulder complaints, so that's why the denial was issued."' (Alterations in original.)

[4] In a memorandum of additional authorities and at oral argument before this court, employer argued that its "Response to Issues" form, where it marked the box denying "That claimant sustained a work-related accidental injury or occupational disease" was sufficient to put claimant on notice with respect to the medical causation issue. Employer failed to raise that argument to the Board and we will not consider it for the first time on review.

Cite as 151 Or App 58 (1997) October 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert K. Schiller, Claimant.

SAIF CORPORATION and Robert E. Jensen, *Petitioners,*
v.
Robert K. SCHILLER, *Respondent.*
(95-05299; CA A92914)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 19, 1996.
David L. Runner argued the cause and filed the brief for petitioners.
J. Michael Casey argued the cause and filed the brief for respondent.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Affirmed.

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151 Or App 60> SAIF Corporation seeks review of an order of the Workers' Compensation Board (Board) reclassifying claimant's injury from nondisabling to disabling. We review for errors of law and substantial evidence, ORS 656.298(6); ORS 183.482(7) and (8), and affirm.

On March 29, 1994, claimant suffered a right hip strain when he tripped over a wood pallet. On April 11, 1994, claimant saw his attending physician, Dr. Peterson, for related treatment. Peterson diagnosed claimant's injury as a "sacroiliac strain," but recommended that claimant "continue on regular work duty." On April 28, 1994, SAIF accepted the claim as nondisabling.[1] On August 8, 1994, Dr. Roy, an associate of Peterson, reevaluated claimant, declaring claimant medically stationary[2] and noting that he had right thigh numbness and had lost some active flexion of his right hip. Roy described the conditions as symptomatic and noted that "the conditions will probably stay as they are." After experiencing a recurrence of symptoms, claimant sought chiropractic treatment and then, on September 21, 1994, again saw Peterson. Peterson rechecked claimant and reported that the chiropractic treatment had resolved "his immediate problem," also noting that claimant had full hip range of motion and full muscle strength and sensation in both legs. On May 15, 1995, Peterson again saw claimant for a recurrence of the right hip strain, reporting that while "[c]hiropractic treatment does give him short term relief, * * * the condition keeps reoccurring." On July 7, 1995, Peterson signed a report in which he agreed that there was a reasonable expectation that permanent disability would result from claimant's sacroiliac strain based on the chronicity of his symptoms. On July 13, 1995, Peterson signed an additional report indicating that this expectation was present at claimant's examination on August 8, 1994.[3]

151 Or App 61> In January 1995, claimant began a series of statutorily prescribed processes to have his claim reclassified. *See* ORS 656.262(6)(b)(C); ORS 656.268(11); ORS 656.277. Claimant first submitted his request to SAIF, then to the Department of Consumer and Business (DCBS) for review and reconsideration, next to a hearings officer and ultimately to the Board for review. The Board ordered SAIF to reclassify the claim as disabling.

At the hearing, claimant introduced Peterson's July 7 and July 13 reports. Although claimant had not produced either report at the reconsideration, SAIF did not object to their admission. The administrative law judge (ALJ) considered the reports in his decision but nevertheless denied claimant's request, concluding that claimant had failed to establish a reasonable expectation of a ratable permanent

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[1] A "nondisabling compensable injury" is one that requires only medical services. ORS 656.005(7)(d).

[2] "Medically stationary" means that claimant's condition is not reasonably expected to improve with additional medical treatment or the passage of time. ORS 656.005(17).

[3] ORS 656.277(1) imposes a one-year limit on reclassification requests. We note that there is no dispute regarding whether claimant's request meets this limitation.

disability sufficient to justify classifying the claim as disabling. The Board reversed the ALJ's order, finding that Peterson's July 7 and July 13 reports, while "rather cursory, in the absence of any evidence to the contrary, * * * [were] sufficient to establish a reasonable expectation that permanent disability [would] result from claimant's injury." The Board relied on ORS 656.005(7)(c), which provides:

> "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury."

In its first three assignments of error, SAIF contends that: (1) the Board "misconstrued the expression 'permanent disability' in ORS 656.005(7)(c) by failing to require proof of an impairment that would constitute a ratable 'permanent disability' under the department's disability standards"; (2) the Board improperly shifted the burden of proof when it concluded "that claimant's claim was disabling 'in the absence of any evidence to the contrary'"; and (3) "[s]ubstantial evidence does not support a finding that there is a reasonable expectation that 'permanent disability' will result from the compensable injury within the meaning of ORS 656.005(7)(c)." We disagree with each of SAIF's contentions.

We review the first assignment of error to determine whether the Board correctly interpreted the statute. ORS **<151 Or App 61/62>** 183.482(8). Specifically, we must determine whether the legislature intended in ORS 656.005(7)(c) to require proof of the existence of a specific, ratable impairment in order to reclassify a claim from nondisabling to disabling.

We interpret a statute by examining its text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). A statute's context includes other provisions of the same statute and other related statutes. *Id.* at 611. The "reasonable expectation" provision in ORS 656.005(7)(c) provides that in a situation where, as here, a claimant suffers an on-the-job injury but experiences no time loss as a result, the injury is not disabling "unless there is a reasonable expectation that permanent disability will result from the injury." The phrase "reasonable expectation" unambiguously refers to a condition that has not yet occurred.

The condition, *i.e.*, "permanent disability," is a term defined elsewhere in the statutes and rules comprising the Workers' Compensation Law. *See generally* ORS 656.206 and ORS 656.214; OAR chapter 436, division 35. Those provisions designate an exclusive set of impairments for compensability and rate the various impairments for compensation levels.

When considered together, the text and context show that the "reasonable expectation" provision requires an evidentiary link between the actual, current condition and a potential, statutorily defined condition. That evidentiary burden does not, however, require evidence of a specific and actual impairment as defined by statute or rule, because under the "reasonable expectation" provision, which concerns an event that has not yet occurred, that kind of proof does not yet exist.[4]

Moreover, to read the "reasonable expectation," provision to require, as SAIF contends, proof of a condition presently "ratable as a 'permanent condition' under the Department's disability standards," would render the "reasonable **<151 Or App 62/63>** expectation" phrase meaningless. We are obligated to avoid such a result. ORS 174.010 ("[W]here there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all.").

Accordingly, we hold that the Board properly interpreted ORS 656.005(7)(c) to require proof of a current condition that could lead to a ratable impairment under the DCBS's impairment standards, not proof of a condition presently ratable under the standards, in order to reclassify a claim from nondisabling to disabling.[5]

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[4] SAIF argues that, because claimant was considered medically stationary before his reclassification request, he should be required to prove at the reclassification phase his injury's rating under the DCBS's disability standards. We disagree, noting simply that the determination of an injury's rating, which occurs at claim closure, and the classification procedure, which occurs at claim acceptance, are distinct processes. *See* ORS 656.262; ORS 656.268.

[5] At oral argument, SAIF contended that the Board did not apply its own administrative rule--OAR 436-030-0045(9)--when deciding this case and therefore erred. SAIF also submitted a memorandum of additional authorities to support its contention. Because SAIF did not make that argument to the Board and did not assign error to it, we decline to consider it. *Saxton v. SAIF*, 80 Or App 631, 634, 723 P2d 355, *rev den* 302 Or 159 (1986).

In its second assignment of error, SAIF contends that the Board improperly shifted the burden of proof to SAIF when the Board stated that "claimant's claim was disabling in the absence of any evidence to the contrary." We disagree. Claimant has the burden of proving that a claim is misclassified. ORS 656.266; *see Normandeau v. Aetna Casualty & Surety Co.*, 120 Or App 184, 187, 852 P2d 217 (1993). Here, claimant's evidence included his relevant medical history and two reports from his attending physician, Peterson, in which Peterson opined that there was a reasonable expectation that permanent disability would result from claimant's injury. SAIF, on the other hand, produced nothing. Consequently, because claimant produced evidence, the Board did not base its findings solely on the lack of contrary proof and, thus, did not reach its conclusion through improper burden shifting. Rather, the Board simply recognized the state of the evidentiary record. There was no error.

In SAIF's third assignment of error, it argues that substantial evidence does not support a finding that there is a reasonable expectation that permanent disability will result from claimant's injury. Substantial evidence supports a finding when the record, viewed as a whole, permits a **<151 Or App 63/64>** reasonable person to make the finding. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988).

Here, the Board had before it uncontradicted and credible medical evidence submitted by claimant that his hip strain was reasonably expected to result in a permanent disability. Moreover, because a loss of internal rotation of the hip is a condition recognized by the DCBS's disability standards, the necessary evidentiary link was present. *See* OAR 436-35-340(10). Because this evidence was uncontradicted and credible, a reasonable person could conclude from the totality of the evidence presented that claimant's injury was likely to result in a permanent disability. Accordingly, we hold that substantial evidence supports the Board's finding.

In SAIF's fourth assignment of error, it contends that the Board improperly based its decision on evidence not admissible under ORS 656.283(7)[6] when it considered Peterson's July 7 and July 13 reports, which claimant did not produce until after the reconsideration.

SAIF's evidentiary argument was not raised at the hearing before the ALJ, nor was it raised in SAIF's brief to the Board, nor did the Board address that evidentiary issue on its own motion. The argument did not surface until judicial review to this court. Because this argument was not preserved, we do not address it.[7] OEC 103(1); *Ailes v. Portland Meadows, Inc.*, 312 Or 376, 823 P2d 956 (1991) (court may not consider issues not raised by parties); *SAIF v. Yokum*, 132 Or App 18, 22, 887 P2d 380 (1994) (court concluded implicitly that it has jurisdiction over only those issues preserved before the Board); *McCarter v. Crown Zellerbach*, 45 **<151 Or App 64/65>** Or App 905, 609 P2d 435 (1980) (a party must preserve error at the hearing in order for the Board to consider issue).

Affirmed.

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[6] 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[.]"

[7] In *Fister v. South Hills Health Care*, 149 Or App 214, 942 P2d 833 (1997), we had occasion to address a similar issue. There, we held that, despite the statutory bar contained in ORS 656.283(7), "[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 inadmissible." *Id.* at 219.

Cite as 151 Or App 76 (1997) October 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lewis H. Titus, Claimant.

WILLAMETTE INDUSTRIES, INC. *Petitioner,*
v.
Lewis H. TITUS, Pope & Talbot, Inc., SAIF Corporation, Pacific Gas & Transmission, and Employers Insurance of Wausau, Inc., *Respondents.*
(94-09737, 94-07998 & 94-06921; CA A92576)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 31, 1997.
Jerald P. Keene argued the cause and filed the briefs for petitioner.
Philip Emerson argued the cause for respondent Lewis H. Titus. With him on the brief was Brothers, Steelhammer & Ash.
David L. Runner argued the cause and filed the brief for respondents Pope & Talbot, Inc., and SAIF Corporation.
David O. Horne argued the cause and filed the brief for respondents Pacific Gas & Transmission and Employers Insurance of Wausau, Inc.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Affirmed.

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151 Or App 78> Willamette Industries, Inc., a self-insured employer, seeks review of an order of the Workers' Compensation Board (Board) assigning it responsibility for claimant's 1994 injury. We review for errors of law and substantial evidence, ORS 656.298(6); ORS 183.482(7) and (8), and affirm.

In 1980, while working as a log truck driver for Pope & Talbot (SAIF's insured), claimant's lower back began to trouble him. Without identifying a specific incident, claimant established, and SAIF accepted, a compensable lower-back strain. Although claimant's attending physician, Dr. Golden, initially thought claimant might have suffered a lumbar disc herniation, a subsequent myelogram "was completely normal." SAIF later closed the claim without an award of permanent disability. Claimant continued working with Pope & Talbot until 1985.

In 1986, claimant obtained a temporary job with Willamette Industries, Inc. (Willamette) and later was hired as a regular employee. Before hiring claimant as a regular employee, Willamette gave him a preemployment physical examination. The examiner reported that claimant had "a history of back strain, possible disc, in 1979 * * * ha[d] no recurrence since then * * * ha[d] been totally pain-free recently and [wa]s feeling fine." Claimant testified that he was relatively pain free from 1980 until his injury in 1989.

In February 1989, as claimant was installing a heat exchanger, he again strained his back. Claimant's attending physician, Dr. Hilles, examined claimant, recommending pain medication and bed rest. Hilles also noted that unless claimant's condition "considerably improved * * * a neurosurgical consult" was necessary. Although his condition was improving, claimant wanted a second opinion and, consequently, went to see Dr. Kendrick. As part of his treatment with Kendrick, claimant received a CAT scan. Dr. Krieves conducted the procedure and noted a "mild central disc protrusion at L5-S1." Kendrick testified that, in 1989, "there was no evidence that claimant had a herniated * * * disc." Willamette accepted the injury as a back strain, later closing the claim without an award of permanent disability. Claimant **<151 Or App 78/79>** testified that, after his 1989 injury, he experienced recurring lower back pain most of the time.

In February 1992, claimant began working for Pacific Gas and Transmission (PG&T) (Wausau's insured) as a mechanic's apprentice. As noted by the administrative law judge (ALJ), "[t]his was a physically undemanding job. The hardest thing on his back was riding around in a company pickup." In early 1994, and without a connection to a specific incident, claimant experienced a significant exacerbation of his recurring lower back pain. Claimant went first to his family physician, Dr. Boggess, who referred him back to Kendrick. Kendrick diagnosed a herniated disc at L5-S1 and recommended surgery. Shortly thereafter, claimant requested that Willamette reopen his claim and authorize surgery. Willamette denied responsibility.

At the hearing, the employers/insurers conceded compensability. Regarding responsibility, claimant argued that Willamette was the actual cause of his condition. Claimant relied on Kendrick's medical opinion. Initially, Kendrick agreed with a report prepared for Willamette by Drs. Bald and Bobker opining that the 1980 injury was the injury that "set the stage" for the later herniation. However, after a subsequent interview with claimant and a review of claimant's medical records, Kendrick changed his opinion, concluding that "[i]t was the gradual worsening of [the] * * * injury of 1989 which led to his surgery in 1994." Kendrick explained that his opinion changed because, after consulting with claimant, claimant's "history point[ed] out two very important facts: (1) that he had very little problem between 1980 and 1989; and (2) that he has had nothing but problems from 1989 until the present time." The ALJ accepted Kendrick's revised opinion.

The ALJ held Willamette responsible for claimant's condition, applying ORS 656.308(1).[1] The Board affirmed the ALJ's decision but on different grounds. It held that ORS **<151 Or App 79/80>** 656.308(1) did not apply because claimant's 1994 injury for a herniated disc was not the "same condition" as the two previous claims for lower-back strains. The Board affirmed on the ground that Willamette was responsible because it was the "actual cause" of claimant's condition. Further, the Board held that it was "unnecessary to rely on [the last injurious exposure rule] * * * to determine responsibility" because the evidence showed that Willamette was the "major contributing cause" of claimant's condition.

Willamette contends that "the Board erred in failing to apply the last injurious exposure rule [of responsibility] based merely upon a determination of major causation at Willamette's employment." Willamette argues specifically that "[t]he policies and purposes of the last injurious exposure rule require it to be applied uniformly except where one of the employments is proven to be the 'actual' or '*sole*' cause of the condition involved." (Emphasis in original.) Essentially, Willamette argues that in all successive-injury cases involving two or more employers, unless the evidence shows that one employer was the sole cause of the claimant's disability, the last injurious exposure rule must be applied to assign responsibility.[2] We disagree with Willamette.

The last injurious exposure rule is both a rule of proof and a rule of assignment of responsibility. *Roseburg Forest Products v. Long*, 325 Or 305, 309, 937 P2d 517 (1997) (citing *Runft v. SAIF*, 303 Or 493, 500, 739 P2d 12 (1987)). The rule of proof allows a claimant to prove the compensability of an injury without having to prove the degree, if any, to which exposure to disability-causing conditions at a particular employment actually caused the claimant's condition. *Id.* Compensability is conceded by all parties, and claimant did not rely on the last injurious rule of proof. Therefore, Willamette does not, and could not, invoke defensively the rule of **<151 Or App 80/81>** proof to shift responsibility to a later employer. *See Roseburg Forest Products*, 325 Or at 312 (explaining *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984)); *Runft*, 303 Or at 501 (same); *Spurlock v. International Paper Co.*, 89 Or App 461, 464, 749 P2d 611 (1988).

Willamette instead seeks to invoke defensively the second part of the rule, the rule of responsibility. It is well established that employers have an interest in the consistent application of the rule and, therefore, may assert the rule of responsibility as a defense even when a claimant has chosen to prove actual causation.[3] *Spurlock*, 89 Or App at 464-65 (citing *Runft*, 303 Or at 501-02).

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[1] ORS 656.308(1) provides, in part:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."

[2] SAIF cross-assigns error, contending that the Board should have applied ORS 656.308 to this case. SAIF argues specifically that claimant's third back injury, involving the herniated disc, was the "same condition" as claimant's previous two lower-back strains. However, we decline to reach this issue because the entire cross-assignment is based on an alleged improper factual finding by the Board, a finding that we conclude is supported by substantial evidence. *See Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 914 P2d 708 (1996) (A determination of whether a new injury involves the same condition as a previously accepted injury is a factual determination.).

[3] SAIF argues that ORS 656.308(2) also allows Willamette to assert a responsibility defense, regardless of whether ORS 656.308(1) applies. Because Willamette legally asserts only the last injurious rule of responsibility as a defense, we decline to address this point.

As a rule of assignment of responsibility, the rule assigns full responsibility to the last employer that could have caused the claimant's injury. *Roseburg Forest Products*, 325 Or at 309. The rule is a substitute for allocation of responsibility among several partially responsible employers in cases where it would be difficult, and expensive, to determine the exact proportion of responsibility. *Bracke v. Baza'r*, 293 Or 239, 245, 646 P2d 1330 (1982). Essentially, it makes the processing of compensation claims more administratively efficient. *See Runft*, 303 Or at 502.

However, the rule is not "intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not." *Boise Cascade Corp.*, 296 Or at 244. The rule imposes responsibility only on the last employer that "*contributed* to the worker's" disability. *Roseburg Forest Products*, 325 Or at 310 (emphasis in original); *see also Beneficiaries of Strametz v. Spectrum Motorwerks*, 325 Or 439, 939 P2d 617 (1997).

Consequently, a necessary factual predicate for the defensive use of the rule of responsibility is proof that "the subsequent employment actually contributed to the worsening of an underlying disease." *Spurlock*, 89 Or App at 465; *see also Peterson v. Eugene F. Burrill Lumber*, 294 Or 537, 543, **<151 Or App 81/82>** 660 P2d 1058 (1983) ("[F]or the last injurious exposure rule to apply * * * under the employer's successive-injury case, there must be evidence of a second injury which materially contributed to the claimant's disability."). Proof that the subsequent employment independently contributed to the current disability is required before the rule of responsibility can be invoked defensively by the targeted employer.

Here, the ALJ and the Board found that Willamette's employment was the major contributing cause of claimant's disability. No party disputes these findings. Conversely, neither the ALJ nor the Board found evidence showing that claimant's subsequent employment at PG&T contributed, even slightly, to claimant's condition. The basic finding about the PG&T employment was that it was a "physically undemanding job." Moreover, claimant's 1994 condition was not linked to a second injury or a specific incident in 1994. Nevertheless, Willamette argues that the Board's finding of "'major' causation as to one employer necessarily implies 'material' or 'minor' causation by another."[4] We disagree. Although the Board's finding does imply other causation, it does not establish proof of other causation "by another" employer. Consequently, without proof linking the other causation to a later work-related incident, the Board's finding does not establish the necessary factual predicate to defensive invocation of the rule: that claimant's later employment at PG&T independently contributed to claimant's condition. As such, it does not support a shift in responsibility to PG&T by invocation of the last injurious exposure rule. Because claimant did not invoke the rule of proof to establish compensability, because the Board found that claimant's **<151 Or App 82/83>** 1989 injury was the major contributing cause of his 1994 injury, and because no proof existed that claimant's subsequent employment at PG&T independently contributed to his current disability, the Board was correct in refusing to invoke the last injurious exposure rule to assign responsibility.

Affirmed.

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[4] The requirement that an employer prove that another employer "solely" caused the injury is necessary only after a worker invokes the rule to prove compensability. In that circumstance,

> "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 employment." *Roseburg Forest Products v. Long*, 325 Or 305,313,937 P2d 517 (1997).

See also Beneficiaries ofstrametz v. Spectrum Motorwerks, 325 Or 439, 444-45, 939 P2d 617 (1997); *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244-45, 675 P2d 1044 (1984). Once the rule is invoked, sole causation, or proof of impossibility, is required to avoid responsibility.

Cite as 151 Or App 131 (1997) October 22, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ronald S. Miller, Claimant.

INTERNATIONAL PAPER COMPANY, *Petitioner,*
v.
Ronald S. MILLER, *Respondent.*
(WCB 96-03652; CA A96000)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1997.
Paul L. Roess argued the cause for petitioner. With him on the brief was Moscato, Skopil & Hallock.
James L. Edmunson argued the cause for respondent. With him on the brief was Cole, Cary & Wing, P.C.
Before De Muniz, Presiding Judge, Haselton, Judge, and Richardson, Senior Judge.
PER CURIAM
Reversed and remanded for reconsideration.

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151 Or App 132> Employer seeks judicial review of a Workers' Compensation Board's order adopting and affirming an order of the administrative law judge (ALJ) setting aside employer's denial of claimant's low back aggravation claim. Employer argues that the ALJ and, by extension, the Board erroneously assumed that proof of a symtomatic worsening, as opposed to a pathological worsening, of claimant's condition was sufficient to establish the statutorily required "actual worsening of the compensable condition." ORS 656.273(1).[1] We agree with employer. *SAIF v. Walker,* 145 Or App 294, 930 P2d 230 (1996), *rev allowed* 325 Or 367 (1997). This case is in the same substantive and procedural posture as *Walker.* Accordingly, we remand for the Board to apply the appropriate standard.

Reversed and remanded for reconsideration.

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[1] 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 * * *."

Cite as 151 Or App 155 (1997) November 5, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas R. Smith, Claimant.

FOSTER-WHEELER CONSTRUCTORS, INC.,
and Liberty Northwest Insurance Corporation, *Petitioners - Cross-Respondents,*
v.
Thomas R. SMITH, *Respondent - Cross-Petitioner,*
and RAYTHEON ENGINEERS AND CONSTRUCTORS and Liberty Mutual, *Respondents.*
(WCB 95-07260, 95-07259; CA A95112)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 3, 1997.
Patricia Nielsen argued the cause for petitioners - crossrespondents. With her on the briefs was Mannix, Nielsen & Crawford P.C.
Robert Wollheim argued the cause for respondent - crosspetitioner Thomas R. Smith. With him on the brief was Welch, Bruun, Green & Wollheim.
Steven T. Maher argued the cause and filed the brief for respondents Raytheon Engineers and Constructors and Liberty Mutual.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed on petition and cross-petition.

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151 Or App 157> Employer Foster-Wheeler Constructors and its insurer, Liberty Northwest Insurance Corporation (Foster/Liberty), seek review of a Workers' Compensation Board (the Board) decision setting aside Foster/Liberty's compensability and responsibility denial and of the Board's refusal to admit certain evidence. Claimant cross-petitions, alleging that the Board erred in restricting attorney fees for the responsibility denial to $1,000 pursuant to ORS 656.308(2)(d). We affirm on the merits and write only to discuss the cross-petition.

The relevant facts show that claimant filed a workers' compensation claim against Foster/Liberty on May 3, 1995, for a L4-5 disc herniation and sciatica. Foster/Liberty denied both compensability and responsibility. Claimant requested a hearing in which the administrative law judge (ALJ) affirmed the denials. Claimant sought review before the Board, which set aside the denials and awarded attorney fees to claimant. Claimant requested $9,000 in attorney fees. The Board awarded claimant $6,500 pursuant to ORS 656.386(1)[1] on the issue of compensability and $1,000 (the maximum that the Board believed it could award) pursuant to ORS 656.308(2)(d) on the issue of responsibility, for a total of $7,500.

We review the Board's interpretation of a statute for errors of law.[2] ORS 656.308(2)(d) provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

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[1] ORS 656.386(1), in relevant part, provides:

> "In such cases involving denied claims where the claimant prevails finally in a hearing before * * * the Workers' Compensation Board, then the * * * board shall allow a reasonable attorney fee."

[2] Claimant makes a secondary, unspecific assertion that the Board's record is insufficient for review. However, because the only issue raised by claimant is whether the board correctly interpreted ORS 656.308(2)(d), a pure question of law, the sufficiency of the record is irrelevant.

151 Or App 158> Claimant does not argue that "extraordinary circumstances" exist. He argues that the purpose of ORS 656.308(2)(d) "was to limit the attorney fee paid to claimant's counsel when responsibility was the only issue."[3] However, claimant cites no authority for that position. Foster/Liberty responds that the text of the statute is "plain on its face" and that it applies whether responsibility is one of the issues or the only issue. We agree that the applicability of the statute does not depend on whether responsiblity is the only issue in the case.

By adopting ORS 656.308(2)(d) the legislature has made the policy decision to limit claimant's attorney fees in a dispute over responsibility. Responsibility addresses only *who* is going to compensate a claimant, not *whether* a claimant will be compensated. The role of an attorney at this stage is generally insignificant compared to his or her role in determining whether an injury is compensable.[4] The text of the statute does not limit its application to cases where responsibility is the only issue.[5] Thus, we hold that the Board properly limited attorney fees for that portion of the proceeding involving responsibility to $1,000 regardless of whether it was the only issue.

Affirmed on petition and cross-petition.

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[3] Claimant also argues that because the Board found that ORS 656.308(1) did not apply, ORS 656.308(2) could not apply. Because we hold that ORS 656.308(2) applies to any responsibility denial, except for one falling under ORS 656.307(5), that argument lacks merit.

[4] There are times when legal representation in responsibility cases is very important. Deciding which employer is on the claim may have a significant impact on the amount of benefits due to such factors as time loss rates, medical providers and aggravation claim periods. However, the more crucial the attorney's role is in the proceeding, the more likely that it will fall under the extraordinary circumstances of ORS 656.308(2)(d).

[5] We have recently held that ORS 656.308(2)(d) does not apply to a responsibility denial under ORS 656.307(5). *See Dean Warren Plumbing v. Brenner*, 150 Or App 422, ___ P2d ___ (1997).

Cite as 151 Or App 307 (1997) November 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joe D. Leonard, Claimant.

HEWLETT-PACKARD CO., *Petitioner,*
v.
Joe D. LEONARD, *Respondent.*
(94-10749; CA A93140)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 17, 1997.
Janet M. Schroer argued the cause for petitioner. With her on the brief were Marjorie A. Speirs and Hoffman, Hart & Wagner.
Stanley Fields argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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151 Or App 309> Employer seeks review of an order of the Workers' Compensation Board (Board) setting aside a denial of claimant's current low back condition. Employer contends that principles of claim preclusion bar claimant's claim, because he failed to assert the compensability of his current condition in an earlier hearing on the question whether employer prematurely closed his original claim. The Board held that the earlier hearing provided no opportunity to establish the compensability of the current condition, because the sole issue at that point was whether employer prematurely closed the original claim. We agree with the Board and affirm.

On September 18, 1992, claimant injured his low back while working for employer. He was treated by an orthopedic surgeon, Dr. Lewis, who diagnosed a back strain superimposed upon a preexisting congenital stenosis, a narrowing of the channel in the vertebrae through which the spinal nerve passes. Employer accepted the claim for disabling lumbar strain. Beginning in February 1993, other physicians who examined claimant suggested that psychological considerations might be contributing to claimant's back pain. On May 21, 1993, Lewis recommended that claimant undergo a psychological evaluation and stated that surgery was not recommended at that time.

On June 4, 1993, employer issued a notice of closure awarding claimant no permanent compensation and determining claimant to be medically stationary as of May 6, 1993. Claimant requested reconsideration. On August 30, 1993, Lewis wrote a letter stating that claimant was not medically stationary, because he needed a psychological evaluation. The Appellate Review Unit of the Workers' Compensation Division issued an order rescinding the June 4 notice of closure as premature. Employer requested a hearing.

Claimant also saw a neurosurgeon, Dr. Lax, who suspected disc herniation and suggested a myelogram. On May 2, 1994, administrative law judge (ALJ) Nichols held a hearing on the June 4 notice of closure. There was some mention at the hearing of Lax's opinion regarding the need for a myelogram. On May 19,1994, Nichols issued an opinion and **<151 Or App 309/310>** order affirming the rescission of the June 4 notice of closure, based on the need for psychological evaluation. Neither party appealed that order.

On May 20,1994, claimant underwent a myelogram, which revealed disc herniation, and Lax recommended surgery. On January 31, 1995, employer issued a denial of claimant's current condition, stating that claimant's need for surgery was unrelated to the September 1992 job-related injury and that the surgery was not reasonable and necessary. ALJ Johnson conducted a hearing on the denial. At the hearing, employer argued that claimant could have raised the compensability of the disc herniation at the hearing before Nichols on the June 4 notice of closure. According to employer, claimant was aware of at least the possibility of a disc herniation at the hearing before Nichols and could have requested a determination of compensability of that herniation at that time. Because claimant did not, and because Nichols held the claim open for a psychological evaluation only, employer argued claimant could not raise the issue of the compensability of the disc herniation.

Johnson held that claimant was not precluded from asserting the compensability of the disc herniation and ordered employer to accept and process the claim. The Board affirmed. On review, employer reiterates its argument that claimant is precluded from asserting the compensability of the disc herniation. Claimant responds that the sole issue before Nichols was whether employer prematurely closed the original claim and that, accordingly, he had no opportunity to establish the compensability of the disc herniation, which, in any event, was not even diagnosed until after Nichols issued her order.

The Supreme Court has explained the branch of preclusion by former adjudication known as "claim preclusion" in the following terms:

> "'[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [*i.e.*, precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was **<151 Or App 310/311>** at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.'"

Drews v. EBI Companies, 310 Or 134, 140, 795 P2d 531 (1990) (quoting *Rennie v. Freeway Transport*, 294 Or 319, 323, 656 P2d 919 (1982)) (brackets in original). Claim preclusion does not require actual litigation of an issue of fact or law, nor that the determination of the issue be essential to the final result. *Id.* Claim preclusion does require that the opportunity to litigate the issue be present, and claim preclusion requires finality in the former adjudication. *Id.* Thus, the determinative question in this case is whether claimant had an opportunity to litigate the issue of the compensability of his herniated disc condition during a hearing on whether employer prematurely had closed the original claim.

At issue in the hearing that resulted in Nichols's order--the order that employer contends has preclusive effect--was whether employer had closed the claim prematurely. Whether an employer has prematurely closed a claim depends on whether the claimant was medically stationary *on the date of closure*, without consideration of subsequent changes in his condition. *See Scheuning v. J. R. Simplot & Company*, 84 Or App 622, 625, 735 P2d 1, *rev den* 303 Or 590 (1987) (to determine whether claim has been closed prematurely "we determine whether the claimant's condition was medically stationary on the date of closure, without consideration of subsequent changes in his condition"); *Alvarez v. GAB Business Services*, 72 Or App 524, 527, 696 P2d 1131 (1985) (whether a claim has been closed prematurely depends on reasonableness of medical expectations at time of closure, "not by subsequent development of the case").

The issue before Nichols, therefore, was limited to whether, at the time of the June 4, 1993, notice of closure, claimant was medically stationary. That claimant may have seen Lax several months after the notice of closure, and, as employer suggests, may have developed a suspicion regarding the possibility of disc herniation after that consultation, was irrelevant to the issue before Nichols. Claimant thus had no opportunity to establish the compensability of the herniated disc condition. Accordingly, we conclude that the Board **<151 Or App 311/312>** did not err in rejecting employer's argument that claimant was precluded from later asserting the compensability of his herniated disc condition.

Affirmed.

Cite as 151 Or App 355 (1997) November 19, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STATE OF OREGON, by and through the Director of the Department of Consumer and Business Services, *Respondent*,
v.
J. M. MARSON CO., INC., an involuntarily revoked California corporation, and Michael A. DeMarie and Kimberly A. DeMarie, individually, *Appellants*.
(96C-10203; CA A94639)

Appeal from Circuit Court, Marion County.
Jamese L. Rhoades, Judge.
Argued and submitted March 3, 1997.
Gregory W. Byrne argued the cause and filed the briefs for appellants.
Mary H. Williams, Assistant Attomey General, argued the cause for. respondent. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before De Muniz, Presiding Judge, and Haselton, Judge, and Joseph, S. J.*
JOSEPH, S. J.
Affirmed.
* Joseph, S. J., *vice* Deits, Chief Judge.

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151 Or App 357> The director of the Department of Consumer and Business Services (DCBS) brought this action pursuant to ORS 656.054 to recover reimbursement from defendants as noncomplying employers for amounts paid relating to a workers' compensation claim filed by an employee of defendants. Plaintiff was awarded a summary judgment for the full amount claimed. Defendants appeal.

Defendant corporation was a California corporation authorized to do business in Oregon; defendant individuals were its president and secretary, respectively. On August 16, 1990, the corporation was working on an apartment project in Portland. An employee reported to the superintendent that another employee, Talley, had fallen from a ladder and broken his wrist. The superintendent told defendant Michael DeMarie about the report. Talley saw a doctor the same day. He hired a lawyer, who notified DeMarie that he would file a compensation claim. DeMarie notified the corporation's Arizona compensation carrier but was told that the Oregon claim was not covered. Talley's attorney then requested that the Oregon Workers' Compensation Division investigate the corporation's compliance with the Oregon workers' compensation law.

On October 25, 1990, the division issued a proposed and final order finding Talley to be a subject employee and the corporation to be a noncomplying employer because it did not meet the self-insured or carrier-insured requirements of ORS 656.017. The order also contained a notice of the right to request a hearing. The corporation requested a hearing on the notice but withdrew the request, and the order became final.

Meanwhile, on December 20, 1990, SAIF, to which the claim had been referred pursuant to the then existing version of ORS 656.054, accepted the claim, despite the fact that the file contained information that Talley had told his first doctor that he had suffered his injury playing sandlot football and only later changed his story to claim that he had fallen from a ladder at work. Defendants did not request a **<151 Or App 357/358>** hearing on the acceptance. SAIF made all the required payments on the claim. Under the statute, DCBS was required to reimburse SAIF for the claim costs. In this action, defendants denied knowing about Talley's differing stories about the accident until DCBS initiated efforts to obtain reimbursement under ORS 656.054(3).

In their reply brief, defendants state their case fairly succinctly:

> "Defendants have not placed compensability in issue. To avoid having to reimburse DCBS defendants do not have to prove that Talley's injury was not compensable, only that SAIF paid compensation as a result of improper claims processing or that

compensability was *questionable* and the rationale for acceptance was not reasonably documented in accordance with generally accepted claims management procedures. ORS 656.054(4). If either fact is proven, DCBS has violated the statute and reimbursed SAIF as a volunteer, and cannot recover from defendants.

"There is no statutory or case authority preventing a noncomplying employer from disputing DCBS's right to reimbursement. Nothing in ORS Chapter 656 precludes a noncomplying employer from contesting a reimbursement claim by DCBS. To be sure, a noncomplying employer may not later dispute the extent of the worker's injury or the amount of compensation to which he was entitled, but defendants are not raising such issues here." (Emphasis defendants'; citation omitted.)

To state it even more succinctly, defendants claim that, by contesting their obligation to DCBS, they may obtain a judicial examination of how DCBS administered its obligation to reimburse SAIF.

When Talley was injured in 1990, and during the time when SAIF was processing his claim and DCBS was incurring its initial liability to reimburse SAIF's claim costs, ORS 656.054 did not contain a provision like subsection (4), on which defendants rely. The first version of that subsection and subsection (5) were added in 1991. Or Laws 1991, ch 679, § 1. They provided:

"(4) Periodically the director shall audit the files of the State Accident Insurance Fund Corporation to validate the **<151 Or App 358/359>** amount reimbursed pursuant to subsection (3) of this section. Reimbursement shall not be allowed, if upon such audit, any of the following are found to apply:

"(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

"(b) Compensation has been paid negligently for treatment of any condition unrelated to the compensable condition;

"(c) The compensability of an accepted claim is questionable and the rationale for acceptance has not been reasonably documented in accordance with generally accepted claims management procedures;

"(d) The separate payments of compensation have not been documented in accordance with generally accepted accounting procedures; or

"(e) The payments were made pursuant to a disposition agreement as provided by ORS 656.236 without the prior approval of the director.

"(5) The State Accident Insurance Fund Corporation may appeal any disapproval of reimbursement made by the director under this section pursuant to ORS 183.310 to 183.550 and such procedural rules as the director may prescribe."

After the 1995 amendments, the subsections now provide:

"(4) Periodically, or upon the request of a noncomplying employer in a particular claim, the director shall audit the files of the State Accident Insurance Fund Corporation and any assigned claims agents to validate the amount reimbursed pursuant to subsection (3) of this subsection. The conditions for granting or denying of reimbursement shall be specified in the contract with the assigned claims agent. The contract at least shall provide for denial of reimbursement if, upon such audit, any of the following are found to apply:

"(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

"(b) Compensation has been paid negligently for treatment of any condition unrelated to the compensable condition;

151 Or App 360> "(c) The compensability of an accepted claim is questionable and the rationale for acceptance has not been reasonably documented in accordance with generally accepted claims management procedures;

"(d) The separate payments of compensation have not been documented in accordance with generally accepted accounting procedures; or

"(e) The payments were made pursuant to a disposition agreement as provided by ORS 656.236 without the prior approval of the director.

"(5) The State Accident Insurance Fund Corporation and any assigned claims agent may appeal any disapproval of reimbursement made by the director under this section pursuant to ORS 183.310 to 183.550 and such procedural rules as the director may prescribe."

Defendants rest their case on the 1991 version. At oral argument, their counsel conceded that it would be difficult for them to prevail under the 1995 amendments. The reason for that is plain. The 1995 amendments to ORS 656.054 quoted above, as well as others not set out in this opinion, reflect a change in the way claims by employees of noncomplying employers are to be administered. Instead of all of them being the responsibility of SAIF, DCBS now has the authority to enter into contracts with what are called "assigned claims agents" for processing the claims. The statute is very clear that it is concerned only with what those contracts must minimally provide in order to provide an audit trail. It would, indeed, be very difficult to argue that, as between DCBS and a noncomplying employer, the statute as amended in 1995 is intended to preserve a route for the employer to secure judicial review of how a particular claim was processed. There is not a word in the statute that would lead us away from the plain meaning of the words used in order to discover an unexpressed legislative intention. If the 1995 version of the law applies here, the trial court was correct in granting the summary judgment.

If we were to apply the 1991 version of the statute and hold that it created a right for noncomplying employers to have judicial review of reimbursement determinations, we would be hard pressed to explain why the 1995 legislature **<151 Or App 360/361>** *sub silentio* took away that right while leaving in place a subsection (5) that is the equivalent of the 1991 subsection that expressly did create a right for SAIF to contest unfavorable DCBS nonreimbursement determinations.

Moreover, defendants' interpretation ignores the last two sentences of the 1991 version of ORS 656.054(1):

"At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim. If an order becomes final holding the claim to be compensable, the employer is liable for all costs imposed by this chapter, including reasonable attorney fees to be paid to the worker's attorney for services rendered in connection with the employer's objection to the claim."

That language, without any change, also appears in the 1995 version. It makes plain the 1991 and 1995 legislatures' intention that the procedure for challenging a claim, and obtaining protection from liability to DCBS, is to request a hearing when the claim is being processed.

Defendants did not do that. We conclude that the statute was never intended to give a noncomplying employer a second chance to avoid its responsibility for an injury to an employee.

The trial court properly granted plaintiff's motion for summary judgment.

Affirmed.

Cite as 151 Or App 398 (1997) November 26, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Roger L. Wolff, Claimant.

SAIF CORPORATION and Nendel's Management & Supply Co., Inc., *Petitioners,*
v.
Roger L. WOLFF, *Respondent.*
(WCB No. 93-06586; CA A93849)

Judicial Review from Workers' Compensation Board.

On respondent's petition for reconsideration filed June 26, 1997, and motion for remand to Workers' Compensation Board and response to memorandum of additional authorities filed August 13, 1997; on petitioners' response to motion to remand filed August 19,1997. Opinion filed June 11, 1997, 148 Or App 296, 934 P2d 630.

Martin L. Alvey for petition.

David L. Runner *contra.*

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

RIGGS, P. J.

Reconsideration allowed; motion to remand denied; opinion adhered to.

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151 Or App 400> Claimant has filed a petition for reconsideration of our opinion in this case, 148 Or App 296, 939 P2d 630 (1997), in which we held that employer is not precluded from denying the compensability of claimant's osteochondritis dessicans, asserting that our opinion is inconsistent with *Messmer v. Deluxe Cabinet Works,* 130 Or App 54, 881 P2d 180 (1994), *rev den* 320 Or 506 (1995) (*Messmer I*), and *Deluxe Cabinet Works v. Messmer,* 140 Or App 548, 915 P2d 1053, *rev den* 324 Or 305 (1996) (*Messmer II*). In this case, the Board relied on those cases and held that a 1981 determination order awarding benefits for permanent partial disability of claimant's left leg included an award for osteochondritis dessicans and precluded employer's denial of the condition. In our original opinion, we rejected employer's invitation to revisit our holdings in *Messmer I* and *Messmer II* but said that substantial evidence did not support the Board's finding that a 1981 determination order awarded benefits for the condition. We adhere to that last holding.

After the filing of our opinion in this case, the 1997 Oregon Legislature amended ORS 656.262(19) by adding the emphasized language:

> "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." Or Laws 1997, ch 605, § 1 (emphasis supplied).

The 1997 amendment is intended to address the issue decided in *Messmer I* by expressly providing that an insurer's failure to appeal a determination order that awards permanent disability benefits for an unaccepted condition does not preclude a later denial of that condition. The amendment is to be applied retroactively. Section 2 of the bill provides:

> **151 Or App 401>** "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."

Section 4 of the bill declares an emergency and says that the Act "takes effect on its passage." The bill was signed into law by Governor Kitzhaber on July 25, 1997.

A claim pending on appeal is a claim "existing" on the effective date of the Act. The amendment to ORS 656.262 is accordingly applicable here. *See Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995). In the light of our holding, however, that the determination order did not award benefits for osteochondritis dessicans and therefore does not preclude employer's denial of that condition, we need not consider the effect of the 1997 amendment on this case.

Reconsideration allowed; motion to remand denied; opinion adhered to.

Cite as 151 Or App 402 (1997) November 26, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Louie J. Plumlee, Claimant.

Mary OLDHAM, *Petitioner,*
v.
Louie J. PLUMLEE, and SAIF Corporation, *Respondents,* and
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, *Intervenor.*
(93-01923; CA A86658)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 2, 1997.

E. Jay Perry argued the cause for petitioner. With him on the brief was Employers Defense Counsel.

G. Duff Bloom argued the cause for respondent Plumlee. With him on the brief was Coons, Cole, Cary & Wing, P.C.

Michael O. Whitty, Special Assistant Attorney General, waived appearance for respondent SAIF Corporation.

Stephanie L. Striffler, Assistant Attorney General, argued the cause for intervenor. With her on the brief were Hardy Myers, Attorney General, and Virginia L. Linder, Solicitor General.

Before De Muniz, Presiding Judge, and Deits, Chief Judge, and Haselton, Judge.

DE MUNIZ, P. J.

Reversed and remanded with instructions to dismiss request for review.

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151 Or App 404> Employer petitioned for judicial review of an order of the Workers' Compensation Board affirming an order of the Director of the Department of Consumer and Business Services that claimant is subject to the Workers' Compensation Act. Director has intervened and argues that this case is controlled by *Lankford v. Copeland*, 141 Or App 138, 917 P2d 55 (1996), in which we held that review of nonsubjectivity determinations lies with the Court of Appeals rather than with the Workers' Compensation Board and, accordingly, the Board did not have jurisdiction in this matter. Director is correct.

The issue before us is the proper disposition of the Board's order here. In *Lankford*, we recognized that the Director's order was not final because it did not provide a correct statement of the parties' rights to appeal. *See Callahan v. Employment Division*, 97 Or App 234, 776 P2d 21 (1989). We reversed the Board's order and remanded with instructions to the Board to dismiss the request for review and to remand the order to Director for issuance of a new corrected order. *Lankford*, 141 Or App at 143.

The order here also is not final because it, too, did not give the correct notice of appeal rights. However, we now conclude that, because the Board has no jurisdiction over the Director's order, it can only dismiss the request for review. Accordingly, we overrule *Lankford* only to the extent that it holds that the proper disposition is that the Board remand the order to the Director.

Reversed and remanded with instructions to dismiss request for review.

Cite as 151 Or App 422 (1997) November 26, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Nevay K. Frymire, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Sherman Brothers, Inc., *Petitioners,*
v.
Nevay K. FRYMIRE, *Respondent.*
(WCB No. 96-02796; CA A95508)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted May 22, 1997; taken in banc September 4, 1997.
David O. Wilson argued the cause and filed the brief for petitioners.
Robert J. Guarrasi argued the cause and filed the brief for respondent.
LANDAU, J.
Affirmed.
Riggs, J., dissenting.

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151 Or App 424> Employer and its insurer seek review of an order of the Workers' Compensation Board (Board) holding that employer is required to pay spousal death benefits to claimant on the basis of a 1987 determination order that employer failed to appeal. The 1987 determination order required employer to pay benefits to "beneficiaries" of a worker, Kenneth Frymire. Employer and insurer now contend, because claimant was not married to Frymire at the time of his death and thus was not a "beneficiary," they are not precluded from challenging the extent to which she is entitled to continued benefits under the terms of that order. We agree with the Board that employer and insurer are precluded from challenging claimant's entitlement to continued spousal death benefits and affirm.

The facts are not in dispute. Claimant once was married to Vernon Lee Marshall. Claimant and Marshall separated. Some time after that, claimant and Kenneth Frymire began living together. Claimant initiated divorce proceedings, but Marshall "disappeared." Meanwhile, claimant and Frymire had a child and, not long after, were expecting a second. The parties finally located Marshall and, on November 12, 1986, claimant once again initiated divorce proceedings, asking for expedited consideration given the impending delivery of the second child. On November 24, 1986, Frymire was killed in an employment-related accident.

Following the accident, employer's insurer informed claimant that she would be entitled to spousal benefits. Claimant told the insurer that the divorce had not yet become final. Insurer paid spousal benefits anyway. The divorce became final in December 1996, and copies of the dissolution judgment were sent to insurer. Insurer continued paying spousal benefits to claimant.

On February 23, 1987, insurer sent a Form 1502 to the Workers' Compensation Department indicating that the claim for benefits arising from Frymire's death is "accepted" and that "[w]idow and dependent benefits [are] being paid." A determination order followed, ordering insurer to pay "to the beneficiaries" benefits for Frymire's death. Insurer did **<151 Or App 424/425>** not appeal that determination order, and, for the next nine years, insurer continued to pay claimant benefits as Frymire's widow.

In February 1996, insurer issued a partial denial, on the ground that claimant never was entitled to spousal death benefits. According to insurer, ORS 656.204 requires the payment of spousal support benefits only "[i]f the worker is survived by a spouse," and, in this case, Frymire and claimant were not married at the time of Frymire's death. Thus, although claimant survived Frymire, she did not do so as a spouse and is not entitled to benefits.

An administrative law judge (ALJ) held that insurer had accepted a claim for spousal death benefits in 1987 and therefore is precluded from denying the claim now. The Board rejected the ALJ's finding that insurer accepted the claim. It nevertheless held that insurer was precluded from denying the claim, because the 1987 determination order "specifically directed the insurer to pay spousal benefits" to claimant, and insurer failed to appeal that determination order.

On review, employer and insurer contend that the Board erred, because the 1987 determination order does not expressly direct insurer to pay *spousal* benefits, only that insurer pay benefits to Frymire's *beneficiaries*. Because the order did not specify the persons who were entitled to benefits, they argue, they are not precluded now from challenging claimant's right to receive benefits under the terms of that order. We disagree. In the light of the facts undisputedly known to the insurer and the Workers' Compensation Division (Division) at the time of the issuance of the 1987 determination order--including the Form 1502 that specifically stated to the Division that insurer was paying spousal benefits to claimant--it cannot reasonably be contended that the reference to "beneficiaries" in the order did not include claimant. The fact that insurer itself continued paying spousal benefits to her for the next nine years bears out the point. Given that insurer failed to appeal that determination order, it is precluded from challenging it now. *Messmer v. Deluxe Cabinet Works,* 130 Or App 254, 257-58, 881 P2d 180 (1994), *rev den* 320 Or 507 (1995).

151 Or App 426> We note that, during the pendency of this matter, the legislature enacted amendments to ORS 656.262(10) that provide that the failure to appeal or seek review of a determination order that requires the payment of disability benefits "shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein." Or Laws 1997, ch 605, § 1. The amendments apply retroactively. Or Laws 1997, ch 605, § 4. *See generally Volk v. America West Airlines,* 135 Or App 565,899 P2d 746 (1995), *rev den* 322 Or 645 (1996). Employer and insurer, however, do not argue that the amendments apply to this case. In any event, it is clear that the amendments apply only to challenges to the compensability of rated conditions, and death is not a rated condition.

Affirmed.

RIGGS, P. J., dissenting.

Because I believe that the majority's holding is inconsistent with the applicable statutes and with our case law, I dissent.

During her cohabitation with Frymire, claimant was married to Marshall. That marriage was dissolved after Frymire's death, on January 3, 1987, and claimant then changed her name from Nevay McManus to Nevay K. Frymire.

In December 1986, insurer began paying spousal and dependent death benefits pursuant to ORS 656.204[1] to claimant and her daughter. Between January 14, 1987, and **<151 Or App 426/427>** April 2, 1987, insurer noted on three separate forms, including the Forms 801, 1502 and 1503, that the claim was "accepted." The Form 801 is the claim form completed by employer on December 11, 1986. It identifies Frymire as an employee who was fatally injured in the course of his employment. The form contains a check-the-box notation indicating that the claim is "accepted." The Form 1502 is the insurer's report to the Department of Consumer and Business Services concerning the status of the claim. The parties have stipulated that a Form 1502, filed in January 1987, placed a claim for death benefits in "deferred" status and that there was never an express acceptance of a claim for death benefits. A second Form 1502 was filed with the Department on February 23, 1987, indicating by check-the-box notations that the claim of "Kenneth D. Frymire" is "accepted" and that no temporary compensation is due. In the "explanation" portion of the form, insurer typed:

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[1] ORS 656.204 provides, in part:

"If death results from the accidental injury, payments shall be made as follows:

"(1) The cost of burial, including transportation of the body, shall be paid, not to exceed 10 times the average weekly wage in any case.

"(2)(a) If the worker is survived by a spouse, monthly benefits shall be paid in an amount equal of 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs.

"(b) *If the worker is survived by a spouse, monthly benefits also shall be paid in the amount equal to 4.35 times 10 percent of the average weekly wage for each child of the deceased until such child becomes 18 years of age."* (Emphasis supplied.)

"cc: Kenneth D. Frymire

"Widow and dependent benefits being paid.

"Claim originally deferred, now accepted."

The Form 1503, the determination request, filed with the Department on April 2, 1987, indicates by check-the-box notation that the claim is "accepted," with payment of medical benefits totaling $3,454. The determination order of April 13, 1987, stated:

> "The Department is advised that Kenneth D. Frymire was fatally injured while covered under the Oregon Workers' Compensation Law. The Department orders the insurer to pay, to the beneficiaries, benefits for fatal injury."

Insurer did not appeal that determination order and paid death benefits to claimant, including spousal benefits and dependent benefits, until February 1996, when it issued the partial denial involved here, on the ground that claimant was not entitled to further spousal death benefits because she was married to Marshall at the time of Frymire's death. The denial stated that insurer would continue to pay dependent death benefits to Frymire's children.

An administrative law judge (ALJ) held that, although claimant was not a person entitled to benefits **<151 Or App 427/428>** under ORS 656.204 or ORS 656.226,[2] through its conduct in paying benefits and issuing forms with the notation "accepted," insurer had accepted the claim for spousal death benefits and was therefore precluded from denying those benefits. The Board rejected the ALJ's finding that insurer's conduct was an acceptance of a claim for spousal death benefits. In the first place, the Board reasoned, the payment of benefits in and of itself does not constitute acceptance of a claim for spousal benefits. ORS 656.262(10). Additionally, it found, the notations of acceptance on the Forms 801, 1502 and 1503 do not demonstrate specific acceptance of a claim for spousal death benefits.

The Board's findings are supported by substantial evidence and are also correct as a matter of law. The Form 801 does not indicate acceptance of a claim for spousal death benefits. The Forms 1502 and 1503 report the status of the claim to the Department and cannot be treated as notification to claimant that the claim is accepted. *EBI Ins. Co. v. CNA Insurance*, 95 Or App 448, 769 P2d 789 (1989).

The Board held, nonetheless, that because insurer did not appeal from the 1987 determination order, which it said had "specifically directed the insurer to pay spousal benefits" to claimant, it was precluded, under the rule stated in *Messmer v. Deluxe Cabinet Works*, 130 Or App 254, 881 P2d 180, *rev den* 320 Or 507 (1995), from denying the claim. In that case, we held that, when a determination order includes an award for a condition that has not been accepted, and the insurer fails to request a hearing on the determination order, the insurer's failure to challenge the determination order on the ground that it includes an award for a noncompensable condition precludes the insurer from contending later that the condition is not part of the compensable claim. *Id.* at 258.[3]

151 Or App 429> Here, the majority holds that the determination order must be understood to award spousal benefits. With that conclusion I disagree. Contrary to the Board's findings, the determination order did not direct insurer to pay *spousal* death benefits. It merely ordered that insurer pay benefits to Frymire's *beneficiaries*. ORS 656.005(2) defines "beneficiary" as "an injured worker, and the husband, wife, child or dependent of a worker, *who is entitled to receive payment under* [chapter 656]." (Emphasis supplied.) The order did not specify which persons were beneficiaries entitled to compensation and accordingly did not determine that claimant was a beneficiary entitled to receive spousal death benefits under ORS chapter 656. Because claimant was married to Marshall at the time of Frymire's death, she was not a beneficiary under ORS 656.204 or ORS 656.226.

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[2] ORS 656.226 provides:

> "In case an unmarried man and an unmarried woman have cohabited in this state as husband and wife for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under this chapter the same as if the man and woman had been legally married."

[3] I agree with the majority's holding with regard to the effect of 1997 legislative changes to ORS 656.262(10).

The Form 1502, on which the majority relies to bolster its conclusion, was merely a status report to the Department and not related to the determinational order. As we have said, it cannot form the basis for an acceptance. *EBI Ins. Co.* Not even the Board relied on the Form 1502 in support of its finding that the determination order made an award of spousal benefits. It looked merely to the language of the order itself, which, as we have noted, was not specific as to the type of death benefits that were to be paid.

The determination order cannot reasonably be understood to award spousal death benefits. Accordingly, I would hold that insurer's failure to appeal from the determination order awarding death benefits to Frymire's "beneficiaries" does not preclude its present denial of a claim for spousal death benefits. I would hold that the Board therefore erred in affirming the ALJ's order setting aside insurer's denial of spousal or cohabitant death benefits, and accordingly I dissent.

Warren and Leeson, JJ., join in this dissent.

Cite as 151 Or App 446 (1997) November 26, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Debra R. STANICH, *Appellant,*
v.
PRECISION BODY AND PAINT, INC., an Oregon corporation; and Maurice Monroe, an individual,
Respondents.
(C950261CV; CA A93401)

Appeal from Circuit Court, Washington County.
Timothy P. Alexander, Judge.
Argued and submitted July 28, 1997.
Craig A. Crispin argued the cause for appellant. With him on the briefs were Steven T. Conklin and Crispin & Associates.
Jeffrey M. Batchelor argued the cause for respondents. With him on the brief were Paula A. Barran and Lane Powell Spears Lubersky.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.

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151 Or App 448> Plaintiff appeals from a judgment entered after the trial court granted defendants' motion for directed verdict on plaintiff's retaliatory discharge claims. ORS 659.410. Plaintiff also appeals from the trial court's granting of defendants' motion for summary judgment on her penalty wage claim, ORS 652.150, and from an award of attorney fees to defendants. ORS 659.121(1). We review for errors of law, ORS 19.125(1), and reverse and remand.

On appeal from a directed verdict, we view the evidence in the light most favorable to the nonmoving party, extending to that party the benefit of every reasonable inference that may be drawn from the evidence. *Shockey v. City of Portland*, 313 Or 414, 422-23, 837 P2d 505 (1992), *cert den* 507 US 1017, 113 S Ct 1813, 123 L Ed 2d 444 (1993). We also view the record on summary judgment in the light most favorable to the nonmoving party. *Jones v. General Motors Corp.*, 325 Or 404, 408, 939 P2d 608 (1997). The moving party has the burden of showing that there are no genuine issues of material fact. *Id.*

The facts, according to plaintiff, are as follows: Plaintiff worked as a marketing manager for Precision Body and Paint, Inc. (Precision), from March 1992 until August 1994. In the final year of her employment, plaintiff experienced increasing stress at work and began having stress-related health problems. In June 1994, she sought medical treatment for heart palpitations.

On August 16, 1994, plaintiff was in the front office talking to the office manager when the office telephone rang. A clerical worker, Nimmo, did not answer it because she was talking to another worker. Plaintiff directed her to answer the telephone. Nimmo refused, because she did not believe that plaintiff had the authority to tell her what to do. Nimmo became very upset and swore at plaintiff.

Plaintiff also became very upset, exchanged heated words with Nimmo and returned to her office. At approximately four o'clock that afternoon, plaintiff talked to her supervisor, defendant Maurice Monroe, about some work files. Neither plaintiff nor Monroe mentioned the altercation between plaintiff and **<151 Or App 448/449>** Nimmo. Plaintiff left work shortly before five o'clock. She saw Monroe and the company controller, Wayne Hess, as she passed through the front office on her way out.

Plaintiff was so upset about the altercation with Nimmo that she decided to see a physician the next day. At about seven o'clock the next morning, August 17, plaintiff called Ron Reichen, co-owner of Precision, and told him that she would not be at work that day, that she would be seeing a doctor and that she intended to file a workers' compensation claim for work-related stress. Reichen replied, "okey-dokey." Plaintiff saw her physician on August 17 and was taken off work for stress-related anxiety and depression. Plaintiff immediately notified defendants of her status. On August 18, defendants mailed plaintiff a termination letter and a final paycheck, which she received on August 19. The termination letter stated that her final paycheck was enclosed, that defendants "regret that [they were] unable to deliver it directly to [her] on the 16th," and that they "understand from [her] statements to other members of Precision Body & Paint" that she knew that defendants had decided to fire her.

In late August, plaintiff filed a workers' compensation claim for mental disorder caused by stress. ORS 656.802(1).[1] Defendants denied the claim. At the hearing, plaintiff contended that her employment conditions were the major contributing cause of her mental disorder.[2] ORS 656.802(2)(a).[3] Defendants responded that plaintiff's stress was the result of her fear that she was going to be fired. Defendants presented evidence that plaintiff told someone that she had overheard Monroe and Hess talking on August 16 about firing her, that plaintiff told someone that she saw **<151 Or App 449/450>** Hess with what she thought was her final paycheck on August 16 and that on August 16 plaintiff told someone that she thought her job was in jeopardy. Plaintiff testified that she did not know or suspect that she was going to be fired on August 16, and her attorney argued that defendants' witnesses were conspiring to falsify evidence of the date on which she was fired. The administrative law judge (ALJ) held that plaintiff's mental disorder was not compensable under ORS 656.802(3)(b).[4] She reasoned:

> "[Plaintiff's] stress arose from her interpersonal conflict at work, which is not compensable under the statute as it is generally inherent in every working situation; or [plaintiff's] fear of being fired which also falls within one of the exceptions of compensability. * * * *[T]he major cause of [plaintiff] seeking medical treatment for her stress was her knowing that she was going to be fired.* * * * I saw no evidence of a conspiracy by the employer's witnesses, as suggested by [plaintiff's] attorney. It was clear from the evidence that [plaintiff] was fired on August 16, 1994, over one more interpersonal conflict involving [plaintiff] and another employee."

(Emphasis supplied; citations omitted.) Plaintiff appealed to the Workers' Compensation Board but withdrew that appeal and pursued this claim for retaliatory discharge.

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[1] ORS 656.802(1) provides, in part:

"(a) As used in this chapter, 'occupational disease' means * * *:

"* * * * *

"(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death."

[2] Neither party provided us with the record of the workers' compensation proceeding. Our understanding of the events of that proceeding comes only from the opinion of the workers' compensation administrative law judge.

[3] ORS 656.802(2)(a) provides:

"The worker must prove that employment conditions were the major contributing cause of the disease."

Plaintiff alleges (1) that defendants terminated her in retaliation for filing a workers' compensation claim in violation of ORS 659.410(1);[5] (2) that Monroe aided and abetted her unlawful termination, in violation of ORS 659.030(1);[6] **<151 Or App 450/451>** and (3) that defendants failed to pay her wages due immediately upon termination, in violation of ORS 652.150.[7] Defendants moved for summary judgment on all three claims. The trial court granted summary judgment on the penalty wage claim and ordered the other two claims to be tried to a jury. After plaintiff's case-in-chief, defendants moved for directed verdicts on the ground of issue preclusion, or, in the alternative, because plaintiff had not proven a *prima facie* case. The court granted the motion on the ground that issue preclusion bars plaintiffs claims. The court entered judgment for defendants and awarded them attorney fees.

We first consider whether the trial court erred in granting defendants' motion for directed verdicts on plaintiff's retaliatory discharge claims on the ground of issue preclusion. The doctrine of issue preclusion bars relitigation of an issue in a subsequent proceeding if the following five requirements are satisfied: (1) The issue in the two proceedings is identical; (2) the issue was actually litigated and was essential to a final decision on the merits in the prior proceeding; (3) the party sought to be precluded had a full and fair opportunity to be heard on the issue; (4) the party sought to be precluded was a party to the prior proceeding; and (5) the prior proceeding was the type of proceeding to which we will give preclusive effect. *Nelson v. Emerald People's Utility Dist.*, 318 Or 99, 104, 862 P2d 1293 (1993). Although the party asserting issue preclusion bears the burden of proof on all five requirements, the party against whom preclusion is sought has the burden of showing that it did not have a full and fair opportunity to litigate. *State Farm v. Century Home*, 275 Or 97, 105, 550 P2d 1185 (1976). Whether the elements of issue preclusion have been established is a question of law. *Id.* An administrative determination can be used as a basis **<151 Or App 451/452>** for issue preclusion in a later civil proceeding. *Chavez v. Boise Cascade Corporation*, 307 Or 632, 634, 772 P2d 409 (1989).

As explained above, in the workers' compensation proceeding plaintiff contended that her working conditions caused her mental disorder. Defendants responded that plaintiff's stress was the result of her fear that she was going to be fired. Defendants presented evidence that they had decided to fire plaintiff several times before. Defendants also presented evidence that plaintiff told someone that she had overheard Monroe and Hess talking on August 16 about firing her, that plaintiff told someone that she saw Hess with what she thought was her final paycheck on August 16, and that on August 16

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[4] ORS 656-802(3) provides, in part:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:

" * * * * *

"(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation * * * or cessation of employment * * * ."

[5] ORS 659.410(1) provides, in part:

"It is an unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS chapter 656 or of ORS 659.400 to 659.460 * * *."

[6] ORS 659.030(1) provides, among other things, that it is an unlawful employment practice:

"(g) For any person, whether an employer or an employee, to aid, abet, incite, compel or coerce the doing of any of the acts forbidden under ORS 659.010 to 659.110 and 659.400 to 659.545 or to attempt to do so."

[7] ORS 652.150 provides, in part:

"If an employer willfully fails to pay any wages or compensation of any employee whose employment ceases, as provided in ORS 652.140 * * * , then, as a penalty for such nonpayment, the wages or compensation of such employee shall continue from the due date thereof at the same hourly rate for eight hours per day until paid * * *."

plaintiff told someone that she thought her job was in jeopardy. Plaintiff testified that she did not know or suspect that she was going to be fired, and her attorney argued that defendants' witnesses conspired to prove otherwise. Based on the evidence, the ALJ concluded that "the major cause of [plaintiff] seeking medical treatment for her stress was her knowing that she was going to be fired" and that plaintiff's "fear of being fired * * * falls within one of the exceptions of compensability." ORS 656.802(3)(b).[8]

Plaintiff's theory to support her claims of retaliatory discharge is that defendants fired her in retaliation for filing a workers' compensation claim. Defendants respond that they fired plaintiff for a legitimate reason before she filed her workers' compensation claim. The ALJ made two findings central to this dispute. First, the ALJ found that "[i]t was clear from the evidence that [plaintiff] was fired on August 16, 1994." According to the trial court, that finding is essential to the ALJ's decision, and, consequently, plaintiff is barred by the doctrine of issue preclusion from relitigating that fact. That fact defeats plaintiff's retaliatory discharge claims because she filed her workers' compensation claim after August 16. If plaintiff is precluded from relitigating whether she was fired on August 16, the trial court did not err in granting defendants' motion for directed verdict.

151 Or App 453> Defendants contend that issue preclusion also bars plaintiff from relitigating the ALJ's second finding, namely, that "the major cause of plaintiff seeking medical treatment for her stress was her knowing that she was going to be fired." If plaintiff is precluded from litigating whether she knew on August 16 that she was going to be fired, that finding--that she knew on August 16 that her job was in jeopardy--supports defendants' theory that they did not fire her in retaliation for filing a workers' compensation claim, but for a legitimate reason. In that case, plaintiff may argue only that defendants merely threatened to fire her on August 16 and that they carried out their threat to fire her because she filed a workers' compensation claim.

Because it is dispositive to the determination of whether plaintiff is precluded from relitigating the ALJ's first finding--that plaintiff was fired on August 16--we first address the second requirement for preclusion under *Nelson*: Whether the issue sought to be precluded in the second proceeding actually was litigated and was essential to a final decision on the merits in the first proceeding. *Nelson*, 318 Or at 104.

At the workers' compensation hearing, the ALJ was required to decide whether plaintiff's mental disorder claim was compensable. In making that determination, the ALJ was required to determine whether events occurred on August 16 that put plaintiff on notice that her job was in jeopardy, whether those events caused plaintiff to fear being fired and whether plaintiff's fear of being fired caused her mental disorder. However, in determining whether plaintiff's mental stress claim was compensable under ORS 656.802(3)(b), the ALJ was not required to decide the legal import of those events, that is, whether they resulted in her termination. A finding that plaintiff feared being fired on August 16 is consistent with a finding that she actually was terminated on August 19, or not fired at all. Accordingly, the date on which plaintiff was fired simply was not essential to the ALJ's determination that plaintiff's mental disorder was caused by her fear of being fired. Because the finding that plaintiff was fired on August 16 was not essential to the ALJ's decision regarding the compensability of plaintiff's claim, the second requirement for issue preclusion under Nelson has not been **<151 Or App 453/454>** satisfied. Consequently, the trial court erred in holding that plaintiff is precluded from litigating in this proceeding the question of whether she was fired on August 16.

However, the finding that plaintiff knew on August 16 that her job was in jeopardy was essential to the ALJ's determination that plaintiff's mental disorder was caused by her fear of being fired, and that, consequently, her mental disorder was not compensable. Precluding plaintiff from relitigating that fact will not entitle defendants to a directed verdict on the ground of issue preclusion because plaintiff's knowledge that her job was in jeopardy does not resolve the question of defendants' motive for firing her. However, on remand, defendants likely will seek to preclude plaintiff from relitigating whether she knew her job was in jeopardy because that knowledge lends support to defendants' contention that they had a legitimate reason for firing her. For that reason we address the issue here. Therefore, we must determine whether the other *Nelson* requirements for issue preclusion are satisfied and, hence, bar plaintiff from relitigating that fact.

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[8] In the light of the ALJ's finding that the major cause of plaintiff's seeking medical treatment was her knowing that she was going to be fired, we do not address plaintiff's argument that the ALJ's decision rested on two grounds and, therefore, was ambiguous.

The first *Nelson* requirement is that the issue in the two proceedings is identical. *Nelson*, 318 Or at 104. Plaintiff concedes that the "underlying factual issue the ALJ decided was the cause of plaintiff's stress." The ALJ found that the cause of plaintiff's stress was her knowledge on August 16 that her job was in jeopardy. That is the same fact on which defendants rely in this civil action to rebut plaintiff's retaliatory discharge claim by contending that they fired plaintiff for a legitimate reason. Consequently, the first requirement for preclusion under *Nelson* is satisfied.

The third requirement under *Nelson* is that plaintiff had a full and fair opportunity to be heard on the issue in the prior proceeding. *Id.* Plaintiff contends that this requirement is not satisfied because she had no incentive in the workers' compensation proceeding to litigate, among other things, whether defendants' employees were telling the truth when they testified that plaintiff knew on August 16 that her job was in jeopardy.

151 Or App 455> Preclusive effect may be given to essential[9] findings in a formal administrative adjudication if the parties had a full opportunity and the incentive to contest the point on a record that was subject to judicial review. *Chavez*, 307 Or at 635. Plaintiff has the burden to "bring to the court's attention circumstances indicating the absence of a full and fair opportunity to contest the issue in the first action." *State Farm*, 275 Or at 105.

In this case, defendants sought to defeat plaintiff's workers' compensation claim filed pursuant to ORS 656.802 *et seq* by presenting testimony that plaintiff's stress was caused by her fear of being fired. Consequently, to meet her burden of proving that her claim was compensable, plaintiff had a strong incentive to establish that she did not know on August 16 that her job was in jeopardy. Plaintiff does not argue that defendants surprised her with their defense, that the ALJ denied a motion for a continuance in order to give plaintiff time to rebut the defense or that she was not allowed to present evidence to rebut the defense. Neither has plaintiff provided any evidence that would assist her in meeting her burden of showing that she did not have a full and fair opportunity to litigate whether she knew that her job was in jeopardy when she filed her workers' compensation claim. *Nelson*, 318 Or at 104. Her contention that "[i]t is unfair and unjust to now hold that the limited testimony and evidence offered" at the workers' compensation hearing precludes relitigation of those issues must fall on deaf ears.

Plaintiff's other ground for arguing that the ALJ's finding is not entitled to preclusive effect is that the record of the workers' compensation hearing was not subject to judicial review. Plaintiff is wrong. The ALJ's opinion and order was subject to review both by the Workers' Compensation Board, ORS 656.295, and this court, ORS 656.298. Plaintiff withdrew her appeal of the ALJ's opinion and order. Consequently, the ALJ's findings are final as between plaintiff and defendants. *Washington Cty. Police Officers v. Washington Cty.*, 321 Or 430, 437, 900 P2d 483 (1995).

151 Or App 456> The fourth requirement for issue preclusion under *Nelson* is that the party sought to be precluded was a party to the prior proceeding. *Nelson*, 318 Or at 104. It is undisputed that that requirement is satisfied in this case.

The final requirement for issue preclusion is that the prior proceeding is the type of proceeding to which this court will give preclusive effect. *Id.* In *Chavez*, the Supreme Court reiterated that "'an administrative determination can be used as a basis for [issue preclusion] in a later civil jurisdiction proceeding.'" *Chavez*, 307 Or at 634-35. However, in footnote 1 of *Chavez*, the court stated:

> "This case presents no claim of a right under Article VII, section 3, of the Oregon Constitution to a jury determination of disputed facts. *Cf. Parklane Hosiery Co. v. Shore*, 439 US 322, 99 S Ct 645, 58 L Ed 2d 552 (1979) (despite the federal Seventh Amendment, juries historically were precluded from retrying issues decided in prior equity proceedings); *id.*, 439 US at 337 (Rehnquist, J., dissenting)."

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[9] In *Chavez*, the court used the word "necessary" to describe findings that will be given preclusive effect. *Chavez*, 307 Or at 635. We assume that the word "necessary" is synonymous with the word "essential" in *Nelson*. 318 Or at 104.

Id. at 634. Plaintiff relies on that footnote for her argument that "the procedure in an administrative proceeding cannot substitute for a jury trial" because administrative process "is expedited and allows evidence inadmissable at trial." She contends that applying the doctrine of issue preclusion to facts found in the workers' compensation proceeding is tantamount to denying her a jury trial of disputed facts to which she has a right under Article VII, section 3, of the Oregon Constitution. Even assuming there is merit to plaintiff's argument, she raises it for the first time in her reply brief, having not argued the point below. Consequently, we do not consider the argument. ORAP 5.45(2); *Ailes v. Portland Meadows, Inc.*, 312 Or 376, 380, 823 P2d 956 (1991).

To summarize: We conclude that the trial court erred in granting defendants' motion for directed verdict on the ground that plaintiff is barred by the doctrine of issue preclusion from relitigating whether she was fired on August 16, because that finding was not essential to the ALJ's determination that her workers' compensation claim is not compensable. However, on remand, plaintiff is barred from relitigating whether she knew on August 16 that her job was in jeopardy.

151 Or App 457> Defendants argue that there is an alternative ground for affirming the trial court's granting of their motion for directed verdict, because they also argued that plaintiff did not present a *prima facie* case of retaliatory discharge. *See Allen v. The Heil Company*, 285 Or 109, 122, 589 P2d 1120 (1979) ("[W]hen the motion states alternative grounds, we ordinarily consider the other grounds to determine if the motion should have been granted upon the alternative grounds."); *Rees v. State of Oregon*, 133 Or App 154, 156, 890 P2d 1012, *rev den* 321 Or 94, 893 P2d 540 (1995) (same). Viewing the evidence in the light most favorable to plaintiff, *Shockey*, 313 Or at 422-23, we disagree. A *prima facie* case of retaliatory discharge under ORS 659.410 is established by proving: (1) that the plaintiff invoked the workers' compensation system; (2) that the plaintiff was discriminated against in the tenure, terms or conditions of employment; and (3) that the employer discriminated against the plaintiff in the tenure or terms of employment because he or she invoked the workers' compensation system. ORS 659.410(1). Although plaintiff is precluded from relitigating the fact that she knew on August 16 that her job was in jeopardy, it is uncontroverted that defendants had decided to fire her on other occasions but had changed their minds and did not do so. It also is uncontroverted that plaintiff notified defendants on the morning of August 17 that she intended to file a workers' compensation claim and that plaintiff's termination letter was dated August 17 and postmarked August 18. In addition, plaintiff presented evidence that defendants conspired to falsify the date of her termination. That evidence is sufficient to establish a *prima facie* case of retaliatory discharge on a theory that defendants carried out their decision to fire plaintiff because she filed a workers' compensation claim. As explained above, because plaintiff is not precluded from relitigating the issue of whether she was fired on August 16, the trial court erred in granting defendants' motion for directed verdicts on plaintiff's discrimination claims.

Finally, we address plaintiff's argument that the trial court erred in granting defendants' motion for summary judgment on her penalty wage claim. ORS 652.140(1); ORS 652.150. The trial court concluded that defendants are entitled to summary judgment on that claim because there are no genuine issues of material fact. ORS 652.150 provides:

> **151 Or App 458>** "If an employer willfully fails to pay any wages or compensation of any employee whose employment ceases, as provided in ORS 652.140 and 652.145, then, as a penalty for such non-payment, the wages or compensation of such employee shall continue from the due date thereof at the same hourly rate for eight hours per day until paid or until action therefor is commenced; provided, that in no case shall such wages or compensation continue for more than 30 days from the due date; and provided further, the employer may avoid liability for the penalty by showing financial inability to pay the wages or compensation at the time they accrued."

Plaintiff argues that notwithstanding defendants' contention that she was fired on August 16 and knew that she was fired on that date, they concede that she was not paid until August 19. Defendants respond that although they decided to fire plaintiff on August 16, they did not "formally" fire her until August 19. As we have explained above, we conclude that there is a genuine issue of material fact about the date on which plaintiff was fired. Nonetheless, defendants argue, they gave plaintiff two weeks severance pay--August 17 to August 31--so they paid her through August 19 and, hence, are not subject to a penalty under ORS 652.150. We already have rejected a similar argument:

> "Defendant contends that the amounts it voluntarily paid * * * should be credited against penalties otherwise due for its wilful failure to pay plaintiff's earned and unpaid wages * * *. * * * There is no evidence that defendant intended its payments to 'satisfy its wage-claim obligations' or that plaintiff accepted the payments with that understanding."

Kling v. Exxon Corp., 74 Or App 399, 403, 703 P2d 1021 (1985). Defendants seek to limit *Kling* to circumstances in which the voluntary payment is the result of a separate agreement. They provide no explanation for why the *Kling* rule, which requires that voluntary overpayments reflect an intent to satisfy wage-claim obligations, must be so limited. As a matter of law, defendants are not entitled to summary judgment on that theory. Defendants must establish at trial that plaintiff was compensated for all wages due within one business day of being fired or that the amount given to her on **<151 Or App 458/459>** August 19 was intended to compensate her for all wages, both regular and penalty.

In the light of this disposition, the award of attorney fees is reversed.

Reversed and remanded.

INDEX CONTENTS

Volume 49

Throughout the Index, page numbers in **Bold** refer to Court Cases.

OVERVIEW OF SUBJECT INDEX

EVIDENCE

See also: REMAND

Administrative notice

Agency order, 1541,1835,2019
AMA Guidelines to Permanent Impairment, 75,129
Color Atlas of Human Anatomy, 75
Correspondence to agency, 1583
Dictionary of Occupational Titles, 1872
Different WCB case from one at issue, 579,1511
DSM-IV manual, 1022
Medical treatise, journal, 1022,1059
Opinion and Order, different claim and employer, 4
Request to take denied, 75,831,1022

Admission of evidence or exhibits issue

ALJ's discretion

Not abused, 214,454,484,495,616,715,1035,1288,1771,1781,1794

Document offered after closing argument, 484
Expertise, **2206**
Foundation, 1794

*** Bold Page = Court Case ***

Frozen record issue, 495
Hearsay, 1794
Height/weight table relied on by doctor, 1288
Medical report

Untimely disclosure, 634

Necessity of objection to submission, 146
New, submitted with brief on review, See REMAND
Objection, when to make, 1491
Post-denial IME report, 576
Post-hearing report or records, 214,616,715,1771,1781,1835
PPD issue

Documents which were part of Reconsideration record, 1303
Extra-reconsideration record issue: when to object, 2028
Lay evidence, impairment issue, 2169
Post closure report submitted for reconsideration, 1333
Post-reconsideration

Arbiter testimony or report, 31,458
Deposition or report, 503,553
Impeachment, 705
Necessity of objection to admission, 1491

Some vs. all documents reviewed by DCBS, 484
Testimony, 527,681,689,712,757,1446,1555,**1643**
Videotapes impeaching claimant, 137

Premature claim closure

Medical vs. non-medical information, 1583
Not considered on Reconsideration, 1116,1583
Post-reconsideration, 712,1132

PTD issue

Necessity of objection to post-reconsideration submission, 146
Post-Reconsideration

Generally, 871,880,2129
Vocational evidence, 26,57,529,871

Rebuttal medical opinion, 2074
Relevancy

Doctor's payment ledger, 1794
Opinion & Order, different claim and employer, 4,1035
Video, not discovered, 1035

Report generated while hearing postponed, 495
Testimony

Claimant's attorney, 454

JURISDICTION (cont.)
- Board vs. Court of Appeals
  - Case on appeal to Court, 1375
  - Subject worker issue, 7,1885,1960
- Board v. D.C.B.S.
  - Authority (WCB) to remand to DCBS, 2117
  - Classification: disabling vs. nondisabling, 1541
  - Incorrect notice of appeal rights, 486,518,618
  - Medical treatment or fees issue
    - Compensability, **385**
    - Medical bills, 1841
    - No denial, underlying claim, **385**
    - Surgery request, 1847
    - Treatment vs. aggravation, 590,628
    - Treatment vs. condition, 475,**899**,1121,1130,1833,1944,1953,2041,2056
  - Order Denying Reconsideration (of D.O. or N.O.C.), 25,618
  - Penalties, 2178
  - Premature claim closure, 538
  - Subjectivity, 486,518,**2250**
  - Temporary total disability: Substantive vs. procedural, 67,339,1541
  - Vocational assistance
    - Attorney fees, 96
    - Generally, 556
    - Penalty, 96
- Board vs. Hearings Division
  - ALJ abates Opinion & Order after Request for Review filed, 7
  - Request for Reconsideration (ALJ's order)
    - Acknowledgement, Request for Review, 17
- D.C.B.S.: Subject matter, 669
- Hearings Division
  - Apportionment of claims costs, 781
  - Claim closure issue; necessity of specifying issue at reconsideration, 59
  - Claimant withdraws request for hearing; no cross-request filed, 781
  - DCBS recovery of costs from NCE, 250
  - PPD issue raised by cross-request, 1819
  - Pre-acceptance interim compensation, 1061
  - TTD rate issue; necessity of specifying issue at reconsideration, 1128,1571
- Incorrect notice of appeal rights, 486
- Subject matter, discussed, 669,763

LABOR LAW ISSUE
- Unemployment benefits issue: light duty refused, **915**
- Unlawful employment practices
  - Damages for discriminatory discharge, **348**
  - Reinstatement demand while compensability issue not final, **353**
  - Reinstatement duty: number of employees issue, **1645**
  - Retaliatory discharge for filing workers' compensation claim, **2254**

LUMP SUM See PAYMENT

MEDICAL CAUSATION
- See also: ACCIDENTAL INJURY; DENIAL OF CLAIMS; EVIDENCE; OCCUPATIONAL DISEASE CLAIMS; PSYCHOLOGICAL CONDITION CLAIMS
- Burden of proof
  - Combined condition accepted, 39,1272
  - Consequential condition, 800,807,856,1437,1753,1833,2172
  - Diagnostic services, **383**
  - Necessity for diagnosis, 188
  - Precipitating vs. major cause, 324,327,545,887,1147,1184,1409,1498,2040,2153
  - Preexisting condition, 39,327,545,755,866,887,1184,1310,1825,1833,1897

*** Bold Page = Court Case ***

MEDICAL OPINION (cont.)

Based on (cont.)

Complete, accurate history, 70,215,250,294,343,508,624,747,775,842,1027,1033,1164,1201, 1216,1312,1589,1593,1753,1786,1798,1803,1889,1912,1970,2066,2139,2159

Consideration of all possible causes or factors, 508,624,805,1064,1272,1312

Consulting physician status, 599

Elimination of other causes, 1474

Exam/treatment before, after key event, 1235

*** Bold Page = Court Case ***

Examination long after key event, 41

Examination, opinion after condition resolved, 725

Expertise, greater/lesser, 147,234,621,790,1136,1289,1378,1990,2021,2159

Failure to address relative contributions of work, non-work factors,1,147,206,215,295,327, 462,748,828,860,866,1022,1035,1077,1083,1261,1409,1818,1826,1957,1962,2017,2107,2172

Failure to consider all factors, 695,730,1035,1119,1140,1277,1416,1474,1482,1918

General information vs. specific to claimant, 106,775,807,1895,1931,1970,2074

Inaccurate history, 41,70,114,115,147,155,159,202,206,280,327,550,616,695,713,725,807,828, 885,1022,1047,1143,1149,1171,1180,1216,1363,1388,1399,1416,1474,1484,1497,1528,1592, 1757,1771,1781,1853,1897,1962,1993,2011,2142

Incomplete history or records, 34,206,447,462,508,621,748,792,885,1162,1184,1264,1285, 1302,1363,1407,1600,1753,1755,1987

Inconsistencies, 97,313,502,790,792,1162,1803,1897,2037

"Magic words", necessity of, 70,80,344,482,688,842,1147,1352,1591,1826,1830,2007

Minority opinion, 1360

Noncredible or unreliable claimant's history, 4

Part of opinion accepted, part rejected, 193

Possibility vs. probability, 97,182,591,635,688,790,800,880,1047,1077,1409,1448,1485,1607, 2007

Probability vs. certainty, 775

Records review vs. exam, 1378,1462,2132

Single exam vs. long term treatment, 755,1136,1159,1378,1507

Speculation, 147,159,804,856,1201,1482

Temporal relationship, 110,250,343,741,880,1118,1180,1261,1289,1342,1474,1498,1771,1823

Work activity, correct understanding of, 106,775,1353,1462,1798

Necessity for

Criteria to determine, 635,725,885,1474

Injury claim

Consequential condition, 621,807,842,1149,1409,2159

Criteria to determine, 247,885,1074,1125,1242,1253,1474

Current condition, old claim, 182,1380

Dispute between medical experts, 206,1080

Generally, 2175

Injury not reported immediately, 304,1171

Multiple potential causes, 202,215,550,715,1074,1171,1781

Preexisting condition, 1,322,327,550,764,1035,1143,1261,1369,1399,1407,1900

Prior injuries, same body part, 41,1074,1143

Medically stationary issue, 1849

Occupational disease claim, 97,138,456,725,775,1099,1353,1360,1466,1547,1558,2055,2140

Occupational disease claim/current condition, 1130

Psychological condition claim, 2017

Treating physician

Opinion deferred to

First attending physician, 206,715

Generally, 72,204,587,596,650,764,856,1027,1047,1064,1164,1363,1380,1477,1558, 1753,1803,1830,1966,2037,2074

Long-term treatment, 34,110,715,717,755,775,842,1033,1136,1159,1213,1235,1437, 1507,**2229**

No persuasive reasons not to defer, 1027,1755,1798,1801,2074

Short-term treatment, 764

Surgeon, 804,888,1437,1966,2132,2153

OCCUPATIONAL DISEASE CLAIMS (PROCESSING) (cont.)

Claim compensable (cont.)

Previous accepted claim, same employer, 1598

"Series of traumatic events", 256

Sufficient medical evidence, 826,1547,1755

Claim not compensable

Insufficient or inadequate medical evidence, 20,97,106,447,456,602,671,725,745,790,1277, 1466,1528,1546,1558,1591,1600,1755,1818,1973,1974

LIER applied, 174,1888

Major cause test not met, 133,147,174,214,282,599,748,1063,1099,1162,1311,1860,1973

Objective findings test not met, 1558

Preexisting condition

Causes condition, need for treatment, 1047

Combined, work exposure not major cause, 282,741,745,1302,1860,1973

Work not major cause, pathological worsening, 741,1099,1360

Symptoms not established as disease, 636

Toxic exposure, 1360

Work-related (possibly), non-work-related conditions inseparable, 1973

Vs. accidental injury, 147,155,304,508,596,635,1094,1164,1249,**1650**,1830,2074

*** Bold Page = Court Case ***

OCCUPATIONAL DISEASE, CONDITION OR INJURY

Acute myelogenous leukemia (AML), 800

Arthritis, 1221

Bunion, 1407

Carbuncle, 621

Carpal tunnel syndrome, 20,43,77,106,133,189,447,599,671,741,745,748,775,1277,1292,1312,1363, 1439,1462,1557,1591,**1627**,**1633**,1753,1798,1923,1987

Charcot-Marie-Tooth disease, 1889

Chondromalacia, 1996,**2197**

Colitis, **1658**

Costochondritis, 1201

Cubital tunnel syndrome, 447

Dermatitis, 1117,1133,1238,1471,1767,1891

Diabetes, 621,1345

Epicondylitis, 870,1112,1466,1786

Failed back surgery syndrome, 1152

Fibromyalgia, 477

Ganglion cyst, 826

Hallux valgus, 1407

Headaches, 1035,1895,1969

Hearing loss, 282,310,456,**894**,1130,1311,1423,1528,1546,**1628**,1797,1877,1888,1931

Hemorrhoids, 1342

Hernia, 34,**390**,1164,1966,2181

Hyperventilation syndrome, 635

Knock knee, **906**

Lyme disease, 790

Memory oss/dementia, 1771

Mesothelioma, 1610

Myofascial pain syndrome, 281

Necrotic fibroid condition, 2037

Neurilemmoma, **1637**

Osteochondritis dissecans, 938,**2249**

Osteonecrosis, 624

Patellofemoral syndrome, 2088

Plantar fascitis, 1099

Popliteal cyst, 600

Porphyria, 1360

Post-concussion syndrome, 1895,2019

Degenerative disc disease (as preexisting condition), 1055,1063

Obesity, 1025

OWN MOTION RELIEF (cont.)
Relief allowed (cont.)
Claimant request
*** Bold Page = Court Case ***
Closure
Modified, 1814
Set aside, 54,162,609,722,727,1536,1817,1916,2009,2064
Medical services, pre-1966 claim, 234,1532,1907
Penalty, 665,783,1276
Temporary disability
Burden of proof, 168,463,611,1015,1170,1331,1763,1928
Compensability decision on appeal, 731
Compensability issue decided in claimant's favor, 2059
Due to injury requirement met, 761,1331,1532,1763,2098
Enforcement order, 783,1276
Full TTD (not 1/3) due, 665
In work force, 168,273,463,487,535,577,611,647,660,864,1015,1170,1329, 1331,1927
Incarceration, 1170
Receipt of Social Security, 1376
Receiving temporary disability in another claim, 490,1531,1927,1928
Retirement issue, 1376,1848
Room & board as earings, 1170
Self-employment, 1329,2060,2063
Surgery issue, 88,485,724,1282,1557,1939
Temporary partial disability, 1553
Willing but unable to work, 761,1331,1376,1813,2061
Relief denied
Carrier request
Abeyance, request to hold order in, 89,165
Motion to compel: records and deposition, 1376
No authority to require DCBS to consent to .307 order, 257
Referral for hearing, 2158
Claimant request
Closure affirmed
Issue moot, 21
Medically stationary date correct, 275,449,572,608,677,688,718,721,771, 1337,1443,1576,1816,1861,2022,2102,2149
No further temporary disability due, 525,572,718
Medical services, pre-1966 injury, 1072,1764,1985
Penalty, 519,786,1839,1940,1947,1977,2098
Permanent partial disability, 525,608
Remand request, 470
Temporary disability
Burden of proof, 493,519,718,1763
Claim CDA'd, 569
Condition requiring disability not compensable, 522
Due to injury requirement, 21,1441,1763,1764,2094
No proven disability, loss of wages, 519,1338
Not in work force at time of disability, 139,470,493,680,853,1986,2094
Overpayment recovery by carrier allowed, 1940
Receipt of Social Security disability, 2094
Release to regular work, 718
Temporary partial disability, 2023
Willingness to work issue, 1763,1913,2098,2111
"Surgery" defined or discussed, 88
TTD due, multiple claims, 665,676
Voluntary payment of benefits, 485

PERMANENT PARTIAL DISABILITY (SCHEDULED)

Affected body part
- Arm, 228,757,796,1084,1167,1286,1298,1320,1404,1472,1543,2100
- Eye, 1066
- Foot, 15,733,799,1284,1367,1418,1468,1870,1934,2147
- Forearm, 49,1059,1348,1358,**1627**,1787,1923,2000,2007,2028
- Hand, 129,141,553,541,557,1110,1333,1561,1891,2003,2025
- Hearing loss, 492,565
- Knee, 59,697,705,874,1388,1594,1898,2129
- Leg, 752,1193,1330,1828
- Thumb, 75,129,1787
- Toe, 799
- Vascular condition, 1320,1333
- Wrists, 75,884,1278,1348,1433,1787,1901

*** Bold Page = Court Case ***

Computing award: Conversion of separate scheduled awards to one award, 1787,2003

Factors considered
- Apportionment, 1348,2129
- Caused by unscheduled injury, 1934
- Chondromalacia, 59
- Chronic condition
  - Award made or affirmed, 1167,1433,1468,1545,1923,2003
  - Award reduced or not made, 59,141,874,884,1084,1241,2007
  - "Significantly limited" discussed, 2007
- Contralateral joint, 59,799,874,1367,1404,1472,1594,1898
- Dermatitis, 1117,1891
- Due to injury requirement, 15,75,697,796,1059,1167,1348,1351,1388,1870,1891,1934,2025, 2100,2129
- Grip strength, 543,553,557,1787,2000
- Medically stationary requirement, 1828
- No preclosure denial, combined condition, 59,697
- Non-anatomic findings, 733
- Objective finding issue, 2025
- Permanency requirement, **1627**,2028
- Preexisting condition, 59,697
- Range of motion, 874,1084
- Sensory loss, 141,799,1110,1298,1348,1561,1923,1934,2025,2147
- Stand/walk limitation, 705,1284,1418,1468
- Strength, loss of, 49,796,1059,1167,1193,1278,1286,1330,1358,1923,2129
- Subjective response to testing, 2147
- Validity issue, 2025

Prior award
- Different claim, 15
- Worsening since requirement, 1898

Rate per degree, 49,847,871

PERMANENT PARTIAL DISABILITY (UNSCHEDULED)

See also: PERMANENT PARTIAL DISABILITY (GENERAL)

Back & neck
- No award, 143,230,233,241,521,603,634,681,733,744,1057,1193,1219,1300,1351,1386,1605, 2097,2145
- 1-15%, 195,227,238,332,334,502,752,760,1095,1344,1594,1787,1819,1849,1872,1942
- 16-30%, 184,228,301,527,548,910,1019,1485,1555,1934,2045
- 31-50%, 320,505,515,1505

Body part or system affected
- Allergy/reactive airway condition, 2169
- Brain damage, 1156
- Dermatitis, 1133,1238,1471,1767
- Dermatitis vs. immune system, 1117
- Gastrointestinal condition, 1030
- Headaches, 1212

PERMANENT TOTAL DISABILITY
- Award
  - Affirmed, 26,615,1527
  - Refused, 529,871,880,**922**,**947**,1602
  - Reversed, 1511
  - Terminated, 297,1505

*** Bold Page = Court Case ***

- Burden of proof
  - Generally, 880,**947**
  - Odd lot, 26,**1639**
  - Termination of PTD, 297
- Factors considered
  - Medical issues/opinions/limitations
    - Due to injury requirement, 880,1511,1602
    - Emotional, cognitive conditions, 615
    - Inability to regularly perform
      - Gainful work, 615
      - Part-time work, 26
    - Preexisting conditions, 1527,1602
    - Who determines, 880
  - Motivation: Willingness to work, 26,871
  - Vocational issues, evidence
    - Gainful employment issue, 297,**947**
    - Labor market issue, 297,**1639**
    - Opinion based on inadmissible medical evidence, 26
    - Part-time work, 297,**922**
    - Suitable work issue, **922**

PREMATURE CLAIM CLOSURE See DETERMINATION ORDER/NOTICE OF CLOSURE

PSYCHOLOGICAL CONDITION CLAIMS
- Occupational disease claim
  - Burden of proof, 1136,1267,2107
  - Claim compensable
    - Major cause test met, 1159
    - Mental disorder, generally recognized, 1136,1159
    - Stressors not generally inherent, 1159
    - Stressors real and objective, 1159
  - Claim not compensable
    - Employment stressors viewed separately, 311
    - Insufficient or no medical evidence, 468,1267,2017
    - Misperception of work events, 468
    - Noncredible claimant, 1592
    - Preexisting condition, 2017
    - Reasonable discipline, corrective action, 860
    - Stressors generally inherent, 311,835,860,1267,2107
- Physical condition, stress caused, **1658**,2034
- Relationship to physical injury claim
  - Burden of proof
    - Consequential condition, 254,316,735,758,1771
    - Preexisting condition, 36,254
  - Claim compensable
    - Conversion disorder, 254
    - Major cause test met, 1771
  - Claim not compensable
    - Alcohol, drug dependency, 316
    - Condition previously DCS'ed; no worsening since, 36
    - Current condition different from accepted condition, 735
    - Insufficient medical evidence, 1066
    - Major cause test not met, 758,1365
    - Preexisting condition: Injury not major cause, need for treatment, 36

* **Bold Page = Court Case** *

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)

* **Bold Page = Court Case** *

SETTLEMENTS & STIPULATIONS (cont.)

*** Bold Page = Court Case ***

TEMPORARY TOTAL DISABILITY (cont.)

Interim compensation (cont.)

Original claim (cont.)

Modified work, 1950

Non-disabling claim, 1061

Requirements for, generally, 690,1253,2161

Start date, 1253

Termination (TTD) with denial issue, 1812

Three-day wait, 1253

Worker fired before TTD authorized, 1452

*** Bold Page = Court Case ***

Penalty issue

Conduct reasonable

Aggravation claim (interim compensation), 83,339,631,831,1417

Following litigation order, 10

Legitimate doubt, 198,809,1947,2135

Retroactive authorization, 753

TPD, 198,1950

TTD, 2029,2135

Conduct unreasonable

Employer knowledge imputed to carrier, 40

Interim compensation, 690,1061,1175,1452

Late payment, 1205

No legitimate doubt, 875,1061

Rate issue, 1991

Suspension of benefits, 1205

TPD ordered by Notice of Closure, 1426

Rate

"Actual weeks" of employment, 127,178,554,1068,1562

Assumed vs. actual wage, **952**

Bonus, 592

Calculation (claimant's) unclear, 1553

Daily wage/payment for single day issue, 1991

Days per week issue, 1128

Earnings vs. expense reimbursement, 592

Extended gaps, 809,1068,1101,1562,2086

Intent at hire, 1068,1101

Layoff and rehire, 554

Mileage, 592

On call, 176,1068

Own Motion case, 1973 injury, 2023

Per diem, 592

"Regularly employed" issue, 176,178

Two jobs, two employers, at time of injury, 176

When to raise issue, 1128

Suspension of benefits

Failure to attend arbiter exam, 2117

Failure to cooperate, 1943

Generally, 1205

Temporary partial disability

Annual increase issue, 2023

Burden of proof, 519

Calculation of, 449,1208,2023

Claimant chooses to work fewer hours than released for, 545

Job offer (modified work) withdrawn, 290

Job offer, requirements for, **2227**

"Modified employment" discussed, 198,1950

Return to pre-aggravation modified work, 519

Schedule change as withdrawal of offer, 1950

Skills center as modified work, 198

Case ..... Page(s)

Case ..... Page(s)

*Page Numbers in **Bold** Refer to Court Cases*

Citations to Cases in *Workers' Compensation Supplemental Reporter* (WCSR)

LARSON CITATIONS

Rule
Page(s)

ORCP 7D(1)
1500

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1607

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1943

ORCP 39
1943

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943

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353

ORCP 71B(1)
345,487,683,1091,
1211

OREGON
EVIDENCE CODE
CITATIONS

Code
Page(s)

OEC 103(1)
2206

OEC 104(1)
1984

OEC 311(1)(a)
393

OEC 401
2206

OEC 403
2206

OEC 702
2206

OEC 704
2206

* Appealed to courts (through 12/31/97)